Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:

Inpatient and Intermediate/Diversionary Behavioral Health/Substance Use Disorder (BH/SUD) Facility

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☐ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health Unify – OneCare Plan (a dual-eligible product)

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☐ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Tufts Health Plan covers medically necessary inpatient and intermediate levels of care BH (mental health and 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, and family stabilization services, 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 portal or by contacting Provider Services.

State and Federal Mental Health Parity Laws

Tufts Health Direct

Under the mental health parity laws, benefits for behavioral health (mental health and substance use disorder) treatment services must be comparable to benefits for medical/surgical services. This means that cost share for behavioral health services must be at the same level as those for medical/surgical services. Also, Tufts Health Plan's review and authorization of behavioral health must be handled in a way that is comparable to the review and authorization of medical/surgical services.

Discharge Planning

Facilitates are expected to implement procedures to ensure timely and effective discharge planning. Discharge planning must involve collaboration between the Tufts Health Plan and the treating hospital and must include actionable strategies to address barriers to discharge and mitigate the risk of decompensation, readmission, and overdose after discharge. Tufts Health Plan, the hospital, the member, and DMH (when DMH is involved) should reach agreement on the discharge plan before placing a member on AND status.

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 information on procedures, services and items requiring referral and/or prior authorization and/or notification, refer to the following resources:

- Medical necessity guidelines available in the Provider Resource Center
- Benefit summary grids available in the Provider Resource Center
- Tufts Health Public Plans Provider Manual
- Tufts Health Together and Tufts Health Direct Behavioral Health Prior Authorization (PA) and Notification Grid
- Tufts Health RITogether Behavioral Health Prior Authorization (PA) and Notification Grid

Inpatient Admission Requirements

Notification is required for members who are admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer.

In most instances, admitting practitioners and facilities are responsible for notifying Tufts Health Plan within two business days following the procedures outlined in the Tufts Health Public Plans Provider Manual. For information on required notification timeframes and submission channels, refer to the following:

- Prior authorization and notification grids for Tufts Health Together/Tufts Health Direct and Tufts Health RITogether
- Behavioral Benefit Summary Grid for Tufts Health Unify

Late Notification

Timely notification of admission is a requirement for payment. Late notification may result in denial of payment for the entire admission, even if the member is still inpatient at the time of notification.

Initial Determination for Coverage

Initial determination for acute inpatient coverage is based on InterQual® criteria, as well as Medicare coverage guidelines for Unify, and ASAM criteria for Tufts Health RITogether members admitted for substance use treatment. ASAM criteria is also used for Massachusetts Residential Rehabilitation Services. Additional clinical information may be requested to support care management and transition of care needs. Determination depends on the completeness and accuracy of the information submitted by the provider at the time of notification.

Providers should log on to the secure Provider portal to view the notification event and status of the event by following the directions provided. When the inpatient notification process is complete, the inpatient notification status will be communicated.

Intermediate Levels of Care

All intermediate levels of care require notification or prior authorization within two business days of start of treatment through the Behavioral Health Department. 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.

Acute BH Admission Notifications

Tufts Health Plan Direct

Effective for DOS on or after April 1, 2023, the notification time frame for acute BH admissions is increased to three business days from admission, in accordance with Massachusetts DOI Bulletin 2023-07. This applies to inpatient and intermediate/diversionary mental health acute treatment, community-based acute treatment (CBAT), and intensive community-based acute treatment (ICBAT) services only.

For DOS through March 31, 2023, notification must be submitted within two business days of admission.

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.

Administratively Necessary Days (AND)

Tufts Health Together and Tufts Health Unify

Per MassHealth guidelines, a member can only move to AND status when clinically ready for discharge to a lower level of care, but an appropriate setting is not available.

A member cannot be placed on AND status when preparing to be discharged from a hospital but is awaiting a placement at another acute inpatient level of care. Equivalent inpatient levels of care may include, but are not limited to, Department of Mental Health (DMH) continuing inpatient psychiatric care (“long-term continuing care”), Intensive Residential Treatment Programs (IRTP), and Clinically Intensive Residential Treatment Programs for Children (CIRT).

- Submit revenue code 169 to report AND services.
- Authorized AND are compensated in accordance with the provider's health service agreement and MassHealth regulations.

Collateral Contact Claims

Tufts Health Together

In accordance with MassHealth requirements, for HCPCS code H0046 compensation must include the appropriate licensure-level modifier and modifier UK. The appropriate licensure-level modifier should be billed in the MOD1 field and modifier UK should be billed in the MOD2 field.

