Outpatient Behavioral Health/Substance Use Disorder Professional 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 behavioral health and substance use disorder (BH/SUD) providers who render professional services in an outpatient office setting. 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 behavioral health and substance use disorder (BH/SUD) services rendered in an outpatient office setting, as described below.

GENERAL BENEFIT INFORMATION

State and Federal Mental Health Parity Law

The Mental Health Parity Law mandates that insurers offering coverage for BH/SUD services apply the same treatment and financial limits to those disorders as applicable to medical/surgical benefits; this includes copayments, coinsurance and deductibles, as well as review and authorization of BH/SUD services.

Note: While BH/SUD services have no limit, the benefit covers medically necessary treatment only. Treatment for members covered under any of the mental health parity laws must still meet any applicable medical necessity guidelines and authorization requirements.

These laws apply to all members enrolled in Massachusetts, New Hampshire, and Rhode Island fully insured, self-insured and individual plans.

Suboxone® and Subutex®

Tufts Health Plan covers medically necessary services for the treatment of an opiate addiction with Suboxone and Subutex when rendered in an outpatient office setting by an appropriately licensed and qualified BH/SUD provider. Suboxone and Subutex are covered in accordance with the member's prescription drug benefit. BH services related to the treatment of an opiate addiction with Suboxone and Subutex are covered based on the member's benefit plan document. For information on how to submit claims for Suboxone and Subutex, refer to the Billing Instructions section.

Note: There is no prior authorization needed for these drugs if obtained by the provider and provided to the member during a visit. The prior authorization only applies if the drug will be prescribed and picked up by the member at the pharmacy.

CareLink℠ Members

Cigna, Tufts Health Plan, or another entity, may administer BH services based on employer plan design. The member's identification card will indicate where the member should be directed for these services. CareLink members are able to self-refer to contracting network providers, according to their plan design.

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

Carve Out
Some employer groups choose to have BH benefits for their employees managed and administered by a designated BH management company (carve out). The telephone number of the carve out company is listed on the back of the member identification card and is available when you call the interactive voice response system (IVR) system or access member information on the secure Provider website.

Pharmacology Visits
Visits billed with CPT code 99214, with or without the addition of a therapy CPT code, require authorization. All visits count against the member's BH/SUD benefit.

CPT codes 99201, 99211-99213 do not require authorization when billed alone and do not count against the member's BH/SUD benefit.

Testing is covered as a medical service and is not considered part of a member's BH benefit; therefore, prior authorizations for testing services do not count again the member's benefit.

Notification is required for outpatient therapy visits. Upon submission of the notification, 8 visits will be available. If these visits are exhausted, submit a notification for another 8 visits.

PREVENTIVE SERVICES

Due to the Patient Protection and Affordable Care Act (commonly referred to as federal health care reform), with the exception of groups maintaining "grandfathered" status, all Tufts Health Plan plans are required to provide 100% coverage for preventive care services. Grandfathered groups are not subject to this requirement, but many of these groups have opted to cover preventive services with no cost-sharing.

This means that most members will have no cost-sharing responsibility when preventive services are rendered by an in-network provider. Members may still be required to pay a copayment, deductible or coinsurance for preventive services received from out-of-network providers (PPO and POS plans), or for nonpreventive services received in conjunction with a preventive services visit. Please refer to the Preventive Services list for a complete list of services that have been deemed preventive in nature.

METHADONE TREATMENT PROGRAMS

Rhode Island-Based Employer Groups[2]
The Rhode Island state mandate applies to fully insured Rhode Island-based employer groups. Some self-insured groups may choose to offer coverage on a voluntary basis.

Tufts Health Plan provides coverage of methadone maintenance treatment for members[3] of Rhode Island-based employer groups.

Massachusetts Fully Insured Group and Individual Plans[4]
The Massachusetts state mandate applies to Massachusetts fully insured group and individual plans. Some self-insured groups may choose to offer coverage on a voluntary basis.

Tufts Health Plan provides coverage of methadone maintenance treatment for members of Massachusetts fully insured group and individual plans[4].

Note: This mandate also applies to Tufts Medicare Complement and Tufts Medicare Preferred Supplement plans.

New Hampshire-Based Employer Groups
In accordance with federal Mental Health Parity laws, Tufts Health Plan provides coverage of methadone treatment programs for fully insured New Hampshire employer groups. Some self-insured groups may choose to offer coverage on a voluntary basis.

Providers may bill the procedure code(s) contained in the table below, in accordance with the applicable financial exhibits of their provider agreements. Authorization for these services is not required.

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[2] Chapter 130: 2014 -- H 8042 SUBSTITUTE A. Enacted 06/14/2014
[3] This benefit does not apply to members enrolled in self-insured groups; however, some self-insured groups may choose to adopt coverage voluntarily. Additionally, some self-insured groups may have their BH/SUD benefits administered by an administrator other than Tufts Health Plan.
[4] Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008, as explained in the Division of Insurance and the Department of Public Health Joint Bulletin 12/09/2014.

