Referral, Prior Authorization and Notification Policy

Applies to the following CarePartners of Connecticut products:

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

The following payment policy applies to providers who render outpatient and inpatient services to members of the CarePartners of Connecticut plans selected above that require referrals, authorizations and/or notifications.

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, appropriately authorized services in accordance with the member's benefits. To ensure the quality of member care, CarePartners of Connecticut monitors authorization, medical necessity, and appropriateness and efficiency of services rendered. Certain services require prior authorization and/or inpatient notification to confirm that the member's primary care provider (PCP), CarePartners of Connecticut, or an approved vendor on behalf of CarePartners of Connecticut has approved the member's specialty care and/or inpatient services.

Providers should submit prior authorization and/or inpatient notifications in accordance with the requirements and time frames outlined in the CarePartners of Connecticut Provider Manual and the supplemental Referral, Authorization and Notification Guide. Refer to the payment policies in the Resource Center to determine specific prior authorization and/or inpatient notification requirements for services.

Referrals

CareAdvantage Premier, CareAdvantage Prime, and CareAdvantage Preferred

PCPs must issue referrals for CarePartners of Connecticut members to see an out-of-network provider. However, referrals are **not** required for an out-of-network facility if the provider rendering services is in the member's network.

A referral assures the out-of-network specialist that the PCP has authorized the member's care and allows the specialist's claims to adjudicate properly. The member's PCP may authorize a referral to an out-of-network specialist for medically necessary services that are consistent with the member's benefit document. Refer to the Referrals, Authorizations and Notifications chapter of the CarePartners of Connecticut Provider Manual for more information on referral requirements and processes.

CarePartners Access

Referrals are not required for specialist services within or outside of the member's network. However, providers are encouraged to request pre-service coverage determinations to ensure services are covered by the member's benefits.

Note: Providers rendering specialty care services are subject to prior authorization requirements for specific items and/or services. A referral does not take the place of prior authorization.

Prior Authorization/Notification Requirements

Prior authorization is required for certain procedures, drugs, items, and/or supplies that require medical necessity or utilization review either through CarePartners of Connecticut or select approved vendors.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that the appropriate authorization has been obtained. Claims submitted to CarePartners of Connecticut that do not have the appropriate authorization(s) on file will deny.

Pharmacy Prior Authorization Requests

Certain prescription medications may require prior authorization. For Part D drugs under the pharmacy benefit, providers must submit using Request For Medicare Prescription Drug Coverage Determination Form. For Part B drugs under the medical benefit, providers must submit using Request for Medicare Part B Prescription Drug Organization Determination Form. Refer to the pharmacy medical necessity guidelines or the online formulary to determine which prescription drugs have prior authorization requirements.

Refer to the Prior Authorization and Inpatient Notification List for specific procedures, services, and/or items that require prior authorization.

Refer to the Referrals, Authorizations and Notifications Authorizations chapter of the CarePartners of Connecticut Provider Manual for a complete description of authorization requirements.

Inpatient Notification

As a condition of payment, CarePartners of Connecticut requires inpatient notification for any member being admitted for inpatient care, regardless of whether CarePartners of Connecticut is the primary or secondary insurer. Inpatient notification must be submitted via electronic submission on the secure Provider portal or by faxing a completed Inpatient Notification Form to the Precertification Operations Department. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all required information is returned to CarePartners of Connecticut. Elective admissions must be reported no later than five business days prior to admission. Urgent or emergency admissions must be reported within one business day of the admission.

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

Refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List for specific services/items that require inpatient notification.

Refer to the Referrals, Authorizations and Notifications chapter of the CarePartners of Connecticut Provider Manual for a complete description of inpatient notification requirements and submission channels.

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.

CarePartners of Connecticut will deny claims if prior authorization, referral and/or inpatient notification have not been obtained or submitted for a specialty appointment or inpatient service when required.

Additional Resources

- Inpatient/Intermediate BH/SUD Facility Payment Policy
- Inpatient Facility Payment Policy
- CarePartners of Connecticut Provider Manual

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- August 2020: Policy reviewed; added boiler plate language
- February 2020: Added reference/link to new Referral, Prior Authorization and Notification Guide
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020; updated links to Request for Medicare Prescription Drug Coverage Determination; and Request for Medicare Part B Prescription Drug Coverage Determination
- January 2019: Document 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.