Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
- ☐ Tufts Medicare Preferred PPO (a Medicare Advantage product)
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting inpatient and intermediate behavioral health/substance use disorder facilities. For information on Senior Products, click here. For information on Tufts Health Public Plans, click here.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

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 behavioral health and substance use disorder (BH/SUD) services, in accordance with the member's benefits. Intermediate levels of care consist of acute residential treatment, partial hospitalization programs and intensive outpatient programs.

**GENERAL BENEFIT INFORMATION**

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

**State and Federal Mental Health Parity Laws**

Under the mental health parity laws, benefits for mental/behavioral health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that cost share for mental/behavioral health and substance use disorder services must be at the same level as those for medical/surgical services. Also, Tufts Health Plan’s review and authorization of mental/behavioral health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

The laws above apply to all members enrolled in Massachusetts, New Hampshire, and Rhode Island fully insured and self-insured plans. For additional information, contact the Behavioral Health Department at 800-208-9565.

**CareLink℠ Members**

Cigna, Tufts Health Plan, or another entity may administer 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 by calling their national customer service number at 800-CIGNA24 (800-244-6224) or refer to Cigna’s website for questions about evaluation management policies.

**Emergency Department Boarding**

Tufts Health Plan provides coverage and appropriate compensation for “specializing” services if a member’s immediate care requires adjustments to a facility’s usual staffing needs. Necessary services and/or high-cost medications for complex co-morbid medical conditions are approved for up to 24 hours and may not be covered for more than 72 hours without review by the Tufts Health Plan Behavioral

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1 Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.

2 Applies to MA providers.
Inpatient and Intermediate BH/SUD Facility Payment Policy

Health Department or a physician reviewer. For more information, refer to the Medical Necessity Guidelines for Behavioral Health Level of Care Determinations or visit the Department of Mental Health’s website.

Services Provided within Acute Care Hospitals for Emergency Psychiatric Inpatient Admission (EPIA) Patients ("BH Boarding")

**Commercial products**

Effective for dates of service on or after November 1, 2022, the Massachusetts DOI has provided updated billing guidance to provide additional compensation for BH care rendered to members to treat and/or stabilize their condition in acute medical facilities while awaiting appropriate inpatient psychiatric placement. Refer to the following payment policies for specific information:

- Emergency Department Services Payment Policy
- Observation Services Payment Policy
- Inpatient Facility Payment Policy

**New Hampshire**

In accordance with N.H. RSA 417-F:4, Tufts Health Plan provides coverage and payment at a per diem day rate for the day(s) an eligible member is required to be boarded and cared for in an emergency department while the member is waiting for inpatient psychiatric admission. The day rate required to board and care for the member may be billed for up to 21 consecutive days or discharge, whichever is sooner, and shall be renewed as needed for patient protection.

Child-Adolescent Behavioral Health Disorders

Tufts Health Plan provides coverage for inpatient and intermediate care to treat child-adolescent behavioral health disorders, including the following:

- Community-Based Acute Treatment (CBAT)
- Family Support and Training (FS&T)
- In-Home Therapy Services (IHTS)
- In-Home Behavioral Services (IHBS)
- Intensive Care Coordination (ICC)
- Intensive Community-Based Acute Treatment (ICBAT)
- Mobile crisis intervention (MCI)
- Therapeutic Mentoring (TM)

Refer to the applicable medical necessity guidelines above for more information on coverage criteria and prior authorization requirements.

Refer to the Commercial Behavioral Health Program Information page for more information on these services.

**REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS**

Refer to the Behavioral Health Outpatient Services Requiring Prior Authorization to determine services that require prior authorization.

**Inpatient Admissions**

All admissions require an inpatient notification. Admitting providers and facilities are responsible for notifying Tufts Health Plan of urgent or emergency admissions within two business days, following the procedures outlined in the Referrals, Prior Authorizations, and Inpatient Notifications chapter of the Commercial Provider Manual.

**Intermediate Levels of Care**

Most intermediate levels of care require prior notification within two business days of admission through the Behavioral Health Department. Providers may obtain authorization/notification by logging on to the secure Provider website or calling the Behavioral Health Department at 800-208-9565. To obtain an authorization for a continued stay, providers must review the case for medical necessity with the Behavioral Health Department by 5 p.m. of the authorized end date by calling 800-208-9565.

Massachusetts HMO members assigned to a capitated DF do not need authorization for a continued stay beyond the initial authorization.

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3 Applies to MA providers in accordance with Massachusetts DOI and DMH Bulletin 2018-07.
**Acute BH Admission Notifications**

Effective for DOS on or after April 1, 2023, the notification time frame for acute BH admissions for members of Massachusetts-based Commercial products is increased to three business days from admission, in accordance with Massachusetts DOI Bulletin 2023-07. This applies to inpatient and intermediate/diversionary mental health acute treatment, community-based acute treatment (CBAT), and intensive community-based acute treatment (ICBAT) services only.

For DOS through March 31, 2023, notification must be submitted within two business days of admission.

**Community Residence Services for Rhode Island Members**

Rhode Island facilities requesting a community residence LOC should contact the Behavioral Health Department at 800.208.9565 to obtain an authorization. Clinical information may be requested in order to provide an authorization.

**BILLING INSTRUCTIONS**

Unless otherwise stated, Tufts Health Plan follows AMA coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements or applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

The primary diagnosis classification (medical, psychiatric or chemical dependency) submitted on the claim must match the primary diagnosis classification on the inpatient notification. 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.

