

REFERRALS, PRIOR AUTHORIZATIONS AND NOTIFICATIONS

- [Overview](#)
- [Referrals](#)
 - [Outpatient Referral Management](#)
 - [Submitting an Outpatient Referral](#)
 - [Distribution of Copies – Paper Referral Form](#)
 - [Referral Inquiry](#)
 - [Referral Adjustments](#)
 - [Services that are Noncovered or Provided without Referral or Authorization](#)
 - [Out-of-Plan Care](#)
 - [Urgent/Emergency Out-of-Area Care](#)
 - [Outpatient Behavioral Health Services](#)
- [Outpatient Prior Authorizations](#)
 - [Prior Authorization through the Precertification Operations Department](#)
 - [Prior Authorization through the Behavioral Health Department](#)
 - [Prescription Drugs](#)
- [Prior Authorizations through Approved Vendors](#)
 - [National Imaging Associates \(NIA\)](#)
 - [Sleep Studies](#)
- [Intermediate Level of Care Notification \(MH/SUD Services ONLY\)](#)
- [Inpatient Notification](#)
 - [Inpatient Notification Requirements](#)
 - [Submission Channels](#)
 - [Required Inpatient Notification Timelines](#)
 - [After-Hours Urgent and Emergency Admissions](#)
 - [Non-Diagnosis Related Group \(Non-DRG\) payment arrangements](#)
 - [Diagnosis Related Group \(DRG\) payment arrangements](#)
 - [Obstetrical and Newborn Inpatient Notifications Procedure](#)
 - [Rescheduled Elective Admissions](#)
 - [Admission to an Out-of-Plan Facility](#)
 - [Payment and Denials](#)

Overview

To help ensure the quality of member care, Tufts Health Plan is responsible for monitoring authorization, medical appropriateness, and cost efficiency of services rendered. Certain services for members enrolled in HMO and POS products require notification, a referral and/or authorization to confirm that the member's primary care provider (PCP) or Tufts Health Plan has approved the member's specialty care services. For HMO members, such authorization is a requirement for coverage, while for POS members it is a requirement for coverage at the authorized benefit level.

A referral verifies that the PCP has authorized the member's care. The PCP is responsible for indicating the number of visits and type of specialty care services authorized. In most cases, a referral is valid in the Tufts Health Plan system for one year, or until the approved number of visits or member's benefit is exhausted.

Some employer groups elect to "carve-out" inpatient and outpatient behavioral health (BH) and substance use disorder (SUD) benefits and contract them to a separately funded and administered managed BH plan. In such situations, the BH carve-out insurer is responsible for the provision and maintenance of its own BH provider network. Tufts Health Plan is not responsible for the compensation or administration of such carve-out plans.

Note: Depending on the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment, you will need to make sure that the prior authorization has been obtained.

Referrals

Outpatient Referral Management

The PCP coordinates the outpatient referral management process to help ensure that appropriate specialty care is provided when medically necessary. With the exception of [behavioral health services](#), the PCP can authorize a standing referral to a specialist in the Tufts Health Plan network when all of the following criteria are met:

- The PCP decides that such a referral is medically necessary
- the specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis
- the health care services to be provided are consistent with the terms of the member's benefit document

A referral assures the specialist that the PCP has authorized the member's care. It also authorizes the Tufts Health Plan Claims Department to pay the specialist's claims.

Referrals are valid in the Tufts Health Plan system until one or more of the following criteria are met:

- The approved number of visits is used
- A specified time frame up to one year from the date of referral
- The member's benefit limit has been met
- The member is no longer eligible

Note: In some instances, the PCP may indicate a specific date range for the member to receive specialty care services. In these instances, the referral is only valid for the specified date range indicated on the referral. The date range specified may not exceed one year from the date of issuance.

Submitting an Outpatient Referral

Tufts Health Plan encourages electronic referral submission through our website for instantaneous receipt of a referral number. To learn more about our web-based offerings, call 888-884-2404 and select the web inquiry option.

