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)[2]
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

The following payment policy applies to Tufts Health Plan Commercial contracting inpatient hospitals For information on Senior Products or Tufts Health Public Plans, refer to their respective Inpatient Facility Payment Policies.

This payment policy does not apply to emergency department services, obstetrical and newborn admissions, observation services, skilled nursing facilities (SNF), acute rehabilitation admissions, or inpatient behavioral health facilities.

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.

DEFINITIONS

Diagnosis Related Groups (DRG) is defined by CMS as a patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. Tufts Health Plan incorporates the DRG methodology outlined in the provider agreement when processing inpatient claims. Tufts Health Plan determines the compensation rate for the inpatient hospital claim based on the DRG assigned according to the methodology, regardless of the DRG submitted on the claim.

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 Commercial Provider Services.

REFERRAL/PRIOR AUTHORIZATION/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.

Note: An inpatient notification does not take the place of a referral or prior authorization requirements for a service. For a comprehensive list of services that require prior authorization, refer to the Medical Necessity Guidelines section of the Resource Center.

Admitting providers and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Referrals, Prior Authorizations and Notifications 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

---

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

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

- Observation (and ED) services that result in an inpatient admission must be reported within one business day after the admission

Note: Refer to the Compensation/Reimbursement Information below for additional information on late notifications.

When the inpatient notification process is complete, the status will be made available on the secure Provider portal.

- The notification number for coverage confirms inpatient level of care for an admission paid under a DRG payment methodology.
- An authorized initial length of stay and authorized end date will be communicated for an admission paid under the Non-DRG payment methodology. The authorized end date is the date the authorized length of stay ends.
  Note: The member's discharge date is the day after the authorized end date.

Initial Determination for Coverage
Initial determination for inpatient coverage is based on InterQual® criteria. Additional clinical information may be requested to support the determination and assess 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 InterQual.

Initial Length of Stay Assignment
The initial length of stay is based on the validity of the following:

- Member benefit and eligibility status
- Procedure
- Diagnosis
- Other medical information pertinent to the admission

The accuracy of the length of stay assignment depends on the completeness and accuracy of the information submitted by the provider at the time of notification.

Refer to the Referrals, Prior Authorizations and Notifications chapter of the Commercial Provider Manual for information on continued authorization.

Joint Surgery Program
Providers must request prior authorization for members for hip, knee and/or shoulder surgery through the National Imaging Associates' (NIA). Tufts Health Plan inpatient admission notification requirements for the facility or hospital admission must be obtained separately and only initiated after the surgery has met NIA's medical necessity criteria. Refer to the Joint Surgery Program page for additional information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard 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 and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

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.

- 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

Discharge
The discharge date must be reported as soon as possible.

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.

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 for admissions under the DRG payment methodology.
  - A denial of payment for the entire admission for admissions under the non-DRG payment methodology.

Transfer to another acute facility

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

Facilities with DRG Arrangements

The following compensation and reimbursement information applies to facilities with a DRG payment arrangement with Tufts Health Plan.

Hospital-Acquired Conditions

Diagnoses for hospital-acquired conditions (HACs) are not included in the DRG calculation. Compensation could vary based on the recalculated DRG. Refer to the Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy for additional information.

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.

Facilities with Non-DRG Arrangements

The following compensation and reimbursement information applies to facilities with a non-DRG payment arrangement with Tufts Health Plan.

Delay Day

Tufts Health Plan does not compensate providers for delay days. A delay day is a day that 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 result in a longer length of stay than if the care had been efficiently provided and/or arranged. Regardless of whether the day meets medical necessity criteria, such days will not be paid. The decision may result in a denial of payment to the hospital, physician, or both.

ADDITIONAL RESOURCES

- Emergency Department Services Payment Policy
- 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
- Obstetrics/Gynecology Professional Payment Policy
- Newborn Payment Policy
- Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy
- Skilled Nursing Facilities Payment Policy

DOCUMENT HISTORY

- January 2021: Reviewed by committee; combined DRG and non-DRG payment policies; added definition of DRG and joint surgery program prior authorization requirements, removed inpatient notification submission channels, time frames and continued authorization requirements referred to the Commercial Provider Manual; removed language for "never events," obstetrical and newborn services, inpatient behavioral health services and linked to applicable payment policies in Additional Resources
- 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

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.