

The following payment policy applies to Tufts Health Plan[®] contracted inpatient and intermediate mental health/substance abuse facilities.

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 inpatient and intermediate levels of care mental health (MH) substance abuse (SA) services as defined by the member's benefit plan document. Intermediate levels of care consist of acute residential treatment, partial hospitalization programs and intensive outpatient programs.

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 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](#).

State and Federal Mental Health Parity Laws

The Federal Mental Health Parity Law applies to fully and self-insured group health plans with 51 or more employees. It does not apply to group health plans with 50 or fewer employees or to those members enrolled in an individual health plan.

The Federal Mental Health Parity Law mandates that insurers that offer coverage for mental health and substance abuse disorders apply the same treatment and financial limits to those disorders as apply to medical/surgical benefits. While mental health and substance abuse services have no limit, the benefit covers medically necessary treatment only.

The [Massachusetts Mental Health Parity Law](#) requires that inpatient and intermediate levels of care be provided for an unlimited number of medically necessary visits/days for the diagnosis and treatment of biologically based mental health disorders. Reference the [Tufts Health Plan Mental Health Parity List for Massachusetts](#) for a complete list of recognized parity diagnoses.

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 Tufts Health Plan Mental Health Parity List for Rhode Island is in development. 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 voluntarily comply. Additionally, some groups may have their MH and SA benefits administered by another plan.

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

² Eligibility is subject to retroactive reporting of disenrollment.

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.

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.

Member Responsibility

Inpatient 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 deductible and/or coinsurance 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 additional information.

Designated Facilities

Tufts Health Plan contracts with select hospitals to provide emergency, inpatient and intermediate levels of care for MH/SA care. These hospitals are called Designated Facilities. Members may be assigned to a specific Designated Facility and must receive care at that facility. To verify a member's Designated Facility assignment access the member's benefit information on our website or by calling the Mental Health IVR at 800-208-9565. The Designated Facilities are responsible for preregistering admissions and/or coordinating alternatives when appropriate. Refer to the [Mental Health](#) section of our website for a complete list of [Designated Facilities](#).

For a complete description of Tufts Health Plan's Mental Health Designated Facility Policies and Procedures, reference the [Behavioral Health Designated Facility Manual](#) located on our website.

Inpatient admissions

All inpatient admissions require preregistration prior to services being rendered. Reference the Preregistration Requirements section of the [Authorization Policy](#) for additional information. Admitting physicians and hospital admitting departments are responsible for notifying Tufts Health Plan in accordance with the following timelines:

- Urgent or Emergency admissions must be reported within the next business day

When an inpatient admission is reported, Tufts Health Plan performs the following steps as part of the preregistration authorization process:

- Confirmation that the case manager (CM) or member's Designated Facility have determined and discussed the member's appropriate level of care (LOC) with the admitting facility based on clinical information presented at the time of the admission.
- Verification of member eligibility
- Screening for coverage/benefit exclusions and procedures requiring [prior authorization](#)
- Identification of the admission so that the appropriate CM may begin early identification of potential discharge needs for the member

- Providing a preregistration number

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

To obtain an authorization for a continued stay, providers will need to review the case for medical necessity with a mental health case manager by calling 800-208-9565, ext. 3089. HMO members assigned to a capitated Designated Facility do not need authorization for a continued stay beyond the initial preregistration.

Intermediate Levels of Care

All intermediate levels of care require prior authorization through the Mental Health Department prior to start of service.

Providers can obtain authorization for intermediate levels of care by:

- Calling the Mental Health Department at 800-208-9565, ext. 3089
- Using the Interactive Voice Response System (IVR) –Designated Facilities only.

When intermediate levels of care are reported, Tufts Health Plan performs the following steps as part of the authorization process:

- Confirmation that the PCP has authorized the admission, if applicable.
- Confirmation that the CM or member's Designated Facility has determined and discussed the member's appropriate level of care (LOC) with the admitting facility based on clinical information presented at the time of the admission
- Verification of member eligibility
- Screening for coverage/benefit exclusions and procedures requiring [prior authorization](#)
- Identification of the admission so that the appropriate CM may begin early identification of potential discharge needs for the member
- Providing an authorization number

To obtain an authorization for a continued stay, providers will need to review the case for medical necessity with a mental health case manager by calling 800-208-9565, ext. 3089. HMO members assigned to a capitated Designated Facility do not need authorization for a continued stay beyond the initial authorization.