Tufts Health Plan uses W.B. Mason to print paper referral forms. To order referral forms, fax a completed [W.B. Mason Provider Forms Requisition](#) to W.B. Mason at 800-738-3272 or email tuftshealthplan@wbmason.com.

Outpatient referrals can be submitted electronically via:

- Secure Provider [portal](#) — Register with Tufts Health Plan to take advantage of our online functionality
- [New England Healthcare EDI Network \(NEHEN\)](#) — Refer to the [Electronic Services](#) section of our website for additional information
- [Change Healthcare™](#) — Refer to Change Healthcare in the [Electronic Services](#) section of our website for additional information. All services requiring referrals can be submitted via this option.

Outpatient referrals can be submitted on paper by mailing them to the Tufts Health Plan address indicated on the front of the paper referral form. Do not fax referrals for Commercial members to Tufts Health Plan or W.B. Mason.

Note: Referrals authorizing more than one visit only have to be submitted once, not with each subsequent date of service billed.

The following table outlines the fields on the paper referral form and gives any special information or instructions needed to complete the form.

Paper Referral Form Fields

MEMBER INFORMATION	
Field Name	Special Instructions
Member name	First, middle initial, last
Date of birth	

Date of referral	This date must precede the date of service
Member ID	Tufts Health Plan member ID number, from ID card or monthly member list
Is the member on a limited-network plan?	Search Limited Network Plans in the Provider Directory

PRIMARY CARE PROVIDER INFORMATION	
Field Name	Special Instructions
Name	PCP's full name is required
Provider NPI	PCP's full NPI is required
Address	
Phone	

SPECIALTY CARE PROVIDER INFORMATION	
Field Name	Special Instructions
Name	Provider's full name is required
Provider NPI	Provider's full NPI is required
Specialty	
Address	
Phone	
Is above provider within the member's network?	Search Limited Network Plans in the Provider Directory.

TYPE OF REFERRAL	
Field Name	Special Instructions
Tufts Health Plan provider (in-plan)	Referral made by a PCP to a specialist within the Tufts Health Plan network
Non-Tufts Health Plan provider (out-of-plan)	All out-of-plan referrals require PCP and physician reviewer approvals. State the diagnosis or presenting problem and list any diagnostic studies already performed, and why an in-network provider cannot provide the service(s). IPA groups that do not have a designated physician reviewer must submit these requests along with the appropriate clinical documentation to Tufts Health Plan for review before providing services.
Provider outside member's limited network plan	Referrals to out-of-plan or out-of-network providers require Tufts Health Plan review. Before providing services to Spirit plan or other limited network plan members, specialty care providers outside of the Spirit or limited networks must fax the Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization Form along with the appropriate clinical documentation to Tufts Health Plan's Precertification Operations Department at 617-972-9409 for approval prior to providing services.

SERVICES REQUESTED (check one)	
Field Name	Special Instructions
Consultation (one visit only)	Authorizes 1 specialty visit
Consultation/second opinion only (one visit only)	Authorizes 1 second opinion visit
Consultation/diagnostic studies	Authorizes up to 3 visits and includes diagnostics
Consultation/diagnostic studies	Enter the specific number of visits requested. If left blank, the default

and treatment	allowed is one visit
Number of visits: Physical therapy	1 evaluation and 8 treatment visits
Number of visits: Occupational therapy	1 evaluation and 8 treatment visits
Number of visits: Speech therapy	Provide number of visits
Diagnostic studies to be performed at	Location where diagnostic studies must be performed
Signature of PCP	Required
Authorization Date	Required
Signature of Physician Reviewer (if applicable)	Required for referrals to non-Tufts Health Plan specialists and facilities. For providers outside of the member's limited network plan, a request must be submitted to Tufts Health Plan for review. Providers must fax the Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization Form along with the appropriate clinical documentation to Tufts Health Plan's Precertification Operations Department at 617-972-9409 for approval prior to providing services. IPA groups that do not have a designated physician reviewer must submit these requests to Tufts Health Plan for review before providing services.
Authorization Date	Required

