Behavioral Health

Tufts Health Public Plans' behavioral health team assists with accessing varying levels of services for members based on their needs, intensity of utilization and/or coexisting medical conditions. Although many of the Behavioral Health Programs and Services are similar for Massachusetts and Rhode Island, there are also some significant differences. Be sure to refer to the appropriate state-specific information in this chapter as outlined in the following sections:

Massachusetts and Rhode Island Behavioral Health Programs

The following Behavioral Health (BH) Programs apply to both Massachusetts and Rhode Island.

Behavioral Health Provider Responsibilities

Responsibilities of the BH service provider include, but are not limited to:

- Complying with provider requirements
- Offering the following appointment availability:
  - Emergency services immediately, on a 24-hour basis, seven days a week. **Note:** For Tufts Health One Care members, emergency service calls must be responded to with a live voice, or face-to-face within 60 minutes.
  - Emergency Services Programs (ESPs) in Massachusetts and Emergency Service Intervention in Rhode Island immediately, 24 hours a day, seven days a week
  - Urgent care (services that are not emergency or routine) within 48 hours of a request (24 hours for Tufts Health RITogether in Rhode Island)
  - For services described in the inpatient or 24-hour Diversionary Services Discharge Plan:
    - Non-24-hour diversionary services within two calendar days of discharge
    - An appointment to review and refill medications within 14 calendar days of discharge

    - Other outpatient services within seven calendar days of discharge
    - Intensive Care Coordination Services within the time frame directed by EOHHS in Massachusetts
  - Non-urgent routine BH services within 10 calendar days of a request
  - All other BH services: within 14 calendar days
  - For Rhode Island: Behavioral Health Providers are required to contact members with missed appointments within twenty-four (24) hours to reschedule appointments
- Performing the Emergency Psychiatric Inpatient Admission (EPIA) Protocol Escalation Steps as outlined in the EPIA Protocol 3.0 for members of Tufts Health Direct, Tufts Health Together – MassHealth MCO Plan and ACPPs and Tufts Health One Care
- Ensuring office hours of operations for Tufts Health Together ACPP members, Tufts Health Together MCO members, and Tufts Health RITogether members are no more restrictive than those for your Tufts Health Direct members, Tufts Health Plan Commercial members, MassHealth/Medicaid or Rhode Island Medicaid fee-for-service patients
- Encouraging members to sign these forms, and then fax them to **888-977-0776** (Massachusetts) or **857-304-6400** (Rhode Island):
  - Authorization to Disclose Protected Health Information Form — allows Tufts Health Public Plans to release information about members to family members, state agencies or others. Submit this form with the Combined MCE (Managed Care Entity) Behavioral Health Provider/Primary Care Provider Communication Form below.
  - Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form (For Tufts Health Direct, Tufts Health Together ACPP and Tufts Health Together MCO members) — allows BH providers and PCPs to share information with each other. Attach to the Authorization to Disclose Protected Health Information form, above.
  - Tufts Health RITogether BH/PCP Communication Form — allows BH providers and PCPs to share information with each other. Attach to the Authorization to Disclose Protected Health Information form, above.
- Coordinating with state agencies as clinically indicated
- Reviewing and verifying the accuracy of their demographic data (including, but not limited to, specialty information, practice location, digital contact information, phone number, hours of operation and if they are accepting new patients). Providers may log into CAQH ProView or fill out the Provider Information Change form and submit the complete form to the appropriate email, as noted on the form.

Medical Necessity and Clinical Criteria

Tufts Health Public Plans authorizes coverage of medically necessary BH services that:

- Prevent, diagnose, alleviate, correct or cure the worsening of conditions that endanger a member's life, cause suffering or pain, threaten to cause or aggravate a disability, or result in illness or infirmity
- Cannot be replaced with a less intensive level of care
- Are substantiated by clinical records
- Meet professional health care standards and
- Are covered benefits as set forth in the member's plan document

Tufts Health Public Plans uses the following medical necessity guidelines and criteria for covered benefits and services:

- InterQual® is the primary source to determine medical necessity and appropriateness of treatment
- The ASAM Criteria are used in Rhode Island for substance-related conditions, and in Massachusetts for Residential Rehabilitation Services (ASAM Level 3.1). The ASAM Criteria were developed by the American Society of Addiction Medicine.
  - Refer to What is the ASAM Criteria?

