



Mental Health Designated Facility Policies and Procedures

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Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472

Document Revision History			
Rev #	Contributors / Reviewers	Approvers*	Approval Date
1	Bob Goldberg, *Marianne Sample	* Marianne Sample	2/23/06
2	Bob Goldberg, *Marianne Sample	*Marianne Sample	12/19/06
3	Bob Goldberg, *Marianne Sample	*Marianne Sample, Judy Herzig-Marx	9/11/07
4	Bob Goldberg, *Marianne Sample, Judy Herzig-Marx	*Marianne Sample, Judy Herzig-Marx	1/25/08
5	Bob Goldberg, Andrea Gewirtz	*Andrea Gewirtz	7/1/08
6	Bob Goldberg, Judy Herzig-Marx, Marianne Sample, Donna Watson	*Donna Watson, Judy Herzig-Marx, Marianne Sample	2/12/09
7	Bob Goldberg, Judy Herzig-Marx, Donna Watson	*Donna Watson, Judy Herzig-Marx	6/26/09
8	Bob Goldberg, Judy Herzig-Marx,	*Judy Herzig-Marx	12/3/09

*Document Owner / Signatory

Table of Contents

1	Introduction to the Designated Facility Program	1-1
	Program Overview	1-1
	Contracting	1-1
	Products	1-2
	Mental Health Designated Facility Program Goals and Objectives	1-3
	Designated Facility Provider Network	1-4
2	Quality Assurance Policies	2-1
	Inpatient and Intermediate Mental Health and Substance Abuse Quality Occurrence Reporting.....	2-1
	Regulatory, Accreditation, or other Oversight Agency Actions	2-1
	Benefits and Eligibility	2-2
	Change of PCP and Its Impact on Designated Facility Assignment.....	2-2
	Designated Facility Referrals for Outpatient Mental Health and Substance Abuse Treatment	2-3
	Commercial Members	2-3
	Tufts Health Plan Medicare Preferred HMO Members.....	2-3
	Financial Responsibility for Medical/Surgical Services Associated with Inpatient Mental Health and Inpatient Substance Abuse Emergency or Inpatient Services	2-4
	Emergency Room.....	2-4
	Capitated Members.....	2-4
	Non-Capitated Members	2-4
	Inpatient Mental Health and Substance Abuse Services	2-4
	Capitated Members.....	2-4
	Non-Capitated Members	2-4
	Physician Services	2-5
	Inpatient Mental Health and Inpatient Substance Abuse Emergency Services Financial Responsibility.....	2-5
	Designated Facility Financial Responsibility - General	2-6
	Financial Responsibility - Incorrect Designated Facility	2-6
	Out-of-Designated Facility Transfers.....	2-7
	Outpatient Clinician Role in Inpatient Care.....	2-7
	Communication to Primary Care Physicians	2-8
	Disclosure of Medical Information to the Member's Primary Care Physician.....	2-8

Permitted Disclosure to PCP: Medical Information Related to a Psychiatric Inpatient Admission.....	2-8
Permitted and Prohibited Disclosure to PCP: Alcohol and Substance Abuse Related Medical Information	2-8
References.....	2-9
Transfer between Hospitals for Mental Health and Substance Abuse	2-9
Transportation	2-9
Policy when Tufts Medicare Preferred HMO Members do not wish to be admitted to the Designated Facility	2-9
Policy on Management of Tufts Medicare Preferred HMO Members with Delirium and Agitation Associated with Dementia	2-10
Financial liability	2-10
Confidentiality with Tufts Health Plan Employee Admissions.....	2-11
Mental Health and Substance Abuse Provider Continuity of Care Standards ..	2-11
General Standards for Documentation of Communication Related to Continuity of Care.....	2-11
Patient Consent.....	2-11
Member Information	2-11
Additional Standards for Tufts Health Plan Medicare Preferred Members.....	2-12
Inpatient Provider Continuity of Care Standards	2-12
Standards for Communication.....	2-12
References	2-13
3 Denials and Appeals	3-1
Late Preregistration of Inpatient MH/SA Admissions Policy.....	3-1
Delay Day Definition and Payment Policy	3-2
Lack of Information Administrative Denial Definition and Payment Policy	3-2
Mental Health Expedited Appeal Policy and Procedure	3-2
Requests for Expedited Appeals	3-2
Tufts Health Plan Medicare Preferred Denials and Appeals.....	3-3
Submitting a Hospital Discharge Appeal	3-3
Providing Hospital Information to Masspro.....	3-3
Notice of Denial of Medical Coverage (NDMC).....	3-4
Monitoring Compliance.....	3-4
Requesting an Expedited Tufts Health Plan Medicare Preferred Appeal.....	3-4
Additional Information.....	3-5
Notification of Discharge and Appeal Rights	3-5
Hospital Discharge Decision Appeal Procedure.....	3-5
4 Inpatient Utilization Management	4-1
Utilization Management Procedures for Inpatient Mental Health and Substance Abuse	4-1
Clinical Coverage Criteria.....	4-1
Utilization Management Clinical Information	4-1
Designated Facility Utilization Management	4-1
Tufts Health Plan Inpatient Care Manager Oversight of Designated Facility Utilization Management.....	4-2
Out-of-Designated Facility Admissions Utilization Management Procedures	4-2
Intermediate Levels of Care - Registration, Review, and Discharge Process	4-2
Capitated Cases.....	4-3
Fee-For-Service Cases (Non-Capitated Membership).....	4-3

	Commercial Case Management Standards for Continuity of Care for Patients with Comorbid Medical and Psychiatric Conditions	4-3
	Court-Mandated Treatment Policy	4-4
	Substance Abuse Treatment Policy	4-4
5	Inpatient Quality Improvement	5-1
	Discharge Planning Standards at Designated Facilities	5-1
	Inpatient Mental Health and Substance Abuse Documentation Standards	5-1
	Partial Hospital Documentation Standards: Mental Health and Substance Abuse	5-3
	Mental Health and Substance Abuse Follow-up After Hospitalization Program	5-5
	Discharge Planning Guidelines for the Seven (7) Day Follow-up Program	5-5
	Family Meeting Incentive Guidelines for Designated Facilities	5-6
6	Benefits and Exclusions	6-1
	Parity Benefits	6-1
	Massachusetts Mental Health Parity	6-1
	Affected Clients	6-1
	Implementation.....	6-2
	Rhode Island Mental Health Parity Benefits.....	6-2
	Federal Mental Health Parity Law	6-3
	Custodial Care Policy: Limitation of Inpatient Mental Health and Substance Abuse Treatment Benefits	6-4
	Custodial Care Procedure	6-4
	Financial Liability	6-6
	Chronic Risk Pool.....	6-6
	Home Care Criteria for Mental Health/ Substance Abuse Services	6-6
	Admission Criteria	6-6
	Exclusion Criteria	6-6
	Discharge Criteria.....	6-7

List of Tables

Table 6-1: Custodial Care Procedure 6-4

1 Introduction to the Designated Facility Program

Program Overview

Tufts Health Plan uses a network of **Designated Facilities** for mental health and substance abuse (MH/SA) services. A Designated Facility is a general hospital or mental health/substance abuse freestanding hospital under contract with Tufts Health Plan to provide inpatient and other hospital-based acute mental health/substance abuse services, including MH/SA emergency room, partial hospital, intensive outpatient, acute residential treatment, and observation services.

The Designated Facilities are chosen for their ability to provide quality care, to manage clinical services across levels of care, and to serve the geographic needs of their assigned Tufts Health Plan membership. Each Designated Facility is contractually responsible to provide the following clinical functions:

- Triage, assessment
- Level-of-care determination
- Acute inpatient MH/SA treatment
- Intermediate levels of care
- Discharge planning

A key component of the Designated Facility program is the close working relationship between Tufts Health Plan, the Tufts Health Plan Care Manager (CM), and the Designated Facility. Each Designated Facility is assigned a Tufts Health Plan Designated Facility CM, whose role is to meet with Designated Facility representatives on a routine basis to review and evaluate Designated Facility utilization and quality of care performance metrics, and to evaluate Designated Facility compliance with Tufts Health Plan policies and procedures.

The CM can provide claims support, benefits clarification, case consultation, and help navigating the Tufts Health Plan system. The CM conducts utilization review for cases identified by the Designated Facility or Tufts Health Plan using InterQual® clinical criteria. A Tufts Health Plan Mental Health Medical Director (a Board-Certified psychiatrist) is assigned to the Designated Facility Program to assist with quality assurance and utilization review, problem resolution, and to consult with the Designated Facility Care Managers and Designated Facility medical leadership as needed.

Contracting

Most Designated Facilities have a capitation contract with Tufts Health Plan for HMO Members. The Designated Facility is responsible for providing or arranging all inpatient and/or intermediate levels

of care for its capitated membership. The Designated Facilities are responsible for all utilization management decisions for their capitated membership except for denials. They are also contracted to make level-of-care and admission decisions for their capitated membership.

The Designated Facilities that are not capitated coordinate level-of-care and utilization management with the assigned Care Manager.

Both capitated and non-capitated DFs are required to participate in Tufts Health Plan's quality initiatives and receive monthly utilization statistics from the Plan. The Network Contracting and Mental Health departments are responsible for negotiating the contracts for inpatient and intermediate levels of care for mental health and substance abuse services.

Products

Each Designated Facility provides or arranges for the delivery of all needed acute inpatient and intermediate levels of care for its assigned HMO membership. The Member's age and Primary Care Physician determine DF assignment. When the Member lives beyond a reasonable travel distance to a Designated Facility, the Member may not be assigned to a DF. Instead, the PCP will direct the Member's inpatient MH/SA care to any in-area contracted inpatient MH/SA facility.

- Tufts Health Plan EPO Members, with the exception of US Family Health Plan adult Members, can receive services at the Designated Facility of their choice. US Family Health Plan adult Members are assigned to a specific Designated Facility. EPO Members are not eligible for out-of-network services.
- Tufts Health Plan POS and PPO Members are not assigned to a specific Designated Facility. They can receive their care at any Designated Facility at the authorized benefit level. PPO Members may also receive care at any contracted facility at the authorized benefit level.
- POS Members can receive services at any non-Designated Facility at the unauthorized benefit level.
- Most PPO Members can receive services at any non-contracted facility at the unauthorized benefit level. Some PPO Members do not have out-of-network benefits.
- All care is subject to applicable deductible and co-insurance. A Tufts Health Plan Care Manager provides initial and concurrent review of all inpatient fee-for-service MH/SA admissions.

