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

This payment policy does not apply to emergency department (ED) services, obstetrical admissions, observation services, skilled nursing facilities (SNF), acute rehabilitation admissions or inpatient behavioral health facilities. For information about SNF admissions for Tufts Medicare Preferred HMO, click here, and for Tufts Health Plan SCO, click here.

In addition to the specific information contained here, providers must adhere to the policy 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 benefit.

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 Senior Products uses the Medicare MS-DRG as established by CMS to assign an MS-DRG to an inpatient claim. Refer to CMS for more information.

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 Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

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 procedures, services, and items requiring prior authorization or notification refer to the following:

- Tufts Medicare Preferred HMO: Prior Authorization and Inpatient Notification List
- Tufts Health Plan SCO: Prior Authorization and Notification lists

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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.

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

Admitting practitioners and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Referrals, Prior Authorizations and Notifications chapter of the Senior Products 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 reported by 5 p.m. the next business day following admission
- Observation (and ED) services that result in an inpatient admission must be reported within one business day after the admission

Inpatient notifications submitted via the web are confirmed on entry. Notifications submitted via fax are confirmed via the secure Provider portal.

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

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.

- Any late charges billed must be received by Tufts Health Plan within 60 days of the date of discharge
- **Same-day transfers:** include condition code 40 on the claim if the member is transferred to another facility before midnight on the same day as the initial admission, in accordance with CMS requirements.

COMPENSATION/REIMBURSEMENT INFORMATION

Compensation for inpatient treatment and related services is based on the applicable contracted rate (e.g., diagnosis-related group [DRG], per diem, per case and/or other arrangements). Refer to the provider's current contract for details regarding inpatient compensation provisions. The inpatient compensation rate is inclusive of all incidental services supplied by the facility, including, but not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Diagnostic services
- Medication and supplies
- Nursing care
- 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.

Note: If a member terminates with Senior Products while receiving inpatient services, Tufts Health Plan is responsible for the entire admission until the patient is discharged.

Acute Admissions that do not Meet Inpatient Level of Payment

Tufts Health Plan care managers will consult with facility care managers on level of payment (LOP) decisions when reviewing admissions concurrently. Tufts Health Plan reserves the right to review admissions retrospectively. Claims for acute admissions will be denied if it is determined that the services provided did not meet criteria for inpatient LOP. In this instance, the hospital's care management department will be notified and the hospital may bill for outpatient services provided.

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 denial of the entire admission

Readmission Policy

Tufts Health Plan aligns their readmission policy for Senior Products members with Medicare. Payment for a readmission to the same acute facility within 30 days can be denied if, through medical record review, the admission was deemed medically unnecessary or due to a premature discharge of the prior admission. Refer to the Readmission Policy for additional information.

ADDITIONAL RESOURCES

Emergency Department Services Payment Policy
Hospice Payment Policy
Inpatient and Intermediate BH/SUD Facility Payment Policy
Inpatient Rehabilitation and Long-Term Acute Care Facility Payment Policy
DRG Validation of Inpatient Hospitals (Medical Claims Review) Policy
Observation Facility Payment Policy
Obstetrics and Gynecology Professional Payment Policy
Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy
Skilled Nursing Facility Payment Policy (Tufts Medicare Preferred HMO)
Skilled Nursing Facility Payment Policy (SCO)

DOCUMENT HISTORY

- January 2021: Reviewed by committee; added definition of DRG, removed inpatient notification submission channels and referred to the Senior Products Provider Manual; removed language for "never events" and inpatient behavioral health services and linked to applicable payment policies in Additional Resources
- November 2020: Added condition code 40 billing requirement for members being transferred to another facility, in accordance with CMS requirements
- June 2018: Template updates
- May 2018: Updated Tufts Health Plan SCO inpatient notification fax number, effective for dates of submission on or after May 1, 2018
- March 2018: Template updates
- November: Policy reviewed by committee; added existing late notification language; removed corrected claim and late charges billing information and linked to applicable claims documents
- April 2017: Updated inpatient notification submission channels
- January 2017: Template updates

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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.