Inpatient Delay Day - Denial of Payment Template – Tufts Medicare Preferred HMO

[Date]

[PROVIDER NAME]

[PROVIDER ADDRESS]

[City, State, ZIP]

Re: Denial of Payment Notice

Member Name:

Member ID#:

Dear *[Dr./Provider Name]:*

After a review of the medical record for ***[Member Name]***, Tufts Health Plan has decided to deny payment for certain charges related to services rendered by ***[Name of hospital] [and related physician payment, if applicable]*** on ***[state specific denied day(s) in question]***. The basis for this denial is undue delay on the part of your facility.

Please note that the member may not be billed for these services under the terms of your Tufts Health Plan Provider Health Services Agreement.

Under the terms of your Health Services Agreement, Tufts Health Plan conducts reviews of inpatient services to determine whether the services are provided or arranged in an efficient manner and in accordance with the Tufts Health Plan Senior Products Provider Manual. The Billing Guidelines define delay day as a day a member spends 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 and therefore usually results in a longer length of stay than if the care had been efficiently provided and/or arranged. The decision may result in a denial of payment to the hospital, physician or both.

According to the information contained in the member's medical record, ***[Name of the member]*** was admitted for the ***[diagnosis/treatment]*** of ***[Type of Diagnosis or treatment]*** at ***[facility]*** on ***[date(s)]*.** In reviewing this case, ***[MD or Medical Director name and title],*** identified that on ***[the date(s)]*** there was a delay in providing or arranging for **[*diagnostic testing, treatments, therapies (including physical therapy), consultations, surgical /other procedures or test result]*** that will ***[likely]*** result in a longer length of stay than if the care were efficiently provided or arranged.

In making this payment decision, Dr. ***[MD or Medical Director name and title]*** considered the medical record and information received verbally from ***[Name of the provider(s)/ CM you have spoken with]***. After assessing all of the information, ***[MD or Medical Director name and title]*** has determined that the services were not efficiently provided or arranged because **[*Include all pertinent details which support that there was a delay in providing services]***. Therefore, Tufts Health Plan has denied payment for certain charges related to services rendered by ***[Name of hospital] [and related physician payment, if applicable]*** on ***[state specific denied day(s) in question]***.

Provider Payment Dispute Information

If you wish to submit a provider payment dispute related to the above hospital payment ***[and related physician payment, if applicable]*** decision, send a communication to the following address:

TUFTS HEALTH PLAN
Provider Payment Disputes
P.O. BOX 9162
Watertown, MA 02471-9162

Your request must be accompanied by the following:

- A copy of this letter and/or the claim(s) in question, and any operative or therapy notes
- Any documentation that refutes our conclusion that there was an undue delay

If you have any questions about the provider payment dispute process, you may contact Provider Services at 800.279.9022.

Respectfully,

[Name]

[Title]

cc: [***MD or Facility]***

Tufts Health Plan Case Management Department