Medical Necessity Guidelines: **Mobile Crisis Intervention (MCI) for Tufts Health Together**

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

Mobile Crisis Intervention is the youth (under the age of 21) serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short- term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any.

This service is provided 24 hours a day, 7 days a week. The service includes: A crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

Clinical Guideline Coverage Criteria

Admission Criteria:

The Plan considers Mobile Crisis Intervention as reasonable and medically necessary when **ALL** of the following criteria are met:

1. The youth must be in a behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage. For youth in ICC, efforts by the care coordinator and Care Plan Team (CPT) to triage and stabilize the crisis have been insufficient to stabilize the crisis and ESP/Mobile Crisis Intervention has been contacted; **and**
2. Immediate intervention is needed to attempt to stabilize the youth's condition safely in situations that do not require an immediate public safety response; **and**
3. The youth demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community.

In addition to the above, at least ONE of the following must be present:

1. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others; **or**
2. The youth is experiencing escalating behavior(s) and, without immediate intervention, he/she is likely to require a higher intensity of services.

In addition to the above, at least ONE of the following must be present:

1. The youth is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community; **or**
2. The demands of the situation exceed the parent's/guardian's/caregiver's strengths and capacity to maintain the youth in his/her present living environment and external supports are required.

Discharge Criteria

The Plan considers continuation of Mobile Crisis Intervention services as not reasonable or medically necessary when **ANY** of the following criteria are met:

1. The crisis assessment and other relevant information indicate that the youth needs a more (or less) intensive level of care and Mobile Crisis Intervention has facilitated transfer to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting; **or**
2. The youth's physical condition necessitates transfer to an inpatient medical facility and the Mobile Crisis Intervention provider has communicated the youth risk management/safety plan to the receiving provider; **or**
3. Consent for treatment is withdrawn and there is no court order requiring such treatment.

**Please note that Psychosocial, Occupational, and Cultural and Linguistic factors may change the risk assessment and should be considered when making level-of-care decisions.*

Limitations

The Plan considers Mobile Crisis Intervention as not reasonable or medically necessary if consent for an evaluation and mobile crisis intervention services is refused.

Codes

The following code(s) require is associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
H2011	Crisis intervention service, per 15 minutes

Please refer to the Inpatient and Intermediate Behavioral Health/Substance Use Disorders Facility Payment Policy for more information regarding billing of these services.

References:

1. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth criteria for coverage of In-Home Therapy Services. Accessed at mass.gov/files/documents/2016/07/tk/mnc-mobile-crisis-intervention.pdf, Last accessed October 1, 2024.

Approval And Revision History

October 17, 2024: Reviewed by MPAC, New MNG effective September 15, 2024.

Subsequent endorsement date(s) and changes made:

- 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.