Child and Adolescent Needs and Strengths (CANS) Payment Policy

Applies to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a 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)

The following payment policy applies to Tufts Health Plan contracting providers who render services for Tufts Health Public Plans products.

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 the administration of the CANS assessment as part of the Children's Behavioral Health Initiative (CBHI) for members under the age of 21, in accordance with the member's benefits.

DEFINITION

The CANS assessment provides a standardized format to organize information gathered during a comprehensive clinical evaluation and supports treatment decisions for behavioral health providers serving MassHealth members younger than 21.

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 Tufts Health Public Plans Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

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, Prior Authorization and Notification Policy.

Prior authorization is not required for CANS assessments administered by in-network providers. Prior authorization is required for CANS assessments administered by nonpreferred in-network and out-of-network providers.

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.

- **Outpatient services:** Claims must include modifier HA (child/adolescent program), CPT code 90791 (psychiatric diagnostic procedures), and the appropriate licensure-level modifier. Modifier HA should be billed in the MOD1 field and the appropriate licensure level should be billed in the MOD2 field.
- **Intensive Care Coordination (ICC) and In-Home Therapy (IHT) services:** CANS assessment is required upon enrollment and every 90 days thereafter. The assessment is billed as part of the typical day/unit rate.

- **Inpatient services:** CANS assessment must be completed within 2 weeks of discharge from the facility. The assessment is billed as part of the daily inpatient rate.

Refer to the MassHealth Frequently Asked Questions document for additional CANS billing guidance.

Tufts Health Plan reimburses for the administration of up to two CANS assessments per member, per treatment episode, per benefit year. Additionally, Tufts Health Plan will allow both of the two CANS assessments to be performed and billed on the same date of service. Tufts Health Plan will reimburse a new set of codes and modifiers at six-month intervals with the same provider.

Note: Claims not billed with the appropriate CPT and modifier combinations may be denied.

Licensure-Level Modifiers

Modifier	Description
AF	Specialty Physician
AG	Physician-non psychiatrist
AH	Clinical psychologist
AI	Principle Physician on Record
AJ	Clinical Social Worker
AM	Physician Team Member Service
AT	Master's Level Clinician
HL	Intern
HO	Master's level
HP	Doctoral Level
SA	APRN
SJ	Master's Level Clinician
TD	Registered Nurse
U1	Psychiatrist
U3	Psychologist Intern
U4	Social Work Intern
U6	MD/DO
UA	MD
UG	Child Psychiatrist

Note: This list of licensure-level modifiers may not be all-inclusive.

COMPENSATION/REIMBURSEMENT INFORMATION

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

State and Federal Mental Health Parity Law (Tufts Health Direct)

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.

DOCUMENT HISTORY

- October 2020: Added licensure-level modifiers to Billing Instructions section
- November 2018: Policy reviewed; clarified billing instructions
- March 2018: Template updates
- February 2017: Template updates

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.