Services Provided within Acute Care Hospitals for Emergency Psychiatric Inpatient Admission (EPIA) Patients ("BH Boarding")

Tufts Health Direct

Providers are eligible for additional compensation for BH care rendered to members to treat and/or stabilize their condition in acute medical facilities while awaiting appropriate inpatient psychiatric placement. Refer to the following payment policies for specific information:

- Emergency Department Services
- Observation Services
- Inpatient Facility

Inpatient/Diversionary Services

Revenue codes and procedure codes for inpatient and diversionary services are outlined below (Note: This is not an all-inclusive list).

Tufts Health Direct

Revenue Code	Description
0114, 0124	Inpatient BH, all-inclusive per diem (Note: These codes may be used to bill for ICBAT services)
0116, 0126	Inpatient SUD, (ASAM Level IV Detox) all-inclusive per diem

Tufts Health Together/Tufts Health RITogether/Tufts Health Unify

Revenue Code	Description
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

Inpatient Psychiatric Admission Add-on Payments

Tufts Health Together

Providers are compensated an additional per-admission payment (in addition to a per diem rate) for each inpatient psychiatric admission, in accordance with MassHealth MCE Bulletin 93. Additional compensation will be based on criteria met upon admission.

- Submit the psychiatric admission day room and board (R&B) revenue code (i.e., 114, 124, 134, etc.) with 1 unit of the appropriate revenue code below to identify the add-on payment:
- 909 (admission beginning on a weekday)
- 910 (admission beginning on a weekend)
- Subsequent days should be submitted with the appropriate revenue codes and units, and ICD-10 procedure/diagnosis codes. The total number of psychiatric R&B revenue code units should not exceed the total length of stay.
- Add-on payment revenue codes (i.e., 909 or 910) should only be submitted on initial or corrected claims; they will be denied if submitted on interim claims.

- Providers will be compensated in accordance with their contracted per diem rate for the standard psychiatric admission; the add-on payment will be compensated once per admission in accordance with the criteria outlined in MCE Bulletin 93.

Timely filing limits to receive original claims for these services will be waived until March 1, 2023 to allow additional time to submit add-on payment revenue codes.

Initial claims that have already been submitted without the add-on payment revenue code will not be automatically reprocessed to compensate the add-on payment. Providers must submit a corrected claim using bill type 1X7 and must include all original claim information in addition to the appropriate add-on payment revenue code (i.e., 900 or 910).

If a corrected claim is submitted, any payments previously made based on the original claim will be re-adjudicated to include the add-on payment revenue code and will be reflected on the provider's explanation of payment (EOP). Refer to the Claim Requirements, Coordination of Benefits, and Dispute Guidelines chapter of the Tufts Health Public Plans Provider Manual for more information on this process.

Specialing (Emergency Department Boarding)

Tufts Health Direct, Tufts Health Together, Tufts Health Unify

Tufts Health Plan provides coverage and appropriate compensation for “specialing” services if a member’s immediate care requires adjustments to a facility’s usual staffing needs. Necessary services and/or high-cost medications for complex co-morbid medical conditions 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 information, refer to the Medical Necessity Guidelines for Behavioral Health Level of Care Determinations or visit the Department of Mental Health’s website.

The specialing services below require authorization and must be billed on a separate claim from the inpatient admission to ensure appropriate compensation.

Procedure Codes	Additional Services
Revenue code 900 and/or HCPCS code T1004	Providing additional staffing overall or mobilizing additional staff to manage added acuity of a disturbed patient from the ED to maintain unit safety (e.g., intensive RN and physical care or 1:1 with a caregiver or personal care attendant, security, or mental health worker) • Outpatient claims (CMS-1500) should be billed with T1004 • Institutional claims (UB-04) should be billed with 0900, T1004, and Bill Type 13X
Applicable HCPCS code for the drug (provided by the facility)	High-cost medication

Program of Assertive Community Treatment (PACT)

Tufts Health Together and Tufts Health Unify

Prior authorization is not required. Refer to the medical necessity guidelines for clinical coverage criteria. Providers should submit claims in accordance with the billing guidance below.

Code	Description
H0040	Assertive community treatment program, per diem (PACT programs with 50 slots)
H0040-HT	Assertive community treatment program, per diem (PACT programs with 80 slots)
H0040-H9	Assertive community treatment program, per diem (forensic program)

Family Stabilization Treatment (FST)

Tufts Health Direct

- Prior authorization is not required for FST services
- Submit 99510 (home visit for individual, family, or marriage counseling/mental health FST, per day) on a CMS-1500 claim form
- Providers should only bill when face-to-face or telehealth encounters occur. The member must be present for every encounter.

