Inpatient Rehabilitation and Long-Term Acute Care Facility Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☐ 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 Tufts Medicare Preferred HMO and Tufts Health Plan SCO, click here.

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 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 Commercial Provider Services.

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 Commercial 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.

Inpatient rehabilitation and LTAC facility admissions require prospective inpatient manager (IM) review and authorization for a specific level of payment (LOC). Disagreements with respect to a member’s authorized LOC should be discussed directly with the IM.

Note: Providers should contact the Tufts Health Plan IM if the member’s inpatient stay is anticipated to exceed the authorized length of stay.

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

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
guideline for the required information needed to conduct an InterQual® review, to Tufts Health Plan by 5 p.m. one business day prior to the authorized end date.

Each change in LOC status must be updated in Tufts Health Plan’s system accordingly. A new inpatient notification number will be assigned 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**
Clinical information must be received by Tufts Health Plan as soon as possible, but no later than 5 p.m. on the day of the authorized end date. Tufts Health Plan will deny payment of claims if the provider fails to submit clinical information within the specified time frame. 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, providers may be asked to provide information within a shorter timeframe.

For a complete description of notification requirements, refer to the Authorizations chapters of the Commercial 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” must be indicated on the UB-04 form in box 84/Remarks to assist in accurate claims adjudication

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

**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 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 not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Chemotherapy
- Diagnostic services
- Dialysis
- Laboratory services
- Medication and supplies
- Nursing care
- Radiation imaging
- Radiation therapy
- Recovery room services
- Therapeutic items (drugs and biologicals)

**DOCUMENT HISTORY**
- July 2018: Policy reviewed by committee; clarified inpatient notification process and billing instructions
- June 2018: Template updates
- 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 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.