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

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
☐ Tufts Medicare Preferred HMO (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 Tufts Medicare Preferred HMO and Tufts Health Plan SCO, click here.

In addition to the specific information contained here, providers must adhere to the policy 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 as defined by the member’s benefit plan document. Intermediate levels of care consist of acute residential treatment, partial hospitalization programs, intensive outpatient programs, and family stabilization services, as described below.

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 website or by contacting Commercial 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 Mental Health Parity Law mandates that insurers that offer coverage for BH/SUD services apply the same treatment and financial limits to those disorders as applicable to medical/surgical benefits. While BH/SUD 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 BH disorders.

The Rhode Island Mental Health and Substance Abuse Parity Law mandates that insurers cover the diagnosis and treatment of mental illness and substance use disorders to the same degree as the diagnosis and treatment of physical conditions.

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.

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

Effective February 1, 2018, Tufts Health Plan provides coverage and appropriate compensation for “specials” if a member’s immediate care requires adjustments to a facility’s usual staffing needs. Necessary services 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 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 website.

Authorization Requirements

Refer to the Behavioral Health Outpatient Services Requiring Prior Authorization for information on services that require a prior authorization.

Massachusetts Designated Facilities

Tufts Health Plan contracts with select designated facilities (DFs) to provide emergency, inpatient and intermediate levels of BH/SUD care. DFs are responsible for submitting an inpatient notification for admissions and/or coordinating alternatives, when appropriate.

To verify a member’s DF assignment, access the member’s benefit information on our secure Provider website or call the Behavioral Health IVR at 800.208.9565. Refer to the Designated Facilities List and the Designated Facilities Manual for additional information.

Inpatient Admissions

All admissions require an inpatient notification prior to services being rendered. Refer to the Inpatient Notification Requirements section of the Authorization Policy for additional information. Admitting providers and facilities are responsible for notifying Tufts Health Plan in accordance with the following timelines:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergency admissions must be reported within the next business day after an admission

Intermediate Levels of Care

All intermediate levels of care require prior notification within one business day of admission through the Behavioral Health Department. Providers may obtain authorization by:

- Logging in to the secure Provider website
- Calling the Behavioral Health Department at 800.208.9565

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

- Confirmation that the UM 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 notification
- Verification of member eligibility
- Screening for coverage/benefit exclusions and procedures requiring prior authorization
- Identification of the admission so the appropriate Behavioral Health Department UM may begin early identification of potential discharge needs for the member
- Assignment of an inpatient notification number

To obtain an authorization for a continued stay, providers must review the case for medical necessity with a Behavioral Health Department UM by 5 p.m. of the authorized end date by calling 800.208.9565.

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

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 and speak with a Behavioral Health Department UM to obtain an authorization.

Note: Providers can contact Cigna by calling their national customer service number at 800.88CIGNA (800.882.4462) or referring to Cigna’s website for questions about evaluation management policies.

2 Applies to MA providers.
authorization. The Behavioral Health Department may request clinical information in order to provide an authorization.

**BILLING INSTRUCTIONS**

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.

**Revenue Codes for Inpatient Services**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0114, 0124</td>
<td>Inpatient BH, all-inclusive per diem</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>

**Family Stabilization Treatment**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99510</td>
<td>BH family stabilization treatment (FST), per day</td>
</tr>
</tbody>
</table>

**Note:** Submit FST claims on a CMS 1500 form.

**Community Residence Services for Rhode Island Members**

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

**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 notification with the Behavioral Health Department within one business day of admission:

<table>
<thead>
<tr>
<th>HCPCS 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</td>
<td>Acute residential program or ASAM Level III SA, per day, all-inclusive per diem</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.

**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. Refer to your current contract for details regarding inpatient compensation provisions.

**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.

**ADDITIONAL RESOURCES**

Outpatient Behavioral Health/Substance Abuse Professional Payment Policy

**DOCUMENT HISTORY**

- July 2018: Template update
- 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
• October 2014: Removed procedure code H2012 as it no longer applies to intermediate services, template updates
• September 2013: Template conversion
• January 2013: Template updates.
• April 2012: Template updates.
• October 2011: Template updates, no content changes
• August 2011: Added information regarding Federal Parity and template updates
• May 2009: Added primary diagnosis classification information under Billing Information
• March 2009: Added Community Residence services for Rhode Island members and Rhode Island Parity Law information
• May 2008: Added FST information
• January 2008: Changed Guide for Completing Blue Forms Using IVR to Guide for Completing Mental Health Care Service Requests Using IVR
• November 2007: Defined by HCPCS the intermediate services requiring prior authorization

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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 CareLink℠ 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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.