Diagnosis Related Group (DRG) Inpatient Facility Payment Policy

The following payment policy applies to Commercial¹ products (including Tufts Health Freedom Plan). For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

This policy applies to Tufts Health Plan contracted inpatient services paid under DRG methodology as set forth in your provider agreement. For services that are not compensated under DRG, refer to the Non-DRG Inpatient Facility Payment Policy.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the standard professional and facility services payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products.

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: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary inpatient services, as described below.

DEFINITION

An inpatient notification is notification to Tufts Health Plan via the secure Provider website, 278 batch EDI transactions or fax that a member is being admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer. The inpatient notification process is completed by the facility where the member is scheduled to be admitted or by the admitting provider.

Inpatient notification is a condition of payment and does not take the place of a referral or prior authorization requirements for a service.

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 Provider Services.

INPATIENT ADMISSION REQUIREMENTS

While you may not be the provider responsible for obtaining prior authorization, as a condition of payment, you must make sure that prior authorization has been obtained. It is the submitting provider's responsibility to verify and confirm individual inpatient notifications.

Inpatient Notification Event

As a condition of payment, Tufts Health Plan requires notification for any member who is being admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer. An authorized status will be assigned for approved DRG admissions.

Providers can log on to the secure Provider website to view the notification event and status of the event in real-time, 24 hours a day, 7 days a week. If a provider is not web-enabled or registered on the secure Provider website at the time of submission, he or she may request a faxed copy of the notification event. An inpatient notification event submitted via fax is available for viewing on the secure Provider website.

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.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Submission Channels
Effective for dates of submission on or after July 1, 2017, providers submitting an inpatient notification request by fax must submit the request on a completed Inpatient Notification Form. No other forms will be accepted by Tufts Health Plan after June 30, 2017.

Providers can submit inpatient notifications through:
- The secure Provider website’s inpatient notification system
- Faxing a completed Inpatient Notification Form to 617.972.9590 or 800.843.3553. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all the information is returned to Tufts Health Plan.
- 278 batch transaction. Contact EDI Operations at 888.880.8699 ext. 54649 or EDD_Operations@tufts-health.com for more information.

The following information is required when submitting a notification for inpatient care to Tufts Health Plan:
- Member’s name
- Member’s Tufts Health Plan ID number
- Member’s date of birth
- Hospital name
- Attending provider’s name
- Date of admission and/or service
- Complete diagnosis and procedure information (a diagnosis code is required)

When the inpatient notification process is complete, the inpatient notification status will be communicated. The notification number for coverage confirms inpatient level of care.

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.

Discharge
The discharge date and inpatient notification number are conditions of payment. 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.

Required Inpatient Notification Time
Admitting providers and hospital admitting departments are responsible for notifying Tufts Health Plan. All inpatient admissions require notification to Tufts Health Plan in accordance with the following timelines:
- Elective admissions must be reported no later than five business days prior to admission.
- Urgent or emergent admissions must be reported by 5 p.m. of the next business day following the admission

When an admission is reported, Tufts Health Plan performs the following steps as part of the inpatient notification process:
- Confirms the presence of a referral to a specialist, if applicable. An inpatient notification number cannot be issued without a PCP’s authorization, if required, when the service is elective
- Verifies member eligibility
- Screens for coverage/benefit exclusions and procedures requiring prior authorization
- Requests clinical information from the hospital or admitting physician if the inpatient notification does not meet criteria for inpatient level of care, based on the diagnosis of procedure code(s) submitted.
- Identifies the admission so that the appropriate care manager may begin early identification of potential discharge needs for the member.
- Assigns an inpatient notification number to the provider

Late Notification
Notification of admission is a requirement for payment.
- 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.

**Readmission**
Payment for a readmission to the same acute facility within seven days may be denied if Tufts Health Plan determines that the admission was due to a premature discharge of the prior admission, or that the readmission was for services that should have been rendered during the previous admission.

**Obstetrical 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. Inpatient notification is **not** required for obstetrical admissions that will result in the planned delivery of a newborn. Newborns requiring inpatient services, beyond the mother’s discharge date, require their own inpatient notification.

For information regarding obstetrical admissions, refer to the [Obstetrics/Gynecology Payment Policy](#).

**BILLING INSTRUCTIONS**

- Submit birthweight in grams for each newborn claim submitted. Refer to the birthweight information in this policy.
- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable.

**Corrected Claims**
Tufts Health Plan defines “corrected claims” as adjustment requests made to an original claim submission. The adjustment requests correct or change information on the original submission. Adding new services or days to the original claim submission is not a corrected claim.

When submitting a corrected claim electronically, providers must submit the following:
- Original reference number, which is the Tufts Health Plan claim number, to expedite processing
- Type of bill 117 (hospital, inpatient, replacement of prior claim)

When submitting a corrected claim on paper, providers must submit the following:
- Type of bill in box 4
- Type of bill 117 for inpatient services
- [Universal Request for Claim Review](#) form in the [Forms](#) section of Provider Resource Center.

