

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 Medicare Preferred HMO's policies and procedures, [click here](#).

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

Policy

Tufts Health Plan covers medically necessary mental health (MH) and substance abuse (SA) services rendered in an outpatient office setting, as described below.

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.

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

Suboxone[®] and Subutex[®]

Effective for fill dates on or after July 1, 2010, Tufts Health Plan will require authorization for coverage of Suboxone and Subutex. Coverage criteria for Suboxone and Subutex can be found in [Tufts Health Plan's Pharmacy Medical Necessity Guidelines](#). Tufts Health Plan covers 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. 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, refer to 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](#).

Refer to the [Rhode Island Mental Health and Substance Abuse Parity Law](#) section of our website for more information about parity laws in Rhode Island

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.

CareLinkSM 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.

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

² Eligibility is subject to retroactive reporting of disenrollment.

Note: Providers can contact CIGNA HealthCare by calling their national customer service number at 800-88CIGNA (800-882-4462) or reference CIGNA HealthCare's website 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 website.

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 90801, it requires authorization within 30 days of the visit.

Psychological and Neuropsychological Testing

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

Preventive Services

Effective for new groups and existing groups when they renew **on or after September 23, 2010**, most Tufts Health Plan employer groups will be required to provide all insured members 100% coverage for preventive care services. A minority of employers who have elected to maintain "grandfathered" status under the Patient Protection and Affordable Care Act (commonly referred to as health care reform) are not subject to this requirement. However, many of these groups have opted to cover preventive services with no cost sharing, and their "grandfathered" status may change over time.

This means that most members will have no cost-sharing responsibility when preventive services are rendered by an in-network provider. Members may still be required to pay a copayment, deductible or coinsurance for preventive services received from out-of-network providers (PPO and POS plans), or for non-preventive services received in conjunction with a preventive services visit. Please reference the [Preventive Services](#) list for a complete list of services that have been deemed preventive in nature.

Member Responsibility

Copayments, deductible and/or coinsurance may apply pursuant to the member's benefit plan document.

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](#)

Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Refer to the [Mental Health Authorization Requirements for Commercial Products](#) for more information.

Providers can obtain initial and additional authorizations by:

- Logging in to the secure section of our [website](#)
- Calling 800-208-9565 to use the Interactive Voice Response System (IVR) or speak with a Mental Health Coordinator

Refer to 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, refer to 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

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

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

Ancillary providers may only bill the following 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

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

Compensation/Reimbursement Information

Providers are compensated according to the Tufts Health Plan network physician contracted rates regardless of where the service is rendered. Reference your current contract for details regarding outpatient MH compensation 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 compensation provisions.

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

Provider Type Modifiers

Effective for dates of service on or after July 1, 2011, Tufts Health Plan will require provider organization-affiliated psychiatrists to append appropriate modifiers for services provided by a non-M.D. clinician in their office. The modifiers will affect compensation according to clinician type. Reference the [Modifier Table](#) for a list of modifiers that are accepted by Tufts Health Plan and may impact claims payment. Codes 96101, 96102, 96103, 96118, 96119 and 96120 will be excluded from the modifier logic when billed with modifier AH and HP.

Note: Tufts Health Plan does not compensate for services provided by a non-independently licensed clinician providing services under the supervision of a provider organization-affiliated psychiatrist.

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.

Effective January 1, 2012, paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website will no longer display embedded procedure code modifiers or any Tufts Health Plan unique characters.

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: Effective January 1, 2010, Tufts Health Plan will adopt CMS' 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.

July 2010: Modified Suboxone and Subutex information to state that **Effective for fill dates on or after July 1, 2010**, Tufts Health Plan will require prior authorization for coverage of Suboxone and Subutex.

September 2010: Added information regarding Preventive Services

May 2011: Updated Rhode Island Parity Law information. Added information about mental health provider type modifiers effective for dates of service on or after July 1, 2011.

October 2011: Template updates, no content changes

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 Medicare Preferred HMO or Private Health Care Systems (PHCS) network also known as Multiplan members. This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink members.