Distribution of Copies – Paper Referral Form

If the PCP office does not submit referrals electronically, the PCP office is responsible for distributing the four copies of the referral authorization form as follows:

Pink: PCP
 Light yellow: Specialist
 Dark yellow: Member
 White: Use a pre-addressed envelope (available at W.B. Mason, phone 508-436-8777) to mail to Tufts Health Plan

Referral Inquiry

Providers may check the status of an existing referral by using **Referral Status Inquiry** on the Tufts Health Plan secure Provider [portal](#). The referral status inquiry tool provides the status of any referral submitted to Tufts Health Plan regardless of how the referral was initially submitted.

Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Plan system, the PCP must contact [Provider Services](#) for assistance. Tufts Health Plan cannot adjust referrals based on the specialist's request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

Services that are Noncovered or Provided without Referral or Authorization

Tufts Health Plan requires members to be responsible for obtaining referrals to the extent required under the member's benefit package. For those products requiring such referral authorization or for services that are not covered by Tufts Health Plan, many offices have patients sign acknowledgements to confirm that the member understands this policy. Refer to the Forms section of our website for Tufts Health Plan's [Agreement to Financial Liability form](#). Under the terms of providers' contracts with Tufts Health Plan, balance billing of members (i.e., attempted collection of fees for services other than a member's applicable cost share amount) is prohibited without such an advance written agreement by a member to pay for the noncovered services. In accordance with the [Consolidated Appropriations Act, 2021](#), members cannot be balance billed and are only responsible for

their in-network cost share for emergency services or services rendered by a non-participating provider at an in-network facility. Where a member has completed a consent form from a provider which satisfies the requirements of the Consolidated Appropriations Act, the member may be held financially liable for certain non-ancillary services rendered by a non-participating provider at an in-network facility.

Note: A general type of acknowledgement (e.g., “I agree to pay for anything that my insurance does not pay for”) is not adequate to confirm the member’s understanding and acknowledgement to proceed without a required referral or necessary authorization, or that they understand it is not a covered service.

Out-of-Plan Care

In the rare instance that it is necessary for a HMO or EPO member to be treated by a provider who does not participate in the Tufts Health Plan network (except with respect to products or services that do not require referrals), the paper referral form must be filled out and signed by a PCP and the Authorized Reviewer associated with the PCP’s Provider Organization. For PCPs who are not associated with a provider organization, the authorized reviewer is Tufts Health Plan. If Tufts Health Plan is the authorized reviewer, requests must be submitted on the [Out-of-Network Coverage at In-Network Level of Benefits Prior Authorization Form](#) prior to providing services. Referrals reviewed by Tufts Health Plan will not be backdated.

Prior to submitting a referral request to an authorized reviewer, the PCP must confirm that a provider in the member’s network could not provide a comparable level of care. Referrals that require authorized reviewer approval should be sent directly to the attention of the authorized reviewer before forwarding to Tufts Health Plan.

The authorized reviewer is responsible for reviewing referrals issued to specialty care providers who are not affiliated with Tufts Health Plan or for out of area specialty care services. The authorized reviewer will either approve and sign the referral form or offer an appropriate in-plan provider option.

Additional requirements may be in place for members of Limited Network plans. Refer to the [Paper Referral Form Fields](#) above for additional information with respect to Limited network plans.

Note: This does not apply to out of plan behavioral health services. See [prior authorization](#) section.

Urgent/Emergency Out-of-Area Care

The PCP is not required to issue a referral for treatment of urgent/emergency care while a member is temporarily outside of the service area. A member may be seen at a provider’s office, walk-in clinic or emergency department. Members are encouraged to call their PCP to coordinate any follow-up care.