Procedure Code	Description
H0001	Alcohol and/or drug assessment
H0004	Behavioral health counseling and therapy, per 15 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0020	Alcohol and/or drug services; methadone administration and/or service
S0109	Methadone, oral, 5 mg (5 mg = 1 unit)

Because Tufts Health Plan has contracted with methadone clinics to provide methadone treatment, methadone administration services will process with the clinic as the provider and payee.

AUTHORIZATION & NOTIFICATON REQUIREMENTS

It is the BH provider's responsibility to obtain the necessary notification number for outpatient BH/SUD services within 30 days of the member's first visit. Upon submission of the notification, 8 visits will be available. If these visits are exhausted, submit a notification for another 8 visits. However, the member or the PCP may also contact the Behavioral Health Department to obtain the initial notification number for outpatient services. Both the member and BH provider will receive confirmation of the initial notification in writing. Refer to the Behavioral Health Outpatient Services Requiring Prior Authorization grid for more information.

Providers can submit requests for initial and additional notifications by:

- Logging in to the secure Provider website
- Calling 800.208.9565 to use the interactive voice response system (IVR) or speak with a BH coordinator

Psychological and Neuropsychological Testing

Prior authorization is required for psychological and neuropsychological testing for all Commercial plans except CareLink. The recommending provider must complete the standard Psychological and Neuropsychological Assessment Supplemental Form (standard form). The requesting provider will be notified of the coverage determination. Refer to the medical necessity guidelines for psychological and neuropsychological testing for additional information.

Note: Testing is covered as a medical service and is not considered part of a member's BH benefit; therefore, prior authorizations for testing services do not count again the member's benefit.

Transcranial Magnetic Stimulation (rTMS)

Prior authorization is required for rTMS for all Commercial plans except CareLink. Click here for additional information on how to submit the form. Refer to the medical necessity guidelines for Transcranial Magnetic Stimulation for more information.

Contact the Behavioral Health Department at 800.208.9565 with any questions regarding prior authorization requests for BH services.

BILLING INSTRUCTIONS

Submit claims with the identification number and name of the rendering provider in box 24j, when applicable.

Suboxone and Subutex

A licensed and qualified BH and/or SUD provider must submit the applicable procedure code(s) when rendering services for the treatment of an opiate addiction with Suboxone and Subutex in an outpatient office setting. For additional information, refer to the Medical Necessity Guidelines for Opioid Dependence Medications.

Ancillary providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements.

Procedure Codes for All Clinicians

Procedure Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)

Procedure Code	Description
90832	Psychotherapy, 30 minutes with patient or family member
90834	Psychotherapy, 45 minutes with patient or family member
90837	Psychotherapy, 60 minutes with patient or family member
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90853	Group psychotherapy (other than of a multiple-family group)

Evaluation & Management

All outpatient BH services require notification, with the exception of E&M codes 99201 and 99211-99213. These codes do not require notification for in-plan providers only when billed alone or with 90785. These specific E&M codes do not decrement the member's BH benefit.

Procedure Codes for Psychological and Neuropsychological Testing

The following psychological and neuropsychological testing CPT codes require prior authorization through the Behavioral Health Department:

Procedure Code	Description
96101	Psychological testing, per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96102	Psychological testing with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report
96116*	Neurobehavioral status exam, per hour
96118	Neuropsychological testing, per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96119	Neuropsychological testing with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing administered by a computer, with qualified health care professional interpretation and report

* Prior authorization is not required for up to a maximum of three hours.

Procedure Codes for rTMS

Procedure Code	Description
90867	Therapeutic repetitive magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Subsequent delivery and management, per session
90869	Subsequent motor threshold re-determination with delivery and management

Codes for Prescribing Clinicians (psychiatrists, nurse clinical specialists and BH clinics)

Procedure Code	Description
90792	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient or family member with an evaluation and management services

Procedure Code	Description
90836	Psychotherapy, 45 minutes with patient or family member with an evaluation and management services
90838	Psychotherapy, 60 minutes with patient or family member with an evaluation and management services
99201	New patient, office or outpatient visit, problem focused
99202	New patient, office or outpatient visit, expanded problem-focused
99203	New patient, office or outpatient visit, low complexity
99204	New patient, office or outpatient visit, moderate complexity
99205	New patient, office or outpatient visit, high complexity
99211	Established patient, office or outpatient visit, five minutes are spent
99212	Established patient, office or outpatient visit, 10 minutes are spent
99213	Established patient, office or outpatient visit, low complexity
99214	Established patient, office or outpatient visit, moderate complexity
99215	Established patient, office or outpatient visit, high complexity
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, low severity 25 minutes
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, moderate severity 35 minutes
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, high severity 45 minutes
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, spends 10 minutes
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, spends 15 minutes
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, spends 25 minutes
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, spends 35 minutes

Additional Codes for Psychiatrists Only

Procedure Code	Description
90849	Multiple-family group psychotherapy
90870	Electroconvulsive therapy
90882	Environmental intervention for medical management
90887	Consultation with family

Health and Behavior Assessment and Intervention

As listed in the CPT AMA® codebook, "health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems."