Most Tufts Health Plan Medicare Preferred HMO Members are assigned to a Designated Facility based on the Member's PCP. Other IPAs are not assigned to a Designated Facility. Instead, their PCPs direct their Tufts Health Plan Medicare Preferred HMO members to their home hospital or a Designated Facility. The PCP is responsible for directing where their Members are treated, and Tufts Health Plan is responsible for level-of-care, coverage, and utilization management decisions.

Tufts Health Plan Medicare Preferred PPO Members can receive care at any of the contracted Medicare certified facilities. This care is also subject to medical necessity review, and any applicable deductible and co-insurance.

Mental Health Designated Facility Program Goals and Objectives

The goals of the Mental Health Inpatient Designated Facility Program are to enhance the quality of service and care in the clinical (patient/Member), operational (delivery system), and administrative (staff/resources) domains. This provides a comprehensive structure in which to define quality objectives. The specific goals and objectives of the Mental Health Inpatient Program are:

- To maintain a comprehensive Designated Facility Program which encompasses a wide range of services including clinical care, provider management, administrative services, and systems in support of clinical care and Member Services.
- To ensure an effective inpatient utilization management program of mental health and substance abuse services through clear and concise reporting mechanisms.
- To assure that quality data is integrated into decision-making regarding network development and quality management of providers.
- To monitor and evaluate the application of clinical guidelines, utilization review criteria and organizational policy and procedures.
- To promote the evaluation of new behavioral health care services, interventions, procedures, psychopharmacological interventions, and their application for the populations served.
- To employ a systematic approach to detecting and addressing problems that arise in the delivery of care.
- To maintain an effective system of risk management.
- To monitor adherence to policies designed to protect patient confidentiality and to promote the rights of Members.
- To monitor compliance with service standards for access to, and timeliness of services, and appropriateness of interpersonal interactions.
- To promote preventive health care programs aimed at targeted segments of the population served.
- To demonstrate improvement in patient outcomes through evaluation of routine measures (focused studies, special projects, and satisfaction surveys).
- To assure an effective system for tracking, trending, and responding to customer complaints, including grievances, and appeals. In this context the customer is defined as Member, provider, or plan.
- To enhance organization-wide communications providing feedback, follow-through, and follow-up on issues identified through quality improvement processes.
- To promote collaboration with relevant medical delivery systems and other healthcare providers, to enhance the processes for the coordination and continuity of care and service delivered to Members.

Designated Facility Provider Network

The Manager of Inpatient Mental Health Programs chairs regular meetings for representatives of the Designated Facility network. Representatives from the Designated Facility Inpatient provider network attend these meetings with the Tufts Health Plan Medical Director of Mental Health and representatives from Tufts Health Plan Mental Health Inpatient, Outpatient, and Program Development departments.

The Designated Facility meeting provides a forum for the Tufts Health Plan Mental Health Inpatient Program to share utilization and quality improvement (QI) performance data, network policy, and procedure changes. In addition the Designated Facility meeting elicits participation from providers regarding Plan decisions related to the current and future direction of the Designated Facility program, and to share information that has the perspective of the “front line” clinician in the Designated Facility program.

Providers are encouraged to present “best practices” that highlight the delivery of clinical services that combine effectiveness and efficiency. All the Designated Facilities are required to participate in these meetings.

The standards, policies, and procedures contained in this Designated Facility manual are designed to ensure that Tufts Health Plan is able to consistently achieve quality, regulatory, and accreditation requirements.

2 Quality Assurance Policies

Inpatient and Intermediate Mental Health and Substance Abuse Quality Occurrence Reporting

In an effort to ensure quality of care for Tufts Health Plan members receiving services at a Designated Facility (DF), Tufts Health Plan requires that all Designated Facilities and contracted facilities complete the “*Quality Occurrence Reporting Document*” for the quality occurrences outlined below. All quality occurrences will be reviewed by a Medical Director within the Mental Health department and scored to determine if the occurrence merits further investigation or a corrective action plan.

The Tufts Health Plan Medical Director may request additional information from the facility, including a copy of the medical record or submission of a written report of the event by the Medical Director at the facility.

The following are Quality Occurrences that must be reported to Tufts Health Plan within 24 hours from the time of occurrence:

- All deaths, excluding those related to end-stage/terminal illness (e.g., metastatic cancer, end-stage Chronic Obstructive Pulmonary Disease). This includes any death subsequent to a case transfer from the DF psychiatric or substance abuse treatment unit to a medical unit.
- A patient who causes harm to self or others and requires medical attention occurring during an inpatient mental health/substance abuse stay, or during an Emergency Room evaluation.
- An adverse medical outcome secondary to care or lack thereof. Examples include:
 - Falls with injury
 - Injury related to restraint and/or seclusion
 - Complications from ECT
 - Medication errors
- Breach of patient confidentiality while in the provider’s care.
- Suspected, alleged, or proven abuse of a patient while in the provider’s care.
- Patient elopement while in the provider’s care.

Regulatory, Accreditation, or other Oversight Agency Actions

Designated Facility staff reports any significant action by a regulatory, accreditation, or other oversight agency that is initiated by a major quality of care concern for a Tufts Health Plan Member,

or that is taken by the hospital against a staff member or program due to a general patient quality of care issue.

Examples of agencies and actions include:

- Department of Health
- Department of Mental Health
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sentinel event
- Board of Registration of medicine reportable event
- Decredentialing, termination, or other adverse action for cause taken by the hospital against a hospital provider.

The Tufts Health Plan Care Manager may observe, over time, events that occur frequently at a specific Designated Facility that may indicate an evolving pattern of care, or a clinical practice that is inconsistent with Tufts Health Plan quality of care standards. The Care Manager discusses any such observations with the Tufts Health Plan Medical Director and the Manager of Mental Health Inpatient Programs. The Care Manager also discusses the observation with the clinical contacts at the Designated Facility. The Care Manager may also convey his or her findings in a written report. The Tufts Health Plan Medical Director, Care Manager, and the Manager of Mental Health Inpatient Programs, determine the appropriate action to be taken.

Benefits and Eligibility

For coordination and verification of benefits and eligibility for services, log into <http://www.tuftshealthplan.com>, call the Interactive Voice Response (IVR), or call the Mental Health department (800-208-9565) prior to admission. **After** admission, contact the Designated Facility Care Manager under the following circumstances.

- Initial Determination cases* [Call the Mental Health department (800-208-9565) to initiate all initial determinations]
- Potential exception to benefit cases
- In-area admissions outside of the assigned Designated Facility and out-of-area HMO admissions
- Cases with plans for transfer to a State facility, long-term residential treatment program, or other service which the Designated Facility does not intend to authorize under capitation, or for fee-for-service intermediate level of care services which require Tufts Health Plan authorization
- Cases where enrollment/eligibility is in question
- Cases involving coordination of benefits where another insurer may be involved
- Any Tufts Health Plan employee admission (or covered dependents)

Change of PCP and Its Impact on Designated Facility Assignment

- Any change of PCP, whether by a commercial HMO or Tufts Health Plan Medicare Preferred HMO Member, that becomes effective while a Member is either on a mental health or substance abuse treatment inpatient unit, or participating in a Designated Facility sponsored intermediate level of care program, does not result in change of Designated Facility assignment until that Member has completed treatment at that level of care.

- Upon discharge from either inpatient or intermediate level of care, Designated Facility assignment is determined by the provider unit (PU) affiliation of the Member's PCP at the time of discharge.

Designated Facility Referrals for Outpatient Mental Health and Substance Abuse Treatment

Commercial Members

The discharge planners or triage clinicians at each Designated Facility assist in arranging outpatient services for Tufts Health Plan Members prior to discharge. The Designated Facility staff can identify Tufts Health Plan contracted providers using the Tufts Health Plan provider search function available at <http://www.tuftshealthplan.com>, or by calling the Mental Health department phone queue at 800-208-9565.

At times, out-of-network outpatient treatment for Members is requested either by the Member or by a Designated Facility clinician. The Mental Health Care Manager assigned to that Designated Facility or a Tufts Health Plan Service Coordinator gathers the information needed to evaluate the request, and reviews the request with the Medical Director for Mental Health Services. If the Medical Director approves the request, authorization for outpatient services is given to the Member. If the request is denied, the Care Manager informs the Designated Facility clinician, and directs him or her to log into <http://www.tuftshealthplan.com>, or call the Mental Health line for a listing of in-plan providers.

Note: HMO/EPO Members do not have out-of network services and require authorization from Tufts Health Plan for outpatient mental health and substance abuse services. POS/PPO Members may have out-of-network benefits. POS/PPO Members with out-of-network benefits are not required to receive authorization to see a non-contracted provider..

Tufts Health Plan Medicare Preferred HMO Members

The PCP approves and authorizes all outpatient specialty care, including outpatient mental health and substance abuse treatment for Tufts Health Plan Medicare Preferred HMO Members. Tufts Medicare Preferred PPO and Private-Fee-For-Service Members are not required to obtain authorization from a PCP or Tufts Health Plan for outpatient mental health and substance abuse services.

Financial Responsibility for Medical/Surgical Services Associated with Inpatient Mental Health and Inpatient Substance Abuse Emergency or Inpatient Services

Emergency Room

Capitated Members

Capitated services include all services rendered in the emergency room setting to Members with primary psychiatric/substance abuse diagnoses, including physician and laboratory services delivered as part of emergency room medical evaluation/clearance. If the Member is evaluated at his or her assigned Designated Facility, whether admitted to Inpatient level of care or not, the services are included in the capitated fee. If the Member is evaluated at a Designated Facility or a contracted facility to which he or she is not assigned, then that facility is reimbursed at contracted rates by Tufts Health Plan.

Non-Capitated Members

For Members who are not capitated, Emergency room visit services are covered by Tufts Health Plan at contracted rates. All Members covered by fee-for-service products are reimbursed on a per diem basis.

Note: For both capitated and non-capitated Members, medical services that are for a primary medical diagnoses are covered under the Tufts Health Plan medical benefits subject to co-payments, co-insurance, or deductibles as stated in the applicable Product Description.

Inpatient Mental Health and Substance Abuse Services

Capitated Members

All hospital billed items for inpatient services rendered to Members with primary psychiatric or substance abuse diagnoses are covered under capitation for Members who receive inpatient mental health and substance abuse services at the assigned Designated Facility. These services include room and board, mental health or substance abuse inpatient MD visits, ECT services, labwork, and radiologic tests for mental health or substance abuse assessment.

