Notifications

Prior Notification Policy

Prior notification is required for the following services:

- Inpatient acute hospital admissions, including acute rehabilitation and long-term acute care
- Inpatient behavioral health and substance use disorder (BH/SUD) admissions
- Skilled nursing facility (SNF) admissions
- Select behavioral health outpatient, intermediate, diversionary and emergency services
- Institutional long-term care and other services provided to members while at a custodial level of care
- Home health agency care
- Sleep studies, sleep equipment and related supplies
- Tobacco cessation services
- Select home- and community-based services

For a complete listing of services requiring notification, please reference the Tufts Health Plan Senior Care Options Notification List.

Inpatient Notification Policy for Medical Services

Inpatient notification is a notification to Tufts Health Plan of utilization of inpatient services. Inpatient notification is required for the following medical admissions and services:

- All elective and urgent/emergent hospital admissions
- Acute rehabilitation and SNF admissions

When an admission is reported, the inpatient notification process does the following:

- Verifies member eligibility (subject to retroactive reporting of disenrollment)
- Screens for coverage/benefit exclusions
- Identifies the facility as an in-network Tufts Health Plan Senior Care Options (SCO) facility
- Verifies authorization for inpatient services outside of the Tufts Health Plan SCO network
- Identifies the facility as Medicare-approved for services that must be performed in a Medicare-approved facility. Certification as a Medicare-approved facility is a requirement for coverage for the following procedures: organ transplants, lung volume reduction surgery (LVRS), and carotid artery stenting (CAS) with embolic protection.

**Note:** This requirement does not apply to CAS performed in a Medicare-approved Category B IDE study or post-approval study, ventricular assist device (VAD), destination therapy, and bariatric surgery. Tufts Health Plan SCO will not pay for services rendered at a non-Medicare approved facility.

- Tufts Health Plan SCO verifies that covered services are directed by the PCP and/or the care manager. The Tufts Health Plan SCO clinical team will also be notified so they can identify and intervene in any potential transition planning and posthospital discharge needs for the member. When the inpatient notification process is completed, an inpatient notification reference number is assigned. The notification number is used as a reference for adjudication of claims associated with a particular service, but the number is not a guarantee of payment. The provider may be liable if he/she provides either nonmedically necessary care or noncovered care. If a contracting specialist provides a service without a referral from the member’s PCP, the claim will be sent to the PCP for review. If the PCP agrees with the service provided, the claim will be released for adjudication. If the PCP does not agree with the service, the contracted specialist will be liable and cannot bill the member unless the specialist has a signed a valid waiver.
Inpatient Notification Requirements

Inpatient notification is a process that makes Tufts Health Plan aware of all inpatient admissions and transfers to another hospital. Providers must notify the Tufts Health Plan’s Inpatient Admissions team within the Precertification Operations Department for all inpatient admissions (elective, urgent/emergent, acute rehabilitation and SNF admissions).

Notification verifies that covered services are directed by PCP and have appropriate approvals by the medical group. The care manager or external care manager is also notified so they can initiate concurrent review using Medicare coverage guidelines and InterQual® criteria and can identify and intervene in any potential discharge needs for the member. InterQual criteria are used for screening purposes only and are not used for medical necessity determinations.

Elective admissions: providers must notify the Inpatient Admissions team at least five business days prior to the admission.

After-hours urgent/emergency admissions: providers must notify the Inpatient Admissions team within one business day. For urgent/emergent admissions occurring on weekends and holidays, notification must be made by 5 p.m. the next business day.

Providers can report admissions via fax at either 617.972.9590 or 800.843.3553, 24 hours a day, seven days a week. The Precertification Operations Department requires inpatient notification via fax be submitted on Tufts Health Plan’s Inpatient Notification Form. No other forms will be accepted by Tufts Health Plan. Forms submitted with missing or incomplete information will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is submitted.

If a previously submitted inpatient notification of admission is cancelled, the Inpatient Admissions team must be notified of that cancellation and the rescheduled date, if applicable.

If an admission changes from surgical day care to inpatient, the provider must notify the Inpatient Admissions team within one business day.

Inpatient Notification Information

- The Tufts Health Plan SCO clinical team monitors all inpatient, SNF, and acute rehabilitation and long-term acute care hospital admissions. The Tufts Health Plan SCO clinical team follows the member’s care throughout the continuum of care, including discharge planning. To facilitate a smooth post-discharge transition, the Tufts Health Plan SCO clinical team will be responsible for communicating with relevant members of the primary care team (PCT) throughout the inpatient stay.
- Inpatient notification is not required for same-day surgery procedures.
- Non-plan providers are encouraged to notify Tufts Health Plan SCO of inpatient events and other out-of-network services. Admissions can be reported to the Inpatient Admissions team by fax at either 617.972.9590 or 800.843.3553, 24 hours a day, seven days a week.
- For admissions reported to the Precertification Operations Department regarding care provided in an out-of-network facility, the SCO clinical team will investigate with the attending provider and do one of the following:
  - Authorize the case and transfer the member to an in-plan facility only after the treating provider agrees that the member is considered stabilized for transfer.
  - Authorize the case and not transfer the member.
  - Deny the case if the care was not emergent or urgent, related to an emergency medical condition, and/or the Member refuses transfer; and inform the member, in writing through a Centers for Medicare & Medicaid Services (CMS)/Executive Office of Health and Human Services (EOHHS)-approved letter, of the denial of services.
  - Deny the case if the care was post-stabilization care where a plan provider (covering PCP or Tufts Health Plan SCO medical director) responded to the request for pre-approval within one hour, and the treating provider agrees with the plan but the member refuses transfer.
- Tufts Health Plan SCO must inform the member in writing, using the appropriate CMS/EOHHS approved letter, of any denial of services.
Confirmation of Inpatient Notification

To obtain an inpatient notification number after submitting a notification request via fax, providers can contact Provider Relations at 800.279.9022.