CPT codes 96150-96155 may be billed for services when the primary diagnosis is a medical condition. A referral from the member's primary care provider is required. E&M codes, as well as psychological service codes, should not be billed on the same day by the provider.

Health and Behavior Assessment and Intervention Procedure Codes

Procedure Code	Description
96150	Health and behavior assessment, each 15 minutes face-to-face with the patient; initial assessment
96151	Health and behavior assessment, each 15 minutes face-to-face with the patient; re-assessment
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	Health and behavior intervention, each 15 minutes, face-to-face; Group (2 or more patients)
96154	Health and behavior intervention, each 15 minutes, face-to-face; Family (with the patient present)
96155	Health and behavior intervention, each 15 minutes, face-to-face; Family (without the patient present)

COMPENSATION/REIMBURSEMENT INFORMATION

Facility Fee Reduction

BH providers who perform services in a hospital may be subject to a facility fee reduction. This reduction is consistent with Medicare's site of service differentiation built into Medicare fees, and parallels the facility fee reduction Tufts Health Plan applies to medical office visits in these settings. Refer to your current contract for details regarding outpatient compensation provisions.

Note: Tufts Health Plan has adopted CMS's differential compensation for office and facility-based services for providers, replacing Tufts Health Plan's standard facility fee reduction. Refer to your contract for details regarding outpatient compensation provisions.

Procedure Code Guidelines

Tufts Health Plan does not compensate for services performed with an E&M service by the same provider unless modifiers AH, AJ, HM, HN, HO, HP, SA, TD, or TE are also on the claim. Refer to the AMA CPT-4 Manual and CMS HCPCS Level II Manual for more information.

Provider Type Modifiers

Tufts Health Plan requires provider organization-affiliated psychiatrists to append appropriate modifiers for services provided by a non-MD clinician in their office. The modifiers will affect compensation according to clinician type. Refer to the Modifier Table for a list of modifiers that are accepted by Tufts Health Plan and may impact claims payment.

Codes 96101-96103 and 96118-96120 will be excluded from the modifier logic when billed with modifier AH and HP.

Note: Tufts Health Plan does not compensate for services provided by a non-independently licensed clinician providing services under the supervision of a provider organization-affiliated psychiatrist.

ADDITIONAL RESOURCES

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

DOCUMENT HISTORY

- June 2018: Template updates
- March 2018: Added notification information for outpatient therapy visits
- June 2017: Added procedure codes and standard form for rTMS; updated standard prior authorization form information for psychological and neuropsychological testing; updated prior authorization requirements for BH services to notification
- April 2017: Updated links to Psychological and Neuropsychological Testing medical necessity guidelines as they are separate effective April 1, 2017
- January 2017: Template updates

- November 2016: Policy reviewed; added Mental Health Parity language and methadone treatment coverage for NH employer groups
- November 2015: Added CPT code S0109 to covered methadone maintenance treatment for members of Massachusetts group and non-group fully insured plans, effective July 1, 2015
- September 2015: Updated parity language, added information regarding prior authorization to Suboxone section, template conversion, template updates
- August 2015: Added information regarding the processing of administration services for methadone clinics
- July 2015: Added information regarding coverage of methadone maintenance treatment for Massachusetts fully insured group and non-group plans effective for dates of service on or after July 1, 2015, template updates
- December 2014: Added information regarding coverage of methadone maintenance treatment for members of Rhode Island-based employer groups, effective for dates of service on or after January 1, 2015, template updates
- May 2014: Added procedure code guidelines policy for billing E & M services without appropriate modifiers effective for dates of service on or after July 1, 2014, template updates
- January 2013: Updated codes for 2014 according to the AMA CPT Manual, template updates
- September 2013: Template conversion
- February 2013: Added information regarding Evaluation (Medication) Management billed as CPT codes 99201, 99211, 99212, 99213, added SCO information. Template updates.
- December 2012: Policy reviewed. Updated codes for 2013 according to the AMA CPT Manual.
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, no content changes
- May 2011: Updated Rhode Island Parity Law information. Added information about mental health provider type modifiers effective for dates of service on or after July 1, 2011.
- September 2010: Added information regarding Preventive Services
- July 2010: Modified Suboxone and Subutex information to state that Effective for fill dates on or after July 1, 2010**,** Tufts Health Plan will require prior authorization for coverage of Suboxone and Subutex
- November 2009: Added a note that: Effective January 1, 2010, Tufts Health Plan will adopt CMS' differential reimbursement for office and facility-based services for physicians, replacing Tufts Health Plan's standard facility fee reduction. Refer to your contract for details regarding outpatient reimbursement provisions
- October 2009: Added Suboxone and Subutex information
- March 2009: Added Rhode Island Parity Law and carve out information
- February 2008: Revised general benefit information with self-service channels information
- January 2008: Added that prior authorization is required for psychological/neuropsychological testing for all commercial plans effective January 1, 2008 and changed Guide for Completing Blue Forms Using IVR to Guide for Completing Mental Health Care Service Requests Using IVR

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.