Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:

Behavioral Health and Substance Use Disorder

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 Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan
☐ Tufts Health One Care – 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

Point32Health reimburses contracted licensed behavioral health (BH) and substance use disorder (SUD) providers for medically necessary services rendered in inpatient, outpatient, and acute residential settings, in accordance with the member's benefits, applicable state mandates and/or federal mental health parity laws.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

Prior authorization may be required for certain behavioral health and/or substance use disorder services. Refer to the Medical Necessity Guidelines for both Harvard Pilgrim Health Care and Tufts Health Plan members.

Point32Health Reimburses

Services provided by participating licensed psychiatrists, community behavioral health centers (CBHCs), psychologists, social workers (LICSW), clinical nurse specialists (CNS, RNCS), licensed mental health counselors (LMHC), board-certified behavior analysts (BCBAs), supervised practitioners, facilities, and supervised clinicians that are pursuing their license when billed by the participating supervising licensed behavioral health clinician. Services are reimbursed based on Point32Health standard methodologies, contract terms, and the appropriate fee schedules.

- Acute residential treatment (including detoxification), crisis stabilization, in-home family stabilization, Intensive Community-Based Acute Treatment (ICBAT) and Community-Based Acute Treatment (CBAT)
- Annual BH wellness exam rendered by a primary care provider (PCP) or licensed mental health professional
- Behavioral Health Integration (BHI) by clinical staff to assess, monitor, and plan care
- BH boarding (temporary placement of a patient in a medical setting awaiting appropriate psychiatric placement)
- Biofeedback therapy
- Care coordination
- Community Crisis Stabilization (CCS) services
- Detoxification
- Drug withdrawal evaluation and treatment to monitor the signs and symptoms from removal or a decrease in the regular dose
- Electroconvulsive therapy (ECT)
- Health and behavior assessment and intervention
- Inpatient behavioral health (psychiatric) services

- Intermediate care services, including Partial Hospitalization Programs (PHP) and Intensive Outpatient Psychiatric (IOP) services
- Mobile Crisis Intervention (MCI) services
- Outpatient psychiatric hospital services
- Psychiatric collaborative care services
- Psychiatric evaluation
- Psychiatric medication evaluation and management
- Psychological/neuropsychological testing and assessment
- Psychotherapy
- Substance use disorder (SUD) treatment, including Medications for Opioid/Alcohol Use Disorders (MOUD/MAUD)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Telehealth/telemedicine services, as appropriate

Point32Health Does *Not* Reimburse

- Adult daycare programs
- Psychoanalysis
- Transportation or outpatient meals
- Testing or training for job skills not part of the BH treatment
- Separate reimbursement is not provided for services identified as integral components of facility-based treatment programs (i.e., ancillary services, supplies, clinical laboratory testing, including drug testing)

Member Cost-Sharing

Services are subject to member out-of-pocket cost (e.g., copayment, coinsurance, deductible), as applicable. Point32Health reimburses contracted providers for services that are covered benefits (benefits vary among employer groups). For benefit determinations, call the Provider Service Center at 800-708-4414 for Harvard Pilgrim Health Care members or 800-884-2404 for Tufts Health Plan members.

Provider Billing Guidelines and Documentation

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

Providers are reimbursed according to the applicable contracted rates and fee schedules, regardless of the address where the service(s) are rendered.

Coding

This code table may not be all-inclusive.

Code	Description
90785	Interactive complexity (List separately in addition to the code for the primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 mins with patient
90838	Psychotherapy, 60 mins with patient when performed with an evaluation and management service (list separately in addition to code for primary procedure)
90839	Psychotherapy for crisis, first 60 mins
90840	Psychotherapy for crisis; each additional 30 mins (List separately in addition to the code for the primary

Code	Description
	procedure)
90846	Family psychotherapy (without patient present), 50 mins
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 mins
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90867	Therapeutic repetitive magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
90870	Electroconvulsive Therapy (ECT); includes necessary monitoring Include revenue code 901 if billing on a UB-04 form or electronic 837I
96116	Neurobehavioral status exam; first hour
96121	Neurobehavioral status exam; each additional hour (list separately in addition to the code for primary procedure)
96130*	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131*	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to the code for the primary procedure)
96132*	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s) when performed; first hour
96133*	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s)), when performed; each additional hour (List separately in addition to the code for the primary procedure)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making); 1 unit max/day
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes; 1 unit max/day
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes; 4 units max/day
96164	Health behavior intervention, group (2+ patients), face-to-face; initial 30 mins; 1 unit max/day
96165	Health behavior intervention, group (2+ patients), face-to-face; each additional 15 mins; 6 units max/day
96167	Health behavior intervention, family (with patient present), face-to-face; initial 30 mins; 1 unit max/day