Outpatient Behavioral Health Services

Tufts Health Plan does not require a PCP referral for outpatient behavioral health services or notification for outpatient psychotherapy. Prior authorization for certain outpatient procedures is still required, see [prior authorization](#) section below.

For more information regarding outpatient behavioral health services, refer to the [Outpatient Behavioral Health/Substance Use Disorder Professional Payment Policy](#).

Outpatient Prior Authorizations

Tufts Health Plan requires prior authorization for certain specialty services, drugs, devices and equipment as a condition of payment. Authorization for services, drugs, devices and equipment is based on InterQual® criteria or on medical necessity guidelines or on medical necessity criteria, as outlined in the [medical necessity guidelines](#) located in the [Provider Resource Center](#). Medical necessity guidelines and InterQual criteria are used in conjunction with the member’s benefit plan document and in coordination with the provider recommending the specialty service, drug, device or equipment.

Note: 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.

[Medical necessity guidelines](#) are established and based on current literature review, including InterQual, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, the policies of government agencies such as the FDA, and standards adopted by national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions. Medical necessity guidelines and InterQual criteria are used in conjunction with the member's benefit plan document and in coordination with the provider recommending the service, drug, device or supply.

Note: Refer to the [CareLink](#) chapter for more information on the CareLink prior authorization process.

Prior Authorization through the Precertification Operations Department

To request authorization for a service, certain medical drugs, device, or equipment requiring prior authorization through the Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the **treating** provider is required to submit documentation of medical necessity for services requiring authorization. Documentation should detail:

- The member's diagnosis
- Planned treatment, including specific procedure codes and medical rationale for the service requested
- All pertinent medical information available for review.

Prior authorization for outpatient medical services can be obtained through the MHK Portal via the secure Provider [portal](#). For more information refer to the [Commercial and Tufts Medicare Preferred HMO MHK Portal User Guide](#).

Prior authorization requests can also be faxed to the Precertification Operations Department at 617-972-9409.

When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation unless specifically indicated. The completed InterQual SmartSheet can be uploaded on the MHK Portal or faxed.

For a more comprehensive list of services that require prior authorization, refer to the [Medical Necessity Guidelines](#) section of the [Resource Center](#).

Prior Authorization through the Behavioral Health Department

Prior authorization is required for some outpatient behavioral health services, including but not limited to the following:

- Transcranial Magnetic Stimulation (rTMS)
- Psychological and Neuropsychological Testing
- Applied Behavioral Analysis (ABA)
- Family Stabilization Treatment
- Non-urgent/non-emergent services out-of-network (for plans without coverage out of network)
- Some Behavioral Health for Children & Adolescents services, such as In-Home Therapy Services and In-Home Behavioral Services

To request authorization for a service requiring prior authorization through the behavioral health department, the treating provider should. Refer to the appropriate medical necessity guidelines located in the [Provider Resource Center](#) of the public Provider [website](#) for medically necessary criteria and prior authorization submission instructions.

In the rare instance that an HMO or EPO member requires non-urgent/non-emergent services by a provider who does not participate in the Tufts Health Plan network, prior authorization is required by Tufts Health Plan. For more information, refer to the medical necessity guidelines for [Out-of-Network Coverage at the In-Network Level of Benefits](#). Providers can also call the BH department at 800-208-9565 for further information.

Prescription Drugs

Certain prescription medications require prior authorization prior to rendering services. For requests regarding prescription medications that have coverage limitations, refer to the [Commercial Pharmacy Medication Prior](#)

[Authorization Submission by State](#) grid.

Refer to the [Pharmacy Medical Necessity Guidelines](#) for a list of prescription drugs that require prior authorization.

Prior Authorizations through Approved Vendors

National Imaging Associates (NIA)

Tufts Health Plan requires providers to obtain prior authorization through NIA for high-tech imaging, cardiac, spinal conditions management (interventional pain management and spine surgeries) and joint surgery utilization management programs.

Refer to the [High-Tech Imaging](#) and the prior authorization program pages and the [Imaging and Cardiac Program Prior Authorization Management Guide](#) for additional information.

