

The following payment policy applies to Tufts Health Plan[®] commercial contracted Mental Health and Substance Abuse providers who render professional services in an outpatient office setting.

This policy applies to commercial¹ products. For information on Tufts Health Plan Medicare Preferred's policies and procedures, [click here](#).

Note: Audit and disclaimer information is located at the end of this document.

Policy

Tufts Health Plan reimburses medically necessary mental health (MH) and substance abuse (SA) services rendered in an outpatient office setting.

General Benefit Information²

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the [Electronic Services](#) section of our Web site for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [Web site](#) or by contacting [Provider Services](#).

Suboxone[®] and Subutex[®]

Tufts Health Plan reimburses medically necessary services for the treatment of an opiate addiction with Suboxone[®] and Subutex[®] when rendered in an outpatient office setting by an appropriately licensed and qualified mental health and substance abuse provider. Suboxone[®] and Subutex[®] are covered in accordance with the member's prescription drug benefit and do not require prior authorization. Mental health services related to the treatment of an opiate addiction with Suboxone[®] and Subutex[®] are covered based on the member's benefit plan document. For information on how to submit claims for Suboxone[®] and Subutex[®], reference page 3.

Parity Law

Outpatient MH benefits for biologically based diagnoses and all other diagnoses follow the guidelines as defined in the [Massachusetts Mental Health Parity Law](#)

The Rhode Island Mental Health and Substance Abuse Parity Law mandates that insures cover the diagnosis and treatment of mental illness and substance abuse to the same degree as the diagnosis and treatment of physical conditions. The Tufts Health Plan Mental Health Parity List for Rhode Island is in development with an anticipated publication date of April 15, 2009. For requests in the interim, contact the Mental Health Department at (800) 208-9565.

Note: The Massachusetts and Rhode Island Mental Health Parity Laws do not apply to members enrolled in self-insured groups; however some self-insured groups may choose to adopt parity voluntarily. Additionally, some groups may have their MH and SA benefits administered by another plan.

¹ Commercial products include [HMO, POS, PPO & CareLink when Tufts Health Plan is Primary Administrator](#)

² Eligibility is subject to retroactive reporting of disenrollment by the member's employer group or Medicare.

CareLink Members

CIGNA HealthCare, Tufts Health Plan, or another entity, may administer mental/behavioral health services based on employer plan design. The member's identification card will indicate where the member should be directed for these services. CareLink members are able to self-refer to contracting network providers, according to their plan design.

Note: Providers can contact CIGNA HealthCare by calling their national customer service number at (800)-88CIGNA (800-882-4462) or reference CIGNA HealthCare's Web site www.cigna.com for questions about medical management policies.

Carve Out

Some employer groups choose to have mental health benefits for their employees managed and administered by a designated mental health management company (carve out). The telephone number of the carve out company is listed on the back of the member identification card and available when you call the Interactive Voice Response System (IVR) system or access member information on the Web site.

Pharmacology visits

Visits are covered as medical services after the initial medication management evaluation. These visits do not count against a member's MH benefit; however, they are subject to a copayment.

Note: If an initial medication visit is billed as a 90801, the visit requires authorization within 30 days of the appointment.

Psychological and Neuropsychological Testing

Testing is covered as a medical service and is not considered part of a member's MH benefit.

Member Responsibility

Copayments, deductible and/or coinsurance may apply depending upon the member's benefit plan specifics.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

[Authorization Requirements](#)

Reference the [Mental Health Authorization Requirements for Commercial Products](#) for additional information.

Providers can obtain initial and additional authorizations by:

- Logging in to the secure section of our [Web site](#)
- Using the Interactive Voice Response System (IVR) or speak with a Mental Health Coordinator by calling (800)-208-9565

Reference the [Guide for Completing Mental Health Care Services Request Using IVR](#) for additional information on how to submit authorization requests through the IVR System.

It is the MH provider's responsibility to obtain the necessary reference number for outpatient MH and SA services within 30 days of the member's first visit. However, the member or the PCP may also contact the Mental Health Department to obtain the initial reference number for outpatient services. Both the member and MH provider will receive confirmation of the initial authorization in writing.

For a complete description of Tufts Health Plan's commercial authorization and notification requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

Psychological and Neuropsychological Testing

Prior authorization is required for psychological and neuropsychological testing for all commercial plans, except CareLink. The recommending provider must complete a [Psychological/Neuropsychological Testing Request Form](#). The requesting provider will be notified of the coverage determination.

Contact the Mental Health Department at (800)-208-9565 for additional information on psychological and neuropsychological testing.

Billing Information

- Submit the most updated industry-standard codes.
- Submit the appropriate ICD-9 diagnosis code carried out to the highest level of specificity.
- Submit the appropriate procedure codes to accurately describe the service(s) rendered.
- Submit claims with the identification number and name of the rendering provider in box 24j, when applicable.

Note: Annually and quarterly, HIPAA medical code sets³ undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.