Code	Description
96168	Health behavior intervention, family (with patient present), face-to-face; each additional 15 mins; 6 units max/day
96170	Health behavior intervention, family (without patient present), face-to-face; initial 30 mins; 1 unit max/day
96171	Health behavior intervention, family (without patient present), face-to-face; each additional 15 mins; 4 units max/day
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0023	Behavioral health outreach service
H0025	Behavioral health prevention education service; used for family support and training
H0033	Oral medication administration, direct observation
H0046	Mental health services, not otherwise specified; description of services required
H2011	Crisis intervention service, per 15 minutes (use when billing for non-independently licensed clinicians)
H2020	Therapeutic behavioral services, per diem
S0109	Methadone, oral, 5 mg
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

*In accordance with American Psychological Association (APA) guidelines, psychological testing evaluations (96130-96131) and neuropsychological testing evaluations (96132-96133) should **not** be billed together in the same episode of care. When a provider can administer/interpret standardized tests that can be used in both psychological and neuropsychological testing evaluations, choose only the code that represents the predominant service being provided.

Modifiers

Modifiers will be required to determine clinician and/or program type, when applicable. To avoid unnecessary denials, always append the appropriate modifier(s). The absence of a modifier may result in a claim denial.

Code	Description	Comments
AF	Psychiatrist	Allows 100% of the contracted allowable rate
AH, HP	Clinical psychologist or doctoral level (PhD, PsyD, EdD)	Allows 100% of the contracted allowable rate
AJ	Clinical Social Worker	Allows 75% of the contracted allowable rate
HA	Child/adolescent program	No impact to reimbursement
HB	Adult program, non-geriatric	No impact to reimbursement
HL	Intern	Allows 85% of the contracted allowable rate
HM	Less than bachelor's degree level	Allows 75% of the contracted allowable rate
HN	Bachelor's degree level	Allows 75% of the contracted allowable rate
HO	Master's degree level	Allows 75% of the contracted allowable rate
HP	Doctoral level	Allows 100% of the contracted allowable rate
SA	Nurse practitioner/physician assistant rendering service in collaboration with a physician	Allows 85% of the contracted allowable rate

Specialing

Tufts Health Plan:

- Outpatient claims (CMS-1500) should be billed with T1004
- Institutional claims (UB-04) should be billed with 0900, T1004, and Bill Type 13X
- Services must be billed on a **separate claim** from the inpatient admission to ensure appropriate compensation.

Harvard Pilgrim Health Care:

- Institutional claims (UB-04) should be billed with 0969 and T1004
- Specialing services must be billed on the **same claim** with another facility service (e.g., Inpatient R&B, observation, ED Boarding) or the claim will be denied as billed incorrectly

Inpatient Services

Report facility inpatient services on a UB-04 form or electronic 837I

Code	Description
0114, 0124, 0134, 0144, 0154, 0204	Inpatient Behavioral Health, all-inclusive per diem
0116*, 0126*, 0136, 0146, 0156	Inpatient Detoxification/Substance Use, all-inclusive per diem

**Submit using bill type 11X*

24-Hour Diversionary Services — Community-Based Acute Treatment (CBAT)

Code	Description
1001 + H0017	Community-Based Acute Treatment (CBAT)

Residential Services

Code	Description
H0017 or H0018	Behavioral health; residential, w/o room & board, per diem
H0011	Alcohol and/or drug services; residential, per diem

Report residential services with the following revenue codes:

- 1001 (Residential – psychiatric)
- 1002 (Residential – chemical dependency)
  - For Harvard Pilgrim Health Care members: use bill type 86X on UB-04 forms or electronic 837I submission
  - For Tufts Health Plan members: use bill type 13X on UB-04 forms or electronic 837I submission

Intensive Outpatient (IOP) or Partial Hospitalization Programs (PHP)

Code	Description
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education
H0035	Mental health or substance use disorder partial hospitalization, less than 24 hours
S9480	Intensive outpatient psychiatric services, per diem

Report IOP/PHP services with the following revenue codes on a UB-04 form or electronic 837I. Each date of service must be billed as a separate line item.