Payment

Inpatient admissions and outpatient surgical procedures for which an inpatient notification has been submitted according to the foregoing requirements are eligible for payment by Tufts Health Plan SCO, as long as all other requirements have been met. Inpatient notification must be submitted for emergency admissions within the next business day following hospitalization.

Denial of payment for late inpatient notification or lack of notification applies to the hospital bills. Tufts Health Plan SCO network providers who are denied payment for late notification or lack of notification cannot bill the member. To appeal a denial of payment in writing, use the Request for Claim Review Form and send it to the appropriate address in the Provider Payment Dispute Policy.

Inpatient Notification Guidelines for Behavioral Health/Substance Use Disorder Services

Inpatient notification is required for members being admitted for BH/SUD inpatient care. The notification process for these services is designed to verify and ensure that all covered BH/SUD services are processed in the appropriate fashion.

Inpatient days for which an inpatient notification has been submitted are eligible for payment by Tufts Health Plan SCO. Inpatient notification must be submitted for emergency admissions within the next business day following hospitalization.

Note: An inpatient notification number or the report of an admission does not guarantee claim payment. Denial of payment for late inpatient notification or the lack of notification applies to the hospital bills. Contracting providers who are denied payment for late notification or lack of notification may not bill the member. Denial of payment can be appealed in writing using the Universal Provider Request for Claim Review Form, which must be sent to the address located on the form or in the Provider Payment Dispute Policy.

There is a 190-day lifetime limit under Medicare for inpatient BH/SUD services provided in a psychiatric hospital. This limit does not apply to inpatient BH/SUD services provided in a general hospital. However, because Tufts Health Plan SCO members have MassHealth Standard (Medicaid) benefits, any stay in a psychiatric hospital that lasts more than 190 lifetime days is covered under the MassHealth Standard (Medicaid) benefit.

Inpatient Notification Process

To admit a member for inpatient BH/SUD treatment, the facility should contact the Inpatient Admissions team via fax at either 617.972.9590 or 800.843.3553, 24 hours a day, 7 days a week. Inpatient notification via fax must be submitted on Tufts Health Plan’s Inpatient Notification Form. No other forms will be accepted by Tufts Health Plan. Forms submitted with missing or incomplete information will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is submitted.

Medicare-Approved Facility Requirements

Medicare has issued several National Coverage Determinations (NCDs) providing coverage for services and procedures of a complex nature, with the stipulation that the facilities providing these services meet certain criteria. These criteria usually require, in part, that the facilities meet minimum standards to ensure the safety of beneficiaries receiving these services. Certification as a Medicare-approved facility is required for performing the following procedures. For coverage criteria, refer to the Medicare National Coverage Determination Manual (NCD manual) on the CMS website.

- Lung volume reduction surgery: NCD manual, Section 240
- Carotid artery stenting (CAS): NCD manual, Section 20.7
Note: This requirement does not apply to CAS performed in a Medicare-covered Category B IDE study or post-approval study.

- Ventricular assist device (VAD) destination therapy: NCD manual, Section 20.9
- Bariatric surgery: NCD manual, Section 100.1
- Certain oncologic positron emission tomography (PET) scans in Medicare-specified studies: NCD manual, Section 200.6

In addition to these procedures, there is also a long-standing requirement that all heart, heart-lung, liver, intestinal/multivisceral, kidney, and pancreas transplants be performed at a Medicare-approved facility. The transplant work-up evaluation must also be performed in a Medicare-approved transplant facility.

To determine if a facility is Medicare-approved to perform a particular service, refer to the following CMS information:

- Lung volume reduction surgery (LVRS), bariatric surgery, carotid artery stenting with embolic protection, and VAD as destination therapy
- Heart, heart-lung, lung, liver, and intestinal transplants
- Kidney and pancreas transplants

Not all in-network providers who perform these services are Medicare-approved. Tufts Health Plan SCO will not pay for services rendered at a non-Medicare-approved facility and network providers cannot hold the member liable for these services.

For a listing of Medicare-approved facilities that are also contracted with Tufts Health Plan SCO for each of the services above, refer to the Tufts Health Plan SCO Medicare-Approved Facilities document.

In addition to the Medicare-approved facility requirement, all plan inpatient notification, prior authorization, and in-network and out-of-network plan rules apply. Providers must be sure members are referred only to Medicare-approved facilities for these services. To the extent a medical group/PCP is involved in referring a member to a non-Medicare-approved facility, the provider will be financially liable for the associated costs. Because these services must be provided in a Medicare-approved facility to be covered, the costs of services in a non-Medicare-approved facility cannot be paid using Medicare funds.

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