Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Inpatient Hospital Admissions

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Point32Health reimburses inpatient admissions to contracted acute medical facilities. Determination of inpatient status occurs at the date and time the admitting physician writes the order to admit the member to inpatient status when the member's clinical status meets Point32Health's criteria for inpatient care.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Point32Health may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Point32Health Reimburses

Point32Health reimburses inpatient acute medical admissions at a single all-inclusive rate as determined by the contracted rate for inpatient services and when notified within appropriate timeframes. Refer to provider contracts as payment methodology may vary. Reimbursement includes but is not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Bedside nursing and equipment
- Diagnostic services
- Medication and supplies
- Nursing care
- Observation services
- Radiology
- Recovery room services
- Semi-private room (or private room, if necessary)
- Surgical procedures
- Therapeutic items (drugs and biologicals)

Per Diem

Pre-admission (may be subject to post-payment audits and retraction)
All services related to the principal diagnosis that are provided within one day of an inpatient admission are included in the inpatient per diem reimbursement.

Re-admission
Separate reimbursement will be made for members who are re-admitted for inpatient services after initial discharge.

Member Enrollment and Termination

- When an inpatient admission occurs prior to a member's effective date, reimbursement begins from the member's effective date if the hospital notifies Point32Health of the admission.
- If a member terminates membership while receiving inpatient services, reimbursement will be paid at the per diem rate up to and including the termination date.
- **Tufts Health One Care:** If a member is enrolled in Tufts Health One Care at the time of acute hospital admission, reimbursement will be made for the entirety of the member's stay through discharge, even if the member disenrolled prior to discharge

Diagnostic-Related Groups (DRG)

Pre-admission (may be subject to post-payment audits and retraction)

- Diagnostic services that are provided within ten days of an inpatient admission are included in the inpatient reimbursement.
- Non-diagnostic services, related to the principal diagnosis, that are provided within ten days of an inpatient admission are included in the inpatient reimbursement.
- Any ambulatory day care, radiology or laboratory procedures that result in an inpatient admission are included in the inpatient DRG reimbursement.

Re-admission
Members who are re-admitted to the same hospital orthe same hospital system, within 30 days of the original inpatient discharge day (not counting the day of discharge), for the same or related condition for which they were treated during the original admission may be subject to review. If it is determined that the member is being treated for the same or a related condition as the original admission, the reimbursement for the re-admission may be retracted.

Other Reimbursement

- If a member leaves against medical advice or expires, DRG reimbursement will be paid in full.
- Claims grouping to a DRG description of Principal Diagnosis Invalid as discharge diagnosis or a description of Ungroupable will be denied. Claims must be resubmitted with corrected data.

Member Enrollment and Termination

- Point32Health will pro-rate DRG payments when an inpatient admission occurs prior to a member's effective date, or if a member terminates membership while receiving inpatient services.
- DRG payments will be prorated based upon the member's eligible days as a portion of the complete inpatient admission.
- An adjustment bill is required for claims associated with the revision of a DRG due to changes or errors occurring in diagnoses and procedure coding.
- **Tufts Medicare Preferred and Tufts Health One Care:** If a member is enrolled in their plan at the time of acute hospital admission, reimbursement will be made for the entirety of the member's stay through discharge, even if the member disenrolled prior to discharge.

Global Case Rate

Pre-admission (may be subject to post-payment audits and retraction)

- Diagnostic services that are provided within ten days of an inpatient admission are included in the inpatient reimbursement.
- Non-diagnostic services, related to the principal diagnosis, that are provided within ten days of an inpatient admission are included in the inpatient reimbursement.
- Any ambulatory day care, radiology or laboratory procedures that result in an inpatient admission are included in the inpatient global case rate reimbursement.

Re-admission
Members who are re-admitted to the same hospital orthe same hospital system, within 30 days of the original inpatient discharge day (not counting the day of discharge), for the same or related condition for which they were treated during the original admission may be subject to review. If it is determined that the member is being treated for the same or a related condition as the original admission, the re-admission will be retracted.

