Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Behavioral Health Inpatient and 24 Hour Level of Care Determinations**

Effective: July 1, 2025

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

☒ 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. The Plan requires notification for all inpatient admissions including behavioral health inpatient services. In addition, facilities may be required to provide updated clinical information for authorization of continued stays ("concurrent review"). This medical necessity guideline applies to the authorization of continued stays, following notification.

Admitting providers and facilities are responsible for notifying The Plan and/or obtaining continued stay authorization as appropriate. Additional documentation including Provider Manuals and payment policies are available in the Provider Resource Center on the Tufts Health Plan or Harvard Pilgrim Health Care web site:

- Harvard Pilgrim Health Care Commercial Products – Harvard Pilgrim Health Care Commercial Provider Manual
- Tufts Health Plan Commercial Products-Tufts Health Plan Commercial Provider Manual
- Tufts Health Direct, Tufts Health Together and Tufts Health One Care-Tufts Health Public Plans Provider Manual
- Tufts Health RITogether-Tufts Health Public Plans Provider Manual
- Tufts Health Plan Senior Products including Tufts Medicare Preferred and Senior Care Options-Tufts Health Plan Senior Products Provider Manual

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim Health Care may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for

HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Clinical Guideline Coverage Criteria

Behavioral Health Inpatient (inclusive of Mental Health and Substance Use Disorder) Levels of Care

The Plan uses InterQual®* and American Society of Addictive Medicine (ASAM)^ criteria for determining medical necessity for behavioral health levels of care. Please see below for specific details:

1. The Plan uses *InterQual criteria for determining continued stay post notification for:
    a. Acute inpatient services
        i. The Plan provides coverage for special resources or accommodations if Member's immediate care requires adjustments to a facility's usual staffing needs. For Massachusetts plans, The Plan will approve coverage in accordance with accepted practice and/or federal and state standards.
    b. Acute Residential Services (which may include Acute Residential Treatment and Community Crisis Stabilization) /24-hour diversionary services unless otherwise specified.
    c. All Substance Use Disorder (SUD)-specific inpatient levels of care unless otherwise specified. See below.
2. The plan uses **InterQual The ASAM Criteria Navigator for determining continued stay post notification for:
    a. Level 4 Medically Managed Intensive Inpatient Services, Adult/Adolescent for the following lines of business:
        i. All Commercial plans
        ii. Tufts Health Direct
        iii. Tufts Health Together
        iv. Tufts Health RITogether
        v. Tufts Health One Care (for non-alcohol Level 4 treatment)
        vi. Tufts Health Senior Care Options (for non-alcohol Level 4 treatment)
    b. Level 3.7 Medically Monitored Intensive Inpatient Services, Adult/Adolescent for the following lines of business:
        i. All Commercial Plans
        ii. Tufts Health Direct
        iii. Tufts Health Together
        iv. Tufts Health RITogether
        v. Tufts Health One Care
        vi. Tufts Health Senior Care Options
    c. Level 3.5 Clinically Managed High-Intensity Residential Services, Adult/Adolescent for the following lines of business:
        i. All Commercial Plans
        ii. Tufts Health Direct
        iii. Tufts Health Together
        iv. Tufts Health RITogether
        v. Tufts Health One Care
        vi. Tufts Health Senior Care Options
    d. Level 3.1 Clinically Managed Low-Intensity Residential Services, Adult/Adolescent for following lines of

business:

i. Tufts Health Together
ii. Tufts Health RITogether
iii. Tufts Health One Care
iv. Tufts Health Senior Care Options

***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 Medicare Only Products, The plan uses the InterQual Medicare Behavioral Health Criteria which consists of CMS NCDs/LCDs, formatted in the InterQual decision support tool.
- For Dual Eligible Products (OneCare and SCO) The Plan also uses the InterQual Medicare Behavioral Health Criteria which consists of CMS NCDs/LCDs, formatted in the InterQual decision support tool. However, In the absence of applicable CMS NCDs/LCDs, The plan will use standard InterQual Criteria or The **ASAM Criteria Navigator for SUD support

****InterQual, The ASAM Criteria Navigator** is a clinical decision support tool consistent with The American Society of Addiction Medicine's The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. ASAM Criteria are nationally recognized treatment criteria for addictive, substance-related and dual diagnosis conditions.

References:

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. Last accessed September 12, 2024.
2. The State of New Hampshire Insurance Department. Bulletin Docket #INS 24-016-AB: Coverage for Insureds 21 Years of Age and Younger Who Are Receiving Mental Health Services Provided by State-Sponsored Community Mental Health Providers. https://mm.nh.gov/files/uploads/nhid/documents/bulletin-ins-24-016-ab.pdf . Last accessed September 12, 2024.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes
Subsequent endorsement date(s) and changes made:

- November 4, 2020: Fax number for Unify updated
- December 16, 2020: Reviewed by IMPAC with following changes approved. Effective January 1, 2021, revised title to include the term "Inpatient". Removed all outpatient services to allow Medical Necessity Guideline (MNG) to represent Inpatient only level of care services. Intermediate services were moved to newly created MNG titled Medical Necessity Guidelines: Behavioral Health Level of Care for Non-24 Hour/Intermediate/Diversionary Services.
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- 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
- October 18, 2023: Reviewed by MPAC. Updated to include language regarding the InterQual, The ASAM Criteria Navigator levels 4, 3.7, 3.5 and 3.1, effective January 1, 2024
- November 2023: Unify name changed to One Care effective January 1, 2024
- May 15, 2024: Reviewed by MPAC, administrative update: TMP PPO and TMP HMO boxes checked, effective July 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee, effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- September 12, 2024: Clarified criterion 1.b Acute Residential Services, to include Acute Residential Treatment and Community Crisis Stabilization.
- September 19, 2024: Reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee, no changes
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update, effective July 1, 2025
- June 18, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template

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.