Refer to the [Spinal Conditions Management](#) and [Joint Surgery](#) program pages for more information. For a list of CPT codes subject to prior authorization, refer to the [Spinal Conditions Management and Joint Surgery Program Prior Authorization Code Matrix](#).

To obtain and verify authorizations or access medical necessity guidelines, log into [RadMD](#) or call NIA at 866-642-9703.

It is the **ordering** provider's responsibility to obtain prior authorization before scheduling appointments for members. **Rendering** providers will need to ensure that all tests have the required authorization number before the service is performed.

Note: For the High-Tech Imaging program, both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim. Diagnostic imaging services performed in the emergency department, observation, and/or inpatient settings do not require prior authorization. Urgent/emergent high-tech imaging and cardiology procedures rendered at a site other than a hospital ED require notification to NIA within **two business days** of the service.

Sleep Studies

Tufts Health Plan requires providers to obtain prior authorization through eviCore healthcare for sleep studies, sleep therapy and/or resupplies. Refer to the [eviCore Sleep Management Program](#) and [Sleep Studies and Sleep Therapies Payment Policy](#) for more information.

Intermediate Level of Care Notification (MH/SUD Services ONLY)

Intermediate services often begin on an urgent or emergent basis. Accordingly, Tufts Health Plan has declined to require prior authorization for these benefits for all intermediate service approvals. Because prior authorization is not required, a member can commence services at the time of need without waiting for authorization. Continued services require medical necessity review. Intermediate services include but are not limited to the following:

- Partial hospital programs (PHP)
- Intensive outpatient programs
- Intensive Care Coordination (ICC) – Massachusetts Plans ONLY

Some HMO members, based on their age and provider organization affiliation of their PCP, are assigned to a designated facility (DF). The DF is responsible for providing and/or coordinating all intermediate levels of care for the member. When a member goes to an assigned DF, only notification is required. No additional concurrent review will be conducted by Tufts Health Plan.

All other in-network providers are required to provide notification to Tufts Health Plan, typically after the first day/visit of treatment.

For plans without out-of-network coverage, coverage is limited to covered services in-network except for emergent/urgent care. Access to any intermediate services out-of-network requires prior authorization by Tufts Health Plan. For more information, refer to the medical necessity guidelines for [Out-of-Network Coverage at the In-Network Level of Benefits](#).

Providers can submit notification or submit a request for continued authorization of services by calling the BH Department at 800.208.9565 or faxing notification or request to 617-972-9424. In network providers can also notify Tufts Health Plan of a PHP admission by logging on to the secure Provider [portal](#). Additional information on utilization review (UR) requirements can be found within the medical necessity guidelines for [Non-24 Hour /Intermediate/Divisionary Services Behavioral Health Level of Care](#) and [Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy](#).

Inpatient Notification

Inpatient notification is a process that notifies Tufts Health Plan of all inpatient admissions. Tufts Health Plan covers medically necessary inpatient services when inpatient notification is given in accordance with the timeframe established by Tufts Health Plan or when applicable, the timeframe as specified by applicable law. Outpatient procedures, including surgical day care and observation services, do not require inpatient notification.

Inpatient notification does not guarantee payment by Tufts Health Plan. Refer to the [Referral, Authorization, and Notification Policy](#) for inpatient notification procedures.

Inpatient Notification Requirements

As a condition of payment, Tufts Health Plan requires an inpatient notification for any Commercial member being admitted for inpatient care, regardless of whether Tufts Health Plan is the primary or secondary insurer. Dependent on facility payment contract, an authorization status will be assigned which may or may not include an authorized initial length of stay and an authorized end date for admissions. A concurrent review is required after the initial inpatient notification period, except for BH admissions to Designated Facilities (DF). **Note:** Providers are also required to perform the Emergency Psychiatric Inpatient Admission (EPIA) Protocol Escalation Steps as outlined in the [EPIA Protocol 3.0](#) for inpatient behavioral health and substance use disorder admissions.