**Inpatient Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0114, 0124</td>
<td>Inpatient BH, all-inclusive per diem (these codes may be used to bill for ICBAT services)</td>
</tr>
<tr>
<td>0116, 0126</td>
<td>Inpatient SUD, (ASAM Level IV Detox) all-inclusive per diem</td>
</tr>
<tr>
<td>0900</td>
<td>Inpatient BH Treatment (use this code when specialing approved)</td>
</tr>
</tbody>
</table>

**Specialing Services**

The specialing services below must be billed on a separate claim from the inpatient admission to ensure appropriate compensation.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Additional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue code 0900</td>
<td>Providing additional staffing overall or mobilizing additional staff to manage the added acuity of a disturbed patient from the ED to maintain unit safety (e.g., intensive RN and physical care, 1:1 caregiver or personal care attendant, 1:1 security, 1:1 mental health worker)</td>
</tr>
<tr>
<td></td>
<td>Institutional claims (UB-04) should be billed with 0900 and Bill Type 13X</td>
</tr>
<tr>
<td>Applicable HCPCS code for the drug (provided by the facility)</td>
<td>High-cost medication</td>
</tr>
</tbody>
</table>

**Family Stabilization Treatment (FST)**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99510</td>
<td>Mental health family stabilization treatment (FST) per day; max. 1 unit/day</td>
</tr>
<tr>
<td></td>
<td>• Submit claims on CMS-1500 form</td>
</tr>
<tr>
<td></td>
<td>• Only bill when face-to-face or telehealth encounters occur</td>
</tr>
</tbody>
</table>

**Community Residence Services for Rhode Island Members**

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and/or other drug treatment program, per diem</td>
</tr>
</tbody>
</table>
Intermediate Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>SUD intensive outpatient program, per day</td>
</tr>
<tr>
<td>H0017 + either: 1001 (res. treatment, psychiatric) or 1002 (res. treatment, chemical dependency)</td>
<td>Acute residential program or ASAM Level III, per day, all-inclusive per diem; must be submitted on UB-04 claim with outpatient bill type 13X (Note: these codes may be used to bill for CBAT services)</td>
</tr>
<tr>
<td>H0035</td>
<td>BH/SUD partial hospital, per day</td>
</tr>
<tr>
<td>S9480</td>
<td>BH intensive outpatient program, per day</td>
</tr>
</tbody>
</table>

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

**Child-Adolescent Behavioral Health Disorders**

Providers may bill the following codes for intermediate care:

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Crisis Intervention (MCI)</td>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes; max. 32 units/day</td>
</tr>
<tr>
<td>In-home behavioral services (IHBS)</td>
<td>H2014</td>
<td>Skills training and development, per 15 minutes; max. 32 units/day</td>
</tr>
<tr>
<td>In-home therapy services (IHTS)</td>
<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes; max. 32 units/day</td>
</tr>
<tr>
<td>Intensive Care Coordination (ICC)</td>
<td>H0023</td>
<td>BH outreach service; planned approach to reach a targeted population; max. 1 unit/day</td>
</tr>
<tr>
<td>Family Support and Training (FS&amp;T)</td>
<td>H0038</td>
<td>Self-help/peer services, per 15 minutes (parent/caregiver peer-to-peer support service provided by a family partner); max. 32 units/day</td>
</tr>
<tr>
<td>Therapeutic Mentoring (TM)</td>
<td>T1027-EP</td>
<td>Family training and counseling for child development, per 15 minutes; max. 32 units/day</td>
</tr>
</tbody>
</table>

**Note:** For codes H2011-H2019, append modifier HN for providers at the bachelors degree level or HO for those with a masters degree level. For code H0023, append modifier HT to indicate services were performed by a multi-disciplinary team.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated according to the applicable network contracted rates and fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

**Delay Days**

Tufts Health Plan does not compensate providers for delay days, wherein a member spends days 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, resulting 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, practitioner, or both.

**DOCUMENT HISTORY**

- February 2023: Added notification time frame information for inpatient and intermediate/diversionary BH admissions, effective for DOS on or after April 1, 2023
- October 2022: Added information for BH boarding services provided during acute hospital stays, effective for DOS on or after November 1, 2022
- May 2022: Updated CareLink phone number
- November 2021: Clarified specialization coverage to include high-cost medications for co-morbid medical conditions; added revenue codes for specialization services

Revised 02/2023
• March 2021: Clarified existing billing instructions for family stabilization treatment
• November 2020: Clarified existing revenue code(s) and billing instructions for acute residential programs
• October 2020: Updated T1027 and H0038 max units to reflect limit of 32 units/day
• May 2020: Added H0038 and T1027-EP, effective for dates of service on or after July 1, 2020
• July 2019: Added NH mandate information for ED boarding services, effective for dates of service on or after July 1, 2019
• May 2019: Added child-adolescent behavioral health services, effective for dates of service on or after July 1, 2019 for members of Massachusetts fully insured Commercial products that renew on or after July 1, 2019
• September 2018: Policy reviewed by committee; clarified parity language
• June 2018: Template updates
• May 2018: Added information regarding Emergency Department boarding, effective February 1, 2018 per the Massachusetts DOI
• March 2018: Added revenue code 0900 for inpatient services
• June 2017: Removed HCPCS codes H0010, H0011, H0018, and S0201 per Allied Health Services; included family stabilization therapy as a covered service in Policy section; updated prior authorization language with notification requirements
• February 2017: Policy reviewed; removed RI behavioral health parity checklist language
• January 2017: Template updates
• September 2016: removed code H0019 as it is a previously implemented benefit exclusion
• September 2015: Template conversion, template updates
• June 2015: Template updates

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. Tufts Health Plan reserves the right to amend a payment policy at its discretion.