Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
Inpatient Rehabilitation and Long-Term Acute Care (LTAC) 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 rehabilitation and acute care hospitals where inpatient rehabilitation and/or long-term acute care (LTAC) services are rendered. For information on Commercial products, 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 rehabilitation and LTAC services, in accordance with the member’s benefit.

**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 Senior Products Provider Relations.

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

**NOTIFICATION REQUIREMENTS**

All inpatient admissions require inpatient notification. Admitting providers and/or facility admitting departments are responsible for notifying Tufts Health Plan, following the procedures outlined in the Authorizations chapter of the Tufts Health Plan Senior Products Provider Manual, and in accordance with the following timelines:

- Elective admissions must be reported no later than 5 business days prior to admission
- Urgent or emergency admissions must be reported by 5 p.m. on the business day following admission.

Note: Obtaining an inpatient notification number is a condition of payment but does not guarantee authorization or coverage.

Prior to admission, the facility must coordinate services in advance with the member’s care manager (CM). The CM determines the member’s appropriate level of payment (LOP) with the facility based on clinical information presented prior to admission.

For Tufts Medicare Preferred HMO members, refer to the Tufts Medicare Preferred HMO Care Management List to find the CM assigned to the specific medical group. To identify the CM for a Tufts Health Plan SCO member, contact Senior Products Provider Relations.

The CM performs ongoing review of the member’s clinical information in order to determine the member’s continued status and LOP. LOP changes are directed and coordinated by the member’s CM for admissions. The CM coordinates all inpatient needs of the member in conjunction with the PCP and/or attending provider.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^\text{SM}\) when Tufts Health Plan is the primary administrator.
Services Excluded From the Per Diem
Services excluded from the per diem must be obtained from a Tufts Health Plan contracting provider. Any nonemergency service that is not provided by a contracting provider will be the financial responsibility of the ordering facility.

Note: Disagreements with a member’s LOP should be discussed directly with the CM. Changes in LOP status must be updated in Tufts Health Plan’s systems accordingly.

Lack of Information
Tufts Health Plan must receive clinical information as soon as possible, but no later than 5 p.m. the next business day following the request. Tufts Health Plan will deny payment of claims if the provider fails to provide required clinical information within the specified time frame. In rare circumstances, providers may be asked to provide the information in a shorter time frame.

For a complete description of notification requirements, refer to the Notifications chapters of the Tufts Health Plan Senior Products Provider Manual.

BILLING INSTRUCTIONS
• Submit a separate claim for each inpatient notification number or distinct LOP
• Special billing circumstances such as “COB-related” or “billing for denial purposes only” should be indicated on the UB-04 form in box 84/Remarks. This will assist in accurate claims adjudication.

Revenue Code and Description

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level R1 — Rehabilitation</td>
<td>0128</td>
</tr>
<tr>
<td>Level R2 — Acute complex rehabilitation</td>
<td>0129</td>
</tr>
<tr>
<td>Level C1 — Long term acute care</td>
<td>0120</td>
</tr>
</tbody>
</table>

Note: The revenue code submitted on the claim must correspond to the authorized level of care. Refer to the Inpatient Rehabilitation and LTAC Level of Payment Guidelines for specific services included in each level of care listed above.

Tufts Medicare Preferred HMO Members Covered Under Medicare Part B:
Tufts Medicare Preferred HMO members who are no longer covered under their Medicare Part A benefit may be eligible for benefits under their Part B benefit. Contact Provider Relations to verify benefit coverage.

COMPENSATION/REIMBURSEMENT
Compensation for inpatient treatment and related services corresponds to the Tufts Health Plan contracted rate for per diem, per case and/or other arrangements, as applicable. Refer to the provider’s current contract for details regarding inpatient compensation provisions. The inpatient compensation rate is inclusive of all services supplied by the facility, including, but is not limited to:
• Ancillary services
• Anesthesia care
• Appliances and equipment
• Chemotherapy
• Diagnostic services
• Dialysis
• Laboratory services
• Medication and supplies
• Nursing care
• Radiology/imaging
• Radiation therapy
• Recovery room services
• Therapeutic items (drugs and biologics)

DOCUMENT HISTORY
• July 2018: Policy reviewed by committee; clarified inpatient notification process and billing 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
• January 2017: Template updates
• November 2016: Policy reviewed, added Tufts Health Plan SCO information
• May 2013: Template updates
• April 2011: Moved Tufts Medicare Preferred HMO information to its own document.

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 CareLinkSM 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.