Medical Necessity Guidelines:
Behavioral Health Inpatient Level of Care Determinations

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

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 including behavioral health inpatient services. In addition, facilities may be required to provide updated clinical information for authorization of continued stays ("concurrent review"). **This medical necessity guideline applies to the authorization of continued stays, following notification.**

Admitting providers and facilities are responsible for notifying Tufts Health Plan and/or obtaining continued stay authorization as appropriate. 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 Inpatient (inclusive of Mental Health and Substance Use Disorder) Levels of Care
Tufts Health Plan uses InterQual® and American Society of Addictive Medicine (ASAM) criteria for determining medical necessity for behavioral health levels of care. Please see below for specific details:

1. Tufts Health Plan uses InterQual criteria for determining continued stay post notification for:
   - Acute inpatient services
     - Tufts Health Plan provides coverage for special resources or accommodations if a member's immediate care requires adjustments to a facility's usual staffing needs. For Massachusetts plans, Tufts Health Plan will approve coverage in accordance with accepted practice and/or federal and state standards.
   - Acute residential services/24-hour diversionary services
   - All Substance Use Disorder (SUD)-Specific inpatient levels of care unless otherwise specified

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

    - RITogether: **All SUD-specific levels of care** (ASAM Level 4 and Levels 3.1-3.7)
    - Together/Unify/SCO: **Residential Rehabilitation Services** (ASAM level 3.1)

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.

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.

REFERENCE

Commonwealth of Massachusetts. Massachusetts Bulletin 2018-01: Prevention of emergency room boarding of patients with acute behavioral and/or substance abuse disorder emergencies. mass.gov/files/documents/2018/01/08/BULLETIN%202018-01%20%28Emergency%20Department%20Boarding%29.pdf. Last accessed December 9, 2020.

APPROVAL HISTORY

- October 27, 2016: Reviewed by the Behavioral Health Practitioner Advisory Committee with one recommended change: replaced "mental health" and "substance use disorder" with "behavioral health" throughout.
- December 14, 2016: Reviewed and approved without changes by the Integrated Medical Policy Advisory Committee (IMPAC).
- February 8, 2017: Reviewed by IMPAC: added Rhode Island RITogether for effective date of August 1, 2017
- 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 with no changes by the Behavioral Health Practitioner Advisory Committee
- November 8, 2017: Reviewed by IMPAC. VNA Home Care Services for Behavioral Health using InterQual added with an effective date of April 1, 2018.
- May 9, 2018: Reviewed by IMPAC. Addition of text reference "specialing" to MA Bulletin 2018-01 and reference to applicable payment policy and Provider Manual
- September 12, 2018: Reviewed by IMPAC. Addition of residential rehabilitation level of care services required by MA EOHHS as contract requirement effective January 1, 2019.
- 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 updated
- December 16, 2020: Reviewed by IMPAC with following changes approved. Effective January 1, 2021, revised title to include the term "Inpatient". Removed all outpatient services to allow Medical Necessity Guideline (MNG) to represent Inpatient only level of care services. Intermediate services were moved to newly created MNG titled Medical Necessity Guidelines: Behavioral Health Level of Care for Non-24 Hour/Intermediate/Diversionary Services.
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- 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.