Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:

Outpatient Behavioral Health & 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)

The following payment policy applies to Tufts Health Plan contracting behavioral health and substance use disorder (BH/SUD) providers who render professional outpatient services for Tufts Health Public Plans products.

For services related to the administration of CANS assessments, refer to the Child and Adolescent Needs and Strengths (CANS) 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, in accordance with the member's benefits and applicable Massachusetts and/or Rhode Island Executive Office of Health and Human Services (EOHHS) regulations.

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 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.

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.

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

The Massachusetts DOI has provided updated billing guidance to provide 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 Payment Policy
- Observation Stay Payment Policy
- Inpatient Hospital Admissions Payment Policy

Psychopharmacology Visits
Tufts Health Direct

Psychopharmacology visits are covered as medical services after the initial medical evaluation. These visits do not count against a member's BH benefit but are subject to applicable cost sharing.

Referral/Prior 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, refer to the following resources:

- Medical necessity guidelines
- Tufts Health Public Plans Provider Manual
- Prior Authorization Resources

Billing Instructions

Unless otherwise stated, Tufts Health Plan follows AMA 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 or applicable fee schedules.

Refer to the individual sections within this policy for applicable procedure codes.

Use the appropriate modifier to identify when services are provided by clinicians recognized by MassHealth and/or Rhode Island EOHHS, but not recognized by Medicare. For clinicians recognized by Medicare, follow CMS modifier rules.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Collateral contact claims for HCPCS code **H0046** reimbursement 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.
- Submit modifier H9 with court-ordered BH/SUD services for Tufts Health RITogether claims.

Certified Community Behavioral Health Clinics (CCBHCs)
Tufts Health RITogether

Appropriately credentialed CCBHCs may render services to Tufts Health RITogether members utilizing the billing information provided by RI's CCBHC guidance.

Community Support Programs (CSP)

Tufts Health Together, Tufts Health One Care

Notification is required within one week of initiation of services.

Refer to the Community Support Programs Medical Necessity Guidelines for clinical coverage criteria and the resources below for additional program information.

Refer to the Behavioral Health Performance Specifications page for more information on individual programs.

Resource	Code	Description
Community Support Program (CSP)	H2015	Comprehensive community support services, per 15 minutes (community support program)
Community Support Program for Individuals with Justice Involvement (CSP-JI)	H2016-HH *Secondary diagnosis code supporting medical necessity must be included*	Comprehensive community support program, per diem (integrated mental health/substance abuse program)
Community Support Program for Homeless Individuals (CSP-HI)	H2016-HK *Secondary diagnosis code:* Z59.00 Homelessness, unspecified Z59.01 Sheltered homelessness Z59.02 Unsheltered homelessness	Comprehensive community support services, per diem (specialized mental health programs for high-risk populations)
Community Support Program-Tenancy Preservation Program (CSP-TPP)	H2016-HE *Secondary diagnosis code:* Z59.811 (housing instability, housed)	Comprehensive community support services, per diem

Crisis Evaluations in Emergency Departments

Tufts Health Together

Acute care hospitals must provide or arrange for crisis evaluations for members presenting to the ED in a behavioral health crisis. Services will include initial risk assessment, diagnosis, determination of treatment needs, initial stabilization interventions, and coordination of appropriate disposition for presenting individuals.

Hospitals may render these services directly or utilize Community Behavioral Health Centers (CBHCs) to provide this service. The rendering provider must submit HCPCS code **S9485** (crisis intervention mental health services, per diem), which allows for additional compensation in accordance with MassHealth guidance.

Behavioral Health Urgent Care (BHUC) Center Services

Tufts Health Together, Tufts Health One Care

Mental health centers (MHCs) that are not designated as behavioral health urgent care centers (BHUCs) may bill and receive additional compensation for certain specialized services:

- Diagnostic new patient evaluations within one calendar day of patient appointment request (initial intake must indicate patient is presenting with urgent BH need)
- Existing patient appointment with urgent BH need within one calendar day of appointment request
- Psychopharmacology appointment and a medication for addiction treatment evaluation within 72 hours of initial diagnostic evaluation (when need is indicated by psychosocial assessment)

Submit claims using Place of Service (POS) code 53. Refer to MCE Bulletin 108 for a list of applicable procedure codes and modifiers that may be used to report these services.

BHUCs are reimbursed for certain outpatient services using a bundled encounter rate per member per DOS. BHUCs must bill for the services in the table below using HCPCS code **H2013** (Psychiatric health facility service, per diem) and one of the following modifiers as appropriate:

- HA (Child/adolescent services)
- HB (Adult services)

H2013 should be billed in conjunction with at least one of the following (zero-pay) procedure codes to indicate the service(s) provided.