Registered providers may submit claim adjustments via the secure Provider website. After the transaction is complete, providers receive a tracking number as confirmation. If submitting paper documentation that corresponds to an online claim adjustment, submit the online tracking sheet to ensure that the claim is processed accurately.

Adjustment requests can be made online for the following reasons:
- To submit a corrected claim, including late charges
- To dispute a denial or compensation amount
- To return funds to Tufts Health Plan

**Note:** Some claims cannot be adjusted online. If your claim cannot be adjusted online, a message will appear indicating the claim is not adjustable online, and must be submitted on paper.

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 180 days from the date of the original adjudication. Corrected claims and duplicate claim denial disputes received after that time will not be considered. For additional information, refer to the [Provider Payment Dispute Policy](#).

**Late Charges**
Tufts Health Plan defines “late charges” as charges for services associated with the original claim submission, but submitted after the initial submission of the claim. Late charges are identified by a bill type ending in “5” (e.g., 115 for inpatient late charges). Late charges can add additional lines and change the original amount billed on the original claim submission. Additional dates of service are not considered late charges. Late charges applied to Tufts Health Plan Commercial claims must be submitted within 90 days of the date of discharge for inpatient or institutional claims.

When submitting a late charge electronically, providers must submit the following:
• Original reference number (i.e., the Tufts Health Plan claim number) to expedite processing. If the late charges are submitted without the original claim number, the claim may be processed as a new claim, resulting in a duplicate submission
• Bill type 115 (hospital, inpatient, late charges only claim)

When submitting a late charge on paper, providers must submit the following:
• Bill type in box 4 when billing for late charges
• Bill type 115 for inpatient services

**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.

**DIAGNOSIS RELATED GROUPING (DRG)**
Tufts Health Plan incorporates the DRG methodology when processing inpatient claims, and applies the DRG Definition outlined in your 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.

Tufts Health Plan uses the following data from the inpatient claim to assign a DRG:
• ICD-CM procedure code(s)
• ICD-CM diagnosis code(s)
• Patient gender
• Patient date of birth
• Birthweight (when applicable)
• POA indicator

Claims assigned to APR DRGs 955 and 956 will deny. The hospital may resubmit corrected claims in a timely manner, in accordance with Tufts Health Plan’s standard payment policies.

Examples of APR DRG claims that will deny include the following:
• DRG 955: Principal diagnosis invalid as discharge diagnosis
• DRG 956: Ungroupable

**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.

Payment methodology used for a hospital claim is determined by the methodology in place at the time of the member's discharge, except in those situations when member enrollment occurred after the admission date. In these instances payment methodology will be determined by the methodology in place at the time of enrollment.

If a member terminates with Tufts Health Plan while receiving inpatient services, the facility payment will be adjusted accordingly, up to and including the last effective date of the member’s coverage. If member coverage begins while the member is receiving inpatient services, the facility payment will be adjusted accordingly starting with the first effective date of member’s coverage.

Refer to your current contract for details. 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
• Preadmission testing
• Radiology/Imaging*
• Recovery room services
• Therapeutic items (drugs and biologicals)

*Routine preadmission testing performed in the three days prior to an admission is not compensated separately.
**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.

**Bedside Nursing Services**
Tufts Health Plan will not separately cover bedside nursing services or procedures performed during the inpatient stay as part of the room and board. Examples of nursing services which are components of room and board fees, include, but are not limited to, blood administration services, medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing, catheterizations, tube feedings and irrigations, telemetry, and equipment monitoring services. 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.

**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 (NQF) 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 healthcare facility. Tufts Health Plan’s longstanding policy has been to deny or retract payment for care related to procedures which meet the definition of a “never event” once they have been identified. Tufts Health Plan will not compensate providers or permit providers to bill members for services related to the occurrence of “never events.” For a list of “never events” refer to the [National Quality Forum](#).

To report a “never event”, fax the DPH SRE 7 day and 30 day report to the Tufts Health Plan’s Clinical Quality Improvement (CQI) Department at 617.673.0973. The CQI Department works directly with the provider to review the clinical event and identify opportunities for quality improvement.

**Behavioral Health (BH)**
Refer to the [Inpatient and Intermediate BH/SUD Facility Payment Policy](#) for information regarding inpatient BH services not compensated under DRG arrangement.

**ADDITIONAL RESOURCES**
- [Skilled Nursing Facilities Payment Policy](#)
- [Inpatient Rehabilitation and Long Term Acute Care Facility Payment Policy](#)
- [Observation Services Payment Policy](#)

**DOCUMENT HISTORY**
- 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. Claims are subject to audit policies. If an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s [audit policies](#), refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines 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 does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the 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.