Non-Capitated Members

All hospital-billed items for inpatient mental health and substance abuse services rendered to patients with a primary psychiatric or substance abuse diagnoses are covered under the per diem or fee-for-service rates per Tufts Health Plan claims policy and procedure at contracted rates. These services include room and board for inpatient days, mental health and substance abuse inpatient MD visits, ECT services, labwork, and radiologic tests for mental health and substance abuse assessment.

Physician Services

Financial responsibility for physician services provided when a Member is hospitalized is described below:

- Physician and hospital services for co-morbid medical diagnoses are not covered under the capitation. These services are covered by Tufts Health Plan consistent with Tufts Health Plan claims policies and procedures at contracted rates.
- Physician, psychiatric, or substance abuse consultation services for patients with medical diagnoses admitted to medical units are not covered under the capitation. Psychiatric or substance abuse services that are for a primary psychiatric or substance abuse diagnosis for a Member on a medical unit are subject to co-payments, co-insurance, and deductibles as stated in the applicable product description, and are subject to applicable medical pre-authorization policies and procedures.

Inpatient Mental Health and Inpatient Substance Abuse Emergency Services Financial Responsibility

Financial responsibility for mental health and substance abuse emergency services depends on whether the Member is capitated and/or is admitted to an inpatient mental health or substance abuse unit in the same facility that provides the emergency services. These scenarios are summarized below:

- When a Tufts Health Plan Member under capitation receives mental health or substance abuse emergency services, then financial responsibility for the mental health or substance abuse emergency services is determined as follows:
 - When the Member receives emergency services in the Member’s assigned Designated Facility, then the mental health or substance abuse emergency services are covered under capitation.
 - When the Member receives emergency services at a Tufts Health Plan contracted facility or at another Designated Facility that is not the Member’s assigned Designated Facility, then the mental health or substance abuse emergency services are covered by Tufts Health Plan based on Tufts Health Plan claims procedures at contracted rates.
 - When the Member receives emergency services at a non-contracted facility (e.g., out-of-area), then the mental health or substance abuse emergency services are covered by Tufts Health Plan based on Tufts Health Plan claims procedures at the facility charges.
- If a Tufts Health Plan Member is not capitated and receives mental health or substance abuse emergency services, then financial responsibility for the emergency services is determined as follows:
 - When the Member receives emergency services at a Tufts Health Plan contracted facility, then the emergency services are covered by Tufts Health Plan based on Tufts Health Plan claims procedures at contracted rates, and subject to any administrative services agreement with a Tufts Health Plan self-funded account.
 - When the Member receives emergency services at a non-contracted facility (e.g., out-of-area), then the emergency services are covered by Tufts Health Plan based on Tufts

Health Plan claims procedures at the facility charges, and subject to any administrative services agreement with a Tufts Health Plan self-funded account.

Designated Facility Financial Responsibility - General

The following policy applies only to capitated Members. Other admissions (e.g., to non-capitated Designated Facilities, other Tufts Health Plan network hospitals and non-contracted hospitals within the service area) are reviewed and processed by the assigned Designated Facility and the Tufts Health Plan mental health program in accordance with Designated Facility agreements.

Capitated Designated Facilities have sole financial responsibility for the costs of providing or arranging for inpatient and intermediate levels of care for mental health and substance abuse services for Members. The Designated Facility is only financially responsible for the cost of the inpatient mental health and substance abuse services when the facility is notified of the admission within one business day. If the capitated Designated Facility is notified more than one business day after the admission, the Designated Facility is financially responsible for the cost of inpatient mental health and substance abuse services provided after the time of notification.

Financial Responsibility - Incorrect Designated Facility

Most Tufts Health Plan HMO Members are assigned to Designated Facilities for inpatient and partial hospital treatment of mental health and substance abuse problems. Some HMO Members are assigned to a Designated Facility paid under capitation. Member assignment is based on the Member's age and the provider unit affiliation of the Member's primary care physician. Occasionally, Members are incorrectly admitted to a Designated Facility. This policy is intended to minimize the time that the Designated Facilities and Tufts Health Plan spend investigating admissions of Members to "incorrect" Designated Facilities, and to support a collaborative relationship among the Designated Facilities.

- All mental health and substance abuse admissions of Members assigned to other Designated Facilities are the financial responsibility of the admitting Designated Facility for the first hospital day.
- If the admitting facility's staff is unsure if they are the assigned Designated Facility, they should continue to exercise every effort to identify the assigned Designated Facility and will continue to be financially responsible for the patient's inpatient care until they have notified either the Tufts Health Plan Mental Health Program or the assigned Designated Facility.
- Upon notification by the Tufts Health Plan Mental Health Program or the admitting Designated Facility that a Member has been admitted to an "incorrect" Designated Facility, the assigned Designated Facility becomes financially responsible for the admission as of the notification date. Both Designated Facilities will expedite transfer of the Member, if clinically appropriate. If a transfer is clinically inappropriate, the assigned Designated Facility authorizes and funds the continued stay at the "incorrect" Designated Facility until the patient can be transferred or discharged.
 - If a patient transfers, both the transferring and receiving Designated Facilities follow the Tufts Health Plan Mental Health Program policy and procedure regarding patient transfers.

- If the transfer occurs within the first hospital day, the "incorrect" Designated Facility does not bill the assigned Designated Facility.
- Should disagreements arise regarding stability for transfer, the Tufts Health Plan Medical Director for Mental Health or his or her designee assists in making this determination.

Out-of-Designated Facility Transfers

A Designated Facility may choose to have a capitated Member's care provided in another facility for one of several reasons:

- The Member needs specialized care that the Designated Facility cannot adequately provide, e.g., eating disorders, specialized adolescent services.
- For confidentiality reasons a Member cannot be adequately treated at his or her Designated Facility.
- Two members of the same family require inpatient or intermediate level-of-care at the same time, and it is clinically contraindicated to provide for their care simultaneously at the same program.
- Treatment has reached a clinical impasse at the Designated Facility.
- There are no beds available at the DF at the time the Member requires treatment.

When a Designated Facility authorizes care at another facility, the Member is not required to return to his or her assigned Designated Facility during that episode of care, even if the Designated Facility recommends it.

The assigned Designated Facility remains responsible for case managing the clinical care the Member is receiving at the other facility. The assigned Designated Facility remains financially responsible for all capitated Members receiving care at the other facility.

Outpatient Clinician Role in Inpatient Care

Communication and collaboration between inpatient and outpatient clinicians is an essential component of high quality, effective managed care.

The direct, on-site involvement of a hospitalized patient's outpatient mental health or substance abuse provider may be of great value in coordinating care, outpatient treatment planning, and/or expediting readiness for discharge back to that provider's care. In cases where the outpatient provider is invited into the hospital to consult with the inpatient treatment team or with the Member, it is reasonable that the outpatient provider be compensated for his or her time and clinical services.

These services should be considered a consultation to the inpatient care, and funded like other consultation services, out of the Designated Facility's capitation budget. The purpose and extent of consultation along with the appropriate fees should be determined by prior agreement between the Designated Facility and the outpatient provider. Under this agreement, it is expected that the provider will document his or her visit in the medical record. Failure of the outpatient provider to get approval from the Designated Facility to see a Member while hospitalized at that facility or to document that clinical visit may result in non-payment of any claims submitted.

The outpatient provider cannot bill services against the Member's outpatient mental health and substance abuse benefits. These benefits are reserved for care rendered in the outpatient setting.

Communication to Primary Care Physicians

All communications related to Tufts Health Plan Member information must be in compliance with the [Tufts Health Plan Corporate Confidentiality Policy Regarding Protected Health Information](#). In addition, Mental Health department staff must follow all applicable laws and practice standards regarding patient confidentiality.

Disclosure of Medical Information to the Member's Primary Care Physician

Permitted Disclosure to PCP: Medical Information Related to a Psychiatric Inpatient Admission

To ensure coordination and continuity of care, Tufts Health Plan may disclose to the Member's PCP that the Member has been admitted to an inpatient psychiatric unit. Disclosure may be made to the PCP without specific written Member consent when the disclosure is necessary to enable the recipients to carry out their responsibilities to the Plan.

Permitted and Prohibited Disclosure to PCP: Alcohol and Substance Abuse Related Medical Information

The Mental Health department may not disclose any information regarding individually-identifying Member medical information of alcohol and substance abuse disorder to the Member's PCP without written consent by the Member.

The Plan may only release alcohol and substance abuse related medical information to the Member's PCP with written Member consent. Following this type of disclosure, the Plan must document the disclosure in the Member's records, including the:

- Name of the medical personnel to whom the disclosure was made
- Name of any affiliated health care facility
- Name of the individual making the disclosure
- Date and time of the disclosure
- Nature of the emergency

In addition, the disclosure must be accompanied by the following statement:

This information has been disclosed to you from records that are protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

References

- [Tufts Health Plan Corporate Confidentiality Policy Regarding Protected Health Information](#), Revised 1/6/06

Transfer between Hospitals for Mental Health and Substance Abuse

A recommendation to transfer a member from an inpatient setting to another facility may be made for reasons of medical necessity (e.g., necessary clinical services are not available at the hospital the Member is to be transferred from that are available at the receiving hospital) or Member health plan benefits and covered services (e.g., a Member who presents for transfer from an out-of-plan to an in-plan hospital).

In the case of a recommendation for transfer, there must be physician-to-physician consultation between the sending and receiving facilities to evaluate the appropriateness of a transfer. The appropriateness of a transfer is based on a determination that the Member's medical condition has stabilized. In general, the Member is considered medically stable and appropriate for transfer if, within reasonable medical probability, no significant deterioration of condition as evidenced by danger to the Member or others, is likely to result from, or occur during, the transfer.

For Members with an assigned Designated Facility, the Designated Facility is responsible for efforts to coordinate care when a recommendation for a transfer is approved. The Designated Facility (or other receiving hospital when the Member is not assigned to a Designated Facility) must have the capacity to provide medical treatment appropriate to the needs of the Member, available space, and qualified personnel to treat the Member. The transferring facility forwards relevant medical records and use qualified personnel and transportation personnel.

The attending physician informs the member or Member representative of the decision to transfer, including the reasons for the transfer. If the Member or Member's representative disagrees with a plan to transfer to a different hospital, the Member or representative may request an initial determination of the decision to transfer with a Tufts Health Plan Medical Director. Although the Designated Facility serves as the authorizing agent for these mental health or substance abuse services, it does not have the authority to deny coverage or treatment without the review by a Tufts Health Plan Medical Director. All denials for coverage or inpatient treatment are issued by Tufts Health Plan.