  - Available for purchase: The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, 2013
  - ASAM provides a guide for patients, families and friends: Opioid Addiction Treatment
- For Tufts Health One Care, Medicare National Coverage Determination (NCD) and Local Coverage Determination (LCD) criteria are also used for Medicare-covered services. NCD and LCD criteria are available on the CMS website at cms.gov.

When criteria are not available either in InterQual, ASAM or CMS, determination is based on medical necessity guidelines developed for Tufts Health Public Plans.

Tufts Health Public Plans will only approve requests that meet guidelines and applicable criteria for a particular service. The provider is responsible for determining if a member meets criteria for services that are delivered. Tufts Health Public Plans' medical necessity guidelines are available on the public Provider website or by calling Provider Services at **888-257-1985** to request a printed copy.

Payment Policies

Tufts Health Public Plans' payment policies are intended to provide Tufts Health Public Plans' providers and facilities with information on benefits, billing, and compensation for services. To ensure accurate claims processing, providers must follow these policies and/or distribute to their office staff on a regular basis. For information on Tufts Health Public Plans' payment policies for different levels of care, refer to the Provider Resource Center.

Behavioral Health Services Prior Authorization and Notification

In-network providers are required to obtain prior authorization or submit notification for most BH services prior to the onset of services. In some cases, notification, initial authorization and/or additional authorization can be completed via fax or online, depending on the service. Providers should refer to the following resources to determine which BH services require authorization or notification and the procedures for obtaining the appropriate authorizations:

- Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid
- Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid
- Tufts Health One Care Behavioral Health Prior Authorization (PA) and Notification Grid
- **Phone:** 888-257-1985

In order to evaluate whether a request meets the standards for medical necessity, the treating provider will need to provide appropriate clinical information to BH clinical reviewers. This includes but may not be limited to the following:

- Current diagnosis and treatment plan, including provider's orders, special procedure and medications
- Clinical rationale for continued care
- Description of the member's response to treatment since the initial authorization or last continued-stay review
- Current mental status, discharge plan and discharge criteria, including actions taken to implement the discharge plan
- Proposed course of treatment during the continuation period
- Any medical conditions needing treatment (routine medical care is included in the per diem rate)
- Any potential barriers to discharge and plans to address such barriers
- Coordination with PCP, state agencies and other treatment providers, as well as involvement of family and/or other supports

Providers will receive receipt confirmation of notification within 24 hours. For authorizations, providers are notified within 24 hours of a determination with written notification sent within two business days. Written determination notifications will indicate the services authorized.

Note: Providers should always verify the eligibility of members at the time services are rendered. For more information about checking eligibility, refer to the Providers chapter.

Inpatient Concurrent Reviews

For continued evaluations on whether cases meet medical necessity guidelines, providers must have appropriate clinical information available for BH clinical reviewers:

- Tufts Health Public Plans member ID number
- Name, gender, date of birth, and city or town or residence
- Designated Emergency Services Program (ESP) provider name, and time and date of evaluation, if involved. **Note:** This only applies to Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health One Care members.
- ICD-10 diagnosis
- Precipitating event and current symptoms indicating clinical need for this level of care
- Description of the recommended treatment plan relating to the admitting symptoms and presenting problem, and progress made to date
- Medication history
- Substance use history
- Prior treatment history
- General medical and psychosocial history (including family)
- PCP information

Note: Prior authorization is not required for inpatient admission. Tufts Health Plan considers all inpatient admissions to be urgent or emergent. Notification is required on the second business day after admission with subsequent medical necessity review. Notification must be provided in order to bill for the initial admission days of which no clinical review is required. Tufts Health Plan will not reimburse for any interval between the last covered day and the date additional authorization is requested by the servicing provider. Refer to the Prior Authorization and Notification grids outlined above for notification processes (including Level 3.7 Detox).

Administrative Denials

Tufts Health Public Plans will administratively deny payment for services where an in-network provider failed to obtain or provide the appropriate prior authorization or notification. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

When an admission, continued inpatient stay or the availability of any other BH service is denied, reduced, modified or terminated, providers are notified within 24 hours and written or electronic confirmation is sent to the provider and member within one business day. The notice will include information on the appeals process and an Authorized Representative Form (for Tufts Health Together and Tufts Health Direct members) or a Tufts Health RITogether Authorized Representative Form (for Tufts Health RITogether members) for the member to sign if they would like their provider to appeal the denial on their behalf.