Note: For services provided via telehealth, H2013 must be billed with POS 11 (Office) while other services performed via telehealth must be billed with POS 02 or 10, as apropriate.

Code	Description
90791	Psychiatric diagnostic evaluation
90791-HA	Psychiatric diagnostic evaluation performed with a CANS (Children and Adolescent Needs and Strengths)

90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
+90833	Psychotherapy, 30 minutes with patient when performed with an E&M 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 E&M service (List separately in addition to the code for primary procedure.)
90837	Psychotherapy, 60 minutes with patient
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy (per person per session not to exceed 10 clients)
90853	Group psychotherapy (other than of a multiple-family group) (per person per session not to exceed 12 clients)
90853-EP	Group psychotherapy (other than of a multiple-family group) (per person not to exceed 12 clients) (preventive behavioral health session)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
S9480	Intensive outpatient psychiatric services, per diem
99202–99205	New patient, office or outpatient visit
99211–99215	Established patient, office or outpatient visit
+99417	Prolonged outpatient E&M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes (List separately in addition to the code of the outpatient E&M service.)
H0046 (excl. H0046-HE)	Mental health services, not otherwise specified (Collateral Contact)
H0032	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)
H2020	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)
99402	Preventative Medicine Counseling, 30 minutes (Psychological Testing)
99404	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)

The following services are excluded from the encounter bundle rate and are reimbursed separately:

- Psychological assessment
- Neurological assessment
- Comprehensive community support services
- Certified peer specialist services
- Peer recovery coach services
- Recovery support navigator services
- Structured outpatient addiction program (SOAP)
- Enhanced structured outpatient addiction program (E-SOAP)
- Intensive Outpatient Program (IOP)

Personal Assistance Services and Supports (PASS)

Tufts Health RITogether

Code	Description
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
T1016	Case management
T1023*	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
T1027	Family Training and counseling for child development, per 15 minutes
H2016	Comprehensive community support services, per diem

Preventive Services

Tufts Health Together

Qualified providers may bill preventive BH services for members under 21 years of age on the date of service, in accordance with MassHealth MCE Bulletin 65 and Bulletin 143. Preventive BH services must be billed using the procedure codes listed below. Providers must also adhere to the following:

- Append modifier EP to the procedure code (in addition to any other applicable modifiers)
- Include the most clinically appropriate ICD-CM diagnosis code(s), including Z-codes which may be used as the primary diagnosis, as appropriate
- If billing T1040 or T1040-HQ, do not also bill codes 90832-90853 for the same member on the same DOS for services rendered at the same location

Code	Description	Services Provided By
90853	Group psychotherapy (other than multiple-family group)	Community- or school-based outpatient providers
90832	Psychotherapy, 30 minutes with patient	PCPs with embedded BH clinician
90834	Psychotherapy, 45 minutes with patient	
90846	Family psychotherapy (conjoint psychotherapy) (without patient present)	
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	
90849	Multiple-family group psychotherapy	
90853	Group psychotherapy (other than multiple-family group)	
T1040*	Community behavioral health clinic service, per diem	BH clinician (or non-licensed clinician/trainee under supervision)
T1040-HQ*	Community behavioral health clinic service, per diem; group setting	

**Effective for DOS beginning Jan. 1, 2026.*

Annual BH Wellness Exams

Annual BH wellness exams may be rendered by a primary care provider (PCP) or licensed mental health professional. Submit claims using the following product-specific information:

Tufts Health Direct

- CPT code **90791** (psychiatric diagnostic evaluation)
- Diagnosis code **Z13.30** (encounter for screening exam; unspecified mental health and/or behavioral disorders); does not need to be billed in primary diagnosis field
- Modifier **33** (evaluation is preventive in nature; exempt from member cost sharing)

Tufts Health Together

Service	Procedure Codes	Diagnosis Code	Notes
Services rendered outside a Community Health Center (CHC):			
Standalone BH wellness visit rendered by PCP or BH provider	90791	Z13.30	Do not append modifier 33
BH wellness visit provided by PCP as part of an office/annual preventive visit	E&M CPT code + U4 modifier	Z13.30	90791 may not be billed on the same day as an E&M when performed by the same provider
Services rendered at a CHC:			
Standalone BH wellness visit rendered by PCP	T1015	Z13.30	Accompanying E&M code not required
BH wellness visit provided by PCP as part of an office/annual preventive visit	T1015 + 90791	Z13.30	Include appropriate E&M code that describes services rendered during the all-inclusive clinic visit 90791 is separately reimbursable; E&M code is included in all-inclusive clinic payment
Standalone BH wellness visit rendered by BH provider	T1040, G0469, or G0470	Z13.30	HCPCS code is dependent on clinician type

Psychological/Neuropsychological Testing

Prior authorization is required for psychological and neuropsychological testing. 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.