Transportation

Tufts Health Plan covers medically necessary ambulance services as determined by the Designated Facility. The Designated Facility arranges medically necessary transportation for the Member with transportation services that have contracts with, or are otherwise approved in advance by Tufts Health Plan. If the Member is at another facility that will be arranging the transfer, the Designated Facility asks that facility to use ambulance services contracted with Tufts Health Plan.

Policy when Tufts Medicare Preferred HMO Members do not wish to be admitted to the Designated Facility

If a Designated Facility offers a treatment that a Member, Member advocate, or other party believes is not sufficient to meet the treatment needs of the Member, and the Member is requesting treatment at another facility, then the Designated Facility must offer the Member an initial determination and contact the Tufts Health Plan Mental Health Department at 800-208-9565 to initiate the process.

The usual policy and procedure is to complete the Initial Determination (see Initial Determination Policy). The focus of the initial determination is on the clinical needs of the Member based on the:

- Evaluation of the services available by the Designated Facility to meet the needs of the patient
- CMS Guidelines

The Initial Determination decision is rendered, and the Designated Facility, the Member, or person requesting the determination on behalf of the Member may request an appeal, consistent with [CMS](#) guidelines.

Policy on Management of Tufts Medicare Preferred HMO Members with Delirium and Agitation Associated with Dementia

The Tufts Medicare Preferred Medical Groups and the Designated Facilities have a joint responsibility in the coordination of appropriate care for Members with medical illnesses who present with acute mental status changes, particularly delirium and agitation associated with dementia.

Because delirium is always considered to be a medical emergency, and agitation associated with dementia is frequently caused by a delirium, the primary responsibility for initial care lies with the PCP and the PCP's medical group. Care should be rendered in a medical setting and managed under the medical benefit. Following medical stabilization to the point where ongoing medical care can be provided at an outpatient level of care, the Designated Facility shall facilitate ongoing psychiatric treatment based on medical necessity criteria if there are ongoing residual psychiatric symptoms or behavioral dyscontrol. The Designated Facilities do not provide authorization for skilled nursing services or for custodial care outside of the Designated Facility.

If the PCP, the medical group, or the attending physician on the medical unit do not agree with the Designated Facility after the PCP or the designated specialist (e.g., hospitalist, neurologist, consulting psychiatrist) consult with a psychiatric specialist at the Designated Facility, then the Designated Facility needs to offer the requesting provider a financial coverage determination. The Designated Facility should contact the Tufts Health Plan Mental Health department at 800-208-9565 to initiate the process.

Financial liability

When a Designated Facility authorizes care at another facility, the Member is not required to return to his or her assigned Designated Facility during that episode of care, even if the Designated Facility recommends it.

The assigned Designated Facility remains responsible for case managing the clinical care the Member is receiving at the other facility. The assigned Designated Facility remains financially responsible for all capitated Members receiving care at the other facility.

Confidentiality with Tufts Health Plan Employee Admissions

Admissions to inpatient mental health or substance abuse facilities for Tufts Health Plan's employees and their dependents are confidential and require a different preregistration and review procedure than the usual procedure. This is consistent with the Mental Health department's commitment to maintaining employee confidentiality in all communications and record keeping when an employee/dependent needs to access mental health or substance abuse services.

When the Designated Facility staff notifies Tufts Health Plan of an employee/dependent who is admitted for inpatient psychiatric or substance abuse treatment, an inpatient mental health care manager who provides utilization management for employees/dependents becomes the contact for that admission. The care manager may not be the same care manager who is the liaison with the Designated Facility.

When an employee/dependent who is being discharged from inpatient mental health or substance abuse treatment requires assistance with finding appropriate outpatient care and obtaining authorization for outpatient services, a Mental Health Outpatient Programs Supervisor is available to assist with this process.

Mental Health and Substance Abuse Provider Continuity of Care Standards

All Mental Health and Substance Abuse providers must meet the applicable Continuity of Care standards.

General Standards for Documentation of Communication Related to Continuity of Care

All communications related to Tufts Health Plan Member information must meet the following standards:

Patient Consent

The mental health provider/facility must obtain and document a release of information, as required by law, to exchange information with any other behavioral, medical, or social service provider. Signed consent for release of information forms for these contacts that are consistent with all applicable federal, state, and related oversight bodies are to be obtained from the patient at the initiation of treatment.

Providers should document a Member's refusal to authorize a release of information in the general medical record. The Member's reason for refusal may be documented if it is relevant to ongoing treatment or coordination of care. Mental Health providers are expected to follow all applicable laws and practice standards regarding patient confidentiality.

Member Information

The behavioral health care provider must document that the information below (where applicable) was communicated to other health care providers to facilitate continuity of care. Documentation may

be in the form of a progress note, copy of a letter, or confidential/secure fax communication with the provider:

- Patient's name
- Diagnosis
- Treatment plan
- Diagnostic tests recommended or ordered (if applicable)
- Referrals (if applicable)
- Medications (if applicable)
- Any other elements the provider deems clinically relevant to coordination of patient care

Additional Standards for Tufts Health Plan Medicare Preferred Members

In addition to all the standards in the following sections, all providers must adhere to the following standards for Tufts Health Plan Medicare Preferred Members:

- Providers must ensure that Members receive information they need to participate fully in their own care, including information on subjects such as: self care, medication management, use of medical equipment, potential complications that should be reported to providers, and scheduling of follow-up services. If a Member is not able to participate fully in his or her treatment decisions, then the Member has the right to be represented by a family member or guardian (authorized representative).
- Providers must ensure that Members who are unable or failing to cooperate in their own treatment, receive counseling and case management. These services should include identifying social, financial, or other barriers that are preventing enrollees from complying or cooperating with their treatment, and referral to appropriate services as necessary.
- Providers must educate patients regarding their own behavioral and medical health needs. Providers must share the results of their evaluation and treatment planning with the Member. Providers must discuss potential treatment options (without regard to plan coverage), and must make patients aware of the effects of any treatment modality, while recognizing that the patient has the final say among any clinically acceptable choices available to them.

Inpatient Provider Continuity of Care Standards

Standards for Communication

Between a Contracted Inpatient Facility (Designated Facility) and a PCP

All contracted Tufts Health Plan inpatient designated facility staff must routinely document communication with the PCP for every Member who has an assigned PCP. This communication must occur at the point of discharge from the facility. However, if there is a serious medical co morbid condition that requires medical intervention, the Designated Facility must document communication with the PCP prior to the initiation of planned medical intervention, or immediately after the provision of emergency medical intervention.

Between a Contracted Inpatient Facility (Designated Facility) and Non-physician Outpatient Treatment Provider(s) (e.g., social worker, psychologist)

All contracted inpatient facilities must document the communication with the mental health or substance abuse outpatient provider(s) during the course of the admission to inform the provider(s) of the admission, to review the course of inpatient treatment, and to assist with the coordination of care and discharge planning.

Between a Contracted Inpatient Facility (Designated Facility) and Outpatient Psychiatrist

1. All contracted inpatient facilities must document the communication with the outpatient psychiatrist (or other physician or health care professional who will follow the Member for outpatient medication management upon discharge) during the course of the admission.
2. Clinical staff of the inpatient-contracted facility must inform the outpatient psychiatrist or other prescribing provider of any clinically significant abnormal laboratory or other medical findings or recommendations.

Between a Contracted Inpatient Facility (Designated Facility) and Employee Assistance Programs, Schools, Courts, Department of Social Services, Department of Mental Health, or Other Social Service Agents

1. All contracted inpatient facilities must document the communication with any other social service agency or provider when that group or person is the primary source of the referral, or when the social service agency follows the Member as the primary referral source post discharge.
2. Contact must occur during the course of the admission to inform the provider(s) of the admission, to review the course of inpatient treatment, and to assist with coordination of care and discharge planning.

References

- *NCQA MCO standard QI 11 and national benchmarks*

3 Denials and Appeals

Late Preregistration of Inpatient MH/SA Admissions Policy

All contracting facilities are required to notify Tufts Health Plan of any inpatient mental health or substance abuse admission within one business day of the admission. This policy is consistent with the Tufts Health Plan preregistration policy for all hospital services, and is consistent with the filing limits imposed on all contracted inpatient facilities. If Tufts Health Plan is notified of a mental health or substance abuse admission after the filing limit, the following procedure is carried out:

The Mental Health department is notified of the admission (either by the Precertification department or the Claims department) to determine if the hospital is a contracted facility, non-contracted facility, or a Mental Health Designated Facility.

- **Contracted facilities** - The Mental Health department notifies the Precertification department to deny coverage for the days prior to notification. A Clinician conducts a clinical review to determine coverage for days from the point of notification.
- **Designated Facilities** - A Mental Health Clinician denies coverage until the date of notification unless there is a late preregistration of a Member assigned to that facility under a capitation based contract, in which case the admission is covered.
- **Non-contracted facilities** - A Mental Health Clinician reviews the case to determine coverage. In addition, the Clinician determines if the Member can be held financially responsible for the cost of treatment.
- **Tufts Health Plan Medicare Preferred Admissions** - A Mental Health Clinician determines the appropriate coverage policy based on CMS regulations. Tufts Health Plan Medicare Preferred Members are not held financially responsible if there is a late preregistration.

Delay Day Definition and Payment Policy

A delay day is a day a Member spends in a facility waiting for medically necessary diagnostic testing, treatments, therapies, consultations, surgical or other procedures, or test results. The delay may be due to facility scheduling or staffing issues that represent an interruption in evaluation or treatment which usually results in a longer length of stay than if the care had been efficiently provided and/or arranged.

Tufts Health plan does not pay for delay days. The decision may result in a denial of payment to the hospital, physician, or both. The Member may not be billed for services associated with the payment denial.

Lack of Information Administrative Denial Definition and Payment Policy

Tufts Health Plan needs to receive clinical information from the provider within the requested time frame to effectively perform telephonic reviews and to meet regulatory and accreditation requirements. Failure to provide the requested clinical information within the specified time frame results in denial of payment to the provider (administrative denial). The Member may not be billed for services associated with this type of payment denial.

