Inpatient Rehabilitation and Long Term Acute Care Facility Payment Policy

The following payment policy applies to Tufts Health Plan contracted rehabilitation and acute care hospitals where inpatient rehabilitation and/or long term acute care services are rendered. This 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.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

POLICY
Tufts Health Plan covers medically necessary inpatient rehabilitation and long term acute care (LTAC) services, as described below.

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 our secure Provider website or by contacting Provider Services.

AUTHORIZATION REQUIREMENTS
All inpatient rehabilitation and LTAC facility admissions require a pre-admission inpatient manager review and authorization for a specific level of care (LOC). Refer to the Authorization Policy for specific referral and authorization requirements.

All inpatient admissions require inpatient notification. Admitting providers or facility admitting departments are responsible for notifying Tufts Health Plan no later than one business day following the member's admission to their facility.

When an admission is reported, Tufts Health Plan performs the following steps as part of the notification process:

- Confirms that the inpatient manager has completed their pre-admission review and authorized the admission and a specific LOC with the facility based on clinical information presented at the time of the admission
- Verifies member eligibility
- Screens for coverage/benefit exclusions and procedures requiring prior authorization
- 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
- Provides an initial authorized length of stay and the authorization end date

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

Note: Disagreements with respect to a member's authorized level of care should be discussed directly with the inpatient manager; change in LOC status must be updated in our system accordingly. Providers may call Provider Services to be connected to the inpatient manager.

Services Excluded From the Per Diem
Services excluded from the per diem must be authorized as medically necessary by the inpatient manager and be obtained from a Tufts Health Plan contracting provider. Any nonemergency service

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is primary administrator.
that is not authorized or provided by a Tufts Health Plan provider will be the responsibility of the ordering facility.

**Continued Authorization**

For inpatient facilities, where Tufts Health Plan inpatient managers obtain clinical information by telephone or fax:

- To request additional inpatient days, submit the [Extended Care Facility Inpatient Continued Stay Clinical Information Form](#). The form should be used to submit the clinical information, or as a guideline for the required information needed to conduct an InterQual® review, to Tufts Health Plan by 5 p.m. on the day of the authorized end date.

**Note:** Commercial inpatient providers should contact their assigned Tufts Health Plan inpatient manager only if the member’s inpatient stay is anticipated to exceed the authorized length of stay. Refer to the [Commercial Extended Care Facility Care Management List](#) to identify the appropriate care manager.

The Precertification Operations Department will assign a new inpatient notification number each time there is a change in the member’s LOC. The inpatient manager will coordinate all inpatient skilled needs of the member in conjunction with the PCP to authorize any additional services that may be required.

**Lack of Information**

Tufts Health Plan must receive clinical information in a timely manner. Tufts Health Plan will deny payment of claims when the provider fails to provide the clinical information to Tufts Health Plan and/or its delegate, as soon as possible, but no later than 4:30 p.m. on the day of the authorized end date. In the event the authorized end date takes place on a weekend or holiday, clinical information must be provided no later than 12 p.m. on the next business day. In rare circumstances, you may be asked to provide the information in a shorter timeframe.

**BILLING INSTRUCTIONS**

- Separate billing must be submitted for each inpatient notification number or distinct LOC.
- 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 accurately processing the claim.

**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>

Refer to the [Inpatient Rehabilitation and LTAC Level of Payment Guidelines](#) for additional information.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Compensation for inpatient treatment and related services corresponds to the Tufts Health Plan network contracted rate for per diem, per case and/or other contractual arrangements, as applicable. Refer to your 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 biologicals)

**DOCUMENT HISTORY**

- January 2017: Template updates
- August 2016: Policy reviewed, clarified inpatient notification process
- September 2015: Template conversion, template updates
- September 2013: Template conversion
- June 2012: Policy reviewed, minor content and formatting changes, template updates
- April 2012: Template updates
• March 2012: Updated CareLink disclaimer language
• November 2011: Template updates, no content changes
• April 2011: Added link to Tufts Medicare Preferred HMO payment policy
• October 2010: Added information on continued care authorizations. Removed language stating the C1 level of care applies to Tufts Medicare Preferred members only.
• January 2010: Removed references to the Tufts Medicare Preferred PPO product.
• March 2008: Revised inpatient rehabilitation revenue codes and descriptions and added a link to the Inpatient Rehabilitation Level of Payment Guidelines.
• February 2008: Revised general benefit information with self-service channels information.
• November 2007: Added Tufts Medicare Preferred lack of information content.

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 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 payment 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 and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

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.