Medical Necessity Guidelines:
Nutrition Extension for Eating Disorders

Effective: October 10, 2018

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

Tufts Health Plan may grant an extension of outpatient nutrition visits beyond the stated policy limits in cases of severe and continuing eating disorders. For self-insured plans requests for extensions can only be considered for Members who participate in a plan with Individual Case Management (ICM) language. For a fully-insured plan, Member's PCP makes referrals for nutritional counseling.

CLINICAL COVERAGE CRITERIA

Determinations to grant such extensions of coverage will be made when the Member's condition meets the following guidelines:

- The Member meets Diagnostic and Statistical Manual of Mental Disorders™ (DSM) criteria for an eating disorder
- The Member continues to either:
  - Be unable to maintain adequate body weight
  - Show eating disorder symptoms

In addition the provider must provide clinical information that supports all of the following:
- There is likelihood that the Member will benefit from these services
- Measurable goals have been established for this treatment
- There is a plan for coordination of care with other health care providers

LIMITATIONS

For all products, initial nutritional counseling services must have been performed by a registered nutritionist and authorized by the Member's PCP. For self-insured plans that do not have the Individual Care Management benefit feature, nutritional counseling is limited to the defined benefit and may not be extended.

CODES

The following codes require prior authorization:

Code	Description
97802	Medical nutrition therapy, initial assessment and intervention. 15 minutes = 1 unit. Maximum 75 minutes (5 units) allowed
97803	Medical nutrition therapy, re-assessment and intervention. 15 minutes = 1 unit. Maximum 60 minutes (4 units) allowed

APPROVAL HISTORY

- July 9, 2003: Original Effective Date
- January 8, 2007: Reviewed and renewed with no changes
- December 4, 2008: Reviewed and renewed with no changes
- February 3, 2009: Reviewed and renewed with no changes
- July 28, 2010: Reviewed and renewed with new format and no additional changes
- September 21, 2011: Reviewed and renewed with changes: Delete "Nutritional counseling services must be performed by an in network registered nutritionist…" and add "Initial nutritional counseling services must be performed by a registered nutritionist and authorized by the Member's PCP." Delete MH-6, add web DMS ID# 2171714
- September 20, 2012 Reviewed and approved by the Mental Health Operations and Policy Committee with no changes
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: changed "independent" Case Management to Individual Case Management, added "most recent" DSM, added must "have been" performed.
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes:
- Removed fax number from Type of Review box; replaced "criteria" in Coverage section with "guidelines"
- 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 and Policy Committee with changes: Overview – Capitalized Self-Insured. Limitations - after PCP added "when the plan requires."
- December 3, 2015: Reviewed with no changes recommended by the Behavioral Health Practitioner Advisory Committee.
- December 9, 2015: Reviewed and approved by 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: Overview – clarified eligibility and referral source for same for self-insured plans and fully insured plans; coverage guidelines – changed wording under second bullet, second point to "show eating disorder symptoms"; limitations – added "for all products" at the beginning of the sentence.
- October 27, 2016: Reviewed and approved with no changes by the Behavioral Health Practitioner Advisory Committee.
- November 9, 2016: Reviewed and approved by Integrated Medical Policy Advisory Committee with the following change. Under Limitations explanation was added that for self-insured plans that have not selected ICM, nutritional counseling is limited to the defined benefit and may not be extended.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- June 20, 2017: Reviewed and approved by Behavioral Health Operations and Policy Committee with the following change – added "all of" under coverage guidelines.
- October 11, 2017: Reviewed and approved with no changes by the Integrated Medical Policy Advisory Committee
- November 8, 2017: Reviewed and approved with no changes by the Behavioral Health Practitioner Advisory Committee
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes

- October, 2018: Template and disclaimer updated

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.