

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, in accordance with the member's benefits.

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

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.

CareLinkSM 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 800.88CIGNA (800.882.4462) or refer to Cigna's [website](#) for questions about evaluation management policies.

Emergency Department Boarding²

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

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

² Applies to MA providers.

information, refer to the Medical Necessity Guidelines for [Behavioral Health Level of Care Determinations](#) or visit the Department of Mental Health's [website](#).

AUTHORIZATION REQUIREMENTS

Refer to the [Behavioral Health Outpatient Services Requiring Prior Authorization](#) to determine services that require 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 the secure Provider website or call the Behavioral Health IVR at 800.208.9565. Refer to the designated facilities [manual](#) and [list](#) for additional information.

Inpatient Admissions

All admissions require an inpatient notification. Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Authorizations chapter of the [Commercial Provider Manual](#) and 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 on the next business day

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

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. 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

Revenue Code	Service Description
0114, 0124	Inpatient BH, all-inclusive per diem
0116, 0126	Inpatient SUD, (ASAM Level IV Detox) all-inclusive per diem
0900	Inpatient BH Treatment (use this code when specialing approved)

Family Stabilization Treatment

Procedure Code	Service Description
99510	Home visit for individual, family, or marriage counseling

Note: Submit FST claims on a CMS 1500 form.

Community Residence Services for Rhode Island Members

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

HCPCS Procedure Codes for Intermediate Services

HCPCS Code	Service Description
H0015	SUD intensive outpatient program, per day
H0017	Acute residential program or ASAM Level III SA, per day, all-inclusive per diem
H0035	BH/SUD partial hospital, per day
S9480	BH intensive outpatient program, per day

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

- 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
- 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 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. 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.