Mental Health Expedited Appeal Policy and Procedure

Tufts Health Plan recognizes that there are circumstances that require immediate consideration of an appeal. Tufts Health Plan expedites an appeal for a denial of coverage determination when there is an ongoing service (concurrent services) or a service to be delivered imminently (prospective urgent or emergent services) whereby a delay in treatment would:

- Seriously jeopardize the life and health of the Member
- Jeopardize the Member's ability to regain maximum function, or
- If an expedited appeal is requested by the provider

The Mental Health expedited appeals procedure is used for appeals of denial determinations related to requests for coverage of urgent or emergent partial hospital or inpatient hospital services and continued hospital level of care services. Expedited appeals are not offered for non-urgent service requests.

Requests for Expedited Appeals

An Expedited Appeals request may be initiated by calling either the Tufts Health Plan Mental Health or Member Services departments. Requests for expedited appeals may be initiated by the Member or by another person acting on the Member's behalf such as:

- Family member
- Primary Care Physician (PCP) or other provider
- Attorney
- Department of Children and Families (DCF)
- Department of Mental Health (DMH)

- Department of Youth Services (DYS)
- Employee Assistance Program (EAP)

An expedited appeal is initiated only after a denial of coverage determination is rendered. If a request for **reconsideration** is made, an expedited appeal is not initiated until the reconsideration process is completed, and the organizational denial determination upheld.

The Tufts Health Plan Appeals and Grievance department manages the expedited appeals process. The Tufts Health Plan Mental Health Program provides consultation regarding mental health or substance abuse clinical issues and benefits to the Appeals and Grievance department.

Tufts Health Plan Medicare Preferred Denials and Appeals

Beginning July 2, 2007, the [Centers for Medicare and Medicaid Services](#) (CMS) revised the process for notifying Medicare beneficiaries about their hospital discharge appeal rights. Hospitals are required to deliver at least one revised version of the *Important Message from Medicare (IM #1 and #2)* to Medicare beneficiaries. The IM informs Medicare beneficiaries about the hospital discharge appeal rights.

Submitting a Hospital Discharge Appeal

Medicare beneficiaries who exercise their right to appeal the discharge must receive a *Detailed Notice of Discharge* from Tufts Medicare Preferred. To initiate a Masspro review, the Member must submit a hospital discharge appeal request to:

Masspro
245 Winter Street
Waltham, MA 02451
Phone: 800-252-5533
Fax: 781-419-2511

When a Medicare beneficiary files an appeal, the beneficiary remains entitled to continuation of coverage for the hospital stay until the Quality Improvement Organization (QIO), which is Masspro, renders a decision. The Member, Member's representative, attorney, or court-appointed guardian may contact Masspro by telephone, in writing, or by fax. Masspro is authorized by Medicare to review the hospital care provided to Medicare and Medicare Advantage patients.

Providing Hospital Information to Masspro

The hospitals and Tufts Health Plan Medicare Preferred (Tufts Medicare Preferred) are required to provide Masspro with any and all information to make a decision about the discharge determination.

This information includes:

- Copy of the medical record
- Hospital-issued notices (*IM #1 And #2*), and
- *Detailed Notice of Discharge*

Masspro must receive the information within three hours of notification by the Tufts Health Plan Mental Health department of the appeal request. Tufts Medicare Preferred requires that hospitals

supply the medical record and hospital issued notices directly to Masspro within three hours of being notified of the appeals request.

Tufts Medicare Preferred:

- a. Prepares a *Detailed Notice of Discharge* for an enrollee who makes a timely appeal request to Masspro
- b. Faxes the completed *Detailed Notice of Discharge* to the hospital, and requires the hospital to deliver it to the enrollee
- c. Provides the *Detailed Notice of Discharge* to Masspro
- d. Notifies hospitals of the appeal as soon as possible

If a hospital fails to provide the clinical information (medical records or hospital issued notices) to Masspro within the mandated time frame, Tufts Medicare Preferred reserves the right (in accordance with their payment policy) to administratively deny payment for each impacted day if the delay results in extended coverage of the Member's hospital services.

Members are held harmless for the payment of services denied for this reason regardless of the outcome of the appeal. If there is a delay in the termination of service due to the hospital's failure to deliver valid *IM #1 and #2*, the hospital may be held financially liable for services incurred as a result of the invalid delivery. Members are held harmless for the payment of services denied for this reason.

Notice of Denial of Medical Coverage (NDMC)

When a Medicare beneficiary requests a future or concurrent service, such as a request for an admission or transfer to a facility other than the Member's Designated Facility, the Designated Facility must notify Tufts Health Plan of the request if the Designated Facility recommends denial.

Designated Facility requests for an initial determination of prospective requests by the Medicare beneficiary to the Designated Facility should be made by calling the Mental Health phone queue at 800-208-9565. Designated Facility requests for denials of a Medicare beneficiary's concurrent request of service is made by notifying the Designated Facility assigned care manager.

All initial determinations are reviewed by a Tufts Health Plan Medical Director after a Designated Facility Medical Director reviews the request. The Tufts Medicare Preferred Appeals and Grievances department sends out all denials with the NDMC Standard Notice to the Member and copies to the Provider.

Monitoring Compliance

Designated Facilities and other Contracting hospitals are obligated to cooperate with, and participate in Tufts Medicare Preferred's Quality Assurance and Utilization Management (QA/UM) programs. In an ongoing effort to work collaboratively with Tufts Health Plan providers, Tufts Medicare Preferred continues to monitor compliance and offer ongoing communication.

Requesting an Expedited Tufts Health Plan Medicare Preferred Appeal

If the Member misses the Masspro deadline (up until midnight on the day of discharge), the Member has the right to request an expedited Tufts Medicare Preferred appeal by calling 1-800-701-9000.

Tufts Medicare Preferred generally makes another decision regarding the service within 72 hours. However, during the Tufts Medicare Preferred appeals process, the Member is financially responsible for hospital charges beginning on the effective date of discharge unless the discharge decision is overturned through the appeals process.

Additional Information

Instructions for the *Important Message (IM)* and *Detailed Notice of Discharge* can be found in the [Tufts Health Plan Medicare Preferred HMO & PPO Provider Manual](#) and on the [Provider Forms](#) web page on the [Tufts Health Plan](#) website.

Notification of Discharge and Appeal Rights

Additional information on the new requirements to the *Notification of Discharge and Appeal Rights* can be found at <http://www.cms.hhs.gov/bni>.

Hospital Discharge Decision Appeal Procedure

The following is the *Hospital Discharge Decision Appeal* procedure:

1. Within two (2) days of a hospital admission, a Member must be issued the *Important Message (IM #1)* by the hospital, which informs then Member of their MassPro appeal rights at the time of discharge.
2. No more than two days before discharge, but as far in advance as possible, the hospital reissues the *Important Message (IM #2)* to the member.
3. If the Member or his or her representative elects to appeal the discharge decision, Masspro notifies the Tufts Medicare Preferred Appeals and Grievance department of the appeal request.
4. Tufts Medicare Preferred contacts the Mental Health staff person (MHSP) to inform the MHSP of the hospital discharge appeal request through Masspro.
5. The MHSP requests that the Designated Facility complete a *Hospital Discharge Summary Form*, which contains the applicable Medicare coverage criteria, and specific information why the member no longer meets the coverage guidelines.
6. The MHSP faxes the *Hospital Discharge Summary Form* to Tufts Medicare Preferred Appeals and Grievances (A&G), Fax # 617-972-9516.
7. Tufts Medicare Preferred A&G takes the information from the *Hospital Discharge Summary Form*, and inserts it into the *Detailed Notice of Discharge*.
8. The *Detailed Notice of Discharge* is faxed to the hospital where it is issued to the Member/representative.
9. Tufts Medicare Preferred faxes a copy of the *Detailed Notice of Discharge* to Masspro directly.
10. The hospital sends all medical records and hospital notices, including *IMs*, to Masspro.
11. If the Member's last covered day is extended due to a delay in Masspro receiving any of the required information, the hospital may be administratively denied payment for those days.
12. If Masspro agrees with the Member, and overturns the decision to discharge, the Member will be reinstated. The process begins again if and when the Member is ready to be discharged again.
13. Tufts Medicare Preferred monitors compliance with the time frames associated with Masspro hospital discharge appeals.

The *Notification of Hospital Discharge and Appeal Rights* replaces the *Notice of Discharge and Medicare Appeal Rights (NODMAR)*. In the old process, the Member initiated an initial determination through the Tufts Health Plan Mental Health Department. In the new process, the Member contacts Tufts Health Plan's QIO (Quality Improvement Organization), Masspro, to dispute a discharge date.

The *Notification of Hospital Discharge and Appeal Rights* **cannot be altered**.

The entire *Tufts Medicare Preferred Provider Manual* and all of the necessary forms can be found on the [Tufts Health Plan](#) website.

4 Inpatient Utilization Management

Utilization Management Procedures for Inpatient Mental Health and Substance Abuse

Clinical Coverage Criteria

Tufts Health Plan determines benefit coverage by using clinical criteria to determine the medical necessity and appropriateness of Mental Health/Substance Abuse (MH/SA) services under the terms of the applicable health plan benefit. These criteria include Tufts Health Plan Admission and Continuing Stay Criteria and the InterQual[®] Clinical Criteria.

Utilization Management Clinical Information

Tufts Health Plan clinical staff gather clinical information relevant to determining Medical Necessity when conducting routine prospective review, concurrent review, or retrospective review at any facility. There should be collaboration between clinical staff at the admitting facility and clinical staff at Tufts Health Plan for utilization management.

Designated Facility Utilization Management

The Designated Facility is responsible for delegated utilization management for capitated Members consistent with URAC, NCQA, *Designated Facility Policies and Procedures*, and all other applicable standards. For all Designated Facility admissions, the Designated Facility staff is responsible for conducting UM and ensuring that treatment is provided in the most medically necessary level of care.

The Tufts Health Plan Care Manager also conducts UM for those admissions that meet criteria for review by Tufts Health Plan. For Members who are admitted to another facility as authorized by their Capitated Designated Facility, the Designated Facility staff is responsible for conducting UM and ensuring that treatment is provided in the most medically necessary level of care.

Tufts Health Plan is responsible for providing program oversight of the Designated Facility to ensure that these functions are performed. In addition, Tufts Health Plan Inpatient Care Managers provide routine case consultation with the Designated Facilities.

Tufts Health Plan Inpatient Care Manager Oversight of Designated Facility Utilization Management

The Tufts Health Plan Inpatient Care Manager may conduct utilization management at the Designated Facility on the basis of specific clinical criteria. The Tufts Health Plan Care Manager conducts utilization review for all admissions to non-Designated Facilities for Members who are not assigned to a Capitated Designated Facility.