Community Residence Services for Rhode Island Members

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

Residential Rehabilitation Services (RRS)

Tufts Health Together and Tufts Health Unify

Procedure Code	Description
H0019	Residential Rehabilitation Services (RRS)
H0019-HF	RRS for transitional age youth and young adults
H0019-HA	RRS for youth
H0019-HR	RRS for families
H0019-TH	RRS for pregnant and post-partum women
H0019-HH	Co-occurring enhanced RRS

Intermediate Services

Procedure codes for intermediate services are outlined below (**Note:** These are not all-inclusive lists).

Tufts Health Direct

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

Tufts Health Together/Tufts Health RITogether/Tufts Health Unify

Submit one HCPCS procedure code per DOS.

Procedure Code	Description
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 lll 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 (Note: bill with revenue code 912; 1 unit = half day, 2 units = full day)
H2012	BH day treatment, per hour
S9480	BH intensive outpatient program, per day

Behavioral Health for Children and Adolescents (BHCA)/CBHI

Tufts Health Direct and Tufts Health Together

Tufts Health Plan provides coverage for inpatient and/or intermediate care to treat child-adolescent behavioral health disorders. Refer to the applicable medical necessity guidelines for more information on coverage criteria and prior authorization requirements for these services. Refer to the BH Covered Services and Benefits page for additional provider resources.

Family Support and Training (FS&T)

No notification or prior authorization is required if FS&T is provided either in conjunction with In-Home Therapy (IHT) or as part of outpatient HUB services. Refer to the medical necessity guidelines for Tufts Health Direct and Tufts Health Together for clinical coverage criteria.

Notification is needed for the first 42 days of service if FS&T is provided in conjunction with Intensive Care Coordination (ICC). During this initial period when ICC is involved, providers must fax a CSA Notification Form to 888-977-0776.

Note: the ICC must request prior authorization for continued stays at the time of ICC medical necessity review, since FS&T services are included in the CSA per diem rate.

- Submit H0038 (Self-help/peer services, per 15 minutes (parent/caregiver peer-to-peer support service provided by a family partner; max. 32 units/day)

Providers may bill the following codes for intermediate care services. (**Note:** refer to CBHI for Providers for Tufts Health Together medical necessity criteria)

Service	Code	Description
Mobile crisis intervention (MCI)	H2011	Crisis intervention service, per 15 minutes; max. 32 units/day

In-home behavioral services (IHBS)	H2014	Skills training and development, per 15 minutes; max. 32 units/day
In-home therapy services (IHTS)	H2019	Therapeutic behavioral services, per 15 minutes; max. 32 units/day
Intensive care coordination (ICC)	H0023	BH outreach service; planned approach to reach a targeted population; max. 1 unit/day
Therapeutic Mentoring (TM)	T1027-EP	Family training and counseling for child development, per 15 minutes; max. 32 units/day

Note: For codes H2011-H2019, append modifier HN for providers at the bachelor's degree level or HO for those with a master's degree level. For code H0023, append modifier HT to indicate services were performed by a multi-disciplinary team.

Substance Abuse Residential Treatment (SART)

Tufts Health RITogether

In accordance with the Rhode Island EOHHS, claims for SART services must include the appropriate combination of HCPCS and revenue codes based on the type of service and facility (bill type) listed in the table below. The taxonomy code must also be included on the claim.

Note: Providers must bill both the HCPCS and revenue codes indicated for each service.

ASAM Level	ASAM Description	HCPCS Code	Revenue Code	Bill Type	Taxonomy Code
Level 3.1	Clinically managed low-intensity residential services	H0018	1003	86X	324500000x
Level 3.3	Clinically managed population-specific high-intensity	H0010	1002	86X	324500000x
Level 3.5	Clinically managed high-intensity residential services	H0010	1002	86X	324500000x
Level 3.7	Medically monitored intensive inpatient services	H0011	1002	11X	324500000x
Level 3.7-WM	Medically monitored inpatient withdrawal management	H0011	116, 126, 136, 146, 156	11X	324500000x

