Ambulatory Surgical Center Payment Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to freestanding ambulatory surgical centers which render surgical services to members of the CarePartners of Connecticut plans selected above. For information on professional surgical services, refer to the Surgery Professional Payment Policy.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

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

Policy

CarePartners of Connecticut covers medically necessary surgical services including surgical day care (SDC) rendered in a freestanding ambulatory surgical center (ASC), 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 portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of labs not participating in the member's applicable network(s) 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, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Submit claims with supporting documentation (e.g., invoices) using industry-standard red paper claim forms. Claims requiring supporting documentation deny if submitted electronically.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Bilateral and Multiple Surgical Procedures

CarePartners of Connecticut applies multiple surgical procedures reduction when the same provider performs two or more surgical procedures, including procedures performed bilaterally and/or different procedures in multiple compartments in the same joint, on the same member within the same operative session. Refer to the Bilateral and Multiple Surgical Procedures Facility Payment Policy for additional information regarding multiple surgical procedures reduction.

New Technology Intraocular Lenses

Reimbursement for new technology intraocular lenses (NTIOLs) is considered part of the surgical procedure.

Additional Resources

- Bilateral and Multiple Surgical Procedures Payment Policy
- Vision Services Payment Policy

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- May 2020: Reviewed by committee; removed information on member cost share and benefit specific information
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut 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, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut 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 CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.