Out-of-Designated Facility Admissions Utilization Management Procedures

Designated Facilities can authorize capitated Members to be admitted to other facilities, per contractual requirements, to insure the most appropriate care for Tufts Health Plan Members. The Designated Facility is primarily responsible for the utilization management of these out-of-Designated Facility admissions. However, Tufts Health Plan maintains the authority in out-of-Designated Facility admissions where there is a cost share arrangement to collaborate in the utilization management of the admission when appropriate.

If a capitated Member and the Designated Facility disagree on an out-of-Designated Facility admission request, the Tufts Health Plan clinical staff, using the “Tufts Health Plan Behavioral Health Criteria for Initial Determinations,” initially reviews the request for the admission to the other facility. Designated Facilities are encouraged to notify Tufts Health Plan at the earliest possible time when there is a disagreement between the Member and the Designated Facility regarding such admissions and LOC decisions to meet the regulatory time frames.

In the case of any denial of inpatient MH/SA services, refer to the [Denials and Appeals](#) section of this manual.

Intermediate Levels of Care - Registration, Review, and Discharge Process

Effective February 1, 2007, Designated Facilities are required to:

- Obtain a registration number for all intermediate levels of care through the *Interactive Voce Response* (IVR) system
- Review non-capitated cases with a Care Manager to obtain authorization for continued stay
- Report the discharge date

Intermediate levels of care, as defined by Tufts Health Plan, include:

- Acute Residential Treatment (ART)
- Partial Hospitalization (PHP)
- Intensive Outpatient Programs (IOP)

To obtain an initial registration number, Designated Facilities should call Tufts Health Plan’s IVR system at (800) 208-9565. Initial registration should be obtained prior to, or by the first day of treatment.

Capitated Cases

DFs should follow the steps below when providing intermediate level of care services to HMO Members who are capitated to a DF:

1. Providers should call the IVR system to register an intermediate level of care admission and receive a registration number.
2. The Designated Facility continues to be responsible for conducting medical necessity reviews for capitated cases.
3. Providers should call the IVR system to report the discharge date.

Fee-For-Service Cases (Non-Capitated Membership)

DFs should follow the steps below when providing intermediate level of care services to fee-for-service cases that are not capitated to a DF:

1. Providers should call the IVR system to register an intermediate level of care.
The registration number that providers receive via the IVR system does not constitute authorization or override the members benefit limit.
2. Providers should review for medical necessity with a Care Manager to obtain continued stay authorization. It is the responsibility of the Designated Facility to contact the Care Manager for continued authorization.
3. When a member no longer meets medical necessity and is discharged from an intermediate level of care, providers should call the IVR system to report the discharge date.

Commercial Case Management Standards for Continuity of Care for Patients with Comorbid Medical and Psychiatric Conditions

All Tufts Health Plan medical and mental health care coordinators follow the Case Management standards for continuity of care.

The Tufts Health Plan medical case manager and mental health care coordinators evaluate active cases for the presence of significant co-morbid medical and psychiatric conditions which may have the potential to interact and adversely impact the course of treatment for the patient.

Examples:

- A medical case manager provides oversight of a surgical case with a co-morbid acute psychiatric or substance use disorder.
- A mental health Care Manager provides oversight of an inpatient psychiatric or substance use disorder case with a major or severe medical condition.

Court-Mandated Treatment Policy

Tufts Health Plan does not discriminate for, or against any Member who is referred for treatment by a court recommendation or order. Each Member so referred is evaluated in the same manner as any other Member being referred for services.

Neither Tufts Health Plan nor its providers can give guarantees to the court or any other party as to what services will be covered prior to evaluation of the Member being completed. Such evaluations are done either in person or by phone, at the discretion of the provider. If a direct patient interview is necessary for purposes of evaluation, the courts must make its own determination about disposition, i.e., whether it will allow a Member to go voluntarily for a Tufts Health Plan clinical assessment and disposition, or remand the Member directly and without Tufts Health Plan involvement for involuntarily evaluation and treatment at a court-designated site.

Tufts Health Plan benefits cover involuntary treatments when:

- Care meets criteria for medically necessary care.
- If the member is capitated to a Designated Facility, the DF must concur that treatment is indicated and covered under the member's benefit plan. Care is rendered at the Designated Facility or is specifically authorized elsewhere by the Designated Facility or the Tufts Health Plan Medical Director.
- In the case of a Member whose care is not managed by a DF, the Tufts Health Plan Medical Director for Mental Health Services will review for concurrence that treatment is indicated and covered under the member's benefit plan.

For the services to be covered under Tufts Health Plan Medicare Preferred, the services must also meet Medicare criteria for coverage. Payment may only be made for services furnished to individuals or groups of individuals that are in the custody of police or other penal authorities, or the custody of a governmental agency under a penal statute if the following conditions are met:

- State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
- The State or local governmental entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

In addition, payment may not be made for services furnished in, or by State or local hospitals that serve only a specific category of the population, but do not serve the general community, e.g., prison hospitals.

Tufts Health Plan contracting providers should offer to assess the court-referred Member as they would any other Member. As noted above, the involvement of the court does not bind Tufts Health Plan to cover any type or duration of service different from that which would otherwise be covered for this Member or any other Member with a similar clinical presentation.

Substance Abuse Treatment Policy

When medically necessary, Tufts Health Plan provides coverage for services for diagnosis, evaluation, and treatment of alcohol and drug abuse. Tufts Health Plan supports the Designated Facility's development of specific and individualized treatment plans for difficult substance abuse

cases. These treatment plans may, on clinical grounds, include specific requirements or criteria that a Member's condition or presentation must meet before referral to specific treatment modalities.

These are the general guidelines for coverage of Substance Abuse treatment:

- Detoxification is a medical benefit and is covered on an unlimited basis when medically necessary.
- Inpatient substance abuse level of care coverage, other than for medical detoxification, is limited to the specific benefit language in the benefit document.
- The Tufts Health Plan Mental Health department is available to any Designated Facility for assistance in the management of the frequently relapsing and/or non-compliant substance abuser.

5 Inpatient Quality Improvement

Discharge Planning Standards at Designated Facilities

Designated Facilities are expected to meet the following standards in arranging outpatient care following discharge from a hospital stay:

- The Designated Facility discharge planners will make every reasonable effort to ensure that the first outpatient appointment occurs within seven (7) days of discharge from an inpatient hospitalization.
- Post-hospitalization medication monitoring appointments may occur at an interval of longer than seven (7) days. However, the discharge plan must provide the patient, family, and involved clinicians with all contact information, including the name of the person who is providing psychopharmacology coverage during the time prior to the first follow-up medication appointment.
- The Designated Facility discharge planner will contact the Tufts Health Plan Medicare Preferred HMO Member's PCP for referrals for outpatient psychotherapy, psychopharmacology, and VNA services.
- The Designated Facility discharge planner will contact a Tufts Health Plan Clinical Coordinator to obtain assistance with locating appropriate Tufts Health Plan providers, if needed, and obtain a reference number for outpatient care for patients beginning a new outpatient treatment.
- The Designated Facility discharge planners will inform the Tufts Health Plan Inpatient Care Manager of any difficulties in making timely referrals, regarding both specific "problem" cases and any general trends or patterns of concern.

Inpatient Mental Health and Substance Abuse Documentation Standards

Designated Facilities must include the following information in a Member's medical record to meet inpatient documentation standards:

- Physician* Admission Note
 - In chart within 24 hours of patient's admission.
 - Should include relevant immediate history of present illness, presenting problems, mental status exam, diagnostic impressions, DSM IV diagnosis, and initial treatment plan.

- Allergies and adverse reactions are clearly documented, and a lack of known allergies and sensitivities to pharmaceuticals and other substances is documented.
- Include documentation that a risk assessment was performed to evaluate harm to self, others, risk for falls, and elopement.

* **Note:** At a freestanding acute care inpatient detoxification or residential detoxification facility, a nurse may complete an admission note instead of a physician.

- Medical Clearance and Physical Exam
 - Documentation needs to occur within 24 hours from the time of admission indicating that a medical clearance and a physical exam were performed.
- Treatment History
 - Include the following documentation of medical and psychiatric history in the Member’s chart:
 - Previous treatment dates
 - Provider identification
 - Therapeutic interventions and responses
 - Relevant family information
 - Results of laboratory tests and consultations
- Treatment Plan
 - A comprehensive, solution-focused treatment plan, identifying the clinical condition that necessitates an inpatient hospital level of care, and clinical picture of specific improvements which are necessary to lead to discharge or to a lower level of care. The treatment plan will be completed by the next business day following admission.
 - The treatment plan must be consistent with the diagnosis, and have measurable objectives, goals, and estimated time frames for goal attainment.
 - Include the initial discharge plan as a component of the treatment plan early in the admission, with a proposed discharge plan (including modality, provider or program), current outpatient provider(s). Address potential barriers to discharge or other anticipated discharge disposition problems.
 - For children and adolescents, include documentation that the family was contacted, and that a family meeting was requested by the next business day following admission.
 - For children and adolescents, include documentation that a face-to-face consultation with the parent(s) or guardian(s) occurred within 72 hours of admission.
 - For adults and children, include documentation that outpatient providers were contacted no later than the close of the next business day following admission.
 - For adults and children, include documentation that outpatient providers were contacted by the next business day following admission.
 - For adults (18 years and older), document contact with involved family members and collaterals unless contraindicated.
 - Include documentation that the aftercare plan was reviewed with the member/family.
- Screening for Alcohol/Substance Use
 - For patients 12 and older, documentation includes past and present use of cigarettes, alcohol, and illicit, prescription, and over the counter drugs.
 - DF staff should appropriately evaluate positive responses to screening questions, and integrate them within the treatment plan if indicated.

- Progress* Notes
 - Relate progress note content directly to problems identified in the Treatment Plan.
 - Enter a primary clinician note for each date of attendance.
 - The treatment record notes must reflect continuity and coordination of care between the primary clinician, collaterals, ancillary providers, and health care institutions.
 - Physician Progress Notes
 - Daily progress notes are required.
 - Include comments on significant clinical events, patient's clinical status, diagnostic findings, and revision of treatment plan (i.e., medication changes, etc.) including any changes in the level of care.
- * **Note:** At a freestanding acute care inpatient detoxification or residential detoxification facility, a nurse may complete an admission note instead of a physician.
- Laboratory Results and Consultations
 - The attending physician should acknowledge any laboratory results or other consultations, and specifically note abnormal laboratory results and any consultant recommendations.
 - Discharge Plan Documentation
 - A physician note written within 24 hours of discharge.
 - The physician note should anticipate discharge, including recommendations for further treatment(s) medication management follow-up.
 - The discharge documentation should include name(s) and phone number(s) of follow-up provider(s) and dates of follow-up appointment(s).
 - A post-discharge follow-up appointment with outpatient provider should be scheduled within one week (7 days) of discharge.
 - Documentation should reflect that the aftercare plan was reviewed with the Member.

