Outpatient Behavioral Health and 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)[2]
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

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.

In addition to the specific information contained in this policy, providers must adhere to the 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, 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 Law

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 copays, coinsurance and deductibles 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.

Note: While BH/SUD services have no limit, the benefit covers medically necessary treatment only. Treatment for members covered under 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.

Behavioral Health Services Performed by Psychiatrist-Supervised Physician Assistants

Effective for dates of service on or after September 17, 2019, and per NH Senate Bill 225, BH services may be provided by psychiatrist-supervised physician assistants (PAs) treating Tufts Health Freedom Plan members in New Hampshire. Services must be billed by the collaborating psychiatrist with the SA modifier appended to indicate that services were provided by a PA.

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. Refer to the Working with CareLink grid for more information.

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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.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

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 also available when accessing the interactive voice response system (IVR) system or member information on the secure Provider website.

REFERRAL/AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Authorization and Notification Policy.

Effective for dates of service on or after January 1, 2021, Tufts Health Plan does not require notification for behavioral health outpatient psychotherapy. Prior authorization for certain outpatient procedures will still be required. Contact the Behavioral Health Department at 800.208.9565 with any questions regarding prior authorization requests for BH services.

Note: CareLink members are able to self-refer to contracting network providers, according to their plan design.

EVALUATION AND MANAGEMENT SERVICES

E&M Procedure Codes

- New patient visit: 99201-99205
- Established patient visit: 99211-99215
- Initial nursing facility care (per day): 99304-99306
- Subsequent nursing facility care (per day): 99307-99310

E&M codes 99201, 99211-99213 do not require prior authorization for in-plan providers when billed alone or with 90785 and do not count against the member's BH/SUD benefit limit.

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.

Refer to the Evaluation and Management Professional Payment Policy for more information on E&M procedure codes.

SUBSTANCE USE DISORDER SERVICES

Coding for Substance Use Disorders

- Claims for SUD follow-up visits must include the appropriate SUD diagnosis code (e.g., Z79.891, long-term current use of opiate analgesic)
- Append "1" as the last digit of the SUD diagnosis code if the condition is in remission

Methadone Treatment Programs

Tufts Health Plan provides coverage of methadone maintenance treatment for members of fully insured employer groups and individual plans based in Massachusetts, Rhode Island, and New Hampshire, in accordance with applicable state mandates and/or federal mental health parity laws. Some self-insured groups may choose to offer coverage on a voluntary basis.

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

Methadone Maintenance Treatment

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)

Note: 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.

Opioid Dependence Medications

Tufts Health Plan covers medically necessary services for the treatment of an opiate addiction when rendered in an outpatient office setting by an appropriately licensed and qualified BH/SUD provider. Opioid dependence medications are covered in accordance with the member's prescription drug benefit. BH services related to the treatment of an opiate addiction with opioid dependence medications are covered based on the member's benefit plan document. 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 opioid dependence medications in an outpatient office setting. For additional information, refer to the Medical Necessity Guidelines for Opioid Dependence Medications.

Medication Assisted Treatment (MAT) and Opioid Agonist Treatment for Fully Insured Massachusetts-Based Plans

Per the Massachusetts Division of Insurance (DOI), Tufts Health Plan covers medically necessary MAT and opioid agonist treatment. Tufts Health Plan covers at least one opioid agonist treatment and at least one partial agonist treatment without prior authorization. Refer to the appropriate formularies for additional information.

All claims that include drugs administered by a provider must include the National Drug Code (NDC).

Codes	Description
H0001	Alcohol and/or drug assessment (substance use disorder programs only)
H0001-U1	Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner, one unit maximum annually; per visit
H0020	Alcohol and/or drug services; methadone administration and/or service (dosing); per dose
H0033	Oral medication administration, with extended direct observation, up to 2.5 hours (buprenorphine and associated drug screens, to be billed once during induction); per visit
T1015	Clinic visit/encounter, all-inclusive (community health centers only)
96372	Therapeutic prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Naltrexone); per visit
99199	Other Medicine Services and Procedures (tracking and monitoring of naloxone dispensing at discharge)
99201-99205	Outpatient visit for the evaluation and management of a new patient
99211-99215	Office or other outpatient visit for the evaluation and management of an established patient
99281-99285	Initial/normal ED charges
99217-99220	Initial observation (new or established patient)
J0571*	Buprenorphine, oral, 1 mg (maximum 32 mg per day) (prior authorization required)
J0572*	Buprenorphine/naloxone, oral, less than or equal to 3 mg (maximum of one unit (film or pill) per day; may be combined with J0573, J0574, and J0575, as medically necessary)
J0573*	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal 3.1 to 6 mg (maximum of one unit (film or pill) per day; may be combined with J0572, J0574, and J0575, as medically necessary)
J0574*	Buprenophine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg. (maximum of 4 units (film or pill) per day; may be combined with J0572, J0573, and J0575, as medically necessary)
J0575*	Buprenorphine/naloxone, oral, greater than 10 mg (max. 2 units (film or pill) per day; may be combined with J0572, J0573, and J0574, as medically necessary)
S0109	Methadone, oral, 5 mg
J1230*	Injection, methadone HCL; up to 10 mg
J2315*	Injection, naltrexone, depot form, 1 mg (max. 380 mg per month)

*NDC required

New Hampshire and Rhode Island-Based Plans
Prior authorization is required for opioid dependence medications if the drug will be prescribed and picked up by the member at the pharmacy. There is no prior authorization needed if obtained by the provider and provided to the member during a visit.

