Non-Diagnosis Related Group (DRG) Inpatient 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 inpatient services paid under non-DRG methodology as set forth in the provider agreement. For services that are compensated under DRG, refer to the DRG Inpatient Facility Payment Policy. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO), click here.

This payment policy does not apply to skilled nursing facilities (SNF) or rehabilitation admissions. Refer to the Skilled Nursing and Inpatient Rehabilitation and Long Term Acute Care facility payment policies for more information.

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.

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.

INPATIENT 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. Refer to the Authorizations chapter of the Commercial Provider Manual for more information.

For PPO members whose care is managed through the Private HealthCare Systems (PHCS, also known as Multiplan) network, inpatient notification is obtained through American Health Holding (AHH). Please refer to the member's ID card to determine inclusion in the PHCS network.

Note: An inpatient notification does not take the place of a referral or prior authorization requirements for a service.

Obstetrical and Newborn Admissions

Inpatient notification is required for obstetrical admissions that fall outside of the mandated 48 hours for a vaginal delivery or 96 hours for a caesarian delivery. Obstetrical admissions that are not for a planned delivery are subject to Tufts Health Plan's notification requirements. Obstetrical admissions resulting in the planned delivery of a newborn do not require inpatient notification. Refer to the Obstetrics/Gynecology Payment Policy for more information.

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1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Newborns requiring inpatient services beyond the mother’s discharge date require their own inpatient notification. In these instances, services should be billed under the mother’s Tufts Health Plan ID number if the newborn has not been added to the plan.

**Submission Channels**

Providers can submit inpatient notifications through:

- The secure Provider website’s inpatient notification system
- 278 batch transaction. Contact EDI Operations at 888.880.8699 ext. 54649 or EDI_Operations@tufts-health.com for more information.
- Faxing a completed Inpatient Notification Form to 617.972.9590 or 800.843.3553. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all the information is returned to Tufts Health Plan.

When the inpatient notification process is complete, an authorized initial length of stay and authorized end date are made available on the secure Provider website. The authorized end date is the date that the authorized length of stay ends for the acute inpatient and extended care admission, if applicable.

**Note:** The member’s discharge date is the day after the authorized end date.

**Inpatient Notification Time Frames**

Admitting providers and facilities 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 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

**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 denial for all inpatient days prior to when notification is received

**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 initial length of stay will be assigned using data supplied by Truven Health Analytics. 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.

**Continued Authorization**

Tufts Health Plan may provide authorization for coverage of a continued stay. The notification number will remain the same throughout the acute hospital inpatient event, even when continued length of stay has been approved. When a level of care change occurs (e.g., from R1 to R2 or SNF level I to level II) for extended care admissions, a new inpatient notification and number are created.

Providers should contact their assigned Tufts Health Plan inpatient manager (IM) only if the member’s inpatient stay is anticipated to exceed the authorized length of stay. Refer to the Commercial Acute Care Hospital Care Management List to identify the appropriate IM.

**If submitting to an onsite Tufts Health Plan IM:**

To request additional inpatient days, providers should contact the assigned Tufts Health Plan IM to review their request.

**If submitting to a Tufts Health Plan IM not onsite at a facility:**

- **Acute Hospitals:** To request additional inpatient days, submit the Acute Inpatient Continued Stay Clinical Information Form to Tufts Health Plan by 5 p.m. on the authorized end date. The
form should be used to submit the clinical information, or as a guideline for the required information needed to conduct an InterQual® review.

- **Behavioral Health and Substance Use Disorder admissions**: To request additional inpatient days, providers should contact the assigned Tufts Health Plan IM by 5 p.m. on the day of the authorized end date to review their request. An InterQual® review will be conducted to determine the medical necessity of the request.

- **Extended Care Facilities**: To request additional inpatient days, submit the [Extended Care Inpatient Continued Stay Clinical Information Form—Initial](#) and for subsequent additional days submit the [Extended Care Inpatient Continued Stay Clinical Information Form—Additional](#).

**Note**: Tufts Health Plan does not send a request for more information (RFMI) to obtain clinical information on Commercial admissions.

### BILLING INSTRUCTIONS
Any late charges billed must be received by Tufts Health Plan within 90 days of the date of discharge.

#### Birthweight
Birthweight for newborns is needed for correct claims processing and should always be submitted in accordance with industry standards on the UB-04 claim form. Refer to the [Newborn Payment Policy](#) for more information.

### 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. Refer to the 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.

#### 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.

#### Discharge Services
Tufts Health Plan does not routinely compensate for more than one hospital discharge day management service per member per hospital stay. Tufts Health Plan will not compensate for the discharge day management service unless the physician of record is on the claim.

#### Newborn Claim Criteria
Compensation for newborns not added to the plan may be limited to the well newborn payment. Refer to the [Newborn Payment Policy](#) for information regarding well newborn criteria.
Serious Reportable Events ("Never Events")
The National Quality Forum defines "never events" as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Tufts Health Plan will deny or retract payment for care related to procedures that meet the definition of a "never event" once they have been identified. Refer to the Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy for more information.

ADDITIONAL RESOURCES
- 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
- Skilled Nursing Facilities Payment Policy

DOCUMENT HISTORY
- May 2019: Clarified existing inpatient notification process
- July 2018: Removed readmission language, as it pertains only to DRG admissions
- June 2018: Template updates
- July 2017: Added "never events" modifier edit effective for dates of service on or after October 1, 2017
- April 2017: Updated inpatient notification submission channels
- January 2017: Template updates
- November 2016: Minor content and formatting changes; added "Non-DRG" to title
- July 2016: Updated inpatient notification process effective July 1, 2016
- January 2016: Template updates
- September 2015: Template conversion
- July 2015: Policy reviewed, minor content and formatting changes, template updates
- April 2015: Template updates
- September 2014: Updated information regarding APR DRG claims, added information regarding payment methodology in situations when member enrollment occurred after the admission date, template updates
- May 2014: Updated information regarding obstetrical admissions, template updates
- November 2013: Moved DRG information into its own policy

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.