CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines:

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

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers blow.	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☒ No ☐

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 857-304-6463

☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 857-304-6463

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Care Partners of Connecticut:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404

Overview

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

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

- CarePartners of Connecticut- CarePartners of Connecticut Provider Manual

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

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

1. The Plan uses InterQual criteria* for the following non-substance use treatment services for :
    a. Partial Hospitalization Services (PHP) for the following lines of business:
        i. CarePartners of Connecticut

***InterQual Criteria** are nationally recognized medical necessity behavioral health criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

- For Medicare Only Products, The plan uses the InterQual Medicare Behavioral Health Criteria which consists of CMS NCDs/LCDs, formatted in the InterQual decision support tool.

Approval And Revision History

May 15, 2024: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent changes and endorsements:

- June 13, 2024: Reviewed and approved by the UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- September 19, 2024: Reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee, no changes
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.