Medical Necessity Guidelines: Outpatient Out of Plan Continuity of Care Coverage for Behavioral Health

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

Continuity of Care allows a new Member to Tufts Health Plan to continue to see a licensed out- of -network provider for a limited number of visits. All Tufts Health Plan Members whose benefit plan does not include out of network coverage, are required to receive treatment from in-network providers. Members whose benefit plan includes coverage for non-contracted providers, have the option of using out-of-network providers at the unauthorized or out-of-network level of benefits (subject to their applicable deductible, co-payment and/or coinsurance). New Members may receive a limited number of visits at the in-network level of benefit.

CLINICAL COVERAGE CRITERIA

When a new Member enrolls in Tufts Health Plan, if none of the health plans offered by their employer group at the time of enrollment include their provider, the Member may continue to see their provider for a limited number of visits, from the date of enrollment, under the following circumstances:

- The Member is undergoing a course of treatment with the out-of- network provider
- The Member has had a least one visit with the provider in the three months prior to joining Tufts Health Plan
- The Member or provider requested an authorization within 90 days of the policy effective date

LIMITATIONS

- The services provided by the out- of- network provider must be covered services.

CODES

Procedure Codes for All Clinicians

Procedure Code	Description
90791[1]	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)
90832	Psychotherapy, 30 minutes with patient or family Member
90834	Psychotherapy, 45 minutes with patient or family Member
90837	Psychotherapy, 60 minutes with patient or family Member
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family Psychotherapy (without patient present)
90847	Family Psychotherapy (with patient present)
90853	Group Psychotherapy

Additional Codes for *Prescribing* Clinicians (psychiatrists and prescribing nurse clinical specialists only)

Procedure Code	Description
99201	New patient, office or outpatient visit, problem focused
99202	New patient, office or outpatient visit, expanded problem-focused
99203	New patient, office or outpatient visit, low complexity
99204	New patient, office or outpatient visit, moderate complexity
99205	New patient, office or outpatient visit, high complexity
99211	Established patient, office or outpatient visit, 5 minutes are spent
99212	Established patient, office or outpatient visit, 10 minutes are spent
99213	Established patient, office or outpatient visit, low complexity
99214	Established patient, office or outpatient visit, moderate complexity
99215	Established patient, office or outpatient visit, high complexity
90792[1]	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient or family Member with an evaluation & management services
90836	Psychotherapy, 45 minutes with patient or family Member with an evaluation & management services
90838	Psychotherapy, 60 minutes with patient or family Member with an evaluation & management services

APPROVAL HISTORY

July 28, 2010: Original Effective Date

Subsequent Endorsement Dates and Changes Made:

- September 28, 2011: Reviewed and renewed with changes: Changed HMO, EPO and CPPO to "members whose benefit plan does not includes coverage for non contracted providers" and POS or PPO to "members who's benefit plan includes coverage for non contracted providers"; remove MH-M14, add DMS ID# 2171715
- September 20, 2012 Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Added "Licensed" out of network provider
- January 1, 2013: Reviewed, added new 2013 CPT codes, deleted end dated 2012 CPT codes
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: added for "a limited number of visits"
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: remove fax number from Type of Review box.

[1] Billing is limited to **two** 90791 or 90792 procedure codes per provider, per Member, per calendar year.

- 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. No changes
- 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.
- September 27, 2016: Reviewed and approved by the Behavioral Health Operations and Policy Committee with changes: Substituted Behavioral Health for Mental health and Substance Use Disorder to reflect current terminology.
- November 9, 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
- June 27, 2017: Reviewed and Approved by the Behavioral Health Operations and Policy Committee with no changes.
- October 11, 2017: Reviewed and approved with no changes by the Integrated Medical Policy Advisory Committee.
- November 3, 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.