Refer to the Referral, Prior Authorization and Notification, Utilization Management and Rights and Responsibilities chapters for more information.

Patient Care Coordination

Tufts Health Public Plans' BH clinicians and care managers, along with providers, work together to help members receive optimal health care by:

- Ensuring members have timely and easy access to appropriate BH care
- Encouraging more direct involvement of members in their treatment planning and recovery
- Finding opportunities for members to receive more effective BH and substance use recovery care
- Enhancing continuity and coordination of care among the member's providers

Tufts Health Public Plans' services include:

- Monitoring treatment compliance
- Reviewing ongoing service needs
- Assisting with discharge planning
- Providing members and their providers with information on community-based services
- Coordination of post discharge support services for safe and appropriate care

Tufts Health Public Plans recognizes more than one provider may contribute to the care of members. Providers, particularly primary care and BH providers, who are caring for members are to explain to members the benefits of care coordination and integration and make their best efforts to secure member consent to share relevant information regarding diagnoses, medication and/or treatment to help improve health outcomes. If consent is not granted, this should be recorded in the member's record.

Treatment Planning

BH treatment planning focuses on identifying barriers to members' ability to follow through with the treatment and discharge plan. Tufts Health Public Plans requires providers to complete an initial BH treatment plan within 24 hours of a member's admission to an acute care or 24-hour intermediate services, and to complete a multidisciplinary treatment plan within 24 hours of the member's admission.

For members under the age of 21, Tufts Health Public Plans expects a parent or guardian to be involved with the treatment planning, with appropriate member consent. If an adult member has a guardian, that guardian must be included in treatment planning. As appropriate, we suggest treatment planning meetings include the member, other providers, the member's family, and/or guardian as well as representatives from other state agencies (e.g., Department of Children, Youth and Families). If BH Care Management from Tufts Health Public Plans is involved in the member's care, please coordinate as appropriate. Contact Provider Services at **888-257-1985** to reach Tufts Health Public Plans' care managers with any questions.

Discharge Planning and Transitional Care Management

During admissions, Tufts Health Public Plan Behavioral Health Utilization Management and Care Management Clinicians collaborate with providers to evaluate medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge or transfer from one level of care to another level of care, including referral to appropriate services.

Treating Providers are expected to engage with BH UM clinicians on discharge planning activities upon the start of treatment and throughout the member's admission. Whenever possible, discharge planning should be developed in partnership with the member and as appropriate or available, their family and or/guardian, care coordinator or clinical care manager, the member's BH Community Partner (BH CP), and other providers active in members care (i.e., PCP or behavioral health provider). Discharge planning should make clear the role of individuals including the BH CP in managing the member's transitional care.

Discharge planning activities should have consideration for the following:

- Medication reconciliation
- Appropriateness of in-person rather than telephonic post-discharge follow up
- Home visits for members with complex needs and

- Appropriate education of enrollees, family members, guardians, and caregivers on post-discharge care instructions

Tufts Health Public Plans recommends using step-down services, such as partial hospitalization, to help members successfully transition back into the community however, at a minimum, inpatient providers must ensure follow-up with an Enrollee within 72 hours of when the Enrollee is discharged from any type of Network hospital inpatient stay or emergency department visit, through a home visit, in-office appointment, telehealth visit, or phone conversation, as appropriate, with the Enrollee. Providers are responsible for meeting appointment availability for inpatient and 24-hour diversionary discharge plans as described earlier in this chapter.

Inpatient Transfers

Members must meet the receiving facility's inpatient admission criteria to be transferred, and the current provider should request prior authorization for the receiving facility from Tufts Health Public Plans prior to the transfer.

Community Health Workers

Tufts Health Public Plans' Community Health Workers can assist with addressing members' non-medical and social issues that may be barriers to care. Refer to the Care Management chapter for more information or call Provider Services at **888-257-1985** to reach Community Health Workers.

Note: Refer to the Tufts Health One Care chapter for comprehensive information on the Tufts Health One Care model of care.

Medical Records Compliance

Providers are required to complete an individualized written assessment and treatment plan for all members treated within the following time frames:

- Acute inpatient treatment: within 24 hours of admission
- Diversionary/Intermediate treatment: within 48 hours of admission
- Outpatient treatment: before the third outpatient visit

Refer to the Performance Specifications for more detailed medical record requirements in Massachusetts.

