Non-Diagnosis Related Group (DRG) Inpatient Facility Payment Policy

The following payment policy applies to Commercial\(^1\) products (including Tufts Health Freedom Plan). For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO), click here.

This policy applies to Tufts Health Plan contracted inpatient services paid under non-DRG methodology as set forth in your provider agreement. For services that are compensated under DRG, refer to the DRG Inpatient Facility Payment Policy. For information on Inpatient and Intermediate Level of Care Behavioral Health services, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the standard professional and facility services payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products.

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

**POLICY**
Tufts Health Plan covers medically necessary inpatient services, as described below.

**DEFINITION**
Inpatient Notification is notification to Tufts Health Plan via the secure Provider website, 278 batch EDI transactions or fax that a member is being admitted for inpatient care regardless of whether Tufts Health Plan is the primary or secondary insurer. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the admitting provider.

An inpatient notification is a condition of payment and does not take the place of a referral or prior authorization requirements for a service.

**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 website or by contacting Provider Services.

**INPATIENT ADMISSION REQUIREMENTS**
While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained. It is the submitting provider’s responsibility to verify and confirm individual inpatient notifications.

**Inpatient Notification Event**
As a condition of payment, Tufts Health Plan requires notification for any member who is being admitted for inpatient care regardless of whether primary or secondary coverage is with Tufts Health Plan. An authorized initial length of stay and an authorized end date will be assigned for approved admissions.

Providers can log on to the secure Provider website to view these authorizations in real-time, 24 hours a day, 7 days a week. If a provider is not web-enabled or registered on the secure Provider website at the time of submission, he or she may request a faxed copy of their authorization. An inpatient notification event submitted via fax is available for viewing on the secure Provider website.

**Submission Channels**
Effective for dates of submission on or after July 1, 2017, providers submitting an inpatient notification request by fax must submit the request on a completed Inpatient Notification Form. No other forms will be accepted by Tufts Health Plan after June 30, 2017.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\textsuperscript{SM} when Tufts Health Plan is the primary administrator.
Providers can submit inpatient notifications through:

- The secure Provider website’s inpatient notification system
- Faxing a completed Inpatient Notification Form to 617.972.9590 or 800.843.3553. 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.
- 278 batch transaction. Contact EDI Operations at 888.880.8699 ext. 54649 or EDD_Operations@tufts-health.com for more information.

The following information is required when submitting a notification for inpatient care to Tufts Health Plan:

- Member’s name
- Member’s Tufts Health Plan ID number
- Member’s date of birth
- Hospital name
- Attending provider’s name
- Date of admission and/or service
- Complete diagnosis and procedure information. A diagnosis code is required.

When the inpatient notification process is complete, an authorized initial length of stay and authorized end date is communicated. The authorized end date is the date that the authorized length of stay ends for the acute inpatient and extended care admission. 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 is created.

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

**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**

Commercial inpatient providers should contact their assigned Tufts Health Plan care manager (CM) 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 CM.

**For inpatient facilities where Tufts Health Plan CMs are on site:**
To request additional inpatient days, providers should contact their assigned Tufts Health Plan care manager to review their request.

**For inpatient facilities where Tufts Health Plan CMs obtain clinical information by fax:**

- **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 their assigned Tufts Health Plan care manager 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 information (RFI) to obtain clinical information on Commercial admissions.
**Required Inpatient Notification Timeline**
Admitting providers and hospital admitting departments are responsible for notifying Tufts Health Plan. All inpatient admissions require notification to Tufts Health Plan in accordance with the following timelines:
- 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. of the next business day following the admission.

When an admission is reported, Tufts Health Plan performs the following steps as part of the inpatient notification process:
- Confirms the presence of a referral to a specialist, if applicable. An inpatient notification number cannot be authorized without a PCP’s authorization, if required, when the service is elective.
- Verifies member eligibility.
- Screens for coverage/benefit exclusions and procedures requiring prior authorization.
- Requests clinical information from the hospital or admitting provider if, based on the diagnosis or procedure code submitted, the length of stay table assigns a length of stay of zero days (i.e., denies coverage for the admission).
- 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 to the provider.

**Late Notification**
Notification of admission is a requirement for payment.
- 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.

For obstetrical admissions, refer to the Obstetrics/Gynecology Professional Payment Policy.

**BILLING INSTRUCTIONS**
Submit birthweight in grams for each newborn claim submitted. Refer to the Newborn Payment Policy.

