Medical Necessity Guidelines:
Behavioral Health – Outpatient Treatment Level of Care

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

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

The purpose of this guideline is to outline the level of care criteria, including the admission, exclusion, continued stay and discharge criteria for the outpatient treatment level of care.

In-network providers, to initiate an authorization request beyond the initial 12 visits, please complete the Tufts Health Plan Behavioral Health Outpatient Psychotherapy Authorization Form and fax to the number above.

Out-of-network providers, to initiate an authorization request for any outpatient services, please complete the Tufts Health Plan Out-of-Network Outpatient Prior Authorization Request Form and fax to the number above.

CLINICAL COVERAGE CRITERIA

Behavioral Health Outpatient Treatment Level of Care Criteria

Admission Criteria

To receive outpatient care, Tufts Health Plan Enrollees require the following:

- Demonstrate symptoms consistent with a primary DSM-V diagnosis (Axis I or II)
- Be motivated, engaged, agree to comply with treatment plans, and have a system in place to ensure follow through with the treatment plan, or if absent, the focus of treatment is on developing them
- Maintain a current level of functioning through outpatient treatment (if the appropriate level of care)
- Have been discharged or are in transition from a more-intensive level of care and are able to benefit from outpatient services
- Have impaired level of functioning in areas such as self-care, work, family living, and social relations, and outpatient care will help increase level of functioning

- Experience increased intensity or symptom duration with a diagnosis of mental illness and/or substance abuse

Continued-Stay Criteria
Enrollees to continue at this level of care, they must:
- Continue to benefit from the treatment
- Make progress toward identified goals
- Receive treatment in a structured and goal-directed manner

Practitioners must:
- Assess that the Enrollee will have decreased functioning if discharged from this level of care
- Make sure that the Enrollee receives different treatment(s) if symptoms change, or if they make or fail to make progress
- Have strategies in place to address any possible treatment plan changes

Discharge Criteria
Enrollees may be discharged from outpatient care if they:
- No longer meet admission criteria and/or meet criteria for a different level of care (higher or lower)
- Have achieved treatment goals
- Does not appear to be participating in the treatment plan, or not making progress towards goals, with little to no expectation of any progress

LIMITATIONS

Enrollees who have any of the following are excluded from the admission criteria above:
- An organic mental disorder (e.g., delirium, dementia, amnesia, and other cognitive disorders);
- Mental disorder due to a primary medical condition, except when accompanied by a DSM-V diagnosis treatable at this level of care and the focus of the intervention.

CODES

The following CPT codes do not require prior authorization when provided by an in-network provider, authorization is required when provided by a non-contracting provider:

CPT Code	Description
90792	Psychiatric diagnostic evaluation
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (add on code)
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (add on code)
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (add on code)
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90853	Group Psychotherapy
99211	Established patient, office or outpatient visit, 5 minutes are spent (with add-on code)
99212	Established patient, office or outpatient visit, 10 minutes are spent (with add-on code)
99213	Established patient, office or outpatient visit, low complexity (with add-on code)
99214	Established patient, office or outpatient visit, moderate complexity (with add-on code)
99215	Established patient, office or outpatient visit, high complexity (with add-on code)

The following CPT code(s) require prior authorization when provided by a non-contracting provider and after the initial 12 visits per benefit year when provided by an in-network provider:

Procedure Codes for All Clinicians

CPT Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90832	Psychotherapy, 30 minutes with patient or family Member

CPT Code	Description
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

REFERENCES

1. MassHealth Contract, 2016
2. Commonwealth Care Contract, 2012
3. Medical Security Plan Contract, 2012

APPROVAL HISTORY

- January 17, 2010: Document reviewed and endorsed by behavioral health practitioners
- February 12, 2010: Document formatted and history added
- January 28, 2011: Utilization Management Committee annual review
- December 16, 2011: Executive Policy Review and Update by UMC Chair and Network Health President, limited to Policy, scope update to include new coverage product (MSP)
- February 17, 2012: Utilization Management Committee annual review
- November 2, 2012: Utilization Management Committee annual review
- February 20, 2013: Utilization Management Committee review, "Network Health Choice" added to S*cope*
- October 10, 2014: Utilization Management Committee annual review, *Purpose* added
- November 8, 2013: Updated to include CarePlus product line
- August 20, 2014: Utilization Management Review Committee annual review, no changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed and approved by the Integrated Medical Policy Advisory Committee with no changes.
- November 9, 2016: Reviewed and approved by the Integrated Medical Policy Advisory Committee with the following changes. Admission criteria of motivation was amended so that if motivation is not present, criterion is still met if developing engagement is the focus of treatment. Reference section updated to the most recent MassHealth contract (2016).
- February 8, 2017: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 3, 2017: Reviewed and approved without changes by the Behavioral Health Practitioner Advisory Committee.
- November 8, 2017: Reviewed and approved by the Integrated Medical Policy Advisory Committee.
- 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.

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.