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.

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 total hours without prior authorization.*

Psychotherapy (Outpatient)

Prior authorization is not required for outpatient psychotherapy. Refer to the Outpatient Psychotherapy Medical Necessity Guidelines for clinical coverage criteria. Providers should use the following codes to bill for outpatient psychotherapy services.

Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family psychotherapy (without patient present)
90847	Family psychotherapy (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than multiple-family group)

Peer Recovery Coach

Tufts Health Together

Code	Description
H2016-HM-HD	Peer recovery coach services for pregnant and postpartum members, per diem

Recovery Support Navigator

Tufts Health Together

Code	Description
H2015-HF-HD	Peer recovery coach services for pregnant and postpartum members, per 15 minutes

Substance Use Disorder Services

General Coding for Substance Use Disorders

- Claims for SUD follow-up visits must include the appropriate SUD diagnosis (e.g., Z79.891, long-term current use of opiate analgesic [**Note:** This code does not denote a SUD])
- Append "1" as the last digit of a SUD diagnosis code if the condition is in remission

Tufts Health RITogether

Providers should use the following codes to bill for SUD services, in accordance with Rhode Island EOHHS and the Behavioral Health Developmental Disabilities and Hospitals (BHDDH) guidelines. These services should not be billed with an inpatient room and board revenue code (i.e., any revenue code less than 0220).

Service	Code	Description
Stabilization Unit	S9485-HE or X0341 (outpatient/professional) or revenue code 0900 (institutional)	Mental health hospitalization step-down unit for acute/crisis episodes for adults 18+, length of stay is generally 3-5 days
Mental Health Psychiatric Rehabilitation Residential (MHPRR)	H0019 (professional only)	Long-term mental health psychiatric rehabilitative residential treatment for adults 18+; length of stay typically exceeds 30 days **Note:** Append modifier (U1-U5) to indicate the appropriate level of care, as outlined in Appendix D.

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. Refer to the Opioid Use Disorder (OUD) Services and Medication Assisted Treatment (MAT) Payment Policy for more information.

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.

There is no prior authorization needed if obtained by the provider and provided to the member during a visit for Tufts Health Direct members. Refer to the Medical Necessity Guidelines for Opioid Dependence Medications or the applicable Opioid Analgesics pharmacy medical necessity guidelines for more information.

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and fee schedules.

General Coding Information

Procedure Code Guidelines

Services performed in conjunction with an E&M service by the same provider are not separately compensated unless modifiers AH, AJ, HM, HN, HO, HP, SA, TD, or TE are on the claim. Refer to the AMA Manual and CMS HCPCS Level II Manual for more information.

Secondary Diagnosis Codes

Tufts Health Plan does not routinely compensate services billed with a secondary diagnosis code as the only diagnosis on the claim.

Provider Type Modifiers

- Provider organization-affiliated psychiatrists must append the appropriate modifier(s) for services provided by a non-MD clinician in their office. Modifiers will affect compensation according to clinician type, as outlined in the table below
- Psychological and neuropsychological testing codes are excluded from modifier logic when billed with modifier(s) AH and/or HP.
- Because Tufts Health Plan has contracted with methadone clinics to provide methadone treatment, methadone administration services will process with the clinic as both the provider and payee.

In accordance with CMS guidelines, Tufts Health Plan compensates appropriately billed claims with the following modifiers:

Modifier	Description	Compensation Impact
AH	Clinical psychologist (PhD, PsyD, EdD)	100% fee schedule/allowed amount
AJ	Clinical social worker (LICSW, LCSW)	75% fee schedule/allowed amount
HM	Less than bachelor's degree level (LSWA)	0% (informational only)
HN	Bachelor's degree level (LSW)	0% (informational only)
HO	Master's degree level (LMHC, LMFT)	75% fee schedule/allowed amount
HP	Doctoral level (PhD, PsyD, EdD)	100% fee schedule/allowed amount
SA	NP/PA services rendered in collaboration with a physician (nonsurgical)	Lesser of: 80% of actual (billed) charge OR 80% of 85% MD fee schedule
TD	Registered nurse (PCNS, APRN, RNCS)	0% (informational only)
TE	LPN or LVN	0% (informational only)
U3	Intern (PhD, PsyD, EdD)	
U4	Intern (Master's)	