Some HMO members, based on their age and affiliated provider organization of their PCP, are assigned to a designated facility (DF). The DF is responsible for providing and/or coordinating all intermediate and inpatient levels of care for the member. When a member goes to an assigned DF, only notification is required. No additional concurrent review will be conducted by Tufts Health Plan. To determine the DF that a given member should use for BH facility-based care, log on to the secure Provider [portal](#) to check member eligibility, or call the Tufts Health Plan BH Department at 800-208-9565 to access the IVR.

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

Submission Channels

Providers can submit inpatient notification and attach supporting clinical information 24 hours a day, 7 days a week through the MHK portal via secure Provider [portal](#) or utilize New England Healthcare EDI Network (NEHEN). In most cases, the inpatient notification number will be made available upon submission and available for view in the portal in real-time 24 hours a day, 7 days a week. For more information on submitting inpatient notifications via the MHK portal, refer to the [Commercial and Tufts Medicare Preferred HMO MHK Portal User Guide](#).

Providers who are not web-enabled or registered may fax a completed [Inpatient Notification Form](#) to the Precertification Operations Department 24 hours a day, 7 days a week at 617-972-9590 or 800-843-3553. No other forms are accepted. Providers without portal access may call Provider Services to obtain the inpatient notification number. The notification number for coverage confirms the approved inpatient level of care.

Forms and portal submissions with missing or incomplete information will require the provider submit missing or incomplete information. Processing of the request will be delayed until all required information is returned to Tufts Health Plan and may be subject to late notification.

Required Inpatient Notification Timelines

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 requests must be submitted to the Precertification Operations Department or the UM Intake Department no later than five business days prior to admission to submit an authorization request.
- Urgent or emergent admissions must be reported to the UM Intake Department within two business days.

Note: Transfers to rehabilitation, skilled nursing facilities (SNFs) or long-term acute care (LTAC) facilities from acute medical facilities are considered elective admissions and providers must submit an authorization request via the channels above as soon as discharge plans are made so as to not delay the transfer.

For **after-hours urgent and emergency admissions**, providers must notify the UM Intake Department of the inpatient admission by 5 p.m. the following business day. For urgent/emergent admissions occurring on weekends and holidays, notification must be made by 5 p.m. the next business day. The inpatient notification number will be viewable on the Provider Inquiry screen by the end of the next business day following the notification.

For **SUD admissions**, in accordance with M.G.L. Chapter 258, Section 17N, medically necessary acute SUD treatment and/or clinical stabilization services are covered without inpatient notification for up to 14 consecutive days for members of Massachusetts plans.

After-Hours Urgent and Emergency Admissions

While prior authorization is not required for urgent and emergency admissions occurring after business hours, on weekends and holidays, such admissions are subject to the same notification requirements described above. Providers may use the following resources 24 hours a day, seven days a week to notify Tufts Health Plan of a member admission after hours:

- Log in to the secure Provider [portal](#)
- Access [New England Healthcare EDI Network \(NEHEN\)](#) (the provider must be a NEHEN member)
- Fax a completed [Inpatient Notification Form](#) along with supporting clinical documentation to the UM Intake Department at 617-972-9590 or 800-843-3553

Note: PPO members whose care is managed through the Private Health Care Systems (PHCS, also known as Multiplan) network are approved for inpatient services through American Health Holding (AHH). For additional information, contact [American Health Holding](#) or call 866-415-7143.

Non-Diagnosis Related Group (Non-DRG) payment arrangements

When the inpatient utilization review process is complete, an authorization status will be made available with the authorized initial length of stay and an authorized end date. The authorized end date is the date the authorized length of stay ends for the acute inpatient non-DRG admission or extended care (SNF, rehabilitation or LTAC) admission. Tufts Health Plan may provide authorization for continued stay coverage, if applicable to facility payment arrangements. The inpatient notification number will remain the same throughout the acute hospital inpatient admission.

