



BEHAVIORAL BENEFIT SUMMARY GRID:

TUFTS HEALTH UNIFY (Medicare-Medicaid One Care for people ages 21 – 64)

Benefit Year: January 1, 2020 – December 31, 2020

Amended: May 19, 2020

ABBREVIATIONS

- BH: Behavioral Health
- ICT: Interdisciplinary Care Team
- IN: In-network
- MM: Medical Management Team (Tufts Health Plan)
- OON: Out of Network
- PA: Prior Authorization
- PCP: Primary Care Provider

Annual co-payment maximum per calendar year per member

Medical and BH = \$0

Pharmacy = \$0

Prior authorizations and referrals

If we require Prior Authorization, providers must contact Tufts Health Plan prior to delivery of the service.

All services rendered by OON providers require prior authorization.

PCP referrals are not required for any behavioral health service.

Please note: We do not list services that apply to children, since *Tufts Health Unify* does not cover members younger than 21.

Tufts Health Plan covers health care screenings, including preventive screenings, and prenatal and postpartum services for pregnant enrollees, as specified in Executive Office for Health and Human Services (EOHHS) guidelines or in accordance with nationally accepted standards and practices.

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
INPATIENT SERVICES					
Inpatient mental health services	Covered if medically necessary	YES <i>Starting 1st business day following admission</i>	YES	YES <i>Provider notifies THP 1st business day following admission</i>	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Inpatient substance use disorder services (Level IV)	Covered if medically necessary	YES <i>After 14 days</i>	YES	YES <i>Provider notifies THP within 2 business days of admission</i>	
Observation/Holding beds	Covered if medically necessary	YES <i>Starting 1st business day following admission</i>	YES	YES <i>Provider notifies THP 1st business day following admission</i>	Observation Services Facility Payment Policy
Administratively Necessary Days	Covered when clinically appropriate	YES	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
24-HOUR DIVERSIONARY SERVICES					
Acute Treatment Services (ATS) for Substance Use Disorders (ASAM Level 3.7)	Covered if medically necessary	YES <i>After 14 days</i>	YES	YES <i>Provider notifies THP within 2 business days of admission</i>	ATS Notification Form
Community Crisis Stabilization (CCS)	Covered if medically necessary	YES <i>After 14 days</i>	YES	YES <i>Provider notifies THP 1st business day following admission</i>	
Clinical Stabilization Services (CSS, ASAM Level 3.5)	Covered if medically necessary	YES <i>After 14 days (Notification needed after 10 days)</i>	YES	YES <i>After day 10</i> <ul style="list-style-type: none"> • <i>No Notification days 1-10</i> • <i>Provider notifies THP for days 11-14</i> 	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Dual Diagnosis Acute Residential Treatment (DDART) (ASAM Level 3.7 Enhanced)	Covered if medically necessary	YES <i>After 14 days</i>	YES	YES <i>Within 2 business days of admission</i>	
Enhanced Acute Treatment Services (EATS) for Substance Use Disorders (ASAM Level 3.7 Enhanced)	Covered if medically necessary	YES <i>After 14 days</i>	YES	YES <i>Within 2 business days of admission</i>	
Enhanced Residential Rehabilitation Services for Dually Diagnosed (ASAM Level 3.1 co-occurring enhanced)	Covered if medically necessary	YES <i>After 90 days</i>	YES	YES <i>Provider notifies THP within 7 days after admission</i>	Residential Rehab Services (Level 3.1 FAQ)
Residential Rehabilitation Services (ASAM Level 3.1)	Covered if medically necessary	YES <i>After 90 days</i>	YES	YES <i>Provider notifies THP within 7 days after admission</i>	Residential Rehab Services (Level 3.1 FAQ)