Additional Resources

Payment Policies

- All-Inclusive Clinic Visit (HCPCS Code T1015)
- Child and Adolescent Needs and Strengths (CANS)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- Opioid Use Disorder (OUD) Services and Medication Assisted Treatment (MAT)

Clinical Resources

- Neuropsychological Testing and Assessment Medical Necessity Guidelines
- Psychological Testing and Assessment Medical Necessity Guidelines
- Home-Based Therapeutic Services (HBTS) Medical Necessity Guidelines

- RI Opioid Prescribing Limits (Commercial and Tufts Health RITogether)

Other Resources

- Behavioral Health Prior Authorization and Notification grids
- Behavioral Health Overview

Document History

- October 2026: Removed MassHealth Community Partners language for Tufts Health Together members in accordance with MCE Bulletin 144
- July 2026: Clarified billing guidelines for psychological and neuropsychological testing evaluation codes
- June 2026: Annual policy review; removed prior authorization language for PASS services for RITogether members; added intern-level modifier information; removed SUD treatment information for RITogether members; added existing MHPRR modifier requirement;
- April 2026: Clarified reimbursement for annual BH wellness services rendered in a CHC, effective for DOS beginning Sept. 23, 2025 for Tufts Health Together members
- December 2025: Added coding for peer recovery coach and recovery support navigator services for pregnant and postpartum members, effective for DOS beginning Sept. 1, 2025; clarified billing instructions for BHUC services rendered via telehealth
- September 2025: Added billing guidance for BHUCs for Tufts Health Together and Tufts Health One Care members, effective for DOS beginning Sept. 1, 2025
- May 2025: Annual policy review; administrative updates
- September 2024: Added annual BH wellness exam information for Tufts Health Together members, effective for DOS beginning Jul. 1, 2024
- August 2024: Added CCBHC information and resources for Tufts Health RITogether members, effective for DOS beginning Oct. 1, 2024
- June 2024: Annual policy review; removed prior authorization content for HBTS services for RITogether members; administrative updates
- April 2024: added billing information for MHCs providing urgent care services for Tufts Health Together members, effective for DOS on or after March 1, 2024 in accordance with MCE Bulletin 108
- March 2024: Added billing information for BH wellness exams for Tufts Health Direct members, effective for DOS on or after March 31, 2024
- August 2023: Annual policy review; added billing instructions for H9 modifier, effective for DOS on or after July 1, 2023 for Tufts Health RITogether members; added billing requirements and resources for Community Support Services for Tufts Health Together and Tufts Health Unify members
- April 2023: Clarified screening and assessment codes T1023 and T1028 no longer need prior authorization beginning April 19, 2023, in accordance with RI EOHHS guidance
- February 2023: Annual code updates
- December 2022: Added billing instructions for BH crisis intervention services rendered in emergency departments, effective for DOS on or after January 3, 2023; added compensation information for CBHCs, effective for DOS on or after January 1, 2023
- 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; Updated title of Peer Recovery Coach Medical Necessity Guidelines; increased notification time frame for services from seven (7) to 14 days
- October 2021: Added existing prior authorization requirements and billing instructions for HBTS and PASS for Tufts Health RITogether 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; added preventive BH services billing instructions for Tufts Health Together members, effective for dates of service on or after September 1, 2021
- April 2021: Removed PA requirement for outpatient psychotherapy for Tufts Health Together and Tufts Health RITogether, effective for dates of service on or after April 1, 2021; clarified psychotherapy PA requirements for Tufts Health Direct and Tufts Health Unify
- December 2020: Added notification requirements and billing instructions for CSP-CHI for Tufts Health Together and Tufts Health Unify members, effective for dates of service on or after January 1, 2021
- November 2020: Corrected Recovery Coach modifier to be submitted with H2016, in accordance with MassHealth guidelines
- October 2020: Added existing billing requirement for POS 58 for OTP services; Updated prior authorization guidelines for outpatient psychotherapy, effective for dates of service on or after January 1, 2021

- June 2020: Added existing coding guidance for SUD claims
- May 2020: added updated coding information for SUD services for RITogether members, effective for dates of service on or after April 1, 2020
- March 2020: Clarified existing authorization and coding information for Recovery Coach and Recovery Support Navigator services; added direction for telemedicine services during the COVID-19 outbreak

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.