Adverse Incident Reporting

Tufts Health Public Plans requires that BH providers immediately report adverse incidents to us, including but not limited to:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual, or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program
- Any unscheduled event that results in the evacuation of a program or facility

If any situation occurs at a BH provider site that fits the criteria for an adverse incident, providers must report the incident to a Tufts Health Public Plans care manager by calling Provider Services at **888-257-1985** the same day the incident occurs. If there are any questions on what would be considered an adverse incident, call to address the event or incident.

In addition, providers must fax a completed Adverse Incident Report Form to 617-673-0973 after reporting the incident on **the same day** the incident is reported. Present all information related to the nature of the incident, including the parties involved (names and telephone numbers) and the member's current condition.

Massachusetts-Specific Behavioral Health Program

Performance Specifications

Tufts Health Public Plans has developed Performance Specifications for BH services and require that BH providers comply with all aspects of these specifications. There is a general Performance Specification that applies to all contracted Massachusetts Tufts Health Public Plans providers and additional Performance Specifications for individual levels of care. Refer to the Performance Specifications in the Provider Resource Center.

Community Partners Program (Tufts Health Together)

Designated Community Partners (CPs) are community-based health care and human services organizations that collaborate with Tufts Health Public Plans and Tufts Health Public Plans Accountable Care Organizations (ACOs) to integrate member care and improve health outcomes for members with complex long-term medical and/or BH needs.

There are two types of CPs, Long-Term Services and Supports CPs (LTSS CPs) and BH CPs (BH CPs). They work collaboratively with Tufts Health Public Plans and ACO clinicians to provide care coordination. BH CPs provide care management and coordination to members ages 22 to 64 with significant BH needs LTSS CPs provide care coordination and navigation to members ages 3 to 64 with complex LTSS needs. Tufts Health Public Plans will communicate needed information about the programs and procedures as they continue to be implemented through Provider Update.

Massachusetts-Specific Behavioral Health Services

Tufts Health Public Plans covers a range of BH benefits and services for members that take psychosocial, occupational, and cultural and linguistic factors into consideration when providing care to members. These factors may influence the risk assessment and service decisions.

The following resources outline the comprehensive continuum of BH services available as covered services for members, along with a brief description of the level of care, the medical necessity guidelines used, and prior authorization or notification procedures:

- Tufts Health Together and Tufts Health Direct Behavior Health Prior Authorization (PA) and Notification Grid
- Tufts Health One Care Behavioral Health Prior Authorization (PA) and Notification Grid

Emergency Services Program (Tufts Health Together and Tufts Health One Care)

Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health One Care members can access contracted specialized Emergency Services Program (ESP) providers 24 hours a day, seven days a week, and 365 days a year. ESP providers offer crisis assessment, crisis intervention, short-term crisis counseling, crisis stabilization and mobile crisis intervention services for members.

Members who require acute treatment must be evaluated by an ESP provider to determine the most appropriate, least restrictive level of care to treat the member.

ESP providers are required to rapidly respond within one hour, assess and deliver a course of treatment intended to promote recovery, ensure safety and stabilize members' crises in a manner that allows them to receive medically necessary services in the community or in an inpatient or 24-hour diversionary level of care. In all encounters, an ESP provider will conduct a BH crisis assessment and offer short-term crisis counseling that includes active listening and support while also providing solution-focused and strengths-oriented crisis intervention. The crisis intervention is aimed

at working with members and their families and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance and treatment.

An ESP provider will coordinate with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. An ESP provider also provides members and their families with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. All ESP provider encounters should minimally include the three basic components of crisis assessment, intervention and stabilization. We believe that crisis services also require flexibility in the focus and duration of the initial intervention, as well as the member's participation in the treatment, and that the provider should always consider the number and type of follow-up services members will require.

ESP providers accept requests and/or referrals for ESP services directly from members who seek them on their own and/or from any other individual or resource, such as:

- Family members and guardians
- Community-based agency staff
- Service providers
- PCPs
- Residential program staff
- School representatives
- State agency personnel
- Law enforcement representatives
- Court representatives

After considering all available input, an ESP provider will determine the most appropriate level of care or service for members and, when appropriate, will call a Tufts Health Public Plans BH care manager at **888.257.1985** for service, coverage authorization, and/or to facilitate access and referral to the service. We will base our level-of-care determination on medical necessity criteria.

For a list of ESP providers, please see the ESP Statewide Directory.

