Medical Necessity Guidelines: Family Stabilization Treatment (FST) Criteria for Behavioral Health Services

Effective September 21, 2022

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
- 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

OVERVIEW

Tufts Health Plan defines family stabilization treatment (FST) as a short term, intensive and flexible service that assists with the stabilization of children and adolescents in their home environment during an acute psychiatric crisis. It is a structured treatment modality that is designed to work with all Members of a family, not just the identified child/adolescent at risk. FST services can be used as an independent level of care or as an adjunct to other levels of care. FST services are designed to prevent repeated hospitalizations and/or out of home placement by providing intensive in home services and arranging successful linkages for the family with outpatient providers.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan will cover FST when the Member's clinical condition meets all of the following guidelines:

- The Member has a diagnosed psychiatric or substance-related disorder consistent with the most recent Diagnostic and Statistical Manual™ (DSM) or with the most recent International Classification of Diseases (ICD)
- The Member is at high risk for hospitalization or out of home placement
- The home environment and primary support system are important components to stabilization and management of the presenting problem.
- FST services are required for reasons other than convenience
- The identified Member is a child/adolescent under the age of nineteen (19)

LIMITATIONS

Tufts Health Plan will not cover FST under the following circumstances:

- The Member's benefit plan does not permit Individual Care Management (ICM).
- The Member is assessed to be at risk for harming self or others, and/or has a significant mental illness that requires a more intensive level of care.
- The Member and/or family have not made progress towards treatment goals, or the treatment interventions available have been exhausted and there is no reasonable expectation of progress at this level of care.

- The Member's home environment presents a safety risk to the family stabilization clinician(s).
- The Member and the Member's family and/or legal guardian do not agree to be involved with the FST treatment plan.
- The Member can be safely and effectively treated at a less intensive level of care.

CODES

Procedure Codes for (FST) Program

Procedure Code	Description
99510	Mental Health Family Stabilization (FST) per day

APPROVAL HISTORY

May 1, 2008: Original Effective Date

Subsequent Endorsement Date(s) and Changes Made:

- July 28, 2010: Reviewed and renewed with new format and no additional changes.
- September 28, 2011: Reviewed and renewed with changes; removed the FST program description; added to Coverage Criteria "the Member is a child/adolescent under the age of 19", moved "the member can be safely and effectively treated at a less intensive level of care" to Limitations. Replace "DSM-IV" with "the most recent Diagnostic and Statistical Manual (DSM)"; remove MH-M13, add DMS ID#2171713
- September 20, 2012 reviewed and renewed with changes: Removed "treat" and added "work with" to: "It is a structured treatment modality that is designed to work with all Members of a family", added "legal" guardian.
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Changed "Intensive" Case Management to "Individual" Case Management
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: remove fax number from 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 13, 2015: Reviewed and approved by the Mental Health Operations & Policy committee with the following changes: Added under coverage guidelines first bullet – "or with the most recent International Classification of Diseases (ICD), under coverage guidelines after "and" added family stabilization is the most appropriate level of care.
- 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 Behavioral Health Operations and Policy Committee with the following changes: Substituted Behavioral for Mental Health to update per current terminology and changed Substance Abuse to Substance Use Disorder. Added the home environment and primary support system are important components to stabilization and management of the presenting problem under coverage guidelines and removed, "the condition or disorder requires treatment and family stabilization is the most appropriate level of care" from the coverage guidelines. Added the word "care" for clarification at the end of the third bullet in the limitations section.
- October 27, 2016: Reviewed by the Behavioral Health Practitioner Advisory Committee with no changes recommended.
- November 9, 2016: Reviewed and Approved by the Integrated Medical Policy Advisory Committee with the following change. Tufts Health Direct was checked off as in scope for this guideline.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 12. 2017: Reviewed by BH Operations and Policy Committee with the following changes: Under Coverage Guidelines section, created a separate bullet for words "The home environment and primary support system are important components to stabilization and management of the presenting problem", which was already included in document; Under

Limitations sections, Added, "Tufts Health Plan will not cover FST under the following circumstances:".
- November 3, 2017: Reviewed by the Behavioral Health Practitioner Advisory Committee and approved with no changes.
- November 8, 2017: Reviewed and approved without changes 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
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- April 6, 2022: Template updated
- February 16, 2022: Reviewed by MPAC, Removal of PA from Guideline for effective date of 07/1/2022
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), 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.