Medical Necessity Guidelines: Custodial Care: Limitation of Inpatient Behavioral Health Treatment Benefits

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

Services that Tufts Health Plan defines as custodial care will not be covered if the Member's inpatient or intermediate (partial hospital, acute residential treatment, intensive outpatient treatment) behavioral health level of care is provided primarily for any of the following:

- For maintaining the Member's or anyone else's safety when there is no reasonable expectation that continued acute care will result in further stabilization
- For the maintenance and monitoring of an established treatment program, when no other aspects of treatment requires an acute hospital or intermediate level of care
- Care provided for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance with mobility, dressing, bathing, eating, preparation of special diets, and taking medication
- Care on a unit while awaiting transition to a clinically appropriate alternative level of care (e.g. long-term residential facility, long term nursing facility or services that are not a covered benefit)
- Care, administered by medically trained personnel, to which the Member shows no beneficial response despite extended and/or repeated treatment trials
- Incomplete or inadequate care which results from a Member's refusal of recommended treatment(s)

APPROVAL HISTORY

September 1, 1993: Original Effective Date

Subsequent Endorsement Dates and Changes Made:

- January 8, 2007: Reviewed and renewed with no changes
- December 4, 2008: Review and renewed with revision
- June 9, 2009: Reviewed and renewed with no changes
- July 28, 2010: Reviewed and renewed with revised format, removed procedure section and Chronic Risk Pool reference, removed Tufts HP Medicare Preferred reference.

- September 21, 2011: Reviewed and renewed with revision. Removed "Designating an illness as "chronic" does not relieve Tufts Health Plan or its contracting providers of coverage responsibility."
- September 20, 2012: Reviewed and renewed with no changes
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Removed "alcohol and drug abuse" and added "substance use disorders", removed "Limitations"; changed "abuse" to "use".
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Removed the fax number from the Type of Review box
- March 16, 2015: Added fax number back into "Applies to" Section.
- 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.
- October 27, 2015: Reviewed and Approved by the Mental Health Operations and Policy Committee with changes from: Clinical Documentation and Prior Authorization are required to Clinical Documentation and/or Prior Authorization required.
- December 3, 2015: Reviewed by the Behavioral Health Practitioner Advisory Committee with no changes recommended.
- December 9, 2015: Reviewed and Approved by the Integrated Medical Policy Advisory Committee, with no changes.
- July 26, 2016: Reviewed and approved by the Behavioral Health Operations and Policy Committee with the following changes. Document title and Overview section – substituted Behavioral for "Mental" health and added the word "disorder after Substance use to reflect current terminology.
- December 14, 2016: Reviewed and Approved by the Integrated Medical Policy Advisory Committee, with no changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 8, 2017: Reviewed by Behavioral Health Operations and Policy Committee with the following changes: added, "when there is no reasonable expectation that continued acute care will result in further stabilization" to first bullet point in the overview section; added ", long term nursing facility or services that are not a covered benefit" to fourth bullet.
- November 3, 2107: Reviewed and accepted without change by Behavioral Health Practitioner Advisory Committee.
- November 8, 2017: Reviewed and accepted without change by 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.