Diagnosis Related Group (DRG) Inpatient Facility Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers of inpatient services paid under DRG methodology as set forth in the provider agreement. For services that are not compensated under DRG, refer to the Non-DRG Inpatient Facility Payment Policy. For information on Tufts Medicare Preferred HMO and Tufts Health Plan SCO, click here.

This payment policy does not apply to skilled nursing facilities (SNF) or rehabilitation admissions. Refer to the Skilled Nursing Facility and Inpatient Rehabilitation and Long Term Acute Care Facility payment policies for more information.

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 medically necessary inpatient 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 website or by contacting Commercial Provider Services.

INPATIENT NOTIFICATION REQUIREMENTS

As a condition of payment, Tufts Health Plan requires inpatient notification for any member who is being admitted for inpatient care, regardless of whether primary or secondary coverage is with Tufts Health Plan. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the admitting provider. It is the submitting provider's responsibility to verify and confirm individual inpatient notifications. Refer to the Authorizations chapter of the Commercial Provider Manual for more information.

For PPO members whose care is managed through the Private HealthCare Systems (PHCS, also known as Multiplan) network, inpatient notification is obtained through American Health Holding (AHH). Please refer to the member's ID card to determine inclusion in the PHCS network.

Note: An inpatient notification does not take the place of a referral or prior authorization requirements for a service.

Obstetrical and Newborn Admissions

Inpatient notification is required for obstetrical admissions that fall outside of the mandated 48 hours for a vaginal delivery or 96 hours for a caesarian delivery. Obstetrical admissions that are not for a planned delivery are subject to Tufts Health Plan's notification requirements. Obstetrical admissions resulting in the planned delivery of a newborn do not require inpatient notification. Refer to the Obstetrics/Gynecology Payment Policy for more information.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

Newborns requiring inpatient services beyond the mother's discharge date require their own inpatient notification. In these instances, services should be billed under the mother's Tufts Health Plan ID number if the newborn has not been added to the plan.

Submission Channels
Providers may submit inpatient notifications through:

- The secure Provider website's inpatient notification system
- 278 batch transaction. Contact EDI Operations at 888.880.8699 ext. 54649 or EDI_Operations@tufts-health.com for more information
- Faxing a completed Inpatient Notification Form to 617.972.9590 or 800.843.3553. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all information is returned to Tufts Health Plan.

When the inpatient notification process is complete, the status will be made available on the secure Provider website. The notification number for coverage confirms inpatient level of care.

Inpatient Notification Time Frames
Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Authorizations chapter of the Commercial Provider Manual, and in accordance with the following time frames:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergent admissions must be within one business day of the admission

Late Notification

- Late notification after a member has been discharged from the hospital will result in denial of payment for the entire admission.
- Late notification of an admission while the member is still receiving medically necessary acute level care will result in a 25 percent reduction in payment for the entire admission.

Initial Determination for Coverage
Initial determination for inpatient coverage is based on data from Truven Health Analytics and InterQual® criteria. Additional clinical information may be requested to support care management and transition of care needs. The accuracy of the determination depends on the completeness and accuracy of the information submitted by the provider at the time of notification.

Authorization for coverage of DRG inpatient services is determined using Tufts Health Plan and nationally-recognized medical necessity guidelines, and criteria published by Truven Health Analytics.

Discharge
The discharge date must be reported within one business day of discharge. For information on extended care, refer to the Skilled Nursing Facility Payment Policy.

Readmission
Payment for a readmission to the same acute facility within 14 days may be denied if Tufts Health Plan determines that the (re-) admission was due to a premature discharge or related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.

BILLING INSTRUCTIONS

- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable
- Late charges must be submitted within 90 days of the date of discharge

Birthweight
Birthweight is needed for correct claims processing and should always be submitted in accordance with industry standards on the UB-04 claim form. Refer to the Newborn Payment Policy for more information.

DRG Grouping
Tufts Health Plan incorporates the DRG methodology when processing inpatient claims, and applies the DRG Definition outlined in the provider agreement to assign a DRG to an inpatient claim. Tufts Health Plan determines the compensation rate for the inpatient hospital claim based on the DRG assigned according to the methodology described above, regardless of the DRG submitted on the claim.

COMPENSATION/REIMBURSEMENT INFORMATION

Compensation for inpatient treatment and related services corresponds to the Tufts Health Plan contracted rate per case and/or any other contractual arrangement. Compensation is determined by the methodology in place at the time of the member's discharge. Refer to the provider's current contract for details.

Tufts Health Plan only compensates for the portion of the member's stay during which they are enrolled as a member. If the member's coverage begins after the admission date, the facility should only bill for services beginning on the first date of coverage. If coverage terminates while the member is receiving inpatient services, the facility payment will be adjusted accordingly.

The inpatient compensation rate, regardless of payment methodology, is inclusive of all services supplied by the facility, including, but not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Bedside equipment
- Diagnostic services
- Medication and supplies
- Nursing care/services
- Observation services
- Operating room services
- Preadmission testing*
- Radiology/Imaging
- Recovery room services
- Therapeutic items (drugs and biologicals)

*Routine preadmission testing performed prior to an admission is not compensated separately.

Bedside Nursing Services

Tufts Health Plan does not separately cover bedside nursing services or procedures performed during the inpatient stay as part of the room and board. These services are subsumed under the inpatient compensation paid to the facility.

Transfer to another acute facility: If a member is transferred to another acute facility, payment may be prorated.

Criteria for Newborn Claims

Compensation for newborns not added to the plan may be limited to the well newborn payment. Refer to the Newborn Payment Policy for information regarding well newborn criteria.

Hospital-Acquired Conditions

Diagnoses for hospital-acquired conditions (HACs) will not be included in the DRG calculation. Compensation could vary based on the recalculated DRG.

Serious Reportable Events ("Never Events")

The National Quality Forum defines "never events" as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Tufts Health Plan will deny or retract payment for care related to procedures that meet the definition of a "never event" once they have been identified. Refer to the Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy for more information.

ADDITIONAL RESOURCES

- Inpatient and Intermediate Behavioral Health and Substance Use Disorder Payment Policy
- Inpatient Rehabilitation and Long Term Acute Care Facility Payment Policy
- Observation Services Payment Policy
- Skilled Nursing Facilities Payment Policy

DOCUMENT HISTORY

- June 2020: Clarified existing inpatient notification process
- May 2019: Clarified existing inpatient notification process
- August 2018: Clarified readmissions; review timeframe changed from 7 days to 14
- June 2018: Template updates
- March 2018: Template updates
- November 2017: Policy reviewed by committee; removed APR DRGs 955 and 956 as they are no longer applicable; clarified payment methodology language; removed corrected claim and late charges billing information and linked to applicable claims documents; added reference to SRE/SRAE/PPC policy
- April 2017: Updated inpatient notification submission channels
- January 2017: Template updates

- November 2016: Updated information regarding Late Notification and Readmission
- September 2015: Template conversion, template updates
- April 2015: Template updates
- September 2014: Updated information regarding APR DRG claims, added information regarding payment methodology in situations when member enrollment occurred after the admission date, template updates
- May 2014: Updated information regarding obstetrical admissions, template updates
- November 2013: Moved DRG information into its own policy.

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.