Note: Members of Rhode Island plans may be subject to opioid prescription limits if they have not had an opioid within the previous 30 days. Refer to pharmacy medical necessity guidelines for RI Opioid Prescribing Limits for more information.

PSYCHOLOGICAL/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 and will be notified of the coverage determination. Refer to the medical necessity guidelines for psychological and neuropsychological testing for additional information.

Code	Description
96116*	Neurobehavioral status exam; per hour
96121*	Neurobehavioral status exam; each additional hour
96130	Psychological testing evaluation; first hour
96131	Psychological testing evaluation; each additional hour
96132	Neuropsychological testing evaluation; first hour
96133	Neuropsychological testing evaluation; each additional hour (list separately in addition to code for primary procedure)
96136	Psychological or neuropsychological test administration and scoring by physician; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician; each additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician; each additional 30 minutes
96146	Psychological or neuropsychological test administration

*96116 and 96121 may be billed up to three hours without prior authorization.

Note: Testing is covered as a medical service and does not count against the member's behavioral health benefit limit.

TRANSCRANIAL MAGNETIC STIMULATION (RTMS)

Prior authorization is required for rTMS for all Commercial plans (except CareLink) using the standard form. Refer to the medical necessity guidelines for Transcranial Magnetic Stimulation for more information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Submit claims with the identification number and name of the rendering provider in box 24j, when applicable.
- Submit claims with unlisted CPT procedures that require explanations or descriptions on an industry-standard paper claim form, as outlined in the Unlisted and Not Otherwise Classified Codes Payment Policy. Claims with attachments are not accepted electronically.
- Ancillary providers may only bill the procedure code(s) below, in accordance with the applicable financial exhibits of their provider agreements.

Procedure Codes for All Clinicians

Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)
90832	Psychotherapy, 30 minutes with member or family member
90834	Psychotherapy, 45 minutes with member or family member
90837	Psychotherapy, 60 minutes with member 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)

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

Code	Description
90792	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient or family member, with an E&M service
90836	Psychotherapy, 45 minutes with patient or family member, with an E&M service
90838	Psychotherapy, 60 minutes with patient or family member, with an E&M service

Additional Codes for Psychiatrists Only

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."

- Health behavior assessment includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health focused clinical interviews, observation, and clinical decision making.
- Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement.

Effective for dates of service on or after January 1, 2020, CPT codes 96156-96171 may be billed for services when the primary diagnosis is a medical condition. Refer to the Health Behavior Assessment and Intervention Billing and Coding Guide for additional information on the new code set.

E&M codes, as well as psychological service codes, should not be billed on the same day by the provider.

Code	Description
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making); 1 unit maximum/day
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes; 1 unit maximum/day
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes; 4 units maximum/day

Code	Description
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes; 1 unit maximum/day
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes; 6 units maximum/day
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes; 1 unit maximum/day
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes; 6 units maximum/day
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 mins; 1 unit maximum/day
96171	Health behavior intervention, family (without the patient present), face-to-face; each addl 15 mins; 4 units maximum/day

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

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.

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.

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 Commercial Modifier Table for a list of modifiers that are accepted by Tufts Health Plan and may impact claims adjudication.

Certain psychological/neuropsychological testing evaluation and administration codes (96130-96133, 96136-96169 and 96146) will be excluded from the modifier logic when billed with modifiers AH and/or 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
- Massachusetts Division of Insurance Bulletin 2019-07

DOCUMENT HISTORY

- February 2021: Removed referral requirement statement for health and behavior assessment and intervention codes, effective for dates of service on or after January 1, 2021
- January 2021: Updated prior authorization guidelines for outpatient psychotherapy
- June 2020: Added existing coding guidance for SUD claims
- March 2020: Updated health behavior and intervention code set, effective for dates of service on or after January 1, 2020
- December 2019: Added coverage for NH PAs rendering services in NH for Tufts Health Freedom Plan members, effective for dates of service on or after September 17, 2019 and benefit information and codes for MAT services per the Massachusetts Division of Insurance Bulletin 2019-07
- May 2019: Clarified existing authorization requirements for neurobehavioral status exam codes 96116 and 96121
- August 2018: Policy reviewed by committee; formatting updates; removed procedure code tables for rTMS, psychological/neuropsychological testing, and E&M codes and added links to applicable medical necessity guidelines and/or payment policies

- 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 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℠ 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.