Member Enrollment and Termination

- When an inpatient admission occurs prior to a member's effective date, or if a member terminates membership while receiving inpatient services, Point32Health will only reimburse the covered days based on member eligibility.
- Global case rate payments will be prorated based on the member's eligible days as a portion of the complete inpatient admission.
- An adjustment bill is required for claims associated with the revision of a DRG due to changes or errors occurring in diagnoses and procedure coding.
- **Tufts Medicare Preferred and Tufts Health One Care:** If a member is enrolled in their plan at the time of an acute hospital admission, reimbursement will be made for the entirety of the member's stay through discharge, even if the member disenrolled prior to discharge.

Hospital at Home Services (DRG and Per-Diem)

Point32Health reimburses CMS-approved contracted providers for medically necessary hospital at home services. The member must be transferred to hospital at home from an emergency department or inpatient hospital bed. A member cannot be sent to hospital at home with a status of observation. A transfer from inpatient to home or home to inpatient is considered one event/ DRG. It is expected that the member would return to the original hospital, if necessary. Readmission guidelines apply as if the member were in an acute inpatient setting.

Administratively Necessary Day (AND)

Authorized AND are compensated in accordance with the provider's health services agreement with Point32Health and any applicable laws and regulatory requirements.

Transfers of Care

If a member is transferred to another facility, the facility will be compensated in accordance with their health services agreement.

Point32Health Does *Not* Reimburse

- Blood and blood products
- Charges for non-covered services
- Charges for services with no authorization obtained, when required, except in a serious medical emergency
- Charges for personal services (e.g., telephones, televisions, guest trays, etc.)
- Charges incurred after hospital discharge or when care is no longer at the inpatient level (e.g., surgical follow-up visit)
- Custodial care, unless otherwise noted in benefit plan documents
- Delay days (Non-DRG)
- Freestanding facility imaging services for inpatient members (Imaging services are included in the inpatient reimbursement rate and should be billed to the admitting hospital)
- Non-emergent ambulance services provided to inpatient members (non-emergent ambulance services are included in the inpatient reimbursement rate and should be billed to the admitting hospital)
- Private room, except when medically necessary

Provider Billing Guidelines and Documentation

Providers are reimbursed according to the applicable contracted rates and fee schedules.

Pre-Admission Services

- For per diem-contracted hospitals, pre-admission services that occur within one day of the admission should be submitted with the inpatient bill.
- For DRG and global case rate contracted hospitals, pre-admission services that occur within ten days of an admission should be submitted with the inpatient bill.

Interim Bills

Commercial, Tufts Health Direct, and Tufts Medicare Preferred products
Do not submit interim bills associated with inpatient services provided in an acute hospital setting.

Tufts Health Together, Tufts Health One Care, and Tufts Health Plan SCO
Providers may submit interim bills for inpatient services every 60 days using the following bill types:

- First claim — 112 (initial interim bill)
- Subsequent claims — 117 (replacement/corrected claim)

Note: Interim bill types 113 and 114 are not allowed for medical inpatient stays.

Each interim bill for a single inpatient admission should be a cumulative bill of all services provided to the member from the date

of admission. The initial interim bill is submitted for the first 60 days; any subsequent bills are submitted in 60-day intervals, except for the final bill, which is submitted upon discharge and must include all services provided during the entire admission and replaces all previously submitted claims.

Hospital at Home Services (DRG and Per Diem)

Submit revenue code 0161 (Hospital at home, room and board [R&B]/Hospital at home), unless otherwise indicated in the provider agreement. Occurrence span code 82 (Hospital at home care dates) will be used to track the from and through dates of the hospital at-home care delivered during an inpatient stay.

Related ancillary services rendered in the home during the hospital stay should not be billed separately and may be subject to post-payment audits and retraction. This includes, but not limited to:

- Ambulance and/or transportation services
- Durable medical equipment
- Food services
- Home health agency services, including skilled nursing and rehab services.
- Infusion services
- Labs and radiology services
- Medicaid-covered long-term support services (LTSS), including personal care attendant (PCA) services
- Pharmacy services
- Respiratory care, including oxygen delivery

Professional services billed on a CMS-1500 claim form or electronic equivalent should be billed using a place of service as if the member were at the facility.