Suboxone® and Subutex®

A licensed and qualified mental health and substance abuse provider must submit the applicable procedure code(s) below when rendering services for the treatment of an opiate addiction with Suboxone® and Subutex® in an outpatient office setting.

Procedure Code	Description
90805	Individual Psychotherapy, face to face office visit, 20 to 30 minutes with Medical Evaluation and Management
90807	Individual Psychotherapy, face to face office visit, 45 to 50 minutes with Medical Evaluation and Management
90811	Interactive Psychotherapy, face to face office visit, 20 to 30 minutes with Medical Evaluation and Management
90813	Interactive Psychotherapy, face to face office visit, 45 to 50 minutes with Medical Evaluation and Management
90862	Pharmacological Management, face to face office visit

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

Ancillary providers may only bill the following procedure code(s) in accordance with their Provider Agreement.

Procedure Codes for All Clinicians

Procedure Code	Description
90801 ⁴	Psychodiagnostic Consultation
90802	Interactive Psychodiagnostic Consultation, face to face office visit
90804	Individual Psychotherapy, face to face office visit, 20 to 30 minutes
90806	Individual Psychotherapy, face to face office visit, 45 to 50 minutes
90810	Interactive Psychotherapy, face to face office visit, 20 to 30 minutes
90812	Interactive Psychotherapy, face to face office visit, 45 to 50 minutes
90846	Family Psychotherapy (without patient present), face to face office visit
90847	Family Psychotherapy (with patient present), face to face office visit
90853	Group Psychotherapy, face to face office visit

Procedure Codes for Psychological and Neuropsychological Testing

The following psychological and neuropsychological testing CPT procedure codes require prior authorization with the Mental Health Department.

Procedure Code	Description
96101	Psychological Testing, per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96102	Psychological Testing with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological Testing administered by a computer, with qualified health care professional interpretation and report
96118	Neuropsychological Testing, per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96119	Neuropsychological Testing with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological Testing administered by a computer, with qualified health care professional interpretation and report

Additional Codes for Prescribing Clinicians - (Psychiatrists and prescribing nurse clinical specialists only)

Procedure Code	Description
90805	Individual Psychotherapy, face to face office visit, 20 to 30 minutes with Medical Evaluation and Management
90807	Individual Psychotherapy, face to face office visit, 45 to 50 minutes with Medical Evaluation and Management
90811	Interactive Psychotherapy, face to face office visit, 20 to 30 minutes with Medical Evaluation and Management
90813	Interactive Psychotherapy, face to face office visit, 45 to 50 minutes with Medical Evaluation and Management
90862	Pharmacological Management, face to face office visit

⁴ Billing is limited to **two** 90801-procedure codes per provider, per member, per calendar year.

Additional Codes for *Psychiatrists* Only

Procedure Code	Description
90849	Multiple-Family Group Psychotherapy
90857	Interactive Group Psychotherapy
90870	Electroconvulsive Therapy
90882	Environmental Intervention for Medical Management
90887	Consultation with Family

Reimbursement Information

Providers are reimbursed according to the Tufts Health Plan network physician reimbursement or contracted rates regardless of where the service is rendered. Reference your current contract for details regarding outpatient MH reimbursement provisions. Claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare & Medicaid Services (CMS), specialty society guidelines, drug manufacturers' package label inserts and National Correct Coding Initiative (CCI).

Facility Fee Reduction

MH providers who perform services in a hospital may be subject to a facility fee reduction. This reduction is consistent with Medicare's site of service differentiation built into Medicare fees, and parallels the facility fee reduction Tufts Health Plan applies to medical office visits in these settings. Reference your current contract for details regarding outpatient reimbursement provisions.

Note: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential reimbursement for office and facility-based services for physicians, replacing Tufts Health Plan's standard facility fee reduction. Reference your contract for details regarding outpatient reimbursement provisions.

Statement of Account (SOA)

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Electronic Remittance Advice (ERA)

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Additional Resources

[Inpatient and Intermediate Mental Health/Substance Abuse Facility Payment Policy](#)

Document History

January 2008: Added that prior authorization is required for psychological/neuropsychological testing for all Commercial plans effective January 1, 2008 and changed Guide for Completing Blue Forms Using IVR to Guide for Completing Mental Health Care Service Requests Using IVR.

February 2008: Revised general benefit information with self-service channels information.

March 2009: Added Rhode Island Parity Law and carve out information.

October 2009: Added Suboxone[®] and Subutex[®] information.

November 2009: Added a note that explains: Effective January 1, 2010, Tufts Health Plan will adopt CMS's differential reimbursement for office and facility-based services for physicians, replacing Tufts Health Plan's standard facility fee reduction. Reference your contract for details regarding outpatient reimbursement provisions.

Audit and Disclaimer Information

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Plan Medicare Preferred, CareLinkSM when CIGNA HealthCare is primary administrator, or Private Health Care Systems (PHCS) network also known as Multiplan members. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM members.