Medical Necessity Guidelines: Behavioral Health Level of Care for Non-24 Hour/Intermediate/Diversionary Services

Effective: January 1, 2021

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: 857.304.6304
*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 or providing notification, as a condition of payment you will need to make sure that prior authorization has been obtained or notification has been provided.

Tufts Health Plan requires notification for all inpatient admissions and certain inpatient and intermediate behavioral health services. In addition, facilities may be required to provide updated clinical information for authorization of continued stays**. This document applies to notification and the authorization of continued stays via medical necessity review**.

Admitting providers and facilities are responsible for notifying Tufts Health Plan and/or obtaining continued stay authorization as appropriate. Please see additional documentation including Provider Manuals and payment policies are available in the Provider Resource Center on the Tufts Health Plan web site:

- Tufts Health Commercial Products-Tufts Health Plan Commercial Provider Manual
- Tufts Health Plan Direct, Tufts Health Together and Tufts Heal Unify-Tufts Health Public Plans Provider Manual
- Tufts Health RITogether-Tufts Health Public Plans Provider Manual

Behavioral Health Intermediate (inclusive of Non 24-Hour and Diversionary Services) Level of Care:
Tufts Health Plan uses InterQual® criteria for determining medical necessity for behavioral health levels of care post notification. Please see below for specific details:

1. Tufts Health Plan uses InterQual® criteria for the following services:
    - Partial Hospitalization Services (PHP)
    - Intensive Outpatient Services (IOP)
    - Psychiatric Day Treatment
    - Structured Outpatient Addition Program (SOAP)

2. Tufts Health Plan uses ASAM (American Society of Addiction Medicine) criteria for determining medical necessity for the following services for **RITogether**:

- Intensive Outpatient Services (IOP)-(ASAM Level 2.1)
- Partial Hospitalization Services (PHP)-(ASAM Level 2.5)

InterQual Criteria are nationally recognized medical necessity behavioral health criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

ASAM Criteria are nationally recognized treatment criteria for addictive, substance-related and dual diagnosis conditions that support decisions regarding available treatment or service options. Refer to *An Introduction to the ASAM Criteria for Patients and Families* for additional description.

APPROVAL HISTORY

December 16, 2020: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), newly created guideline, effective January 1, 2021. Intermediate and outpatient services removed from BH LOC Determinations Medical Necessity Guideline (MNG) and added to this document.

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.

Provider Services