For extended care admissions, a new inpatient notification and number is created when there is a level of care change (e.g., from R1 to R2 or SNF level I to level II). Inpatient notifications submitted via fax will also be available for viewing on the secure Provider portal.

Continued stay requests and the accompanying clinical information must be submitted to Tufts Health Plan **by 5 p.m.** on the day of the authorized end date.

Concurrent Review

For non DRG payment arrangements, the Tufts Health Plan Inpatient Manager will perform concurrent reviews

using established criteria.

Diagnosis Related Group (DRG) payment arrangements

When the inpatient notification process is complete, the inpatient notification status will be communicated. The notification number for coverage confirms that notification has been received.

Requests for continued authorization are not required for an admission paid under a DRG payment methodology once the admission receives an authorized status. Tufts Health Plan may require additional clinical information to review the member's status and anticipated discharge plan throughout the member's hospitalization.

BH/SUD 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/or additional clinical documentation and for subsequent additional days submit the [Extended Care Inpatient Continued Stay Clinical Information Form—Additional Form](#).

Obstetrical and Newborn Inpatient Notifications Procedure

Obstetrical admissions that will result in the planned delivery of a newborn do not require inpatient notification. Well newborns are covered under the mother's inpatient notification for delivery. Inpatient notification for sick newborns who will be staying in the hospital beyond the mother's discharge date must be performed **separately** within one business day following the discharge of the mother.

Inpatient notification is required for obstetrical admissions that are likely to exceed the mandated minimum of 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. Inpatient notification is not required if emergency room or observation care occurs without an inpatient admission. Obstetrical admissions that are not for a planned delivery are subject to Tufts Health Plan's notification requirements.

Inpatient admission notification for pregnant women with multiple inpatient admissions must be performed for **each** admission up to the actual delivery.

Pregnant women must be registered with our Health Programs department for delivery by 20 weeks gestation to receive full maternity benefits. To submit an inpatient notification, complete the [Prenatal Registration Form](#) and fax it to the Health Programs Department at 617-972-9417. Refer to the [Obstetrics/Gynecology Professional Payment Policy](#) for more information.

Note: Obstetrical care management services are available to assist high-risk members and manage antepartum care during their pregnancy. When the member's obstetrician completes the Prenatal Registration Form, a Tufts Health Plan care manager may enroll the member in the obstetrical care management program, if applicable.

Rescheduled Elective Admissions

If an elective admission is rescheduled, fax the change to the UM Intake Department at 617-972-9590 or 800-843-3553 within the reporting time frame guidelines outlined in the [Required Inpatient Notification Timelines](#) section above.

Admission to an Out-of-Plan Facility

When an HMO member requires an elective admission to an out-of-plan facility, approval for the admission must be obtained from both the PCP and physician reviewer prior to the admission.

Note: Tufts Health Plan considers all BH admissions urgent or emergent and therefore approval prior to an inpatient admission is not required.

Payment and Denials

Only those hospital-based inpatient days of which Tufts Health Plan has been notified in accordance with requirements are eligible for payment by Tufts Health Plan. Notification of emergency admissions within the

next business day (or as required by law), following hospitalization are considered to have a valid notification. Denial of payment for not following the inpatient notification policy will apply to both the hospital and related physician services. Denial of payment to physicians may be waived when the admission was the result of an emergency.

Note: Payment denial for lack of notification does not apply to BH/SUD admissions.

Providers who are denied payment due to lack of inpatient notification cannot bill the member. However, providers can exercise their right to dispute payment by submitting a provider payment dispute using the claim adjustments tool on the secure provider [portal](#). Providers who are not registered users of the secure website may go to the secure Provider [portal](#) and follow the instructions to register or submit a provider payment dispute by mailing a [Request for Claim Review Form \(v1.1\)](#) to Tufts Health Plan. Refer to the [Provider Payment Dispute Policy](#) for additional information on submitting disputes.