Community Residence Services for Rhode Island Members

Rhode Island facilities requesting Community Residence level of care should contact the Mental Health Department at 888-880-8699, ext. 3089 and speak with a mental health case manager to obtain an authorization. The Mental Health Department may request clinical information in order to provide an authorization.

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 Revenue code (s) with corresponding CPT/HCPSCS procedure code(s), where applicable.
- Submit standard CPT and HCPSCS modifiers in accordance with the appropriate CPT or HCPSCS procedure code(s).
- For more information regarding modifiers refer to the [Modifier Payment Policy](#).
- Submit the appropriate authorization/preregistration number.
- The primary diagnosis classification (medical, psychiatric or chemical dependency) submitted on the claim must match the primary diagnosis clarification on the preregistration for those services. If the primary diagnosis classifications do not match, the claim for those services will be denied and the member will not be responsible for payment.

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.

Revenue Codes for Inpatient Services

Revenue Code	Service Description
0114, 0124	Inpatient MH, all inclusive per diem
0116, 0126	Inpatient SA, (ASAM Level IV Detox) all inclusive per diem

Family Stabilization Treatment

Procedure Code	Service Description
99510	MH Family Stabilization Treatment (FST), per day

Note: Submit FST claims on a CMS 1500 form. Claim line(s) billed with non-standard codes or modifiers will deny.

Community Residence Services for Rhode Island Members

Procedure Code	Service Description
H2036	Alcohol and/or other drug treatment program, per diem

Note: Submit HCPCS procedure code H2036 (Alcohol and/or other drug treatment program, per diem) when billing for Community Residence services for Rhode Island members.

HCPCS Procedure Codes for Intermediate Services

The following HCPCS procedure codes require prior authorization with the Mental Health Department.

HCPCS Code	Service Description
H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0015	SA Intensive Outpatient Program, per day
H0017	Acute Residential Program or ASAM Level III SA, per day, all inclusive per diem
H0018	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0035	MH/SA Partial Hospital, per day
H2012	Behavioral health day treatment, per hour
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	MH Intensive Outpatient Program, per day

Note: Providers should bill only one HCPCS procedure code per date of service.

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

EDI Claim Submitter Information

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

Paper Claim Submitter Information

- Submit claims on a UB-04 form for facility services. Claim line(s) billed with non-standard codes or modifiers will deny.

Compensation/Reimbursement

Compensation for inpatient treatment and related services corresponds to the Tufts Health Plan contracted rate for per diem, per case and/or other arrangements, as applicable. Reference your current contract for details regarding inpatient 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).

Designated Facilities

For information on how Designated Facilities are compensated, reference the Quality Assurance Policies Chapter within the [Behavioral Health Designated Facility Manual](#).

Delay Day

Tufts Health Plan does not compensate providers for delay days. A delay day is a day a member spends in a facility waiting for medically necessary diagnostic testing, treatments, therapies (including physical therapy), consultations, surgical/other procedures or test results. The delay may be due to facility scheduling or staffing issues, which represent an interruption in evaluation or treatment and therefore result in a longer length of stay than if the care had been efficiently provided and/or arranged. Regardless of whether the day meets medical necessity criteria, such days will not be paid. The decision may result in a denial of payment to the hospital, physician, or both.

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

[Outpatient Mental Health/Substance Abuse Professional Payment Policy](#)

Document History

November 2007: Defined by HCPCS the intermediate services requiring prior authorization.

January 2008: Changed Guide for Completing Blue Forms Using IVR to Guide for Completing Mental Health Care Service Requests Using IVR

May 2008: Added FST information.

March 2009: Added Community Residence services for Rhode Island members and Rhode Island Parity Law information.

May 2009: Added primary diagnosis classification information under Billing Information.

August 2011: Added information regarding Federal Parity and template updates.

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.