Partial Hospital Documentation Standards: Mental Health and Substance Abuse

Designated Facilities must include the following information in a Member's medical record to meet partial hospital documentation standards:

- Physician Admission Note
 - In chart within 24 hours of patient's admission.
 - If day treatment is a continuation of an inpatient stay, a copy of the original admission note with a brief "interval note" addendum is adequate.
 - Should include relevant history of present illness, presenting problems, mental status examination, diagnostic impression, and initial treatment plan.
 - Allergies and adverse reactions are clearly documented.
 - Specifically note a lack of known allergies and sensitivities to pharmaceuticals and other substances.
 - Specifically note and document special status situations, such as imminent risk of harm, suicidal ideation, or elopement risk.

- Medical Clearance and Physical Exam
 - Medical clearance and a physical exam are not required, except in cases of a known active medical illness (in which case, a history and physical exam note by attending physician or patient's PCP should be in record by the end of the first week of the Member's attendance in the partial hospital program).
- Treatment History
 - Document a medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultations.
 - For children and adolescents, document a complete developmental history (physical, psychological, social, intellectual, and academic).
- Treatment Plan
 - Comprehensive, solution-focused treatment plan, identifying a clinical condition which necessitates partial hospital level of care.
 - The treatment plan must be consistent with diagnosis, and contains both objective measurable goals and estimated time frames for goal attainment or problem resolution.
 - The initial discharge plan, as a component of the treatment plan, must include a proposed discharge plan (including treatment modality, provider, or program). Note the current outpatient provider(s), and address potential barriers to discharge or other anticipated discharge disposition problems.
 - For children and adolescents, conduct face-to-face consultation with the parent(s) or guardian(s) within 72 hours following admission.
 - For children and adolescents, family therapy and/or parent/guardian psychoeducation is a key treatment modality unless contraindicated.
 - For adults, document consultation with involved family members unless contraindicated. Consultation may include treatment recommendations, aftercare and discharge plans, psychoeducation, and medication management issues.
- Screening for Alcohol/Substance Use
 - For patients 12 and older, documentation includes past and present use of cigarettes, alcohol, and illicit, prescribed, and over-the-counter drugs.
 - DF staff should appropriately evaluate positive responses to screening questions, and integrate them into the treatment plan if indicated.
- Progress Notes
 - Enter a primary clinician note for each date of attendance.
 - Progress note content must be related directly to problems identified in treatment plan, and the treatment record notes must reflect continuity and coordination of care between the primary clinician, consultants, ancillary providers, and health care institutions.
 - Physician note minimum of once per week should include comments on significant clinical events, patient's clinical status, diagnostic findings, revisions of treatment plans, and disposition plans including changes in the level of care provided.
- Laboratory Results and Consultations
 - Attending physicians should acknowledge any laboratory results or other consultations, and specifically note abnormal laboratory results and any consultant recommendations.
- Discharge Plan Documentation

- The discharge note should include recommendations for further treatment(s) and medication management follow-up.
- Discharge documentation should include name(s) and phone number(s) of follow-up provider(s), date(s) of follow-up appointment(s).
- Schedule post-discharge follow-up appointment with the outpatient provider within one week (7 days) of discharge.

Mental Health and Substance Abuse Follow-up After Hospitalization Program

The seven (7) day mental health and substance abuse follow-up after hospitalization program was created to ensure quality care for Tufts Health Plan's Members, and complies with the HEDIS, CMS, and NCQA requirements for outpatient follow-up care. Post-discharge follow-up care is good clinical practice that reduces readmission rates.

It is expected that Designated Facilities will schedule mental health and/or substance abuse follow-up appointments to occur within seven (7) days of discharge for Tufts Health Plan Members who are hospitalized with a psychiatric or substance abuse diagnosis.

A financial incentive bonus is in place in 2009 for Designated Facilities for the scheduling of seven (7) day follow-up appointments for substance abuse admissions for Commercial Members and for psychiatric admissions for Tufts Medicare Preferred Members. It is the responsibility of the Designated Facilities to report these scheduled appointments to Tufts Health Plan through the Interactive Voice Response (IVR) System when reporting discharge information. Each Designated Facility's respective agreement outlines the specifics of this bonus incentive program.

On a monthly basis, Designated Facilities receive reports detailing their compliance rates with these incentive measures. Tufts Health Plan staff work cooperatively with the Designated Facilities to ensure a high rate of compliance with these measures. After the end of the year, compliance rates will be determined, and financial incentives distributed accordingly.

Discharge Planning Guidelines for the Seven (7) Day Follow-up Program

- The bonus incentives for 2009 include substance abuse discharges for all Tufts Health Plan Commercial Products and psychiatric discharges for Tufts Medicare Preferred Members:
- Day number one (1) is the day after discharge. Follow-up appointments need to occur within seven days, (not seven "business" days) after the discharge date. Holidays and weekends are counted in the seven (7) days.
- A variety of outpatient mental health visits count as compliant, including partial hospital programs, intensive outpatient programs (IOP), ECT, psychopharmacology appointments, and individual, family, and group counseling.
- If a Member already has a relationship with an outpatient provider, The DF is encouraged to contact this provider as soon as the Member is admitted to discuss a probable discharge date and a timely follow-up appointment.
- If the DF is having difficulty scheduling an appointment within seven (7) days, consider having the Member return to the DF for an interim follow-up appointment.

- If the DF is planning to use the Visiting Nurses Association (VNA) for aftercare, please ask the VNA to send a social worker in addition to the nurse for at least one home visit. VNA visits only count as compliant if the visit is made by a **psychiatric nurse or social worker**. Usually, VNAs do not have psychiatric nurses available to do home visits. VNA social work visits do count as compliant.
- PCP follow-up visits do **not** count as compliant for follow-up appointments.
- Alcoholics Anonymous (AA) meetings do **not** count as compliant for follow-up appointments.
- Members who are discharged to another inpatient facility, nursing home, or a psychiatric or substance abuse residential program are excluded.
- Do not send Tufts Health Plan discharge plans for Tufts Health Plan Employees due to confidentiality issues.
- The Tufts Health Plan website is a useful resource for locating [mental health providers](#). If you are experiencing difficulty arranging timely follow-up care, you may call the outpatient department at 800-208-9565 for assistance. Calling the Mental Health department while the member is still an inpatient helps make the entire process go more smoothly.

Family Meeting Incentive Guidelines for Designated Facilities

It is considered a measure of quality care for psychiatric unit staff to meet with family members and/or significant others for diagnostic, treatment, and discharge planning purposes. To encourage this practice, Tufts Health Plan's Mental Health department is instituting a new quality initiative with a financial incentive bonus effective January 1, 2009.

Tufts Health Plan's Mental Health department requests that Designated Facilities (DFs) make every effort to hold a family meeting within 72 hours after the time of admission for all child and adult psychiatric admissions.

The following criteria determines compliance to this measure:

- Family includes any family member, guardian, or significant other who is a major support to the Member.
- The family meeting needs to be a face-to-face contact held within 72 hours of a Member's admission.
- Compliance does not include a family meeting held in the emergency room.
- Compliance is based on **Commercial psychiatric** admissions only. Compliance is not based on substance abuse admissions. This incentive does not include Tufts Medicare Preferred Members.
- Compliance is measured for adult and child admissions.
- Designated Facilities will report this information to Tufts Health Plan through the Interactive Voice Response (IVR) System when submitting discharge information.
- Monthly, Designated Facilities will review reports detailing their compliance rates with this incentive measure. Tufts Health Plan staff work cooperatively with the DFs to ensure a high rate of compliance. After the end of the year, compliance rates will be determined, and financial incentives distributed according to each DF's respective agreement with Tufts Health Plan.

6 Benefits and Exclusions

Parity Benefits

Massachusetts Mental Health Parity

Affected Clients

- Massachusetts Mental Health Parity applies to all Massachusetts fully-insured employer groups and members of fully-insured individual products.

Note: The Massachusetts mandate does not apply to Rhode Island fully-insured policies.

In compliance with Massachusetts Chapter 80 of the Acts and Resolves of 2000 – An Act Relating to Mental Health Benefits, Tufts Health Plan will provide the following benefits, subject to review for medical necessity. In addition, in compliance with Chapter 256 Acts of 2008, Tufts Health Plan has expanded the conditions to the list of biologically based disorders and allows the Commissioner of the Department of Mental Health sole authority to add new conditions to the list as necessary. This law applies to Members enrolled in the HMO and fully-insured products. It does not apply to Members enrolled in self-funded employer group benefit plans, nor does it apply to Members enrolled in Tufts Health Plan Medicare Preferred Plans. These benefits will also be provided to self-insured groups whose employer has elected to provide parity benefits. The benefits include:

- Outpatient and inpatient care will be provided for an unlimited number of medically necessary visits/days for the diagnosis and treatment of Members with biologically-based mental disorders. As specified by the law, biologically based diagnoses include the following, as described in the most recent edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSMIV):
 - Schizophrenia, schizoaffective disorder, major depressive disorder, bi-polar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, delirium and dementia, affective disorders, and any biologically based mental disorder that appears in the DSM and is scientifically recognized by the Department of Mental Health and the Division of Insurance.
 - Effective July 1, 2009 on the employer group’s renewal date, Chapter 256 of the Acts of 2008 expands the existing list to also include: eating disorders, post traumatic stress disorder, substance abuse, and autism.

View a list of [ICD-9 diagnoses](#) included in the Tufts Health Plan definition of parity.

