Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy

The following payment policy applies to Tufts MedicarePreferred HMO and Tufts Health Plan Senior Care Options (SCO) contracting inpatient and intermediate behavioral health/substance use disorder (BH/SUD) facilities.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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 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 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 our secure Provider website or by contacting Provider Relations.

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

AUTHORIZATION REQUIREMENTS
Designated Facilities
Tufts Medicare Preferred HMO and Tufts Health Plan SCO contract 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. Refer to the Designated Facilities List and the Designated Facilities Manual for additional information.

Inpatient Admissions
All inpatient admissions require inpatient notification. Refer to the Inpatient Notification Requirements section of the Authorization and Notification Policy for additional information. Admitting practitioners and hospital admitting departments 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

Intermediate Levels of Care
All intermediate levels of care require prior authorization through the Behavioral Health Department prior to start of service. Providers can obtain authorization by:

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

When an admission or intermediate level of care is reported, the following steps occur as part of the inpatient notification process:

- Confirmation that the PCP authorizes the admission with a referral to a specialist, if applicable
- Confirmation that the Behavioral Health Department care manager (CM) or member’s DF 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 the appropriate BH Department CM 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 BH Department CM by calling 800.208.9565. 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.

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>0134</td>
<td>RM &amp; BD psychiatric — S/P 3-4</td>
</tr>
<tr>
<td>0136</td>
<td>RM &amp; BD detox — S/P 3-4 Bed</td>
</tr>
<tr>
<td>0144</td>
<td>RM &amp; BD psychiatric — private deluxe</td>
</tr>
<tr>
<td>0146</td>
<td>RM &amp; BD detox — private deluxe</td>
</tr>
<tr>
<td>0154</td>
<td>RM &amp; BD psychiatric ward</td>
</tr>
<tr>
<td>0156</td>
<td>RM &amp; BD detox ward</td>
</tr>
<tr>
<td>0204</td>
<td>RM &amp; BD psychiatric</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.

HCPCS Procedure Codes for Intermediate Services
The following HCPCS procedure codes require prior authorization

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0010</td>
<td>Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)</td>
</tr>
<tr>
<td>H0011</td>
<td>Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)</td>
</tr>
<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 SUD, per day, all-inclusive per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0035</td>
<td>BH/SUD partial hospital, per day</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</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 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**

- 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 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. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither 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, adherence to plan policies and procedures and claims editing logic.