Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Intensive Hospital Diversion (IHD)**

Effective: November 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☒ No ☐

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

The provider must submit notification to the plan within one week of initiation of services. Concurrent review for medical necessity is required for services that continue following the initial 30-day period.

Intensive Hospital Diversion (IHD) is a specialized service of In-Home Therapy (IHT). The Intensive Hospital Diversion Program will provide intensive short-term, in-home crisis stabilization and treatment to youth and their families to support diversion from psychiatric hospitalization and other out-of-home placements.

The clinical goal of this program is to provide youth under 21 and their parents/caregivers with the intensive short-term treatment and support needed to maintain the youth at home safely and to (re)connect them to ongoing outpatient and/or community-based services.

Clinical Guideline Coverage Criteria

The Plan considers Intensive Hospital Diversion (IHD) Services as reasonable and medically necessary when **ALL** of the following are met:

1. The member must meet current Medical Necessity Criteria for IHT and have additional acute needs that cannot be met by IHT, as defined by the following:
    a. Member is in acute crisis and at imminent risk of 24-hour level of care and has been evaluated by a

Mobile Crisis Intervention (MCI) team or an ED clinician; **and**

b. MCI or other crisis evaluation indicates the need for more intensive treatment than In-Home Therapy and Mobile Crisis Intervention together, and member can safely be maintained in the community with Intensive Hospital Diversion in place as agreed upon by family and crisis clinician.

The Plan considers discharge from IHD services as reasonable and medically necessary when **ONE** of the following is met:

1. The youth no longer meets admission criteria for this level of care; **or**
2. or meets criteria for a less or more intensive level of care; **or**
3. The treatment plan goals, and objectives have been substantially; **or**
4. met and continued services are not necessary to prevent worsening; **or**
5. of the youth's behavioral health condition; **or**
6. The youth is no longer living in a home setting.

Limitations

The Plan will not cover Intensive Hospital Diversion services for **ANY** of the following:

1. The Member is concurrently receiving In-home therapy or other intensive home-based service, including those provided by other state agencies; **or**
2. The Member has reached their 21st birthday.

Codes

The following code(s) are associate with this service:

Table 1: CPT/HCPCS Codes

Code	Description
H2022-HE	Community-based wrap-around services, per diem

References:

1. Executive Office of Health and Human Services, State contracted requirement for Intensive Hospital Diversion Program effective January 1, 2022.
2. Massachusetts Executive Office of Health and Human Services. Managed Care Entity Bulletin 83: Intensive Hospital Diversion Program. Commonwealth of Massachusetts; 2022, Accessed October 10, 2024 at https://www.mass.gov/doc/managed-care-entity-bulletin-83-provides-rate-increase-guidance-to-specific-mces-for-covid-19-positive-members-covering-behavioral-health-services-and-to-temporarily-suspend-concurrent-review-for-ccs-services-0/download.

Approval And Revision History

March 16, 2022: Reviewed by the Medical Policy Approval Committee (MPAC), approval of new guideline with effective date of January 1, 2022.

Subsequent endorsement date(s) and changes:

- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- August 16, 2023: Reviewed by MPAC, renewed without changes, template updated effective November 1, 2023
- November 2023: Unify name changed to One Care effective January 1, 2024
- September 19, 2024: Reviewed by MPAC, renewed without changes, effective November 1, 2024

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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.