Medical Necessity Guidelines:
Behavioral Health Enhanced Outpatient Services (EOS)

Effective: October 16, 2019

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☐ No ☒**

Applies to:
COMMERCIAL Products
☐Tufts Health Plan Commercial products; Fax: 617.972.9409
☐Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☐Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

OVERVIEW

Enhanced outpatient services are home/community-based clinical services provided for up to 5 days per week, 4 hours per day by a team of specialized licensed therapists, case managers and paraprofessional, to children who have serious emotional disturbances and their families.

Examples of EOS clinical specialists include providers with expertise in the treatment of developmental disabilities, sexual abuse, and post-traumatic stress disorder.

EOS are intended to stabilize members who are at risk of admission to inpatient or residential treatment center or are used to assist members who are transitioning from inpatient or residential treatment center back into the community.

Providers offer prompt access to this service and are able to provide varying levels of service intensity (multiple times per day and tapering to multiple times per week) to meet the unique needs of children and their families. This service may be used to assist a child transitioning from an inpatient stay or to prevent an admission.

Minimum program requirements include:
- Home/community based clinical services provided to meet the Member's clinical needs. It is recommended that services are provided for up to 5 days per week.
- Services are provided to the Member based on the Member's need. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

CLINICAL COVERAGE CRITERIA

Admission Coverage Criteria
All the following criteria must be met:
1. Member has a current DSM or corresponding ICD-CM diagnosis
2. Member is presenting with moderate to severe behavioral health symptoms and serious impairment is evident in multiple settings (i.e., family, social, school).

3. There is disruption in behavior or functional status and the Member requires more than office-based outpatient behavioral health treatment services.
4. There is an expectation for improvement with these EOS services.
5. Member currently does not have any other therapeutic behavioral health home-based treatment service in place. Other support services may continue with the expectation that care be coordinated (e.g., Kids Connect, PASS or Respite)
6. Treatment will occur in a safe and stable home residence (excluding residential treatment facilities).
7. Parent or guardian agrees to work with the EOS provider and actively participate in the jointly developed treatment plan.
8. At least **ONE** of the following:
    a. Member discharged from a higher LOC (e.g., inpatient, ARTS, PHP, IOP or day treatment) in the past 30 days;
    b. Member had a recent admission (within 6 months) to a higher LOC.
    c. Member evaluated by licensed child clinician and determined to need diversionary service to avoid a more restrictive LOC;
    d. An EOS intervention was successful prior to the current crisis (in the past 30 days) and EOS involvement is likely to stabilize the family.

Continuation Coverage Criteria:
Members must meet **all** the following:
1. Member continues to meet admission criteria and another LOC, either higher (e.g., ARTS, PHP, day treatment, or IOP) or lower is not appropriate.
2. A treatment plan has been updated which addresses severity, current condition, and ongoing progress towards goals.
3. Clinical services are provided at a minimum of **three (3)** face-to-face clinical hours weekly.
4. Member progress is reviewed at least weekly, and the treatment plan modified, with interventions necessary to address targeted behaviors and goals for discharge.
5. Medication assessment has been completed when appropriate; medication trials have been considered, started or ruled out.
6. Parent or guardian continues to actively participate in, and are present for treatment as clinically required and appropriate; or engagement efforts are underway.
7. Coordination of care and active discharge planning are occurring with a goal of transitioning the Member to a less intensive treatment setting.
8. Member continues to not have any other therapeutic behavioral health home-based treatment service in place. Nontherapeutic support services (e.g., Kids Connect, PASS or respite) may continue with the expectation of care coordination.

Discharge Coverage Criteria
Any one of the following criteria will result in suspension of service coverage:
1. Member no longer meets admission criteria and another LOC, either higher (e.g., ARTS, PHP, day treatment, or IOP) or lower is more appropriate.
2. Member's individual treatment plan and goals have been met.
3. Member has reached their optimal level of functioning based on their cognitive, psychological and social limitations.
4. Member, parent, or guardian withdraws consent for treatment.
5. Member and parent/guardian do not appear to be actively participating in the treatment plan.
6. Member is not making progress toward the treatment goals, nor is there expectation of any progress.
7. Member is clinically appropriate to attend routine outpatient treatment in an office or community based treatment setting.

LIMITATIONS

Exclusions
Any of the following criteria are sufficient for exclusion from this level of care:
1. The Member is no long eligible for Medicaid or is covered by Substitute Care.
2. The Member requires a level of structure and supervision beyond the scope of EOS.
3. The Member has medical conditions or impairments that would prevent beneficial utilization of services.

In some instances, the following criteria may also apply:

- EOS is not intended to serve as emergency care and referrals do not provide immediate access. EOS may not be provided when child and adolescent intensive treatment services (CAITS), child and family intensive treatment (CFIT) or HBTS are being used[1].

CODES

The following codes require notification and a continued stay authorization.

Table 1: ICD-10 Codes

CPT/HCPCS Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90832	Psychotherapy, 30 minutes with patient or family Member
90834	Psychotherapy, 45 minutes with patient or family Member
90837	Psychotherapy, 60 minutes with patient or family Member
90846	Family Psychotherapy (without patient present)
90847	Family Psychotherapy (with patient present)
90849	Multiple-family group psychotherapy
H0046	Behavioral health services, not otherwise specified, 15 minutes
H0004	Behavioral health counseling and therapy per 15 minutes
H0031	Behavioral health assessment, by nonphysician
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes

REFERENCES

1. State of Rhode Island, General Laws. (2014). Title 40.1: Chapter 5.45, Division of Mental Health.
2. Contract between State of Rhode Island and Providence Plantations EOHHS and Tufts Health Public Plans, Inc., for Medicaid Managed Care Services, March 1, 2017, Attachment O: Mental Health, Substance Use and Developmental Disabilities Services for Children.

APPROVAL HISTORY

February 8, 2017: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC) for effective date of August 1, 2017.

Subsequent endorsement date(s) and changes made:

- May 10, 2017: Reviewed and approved by IMPAC, based on RI Medicaid recommended edits.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

[1] State of Rhode Island, EOHHS Certification Standards Providers of Home Based Therapeutic Services (inclusive of ABA), January 1, 2016, page 12.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.