Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Behavioral Health Level of Care for Non-24 Hour/Intermediate/Diversionary Services

Effective: October 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:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care
- Tufts Medicare Preferred HMO/PPO

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

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.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools,. 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 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

Overview

The Plan requires notification for all inpatient admissions and certain inpatient and intermediate behavioral health services. In addition, facilities may be required to provide updated clinical information for authorization of continued stays. **This document applies to notification and the authorization of continued stays via medical necessity review.**

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

- Harvard Pilgrim Health Care Commercial Products – Harvard Pilgrim Health Care Provider Manual
- Tufts Health Commercial Products-Tufts Health Plan Commercial Provider Manual
- Tufts Health Plan Direct, Tufts Health Together and Tufts Heal 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

Clinical Guideline Coverage Criteria

Behavioral Health Intermediate (inclusive of Non-24-Hour and Diversionary Services) Level of Care:

The Plan uses InterQual® criteria for determining medical necessity for behavioral health levels of care post notification. Please see below for specific details:

1) The Plan uses InterQual criteria* for the following non-substance use treatment services for :
   a) Partial Hospitalization Services (PHP)

Applicable for the following lines of business:

- All Commercial Plans
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care
- Tufts Medicare Preferred

2) The Plan uses InterQual, The ASAM Criteria Navigator** for the following substance use treatment services:
   a) Level 2.7:
      i) Medically Monitored Intensive Outpatient (Partial Hospitalization Services/PHP) Adult and/or
      ii) Youth Medically Focused Intensive Outpatient Treatment
   b) Level 2.5:
      i) High Intensity Outpatient (Partial Hospitalization Services/PHP) Adult and/or
      ii) Youth High-Intensity Outpatient Treatment

Applicable for the following lines of business:

- All Commercial Plans
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

***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 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.

Approval And Revision History

December 16, 2020: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), newly created guideline, effective January 1, 2021. Intermediate and outpatient services removed from BH LOC Determinations Medical Necessity Guideline (MNG) and added to this document.

Subsequent endorsement date(s) and changes made:

- September 15, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- February 16, 2022: Reviewed by MPAC, Removal of Notification and Concurrent Review for Commercial Plans for IOP effective July 1, 2022.
- July 20,2022: Reviewed by MPAC, Removal notification and concurrent review of the following:
    - Psychiatric Day Treatment-for Together effective 9/1/2022 and Unify effective 1/1/23.
    - IOP-Intensive OP Program-for Direct, Together and RITogether effective 9/1/2022 and Unify effective 1/1/23
    - SOAP-Structured OP Addiction Program- for SOAP for Direct, Together, RITogether effective 9/1/22, and Unify effective 1/1/23
- 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 2.7 and 2.5, 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 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
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026
- July 15, 2026: Reviewed by MPAC. Updates to InterQual and ASAM Criteria effective October 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.