Tufts Health Direct, Tufts Health Together and Tufts Health Unify

Service	Code	Description/Notes
Acute Treatment Services Level 3.7 Inpatient Stay (ATS)	H0011 + 1002	• Alcohol and/or drug services; acute detoxification (residential addiction program inpatient); 1 unit = 1 day • Submit on a UB form
Community Crisis Stabilization (CCS)	S9485-TG	• Crisis intervention mental health services, per diem (1 unit = 1 day) • Submit on a CMS-1500
CSS Level 3.5	H0010 + 1002	• Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient); 1 unit = 1 day • Submit on UB-04 form • No prior authorization required for first 10 days of treatment
Dual Diagnosis Acute Residential Treatment (DDART)	H0037-HH + 1001 or 1002	• Community psychiatric supportive treatment program, per diem (1 unit = 1 day) • Submit on UB04 form
Enhanced Acute Treatment Services (EATS)	H0011-HH + 1002	• Alcohol and/or drug services; acute detoxification (inpatient residential addiction program); 1 unit = 1 day • Submit on UB-04 form
Inpatient Level 4 Detox	0116, 0126, 0136, 0156	• Room and board, detoxification (1 unit = 1 day) • Submit on UB-04 form
Intensive Community-Based Acute Treatment	H0037-TG + 1001 or H0037-TG (no rev)	• Community psychiatric supportive treatment program, per diem (1 unit = 1 day) • Submit on UB-04 form

Transitional Care Unit (TCU)	0100	• All-inclusive room and board, plus ancillary • Submit on UB form

Youth and Transition-Age Detoxification and Stabilization Programs

Tufts Health Together

Effective for DOS on or after July 1, 2023, submit H0011 with modifier HV when billing for youth and transition-age youth detoxification and stabilization services for Tufts Health Together members. Refer to the applicable performance specifications for more information on providing these services

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules. 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 the 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 and the member will not be responsible for payment.

Secondary Diagnosis Codes

Services billed with a secondary diagnosis code as the only diagnosis on the claim are not compensated.

Related Policies and Resources

Payment Policies

- Outpatient Behavioral Health & Substance Use Disorder
- Opioid Replacement Therapy and Medication Assisted Treatment Payment Policy

Clinical Policies

- Medical Necessity Guidelines

Publication History

- November 2023: Added current billing information for SART services for Tufts Health RITogether members (ASAM Levels 3.1-3.5); corrected HCPCS code to be used with level 3.7 is H0011
- September 2023: Annual policy review; added billing instructions for youth and transition-age detoxification and stabilization programs effective for DOS on or after July 1, 2023 for Tufts Health Together members; removed IHD information, located in the Intensive Hospital Diversion medical necessity guidelines; template updates
- February 2023: Added notification time frame information for inpatient and intermediate/ diversionary BH admissions, effective for DOS on or After April 1, 2023
- January 2023: Added billing guidance for inpatient acute psychiatric add-on payments for Tufts Health Together members, effective for DOS on or after October 1, 2022
- October 2022: Added information for BH boarding services provided during acute hospital stays, effective for DOS on or after November 1, 2022
- June 2022: Annual policy review; administrative updates
- May 2022: Added Intensive Hospital Diversion (IHD) program information, effective for dates of service on or after January 1, 2022
- November 2021: clarified specialing coverage for Tufts Health Direct, Tufts Health Together, and Tufts Health Unify members to include high-cost medications for complex co-morbid medical conditions; clarified specialing billing instructions for Tufts Health Direct, Tufts Health Together, and Tufts Health Unify members
- September 2021: Added information for appropriate code combinations for SART in accordance with RI EOHHS,

effective for dates of service on or after October 1, 2021
- August 2021: added AND services billing instructions for Tufts Health Direct, Tufts Health RITogether and Tufts Health Unify members, effective for dates of service on or after October 1, 2021
- March 2021: Clarified existing billing instructions for family stabilization treatment for Tufts Health Direct
- January 2021: Removed Prior Authorization requirement for Program of Assertive Community Treatment (PACT) for Tufts Health Unify; clarified existing H0038 and T1027 max units/day for CBHI/BHCA services for Tufts Health Direct and Tufts Health Together members
- October 2020: Added procedure codes and billing instructions for Tufts Health Direct, Tufts Health Together and Tufts Health Unify members
- July 2020: Revised billing instructions boiler plate language
- June 2020: Added HCPCS code H0040 and clarified prior authorization requirements for existing PACT services for Tufts Health Together and Tufts Health Unify members; updated effective date for Family Support and Training (FS&T) and Therapeutic Mentoring (TM) services to January 1, 2021, per the Massachusetts DOI
- May 2020: Added H0038 and T1027-EP, effective for dates of service on or after July 1, 2020; added existing code set for CBHI services for Tufts Health Together members
- October 2019: Policy created

Background and disclaimer information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.