- 905 (Intensive outpatient services – psychiatric)
- 906 (Intensive outpatient services – chemical dependency)
- 912 (Partial hospitalization – less intensive)
- 913 (Partial hospitalization – intensive)

Ancillary Services

Services must be billed with below revenue codes and a CPT or HCPCS code describing the encounter.

Revenue Code	Description
250	Drugs and Biologicals
43X	Occupational therapy
900	Behavioral health treatment/services
904	Activity therapy
914, 915, 916	Individual/group/family therapy
918	Testing
942	Education training
949	Other therapeutic services

Interim Billing Guidelines and Documentation

Point32Health will allow interim billing for payment of inpatient behavioral health services. Applicable to per diem-contracted hospitals and PAF providers only.

Interim bills must include the following:

Initial interim bill:

- Admission or start of care date
- Statement covered “from” date must equal the admission date

- Patient discharge status equal to 30 (still a patient)

Continuing interim bill:

- Admission or start of care date
- Statement covered “from” date must NOT equal the admission date
- Patient discharge status equal to 30 (still a patient)

Final interim bill:

- Admission or start of care date
- Statement covered “from” date must NOT equal the admission date
- The statement covered “through” date must reflect date of discharge
- Patient discharge status is NOT equal to 30 (still a patient)

Interim billing is once every 30 days (per month) except for the final interim bill. Bill for a single stay in the sequence in which it occurs.

Type of Bill Coding

Designate the type of bill in Form Locator 4 on the paper UB-04 claim form, using a three-digit number or loop 2300, CLM segment with appropriate codes in data element CLM05-1, CLM05-2, CLM05-3 of the electronic 837I.

Annual BH Wellness Exams

Providers should submit claims using the following information:

- CPT code 90791 (psychiatric diagnostic evaluation)
- Diagnosis code Z13.30 (encounter for screening examination for unspecified mental health and/or behavioral disorders) billed in the primary diagnosis position
- Modifier 33 (evaluation is preventive in nature; exempt from member cost sharing)

Community Behavioral Health Centers (CBHCs)/Community Mental Health Centers (CMHCs)

Mobile Crisis Intervention (MCI) and Community Crisis Stabilization (CCS) services should be submitted using the specific procedure code, modifier, and Place of Service (POS) codes below.

Note: Adults are aged 18 or older and youths are aged 17 or younger on the DOS.

- Claims should be submitted on CMS-1500 claim forms
- The procedure codes below are not all-inclusive; additional services may be billed as necessary. Medically necessary routine and urgent outpatient services should be billed separately for reimbursement.
- Services provided at a community-based site of service (as opposed to a CBHC) should use POS 15 (Mobile Unit)

Service Description	Code	Modifier
Adult community crisis stabilization (CCS), per diem	S9485	ET
Youth CCS, per diem	S9485	HA + ET
Adult mobile crisis intervention (MCI) provided at CBHC site, per diem. Includes initial evaluation and first day crisis interventions.	S9485	HE
Youth MCI provided at CBHC site, per diem. Includes initial evaluation and first day crisis interventions.	S9485	HA + HE
Adult MCI provided at hospital emergency department (ED), per diem. Includes initial evaluation and all follow-up intervention. (Use POS code 23 for ED)	S9485	HB
Adult MCI provided at community-based sites of service, per diem. Includes initial evaluation and first day crisis interventions.	S9485	n/a
Youth MCI provided at community-based sites of service, per diem. Includes initial evaluation and first day crisis interventions.	S9485	HA
Adult MCI provided at CBHC site by a paraprofessional or bachelor’s level staff, per 15 minutes. Follow-up interventions provided up to the third day following initial evaluation.	H2011	HN + HB
Youth MCI provided at CBHC site by a paraprofessional or bachelor’s level staff, per 15 minutes. Follow-up interventions provided up to the seventh day following initial evaluation.	H2011	HN + HA
Adult MCI provided at CBHC site by a master’s level clinician, per 15 minutes. Follow-up interventions provided up to the third day following initial evaluation.	H2011	HO + HB
Youth MCI provided at CBHC site by a master’s level clinician, per 15 minutes. Follow-up	H2011	HO + HA