- Outpatient care is provided for up to 24 medically necessary visits for the diagnosis and treatment of Members with non-biologically based mental disorders.
- Inpatient care is provided for up to 60 medically necessary inpatient days per calendar year for the diagnosis and treatment of Members with non-biologically-based mental disorders, regardless whether services are provided in a general hospital or in a psychiatric hospital.
- Unlimited medically necessary visits are provided for the diagnosis and treatment of rape-related mental or emotional disorders for victims of rape or victims of an assault with the intent to commit rape when Tufts Health Plan mental health benefits have been exhausted, and costs exceed the amount provided by the *Victim Compensation and Assistance Program*.
- Unlimited medically necessary outpatient and inpatient care are provided for the diagnosis and treatment of children under the age of 19 with non-biologically-based mental, behavioral, and emotional disorders that significantly impair their functioning or social interaction. The PCP, primary pediatrician, or a licensed mental health professional must document substantial interference or limitation in functioning, or there is other documented evidence of substantial interference or limitation in functioning as evidenced by one or more of the following:
 - Inability to attend school as a result of such a disorder.
 - Need to hospitalize the child or adolescent as a result of such a disorder.
 - Pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.
 - Other conduct that causes substantial limits to the functioning of the child or adolescent of comparable severity to the examples cited above.

Implementation

This policy was implemented for:

- Insured Large Employer Groups (51 or more eligible employees) in 2001 on the employer group's renewal date.
- Small Employer Groups (50 or fewer eligible employees) on January 1, 2002.
- Members enrolled in insured non-group coverage on December 1, 2001.
- Chapter 256 expands the list of diagnoses (eating disorders, post traumatic stress disorder, substance abuse, and autism) on July 1, 2009 on the employer group's renewal date.

Self-insured Employer Groups are not required, but may choose to implement this policy.

Rhode Island Mental Health Parity Benefits

The Rhode Island Mental Health and Substance Abuse Parity law mandates that insurers cover the diagnosis and treatment of mental illness and substance abuse to the same degree as the diagnosis and treatment of physical conditions.

The law applies to HMO, POS, and PPO members enrolled in products underwritten by Tufts Health Plan (fully insured plans). The law does not apply to POS, PPO, and EPO members who are enrolled in self-insured group plans, although some self-insured plans may choose to implement parity. Treatment is for medically necessary care.

- **Mental illness coverage** means inpatient hospitalization, partial hospitalization provided in a hospital or any other licensed facility, intensive outpatient services, outpatient services, and community residential care services for substance abuse treatment. It does not include methadone maintenance services or community residential care services for mental illnesses

other than substance abuse disorders. The law applies only services delivered within the state of Rhode Island.

- The inpatient and intermediate benefit is unlimited. However, for detoxification admissions, the benefit is provided for up to five detoxification occurrences or for 30 detoxification days in a calendar year, and an additional 30 days in a substance abuse community residence in a calendar year. All benefits are based upon medical necessity.
- Outpatient services, with the exception of outpatient medication visits, is provided for up to 30 visits in any calendar year; outpatient services for substance abuse treatment is provided for up to 30 hours in a calendar year.
- **Mental illness** means any mental disorder and substance abuse disorder that is listed in the most revised publication of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. However, tobacco and caffeine disorders are excluded as well as mental retardation, learning disorders, motor skills disorders, communication disorders, and mental disorders classified as “V” codes. For a complete list, refer to the *Rhode Island Mental Health and Substance Abuse Parity Diagnosis Exclusions*.

Federal Mental Health Parity Law

The federal law, originally enacted in 1996, prohibits plans from imposing any annual lifetime or dollar limit on coverage for behavioral health services that differ from those applied to medical or surgical benefits.

On October 3, 2008, the President of the United States signed into law the **Emergency Economic Stabilization Act of 2008**, which contained the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The new federal law requires equity in coverage for all financial requirements, including deductibles, copayments, coinsurance, out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, another other similar limits. It requires all group health plans that offer coverage for mental health and substance abuse disorders to apply the same treatment and financial limits to those disorders as apply to medical/surgical benefits.

- The Federal Mental Health Parity law is effective for plan years beginning on and after October 3, 2009.
- While mental health and substance abuse services have no limit, the benefit covers medically necessary treatment only.
- The Federal Mental Health Parity law does not distinguish between coverage requirements for a biologically based illness and coverage requirements for non-biologically based illness.
- The law applies to all members enrolled in Massachusetts and Rhode Island fully insured and self-insured group health plans with 51 or more employees that offer coverage for mental health and substance abuse disorders. The law does not apply to members enrolled in a group health plan through an employer with 50 or fewer employees or to those members enrolled in an individual health plan.

Note: If a Tufts Health Plan member is not eligible for Federal Mental Health and Substance Abuse Parity, the Member may be eligible to applicable state parity. For additional information, refer to information about [Massachusetts Mental Health Parity](#) and [Rhode Island Mental Health Parity Benefits](#).

Custodial Care Policy: Limitation of Inpatient Mental Health and Substance Abuse Treatment Benefits

Tufts Health Plan defines custodial care as inpatient mental health or substance abuse level of care, given primarily for one or more of the following reasons:

Tufts Health Plan provides coverage for medically necessary services for diagnosis, evaluation, and treatment of mental conditions, alcohol abuse, and drug abuse. Designating an illness as "chronic" does not relieve Tufts Health Plan or its contracting providers of coverage responsibility. However, Tufts Health Plan does not pay for care that they determine to be custodial, including the following:

- For maintaining the Member's or anyone else's safety
- For maintaining and monitoring an established treatment program, when no other aspects of treatment require an acute hospital level of care or intermediate care
- Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance with mobility, dressing, bathing, eating and preparing special diets, and taking medication
- To provide care on an inpatient unit while awaiting transition to a clinically appropriate alternative level of care (e.g., long-term residential facility)
- Care administered by medically trained personnel to which the Member shows no beneficial response despite extended and/or repeated treatment trials
- Incomplete or inadequate care which results from a Member's refusal of recommended treatment or any medically substantive part thereof, providing that this is consistent with the Tufts Health Plan obligation to comply with state and federal mandated benefits law.

Determinations of "custodial level of care" are made when, in the judgment of a Tufts Health Plan Medical Director, the care a Member is receiving in hospital meets one or more of the criteria described above. As described and defined in Tufts Health Plan benefit documents, this care is not a covered benefit. As this is a determination regarding the nature of **inpatient, acute residential, and partial hospital care only**, these determinations have no effect on other benefits, including outpatient mental health services.

Custodial Care Procedure

Table 6-1: Custodial Care Procedure

Task	Step
1.	Any party involved in the direct treatment of, or peer review for a Member may identify the Member as possibly receiving a custodial level of care. This includes both the treating facility staff and Tufts Health Plan peer reviewers.
2.	The party that initiates a custodial care initial determination conducts a telephonic peer review on the case. The Tufts Health Plan Medical Director for Mental Health Services or designee participates in the initial assessment/consultation regarding the determination that care is custodial.
3.	Tufts Health Plan may gather further clinical information from other sources deemed relevant (e.g., Primary Care Physician, attending physician, outpatient therapist).

Table 6-1: Custodial Care Procedure

Task	Step
4.	Based on the information obtained, the Tufts Health Plan Medical Director or designee makes an administrative determination as to the level of care the Member is currently receiving, or that is requested. This determination is made within one day of the Tufts Health Plan Medical Director receiving all the information necessary to render a decision.
5.	<p>If the determination is that the Member is receiving custodial care, the process below will be followed:</p> <ul style="list-style-type: none"> a. Within one day of making the determination, the Tufts Health Plan Medical Director verbally notifies the Designated Facility or other treating hospital and the Mental Health Care Manager (CM) of the custodial care determination. The Designated Facility or other treating hospital staff verbally notifies the Member of the determination and the last date of covered inpatient services. <ul style="list-style-type: none"> The last date of covered inpatient benefits is always at least one day after the verbal notification to the Member. b. Tufts Health Plan notifies the Member and provider in writing of the decision. The letter is sent within one business day of the verbal notification. This letter specifically indicates the last day of covered inpatient services, explains the specific reasons for the determination, indicates the person making the determination, and explains the Member Appeals Procedure. c. The Member's immediate further care is determined and arranged by the Designated Facility or other hospital attending physician and Members of the treatment team, in coordination with the clinical director of the facility and the Tufts Health Plan CM. <ul style="list-style-type: none"> If it appears that the Member's care is best met with services provided by state agencies such as the Department of Mental Health (DMH) or the Department of Youth Services (DYS), the attending physician and/or members of the treatment team contacts the agency as soon as possible to allow the agency to perform an evaluation, and create a smooth and timely transition to agency services.

Financial Liability

The Member may be liable for the cost of care for treatment when a determination of custodial level of care is made, with the exception of a Tufts Health Plan Medicare Preferred Member who is waiting for an available bed in a skilled nursing facility. Such Member is not held financially liable for the cost of care for treatment under these circumstances.

Chronic Risk Pool

For capitated Members, custodial care days are not counted towards the Designated Facility chronic risk pool.

Home Care Criteria for Mental Health/ Substance Abuse Services

Medically necessary mental health services covered by Tufts Health Plan are provided in the home when the Member is confined to the home, or is temporarily unable to obtain services in the community.

The Member may be considered homebound based on a physical illness or a psychiatric disorder, which prevents the Member from safely leaving the home environment. At times, the home environment may be considered the most appropriate environment to render the services even if the Member is not homebound. The frequency and length of treatment varies based on medical necessity.

A psychiatric nurse usually provides home care services and treatment through a VNA or other in-plan home care agency.

Admission Criteria

A Member may require home care services in any of the following situations:

- Member is confined to the home due to a physical illness or injury and is experiencing deterioration in mental health.
- Member requires a psychiatric evaluation and/or monitoring of his or her mental status while homebound.
- Member is in need of medication teaching, monitoring of medication compliance, or psychopharmacological management. For clinical reasons, the home is determined to be the most appropriate setting to render services.
- Member has a psychiatric illness, which is manifested in part by a refusal or inability to leave the home.

Exclusion Criteria

Any of the following criteria will disqualify the Member for coverage of home care services:

- Requested services are specifically excluded in the Member's Tufts Health Plan Evidence of Coverage or other plan description.
- Member can be safely maintained or treated in a less intensive level of care (outpatient or community based services).
- Member does not meet any of Tufts Health Plan criteria for home care services:

- Member is not confined to the home due to physical illness and/or is not experiencing a deterioration of mental health.
- The Member does not require a psychiatric evaluation and/or monitoring of his or her mental status while homebound.
- The Member does not have a psychiatric illness which is manifested in part by a refusal to leave home.
- Home care services are requested for the Member's convenience.

Discharge Criteria

Any of the following criteria will serve to disqualify the Member for continuation of coverage of this level of care:

- Member's documented treatment goals and objectives are met.
- Member no longer meets the home care criteria.
- Member's progress has allowed for a less restrictive environment for ongoing treatment.

