

## Medical Necessity Guidelines: Rhode Island Substance Use Community Residence Services

Effective: October 16, 2019

<b>Prior Authorization Required</b>	<b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
<p><b>Applies to:</b>  <b>COMMERCIAL Products</b>  <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409  <input type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409  <ul style="list-style-type: none"> <li>CareLink<sup>SM</sup> – Refer to <a href="#">CareLink Procedures, Services and Items Requiring Prior Authorization</a></li> </ul> <b>TUFTS HEALTH PUBLIC PLANS Products</b>  <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055  <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055  <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404  <input 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><b>SENIOR Products</b>  <ul style="list-style-type: none"> <li>Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the <a href="#">Tufts Health Plan SCO Prior Authorization List</a></li> <li>Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the <a href="#">Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</a></li> </ul> </p>	

**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. **This level of service only applies to members with Rhode Island products.**

### OVERVIEW

Tufts Health Plan defines Substance Use Community Residence Services as services offered on a 24 hour basis in a facility that provides treatment and rehabilitation for individuals diagnosed with substance use disorders. Substance use Community Residential Care Services are provided by trained substance use staff at a licensed facility. Clinical services are flexible and designed to meet the individual needs of the Member. Treatment planning continues to be modified to address the Member's current symptoms. Community services and after-care supports may be utilized as necessary.

### CLINICAL COVERAGE CRITERIA

All of the following guidelines must be met for Substance Use Community Residence Services to be authorized:

- The Member has a substance-related diagnosis consistent with the most recent edition of the Diagnostic and Statistical Manual™ (DSM).
- The disorder requires treatment and Substance Use Community Residence Services is the most appropriate level of care.

### LIMITATIONS

- The service is not a covered service in the Member's benefit document.
- Tobacco and caffeine are excluded from the definition of "substance."
- The Member is at risk for harming self or others and requires a more intensive level of care.
- The Member has not made progress towards treatment goals, or available treatment interventions have been exhausted and there is no reasonable expectation of progress at this level of care.
- The Member has an unstable co-occurring medical or psychiatric condition.
- Community Residence Services for a diagnosis other than substance use disorders is not covered.

## LIMITATIONS

The following code requires prior authorization:

Code	Description
H2036	Alcohol and/or other drug treatment program, per diem

## APPROVAL HISTORY

January 1, 2009: Original effective date

Subsequent endorsement date(s) and changes made:

- June 10, 2011: Reviewed and renewed with no changes
- September 28, 2011: Reviewed and renewed with changes: Removed "assessed to be" and "has a significant mental illness" from the limitation statement that references risk for harm to self or others; Removed Continuing Stay Criteria and Discharge Criteria from the MNG.
- September 20, 2012: Reviewed and renewed with changes: changed "Residential Care" to "Residence Services."
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: changed "abuse" to "use."
- 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 and Policy Committee with changes: add "Substance Use Community Residence Services is the most appropriate level of care." To the second bullet of the Coverage Guidelines section.
- December 3, 2015: Reviewed by the Behavioral Health Practitioner Advisory Committee with no changes recommended.
- December 14, 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
- September 12, 2017: Reviewed by BH Operations and Policy Committee with no edits.
- November 3, 2017: Reviewed and approved with no changes by Behavioral Health Practitioner Advisory Committee.
- November 8, 2017: Reviewed and approved with no changes by 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
- March 7, 2019: Administrative update
- 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](#)