If a Tufts Health Public Plans member with a BH condition develops or has an emergency condition, refer them to the nearest emergency room and ensure that transportation is available and provided as needed. Examples of such situations include:

- Drug and/or alcohol overdose
- Chest pain
- Neurological functioning, consciousness level, or motor impairment changes
- Premature labor or bleeding in the case of pregnancy
- Malignant hypertension
- Self-mutilation requiring immediate medical attention

ESP Initial Assessment and Notification Required for Urgent Admissions

While a prior authorization is not required for an acute admission directly from an emergency department, Tufts Health Together ACPP and MCO members should be seen by a designated ESP provider for an assessment prior to such an admission.

The ESP (and the admitting facility) is required to notify Tufts Health Public Plans of urgent BH admissions within two business days after admission. The ESP provider is required to fax the ESP Notification to 888-977-0776, and include relevant clinical information and disposition within one business day of the encounter.

Mobile Crisis Intervention

ESP providers deliver mobile crisis intervention services in the community 24 hours a day, seven days a week, and 365 days a year. Mobile crisis intervention services should be integrated into the ESP provider's infrastructure, services, policies and procedures, staff supervision and training, and community linkages.

An ESP provider's mobile crisis intervention services and staff provide all ESP services for members. A best practice for delivering crisis services is via a discreet and minimally disruptive mobile response in a natural setting, such as in a member's home or school, or a neutral community-based site. Delivering strengths-based and solution-focused intervention aims to resolve the crisis, mobilize natural supports and provide rapid linkage to the right level of care. Mobile crisis intervention services include consultative and collaborative services, placing a high value on achieving a least restrictive consensus disposition while ensuring access to medically necessary services.

Mobile crisis intervention services provide a short-term, on-site, face-to-face therapeutic response to members experiencing a BH crisis. These services help members to identify, assess, treat, and stabilize the situation and reduce immediate risk of danger to themselves or others, consistent with their risk management/safety plan, if any.

Youth Mobile Crisis Intervention

Youth Mobile Crisis Intervention includes services from an ESP provider for members under the age of 21. Youth Mobile Crisis Intervention services are short-term services. They are a mobile, on-site, face-to-face therapeutic response to a patient's BH crisis. Goals of these services include identifying, assessing, treating and stabilizing the situation, and reducing immediate risk of danger to the patient or others by following the patient's risk management/safety plan, if any. This service is provided 24 hours a day, seven days a week.

Youth Mobile Crisis Intervention includes:

- A crisis assessment
- Development of a risk management/safety plan if the patient/family does not already have one
- Crisis intervention and stabilization services for up to seven days, including, as needed:
  - On-site, face-to-face therapeutic response intervention
  - Psychiatric consultation
  - Urgent psychopharmacology intervention
  - Referrals and linkages to all medically necessary BH services and supports, including access to appropriate services along the BH continuum of care

For members under the age of 21 who are receiving Intensive Care Coordination (ICC), Youth Mobile Crisis intervention staff will coordinate with the member's ICC care coordinator throughout the delivery of the service. Staff will also coordinate with the member's PCP, any other care management program, or any other BH providers offering services to the member throughout the delivery of the service.

Children's Behavioral Health Initiative Services (Tufts Health Together)

Children's Behavioral Health Initiative (CBHI) is part of the MassHealth Office of Behavioral Health. Refer to CBHI for Providers and State Agency Partners for additional information.

Child and Adolescent Needs and Strengths (CANS) Requirements

As part of the CBHI, Tufts Health Public Plans requires outpatient providers to be CANS-tool-certified and to use the CANS tool as part of an initial BH assessment when conducting outpatient therapy for our MassHealth Tufts Health Together MCO and ACPP members up to and including the age of 21. Outpatient providers must complete a CANS assessment for outpatient visits and all other CBHI services. The state requires outpatient providers to update the CANS assessment through the Virtual Gateway Children's Behavioral Health Initiative (CBHI) Application at least every 180 days following the initial CANS assessment, or more often as clinically appropriate or as prompted by any significant changes in the youth's life.

Conduct a CANS assessment for the following services:

- Outpatient therapy (diagnostic evaluations and individual, family and group therapy)
- In-home therapy
- Intensive care coordination
- Discharge planning for the following 24-hour care services:
  - Psychiatric inpatient hospitalization
  - Community-based acute treatment (CBAT)
  - Intensive community-based acute treatment (ICBAT)

For additional information, refer to the In-Home Therapy Services and Intensive Care Coordination Performance Specifications and Child and Adolescent Needs and Strengths (CANS) Payment Policy in the Provider Resource Center.