Behavioral Health Services Provided within Acute Care Hospitals for Emergency Psychiatric Inpatient Admission (EPIA) Patients ("BH Boarding")

Acute care hospitals should bill using the following information for members receiving appropriate behavioral health (BH) care to treat and/or stabilize their condition while awaiting appropriate inpatient psychiatric placement.

Commercial products

Providers should submit one claim for medical services and another claim for BH boarding services, as follows:

- **Medical services:**
  - Submit Bill Type 11X
  - Submit standard R&B revenue code; CPT/HCPCS code not required
  - Use transfer discharge status code 65 (psych transfer) (Note: use this code for either transfer to a BH unit within the same facility or transfer to a separate BH facility)
  - Ancillary services related to the medical portion of the stay should be included on the claim
- **BH boarding services:**
  - Submit Bill Type 11X
  - Submit revenue code 0160 (Other R&B) (units should be submitted in days)
  - Ancillary services related to BH services should be included on the claim for boarding services
  - If the member is ultimately transferred to a BH facility, use discharge status code 65 (psych transfer)

Tufts Health Direct

Submit one claim with Bill type 11X

- All services should be included on one claim; it is not necessary to submit separate claims.
- **Medical services:**
  - Submit standard R&B revenue code; CPT/HCPCS code not required
  - Use transfer discharge status code 65 (psych transfer) (Note: use this code for either transfer to a BH unit within the same facility or transfer to a separate BH facility)
- **BH boarding services:**
  - Submit revenue code 0160 (Other R&B) (units should be submitted in days) and HCPCS code S9485
  - If the member is ultimately transferred to a BH facility, use discharge status code 65 (psych transfer)

Other Info

- The admission date determines the reimbursement terms for the inpatient stay. When an admission bridges contracted effective dates, the contracted rate on the date of admission applies to the entire inpatient stay.
- For non-DRG contracted hospitals when a member is partially active, an itemized bill may be required to determine appropriate reimbursement.
- Identify a claim as a transfer to another facility with the discharge status code of 02 or 05 in Form Locator 17 of paper UB04 or Loop 2300, segment CL1, data element CL103 of electronic 837I.

    - Include condition code 40 on the claim if the member is transferred to another facility before midnight on the same day as the initial admission.
- Submit revenue code 0169 (R&B, Other) to report Administratively Necessary Days (AND)
- Submit a Present on Admission (POA) indicator for each diagnosis code, when applicable.

Related Policies and Resources

Payment Policies

- Ambulance and Transportation Services
- Behavioral Health and Substance Use Disorder
- Emergency Department Services
- Hospice
- Inpatient Rehabilitation and Long-Term Acute Care Facility
- Newborn Care
- Observation Stay
- Obstetrics/Gynecology
- Skilled Nursing Facility (SNF)
- Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions

Clinical Policies

- Acute Hospital Level-Care at Home
- Inpatient Acute and Post-Acute Levels of Care (Medical/Surgical)
- Inpatient Setting for Elective Total Joint Arthroplasty; Hip and Knee

Audit Policies

- Audit Policy
- Diagnosis-Related Group (DRG) Audit Policy
- DRG Validation of Inpatient Hospitals Policy

Additional Resources

- Prior Authorization Resources
- Evolent

Publication History

10/01/2026:	Annual policy review; updated Readmission sections for clarity; administrative updates
01/01/2026:	Added interim billing information effective for admission dates beginning July 1, 2024 for Tufts Health Together, Tufts Health One Care, and Tufts Health Plan SCO claims; clarified existing enrollment and termination reimbursement for Tufts Medicare Preferred members
10/01/2025:	Annual review; administrative updates
05/01/2025:	Updated pre-admission testing window to include services rendered within 10 days of an inpatient admission, effective for DOS beginning July 1, 2025 for DRG and global case rate payment methodologies
04/01/2025:	Updated readmission criteria to include the same hospital system, effective for DOS beginning June 1, 2025 for DRG and global case rate facilities
12/31/2024:	Policy moved to new template, includes all lines of business; added billing instructions for Hospital at Home program

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable;

please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.