**Corrected Claims**
Tufts Health Plan defines “corrected claims” as adjustment requests made to an original claim submission. The adjustment requests correct or change information on the original submission. Adding new services or days to the original claim submission is not a corrected claim.

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 180 days from the date of the original adjudication. Corrected claims and duplicate claim denial disputes received after that time will not be considered.

When submitting a corrected claim electronically, providers must submit the following:
- Original reference number (i.e., the Tufts Health Plan claim number) to expedite processing.
- Type of bill 117 (hospital, inpatient, replacement of prior claim)

When submitting a corrected claim on paper, providers must submit the following:
- Type of bill in box 4 when submitting a corrected claim.
- Type of bill 117 for inpatient services.

**Late Charges**
Tufts Health Plan defines “late charges” as charges for services associated with the original claim submission, but submitted after the initial submission of the claim. Late charges are identified by a type of bill ending in “5” (for example, 115 for inpatient late charges). Late charges can add additional lines and change the original amount billed on the original claim submission. Additional dates of service are not considered late charges.

Services submitted after initial submission of the claim are considered late charges. Late charges applied to Tufts Health Plan Commercial claims must be submitted within 90 days of the date of discharge for inpatient or institutional claims.

When submitting a late charge electronically, providers must submit the following:
• Original reference number (i.e., the Tufts Health Plan claim number) to expedite claim processing. If the late charges are submitted without the original claim number, the claim may be processed as a new claim, resulting in a duplicate submission.
• Bill type 115 (hospital, inpatient, late charges only claim)

When submitting a late charge on paper, providers must submit the following:
• Bill type in box 4 when billing for late charges
• Include bill type 115 for inpatient services

When submitting claim adjustments via mail, providers are required to include the Request for Claim Review Form. This form can be found under Forms of the Provider Resource Center and on the HCAS website. For additional information, refer to the Provider Payment Dispute Payment Policy.

COMPENSATION/REIMBURSEMENT INFORMATION
Payment methodology used for a hospital claim is determined by the methodology in place at the time of the member's discharge, except in those situations when member enrollment occurred after the admission date. In these instances payment methodology will be determined by the methodology in place at the time of enrollment.

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 your current contract for details.

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
• Preadmission testing
• Radiology/imaging*
• Recovery room services
• Therapeutic items (drugs and biologicals)

*Routine preadmission testing performed in the three days prior to an admission is not compensated separately.

Bedside Nursing Services
Tufts Health Plan will not separately cover bedside nursing services or procedures performed during the inpatient stay as part of the room and board. Examples of nursing services which are components of room and board fees, include, but are not limited to, blood administration services, medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing, catheterizations, tube feedings and irrigations, telemetry, and equipment monitoring services. 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 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. Refer to the AMA CPT Manual and the CMS Internet-only Manual for more information.

2 Effective for dates of discharge on or after January 1, 2016.
**Inpatient Behavioral Health Services**
Tufts Health Plan covers medically necessary inpatient and intermediate behavioral health (BH) and substance use disorder (SUD) services. Refer to the [Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy](#) for additional information.

**Newborn Admissions and Claims**
Compensation for newborns not added to the plan may be limited to the well newborn payment. Compensation is dependent upon the status of the newborn, either defined as well or sick based on the criteria outlined in the [Newborn Payment Policy](#). Diagnosis code(s) and the revenue code(s) on the claim are used to determine the status of the newborn (well or sick).

**Serious Reportable Events ("Never Events")**
The National Quality Forum (NQF) 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’s policy has been to deny or retract payment for care related to procedures which meet the definition of a “never event” once they have been identified. Tufts Health Plan will not compensate providers or permit providers to bill members for services related to the occurrence of “never events.” For a list of “never events” refer to the [National Quality Forum](#).

To report a “never event,” fax the report to Tufts Health Plan’s Clinical Quality Improvement (CQI) Department at 617.673.0973. Tufts Health Plan’s CQI Department works directly with the involved provider to review the clinical event and identify opportunities for quality improvement.

Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate for any procedure when billed with modifier PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), or PC (wrong surgery or other invasive procedure on patient).

**ADDITIONAL RESOURCES**
- [Skilled Nursing Facilities Payment Policy](#)
- [Inpatient Rehabilitation and Long Term Acute Care Facility Payment Policy](#)
- [Observation Services Payment Policy](#)

**DOCUMENT HISTORY**
- 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. Claims are subject to audit policies. If 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 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/authorization and utilization management guidelines 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 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.