Rhode Island-Specific Behavioral Health Services

Tufts Health Public Plans covers a range of BH (mental health and substance use) benefits and services for members which are identified on the Benefit Grids. Coverage of some BH services require notification and others may require prior authorization which is noted on the Tufts Health Rhode Island Together Behavioral Health Prior Authorization (PA) and Notification Grid. Providers should take psychosocial, occupational and cultural and linguistic factors into consideration when providing care to members. These factors may influence the risk assessment and service decisions. Services include:

Levels of Care for Members Under the Age of 21	
Acute	Emergency Services Intervention Observation/Crisis Stabilization/Holding Bed Inpatient Acute Hospitalization Acute Residential Treatment (ART) including dual diagnosis
Outpatient Services	Traditional Outpatient Services: • Individual Therapy • Family Therapy • Group Therapy • Specialty Group Therapy (Special populations) • Diagnostic Evaluation • Developmental evaluations • Psychological and Neuropsychological Testing • Medication Management
Intermediate Services	Partial Hospitalization (PHP) Day/Evening Treatment Intensive Outpatient Treatment (IOP) Enhanced Outpatient Services (EOS)
Home and Community Based Services	Home Based Therapeutic Services (HBTS) Evidence Based Practices (EBP) Personal Assistance Services and Supports (PASS) Respite

Levels of Care for Members Age 18 Years or Older	
Acute	Emergency Service Intervention Observation/Crisis Stabilization/Holding Bed Inpatient Acute Hospitalization Acute Residential Treatment (ART), including dual diagnosis Inpatient (non-hospital) detoxification (ASAM Level 3.7)
Substance Use Residential Services	ASAM Level 3.5 Clinically Managed – High Intensity Residential ASAM Level 3.3 Short-Term Clinically Managed – Medium Intensity Residential Adults only ASAM Level 3.1 Clinically Managed – Low Intensity Residential Services
Intermediate and Outpatient Services	Partial Hospitalization (PHP) Day/Evening Treatment Intensive Outpatient Treatment (IOP) Enhanced Outpatient Services (EOS) for member under age 21 only General Outpatient Medication Assisted Treatment including Methadone Maintenance (including Opioid Rx Program), Buprenorphine, and Suboxone Treatment
ACT – Assertive Community Treatment	Bundled Services for eligible members age 18 and older carried out by Rhode Island's Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) designated Community Mental Health Organizations (CMHOs)
IHH – Integrated Health Home	Services carried out by BHDDH designated CMHOs, for eligible members age 18 and older

Emergency Services Intervention (ESI)

Tufts Health Public Plans members can access Emergency Services 24 hours a day, 7 days a week, for face-to-face care management and intervention when experiencing a BH crisis. Such crisis includes an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed BH provider in a hospital emergency room, residential placement setting, the individual's home, police station or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the BH crisis.

Providers need to ensure that members who are evaluated in Emergency Rooms for BH issues, and not admitted to an inpatient level of care, have a follow-up appointment with the member's PCP within three (3) business days of discharge from emergency services.

If a Tufts Health Public Plans member with a BH condition develops or has an emergency condition, refer them to the nearest emergency room and ensure that transportation is available and provided as needed. Examples of such situations include:

- Drug and/or alcohol overdose
- Chest pain
- Neurological functioning, consciousness level, or motor impairment changes
- Premature labor or bleeding in the case of pregnancy
- Malignant hypertension
- Self-mutilation requiring immediate medical attention

Mental Health Parity

Federal and state laws require that we provide behavioral health (mental health and/or substance abuse) services to our members in the same way we provide physical health services. We refer to these laws as “parity.” It means that:

- We will give members the same level of benefits and charge the same co-payments, co-insurance and deductibles for mental health and substance abuse needs as for physical health needs.
- We have similar prior authorization (permission) requirements and treatment limitations for mental health and substance abuse services and physical health services.
- We will provide you or your member with the medical necessity criteria that we use for prior authorization upon you or your member’s request.
- We will give the member the reason for any denial of authorization for mental health or substance abuse services within a reasonable time frame.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
03/12/24	Revisions to Care Management; revisions to Patient Care Coordination; administrative edits
06/17/24	Revisions to Medical Records Compliance section to remove link to Medical Inpatient Chart Documentation Tool