

## **Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options 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)<sup>1</sup>
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting inpatient and intermediate behavioral health/substance use disorder (BH/SUD) facilities as well as noncontracting BH/SUD facility providers outside the network who have been authorized to render services. For information on Commercial products, [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 for BH/SUD services, as described below. Intermediate levels of care consist of acute residential treatment, partial hospitalization programs and intensive outpatient programs.

There is a 190-day lifetime limit for BH/SUD services provided in a freestanding psychiatric hospital; however, this limit does not apply to services provided in the psychiatric unit of a general hospital.

### **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 [Senior Products Provider Relations](#).

**Note:** There is no member responsibility for covered services for Tufts Health Plan SCO members.

### **AUTHORIZATION REQUIREMENTS**

#### **Designated Facilities**

Tufts Health Plan contracts with select designated facilities (DFs) to provide emergency, inpatient and intermediate levels of care for BH/SUD services. DFs are responsible for submitting an inpatient notification for admissions 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 inpatient admissions require inpatient notification. Admitting practitioners and hospital admitting departments are responsible for notifying Tufts Health Plan, following the procedures outlined in the Notifications chapter of the [Senior Products 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

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

### **Intermediate Levels of Care**

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

- Calling the Behavioral Health Department at 800.208.9565
- Using the interactive voice response (IVR) system

To obtain an authorization for a continued stay, providers must review the case for medical necessity with the BH Department by calling 800.208.9565.

**Note:** Members assigned to a capitated DF do not need authorization for a continued stay beyond the initial inpatient notification.

### **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.

### **Inpatient Services**

<b>Procedure Code</b>	<b>Description</b>
0114, 0124	Inpatient BH, all-inclusive per diem
0116, 0126	Inpatient SUD, (ASAM Level IV detox) all-inclusive per diem
0134	RM & BD psychiatric – S/P 3-4
0136	RM & BD detox – S/P 3-4 Bed
0144	RM & BD psychiatric – private deluxe
0146	RM & BD detox – private deluxe
0154	RM & BD psychiatric ward
0156	RM & BD detox ward
0204	RM & BD psychiatric

### **Family Stabilization Treatment**

<b>Procedure Code</b>	<b>Description</b>
99510	Home visit for individual, family, or marriage counseling

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

### **Intermediate Services**

<b>Procedure Code</b>	<b>Description</b>
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	SUD intensive outpatient program, per day
H0017	Acute residential program or ASAM Level III SUD, per day, all-inclusive per diem
H0018	BH; short-term residential (non-hospital residential treatment program), without room and board, per diem
H0035	BH/SUD partial hospital, per day
H2012	BH day treatment, per hour
S9480	BH intensive outpatient program, per day

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

### **COMPENSATION/REIMBURSEMENT INFORMATION**

Compensation for inpatient treatment and related services corresponds to the applicable contracted rate for per diem, per case, and/or other arrangements, as applicable. Refer to the current provider 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, staffing or equipment issues that 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 Use Disorder Professional Payment Policy](#)

### **DOCUMENT HISTORY**

- September 2018: Policy reviewed by committee; added lifetime limit content for inpatient psychiatric days
- June 2018: Template updates
- February 2017: Policy reviewed by committee; added existing delay days policy; clarified elective vs emergency inpatient admission notification timeframes
- January 2017: Template updates
- September 2016: Removed code H0019 as it is a previously implemented benefit exclusion
- September 2015: Template conversion
- April 2014: Added information regarding Tufts Health Plan SCO; template updates
- May 2013: Template updates
- March 2013: Template updates
- April 2011: Reviewed document for clarity; no content changes made
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
- March: 2009: Moved Tufts Medicare Preferred information to its own document
- May 2008: Added FST information
- 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 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 CareLink<sup>SM</sup> 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.