

Medical Necessity Guidelines: Behavioral Health Level of Care Determinations

Effective: October 16, 2019

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</p> <p>TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> 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.</p> <p>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</p>	

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 certain behavioral health services. Facilities may also be required to provide updated clinical information for authorization of continued inpatient stays. Please consult the [Tufts Health Plan Commercial Provider Manual](#) or the [Tufts Health Public Plans Provider Manual](#) for MassHealth or the [Tufts Health Public Plans Provider Manual](#) for RITogether for prior authorization, notification and clinical documentation submission requirements. Information on authorization and notification requirements is also available in the payment policies for the services listed below; these policies are available in the Provider Resource Center on the Tufts Health Plan web site.

Behavioral Health/Substance Use Disorder Levels of Care

Coverage for behavioral health is for medically-necessary treatment only. Tufts Health Plan uses the following criteria for determining medical necessity for behavioral health and substance use disorder (SUD) levels of care:

- Tufts Health Plan uses McKesson InterQual[®] criteria for determining medical necessity for the following levels of care for behavioral health and SUD*:
 - Acute inpatient services (**Note:** for this service, notification only is required)**
 - Acute residential services (**Note:** for this service, notification only is required)
 - Partial hospitalization services
 - Intensive outpatient services
 - VNA home care services for behavioral health

*For Tufts Health RITogether, Tufts Health Plan uses American Society of Addiction Medicine (ASAM) for determining medical necessity for SUD levels of care
- Tufts Health Plan also uses ASAM criteria to review Residential Rehabilitation Services (ASAM level 3.1) for Massachusetts Together and Unify.

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.

**For Tufts Health Plan Commercial plans in Massachusetts, Tufts Health Plan will approve coverage and payment for an additional service for “specials” in accordance with Massachusetts Bulletin 2018-01¹ when approved on a case by case basis. Refer to the [Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy](#).

- Tufts Health Plan uses internally developed criteria for outpatient and other levels of care:
 - For Tufts Health RITogether, consult the level of care criteria details on the [Provider Tool for Requesting Behavioral Health Service Authorizations](#).
 - For Tufts Health Plan Commercial plans, also consult [Custodial Care: Limitation of Inpatient Behavioral Health and Substance Use Treatment Benefits](#) for additional benefit limitations.

REFERENCE

1. 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](https://www.mass.gov/files/documents/2018/01/08/BULLETIN%202018-01%20%28Emergency%20Department%20Boarding%29.pdf). Last accessed March 29, 2018.

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

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](#)