Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Family Stabilization Treatment (FST) Criteria for Behavioral Health Services**

Effective: January 1, 2026

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

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth 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); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

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

Tufts Health Plan defines family stabilization treatment (FST) as a short term, intensive and flexible service that assists with the stabilization of children and adolescents in their home environment during an acute psychiatric crisis. It is a structured treatment modality that is designed to work with all Members of a family, not just the identified child/adolescent at risk. FST services can be used as an independent level of care or as an adjunct to other levels of care. FST services are designed to prevent repeated hospitalizations and/or out of home placement by providing intensive in-home services and arranging successful linkages for the family with outpatient providers.

Clinical Guideline Coverage Criteria

The Plan considers Family Stabilization Treatment as reasonable and medically necessary when **ALL** of the following is met:

1. The Member has a diagnosed psychiatric or substance-related disorder consistent with the most recent Diagnostic and Statistical Manual™ (DSM) or with the most recent International Classification of Diseases (ICD); **and**
2. The Member is at high risk for hospitalization or out of home placement; **and**
3. The home environment and primary support system are important components to stabilization and management of the presenting problem; **and**
4. FST services are required for reasons other than convenience; **and**
5. The identified Member is a child/adolescent under the age of nineteen (19)

Limitations

The Plan does not cover FST under the following circumstances:

1. The Member's benefit plan does not permit Individual Care Management (ICM).
2. The Member is assessed to be at risk for harming self or others, and/or has a significant mental illness that requires a more intensive level of care.
3. The Member and/or family have not made progress towards treatment goals, or the treatment interventions available have been exhausted and there is no reasonable expectation of progress at this level of care.
4. The Member's home environment presents a safety risk to the family stabilization clinician(s).
5. The Member and the Member's family and/or legal guardian do not agree to be involved with the FST treatment plan.
6. The Member can be safely and effectively treated at a less intensive level of care.

Codes

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

Table 1: CPT/HCPCS Codes

Code	Description
99510	Mental Health Family Stabilization (FST) per day

Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC), renewed without changes

Subsequent endorsement date(s) and changes made:

- November 4, 2020: Fax number for Unify
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- April 6, 2022: Template updated
- February 16, 2022: Reviewed by MPAC, Removal of PA from Guideline for effective date of 07/1/2022
- 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
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026

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.