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
NON-24-HOUR DIVERSIONARY SERVICES					
Community Support Program (CSP)	Covered if medically necessary	YES <i>After 60 days or 240 units</i>	YES	NO	
Intensive Outpatient Program (IOP)	Covered if medically necessary	YES <i>(After 1st visit for substance use treatment)</i>	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Partial Hospitalization Program (PHP)	Covered if medically necessary	YES <i>(After 1st visit for substance use treatment)</i>	YES	NO	
Psychiatric Day Treatment	Covered if medically necessary	YES <i>(After 1st visit for substance use treatment)</i>	YES	NO	
Recovery Coaching	Covered if medically necessary	YES <i>After 180 days</i>	YES	YES <i>Provider notifies THP within one week of starting services</i>	FAQs: Recovery Coaching Medical Necessity guidelines: Recovery Coaching
Recovery Support Navigator	Covered if medically necessary	YES <i>After 90 days or 360 units</i>	YES	YES <i>Provider notifies THP within one week of starting services</i>	FAQs: Recovery Support Navigators
Structured Outpatient Addiction Program (SOAP)	Covered if medically necessary	YES <i>After 1st visit for substance use treatment</i>	YES	YES <i>For 1st visit</i>	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
OUTPATIENT SERVICES					
Acupuncture Detoxification Treatment	Covered if medically necessary	NO	YES	YES <i>For first visit</i>	Medical Necessity Guidelines: Acupuncture Detoxification

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Ambulatory Detoxification (Level II.d)	Covered if medically necessary	YES <i>After 1st visit</i>	YES	YES <i>For first visit</i>	Medical Necessity Guidelines: Acupuncture Detoxification
Case consultation	Covered if medically necessary	NO	YES	NO	
Collateral Contact	Covered if medically necessary	NO	YES	NO	
Couples/Family Treatment	Covered if medically necessary	YES <ul style="list-style-type: none"> • <i>PA required for visits 13+ of non-substance use treatment</i> 	YES	YES <ul style="list-style-type: none"> • <i>No PA or Notification for first 12 visits of Individual or Couples/Family Treatment</i> • <i>Notification for substance use treatment visits 13+</i> 	
Diagnostic Evaluation	Covered if medically necessary	No PA or Notification or when part of first 12 Outpatient Individual or Couples/Family treatment visits	YES	NO	
Dialectical Behavioral Therapy (DBT)	Covered if medically necessary	YES	YES	NO	
Family Consultation	Covered if medically necessary	NO	YES	NO	
Group Treatment	Covered if medically necessary	NO	YES	NO	
Individual Treatment	Covered if medically necessary	YES	YES	YES	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
		<i>PA required for visits 13+ of non-substance use treatment</i>		<ul style="list-style-type: none"> <i>No PA or Notification for first 12 visits of Individual or Couples/Family Treatment</i> <i>Notification for substance use treatment visits 13+</i> 	
Inpatient/Outpatient Bridge Visit	Covered if medically necessary	NO	YES	NO	
Medication Visit	Covered if medically necessary	NO	YES	NO	
Opioid Replacement Therapy	Covered if medically necessary	NO	YES	NO	
Program of Assertive Community Treatment (PACT)	Covered if medically necessary	YES	YES	NO	
Psychiatric Consultation on an inpatient medical unit	Covered if medically necessary	NO	YES	NO	
Psychological Testing	Covered if medically necessary	YES	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
EMERGENCY SERVICES					
Emergency Services Program (ESP)	Covered if medically necessary. Includes ESP encounter, assessment, intervention, and stabilization.	NO	NO	NO <i>ESP/hospital is required to notify THPP when a member has been admitted to a 24-hour</i>	Notification Form: Emergency Services Program



SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
				<i>facility, or is waiting for bed placement</i>	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
OTHER BEHAVIORAL HEALTH SERVICES					
Clubhouse	Covered if medically necessary	YES	YES	NO	
Electroconvulsive Therapy (ECT)	Covered if medically necessary	NO	YES	NO	
Specialing	Covered if medically necessary	YES	YES	NO	