Service Description	Code	Modifier
interventions provided up to the seventh day following initial evaluation.		
Adult MCI provided at a community-based site of service by a paraprofessional or bachelor's level staff, per 15 minutes. Follow-up interventions provided up to the third day following initial evaluation.	H2011	HN + HB
Youth MCI at a community-based site of service by a paraprofessional or bachelor's level staff, per 15 minutes. Follow-up interventions provided up to the seventh day following initial evaluation.	H2011	HO + HA

Mobile Response Stabilization Services (MRSS)

Effective for DOS beginning Jan. 1, 2026, the following codes may be used for members of Rhode Island Commercial plans under the age of 19 on the DOS:

Code	Description
H2011	Mobile Crisis Intervention (MCI), each 15 mins
S9485	Community Crisis Stabilization (CCS), per diem

General Guidelines and Documentation

Requirements for All Providers

The documentation of each patient encounter should include:

- First and last name of the member
- Date of service (DOS)
- Legible identification of the provider, including credentials
- Start and stop time or total time of session for time-based codes
- Subject covered in group counseling (if applicable)
- Therapy intervention techniques indicated
- Patient's progress or response to treatment, as indicated
- Relationship identification as to who in the family attended (if applicable)

All the above must be documented in the patient's medical record

For any service a treatment plan is required, with measurable goals, that is updated and documented when clinically indicated. Changes in treatment and revision of diagnosis should also be documented in the member's medical record.

Supervised Practitioners

Supervised practitioners will only be considered for reimbursement when the supervising practitioner is credentialed and participating. All claims rendered by a supervised practitioner must be submitted by the contracted supervising practitioner and must be submitted with the appropriate modifier that indicates the licensure level of the supervised practitioner. The contracted allowable rate of the supervising practitioner will be used to determine the reimbursement of services rendered by the supervised practitioner.

Point32Health expects documentation in the member's medical record that supports the supervisor/supervisee relationship.

The supervising practitioner must have screening protocols in place to ensure that members are screened and assessed to ensure that member is receiving the proper clinical care.

Any member treated for behavioral health services that are supervised must:

- Be informed of the supervisory relationship
- Be provided with the contact information of the supervising practitioner, and
- Provide written consent to treatment rendered by the supervised practitioner

All the above must be documented in the patient's medical record.

Related Policies and Resources

Payment Policies

- Applied Behavioral Analysis (ABA) Services
- Early Intervention
- Site of Service

Clinical Policies

- Behavioral Health Medical Necessity Guidelines
- Medical Benefit Drugs: Spravato (esketamine)

Publication History

11/01/2026:	Clarified reimbursement of supervised practioners
07/01/2026:	Clarified billing guidelines for psychological and neuropsychological testing evaluation codes
06/01/2026:	Annual policy review; updated related policies; removed incorrect phone number
01/01/2026:	Added coding information for Mobile Response Stabilization Services (MRSS), effective for DOS beginning Jan. 1, 2026 for members in Rhode Island
11/01/2025:	Corrected code description for H0023; removed outdated prior authorization resource for Harvard Pilgrim Health Care members
05/30/2025:	Annual review; administrative edits
11/01/2024:	Removed services from Point32Health Does Not Reimburse section to align with covered benefits; added 96136 and S9484 to the coding grid
08/01/2024:	Added revenue code 949 to allowable billed revenue codes
05/31/2024:	Annual review; administrative edits
03/01/2024:	Added billing information for BH wellness exams, effective for DOS on or after Mar. 31, 2024
01/02/2024:	Added specialing and CBAT billing information
11/28/2023:	Clarified CCS and MCI billing requirements for CBHCs/CMHCs; corrected Tufts Health Plan Provider Services phone number
09/01/2023:	Added Harvard Pilgrim Health Care inclusion, effective for DOS on or after November 1, 2023
08/01/2023:	Added MCI and CCS billing instructions for CBHCs, effective for DOS on or after June 22, 2023
04/28/2023:	New payment policy for DOS on or after July 1, 2023

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.