Inpatient Facility Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render inpatient services to members of the CarePartners of Connecticut plans selected above.

This payment policy does not apply to emergency department (ED) services, obstetrical admissions, skilled nursing facilities (SNF), acute rehabilitation admissions or inpatient behavioral health facilities.

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

Policy

CarePartners of Connecticut covers medically necessary inpatient services, in accordance with the member's benefits.

Definition

Diagnosis Related Groups (DRG) is defined by CMS as a patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. CarePartners of Connecticut use the Medicare MS-DRG as established by CMS to assign an MS-DRG to an inpatient claim. Refer to CMS for more information.

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

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

As a condition of payment, CarePartners of Connecticut requires inpatient notification for any member who is being admitted for inpatient care, regardless of whether primary or secondary coverage is with CarePartners of Connecticut. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the admitting provider. All inpatient admissions require inpatient notification prior to services being rendered, except for urgent or emergency care. It is the submitting provider's responsibility to verify and confirm individual inpatient notifications.

Note: An inpatient notification does not take the place of prior authorization requirements for a service. For a list of procedures, services, and items requiring prior authorization or notification refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List.

Admitting practitioners and facilities are responsible for notifying CarePartners of Connecticut, following the procedures outlined in the Referrals, Authorization and Notifications chapter of the Provider Manual.

Inpatient notifications submitted via the web are confirmed on entry. Notifications submitted via fax are confirmed via the secure Provider portal.

Refer to the Compensation/Reimbursement Information below for additional information on late notifications.

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.

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.

Any late charges billed must be received by CarePartners of Connecticut within 60 days of the date of discharge.

Same-day transfers: include condition code 40 on the claim if the member is transferred to another participating facility before midnight on the same day as the initial admission, in accordance with CMS requirements.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates (e.g., diagnosis-related group [DRG], per diem, per case and/or other arrangements) and applicable fee schedules, regardless of the address where the service is rendered. Refer to the provider's current contract for details regarding inpatient compensation provisions. The inpatient compensation rate is inclusive of all incidental services supplied by the facility, including, but not limited to:

- Ancillary services
- Anesthesia care
- Appliances and equipment
- Diagnostic services
- Medication and supplies
- Nursing care
- Operating room services
- Preadmission testing
- Radiology/Imaging
- Recovery room services
- Therapeutic items (drugs and biologicals)

Note: If a member terminates with CarePartners of Connecticut while receiving inpatient services, CarePartners of Connecticut is responsible for the entire admission until the patient is discharged.

Preadmission Testing

Tufts Health Plan does not separately compensate routine preadmission testing performed prior to an admission. The following procedure codes will be included as part of in the inpatient compensation:

Code	Description
71020	Radiologic examination, chest, two views, frontal and lateral
80051	Electrolyte panel
80053	Comprehensive metabolic panel
82565	Creatinine; blood
84520	Urea nitrogen; quantitative
86900, 86901	Blood typing; ABO, Rh (D)
85004	Blood count; automated differential WBC count
85014	Hematocrit (Hct)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Tracing only, without interpretation and report
93010	Interpretation and report only

Acute Admissions that do not Meet an Inpatient Level of Payment

CarePartners of Connecticut care managers will consult with facility care managers on level of payment (LOP) decisions when reviewing admissions concurrently. CarePartners of Connecticut reserves the right to review admissions retrospectively. Claims for acute admissions will be denied if it is determined that the services provided did not meet criteria for inpatient LOP. In this instance, the hospital's care management department will be notified, and the hospital may bill for outpatient services provided.

Late Notification

- Late notification after a member has been discharged from the hospital will result in denial of payment for the entire admission.
- Late notification of an admission while the member is still receiving medically necessary acute level care will result in a denial of the entire admission

Readmission Policy

CarePartners of Connecticut aligns their readmission policy for members with Medicare. Payment for a readmission to the same acute facility within 30 days can be denied if, through medical record review, the readmission was deemed medically unnecessary or due to a premature discharge of the prior admission. Refer to the Readmission Policy for additional information.

Inpatient Behavioral Health Services

CarePartners of Connecticut compensates medically necessary inpatient and intermediate behavioral health and substance use disorder services. Refer to the Inpatient and Intermediate Behavioral Health/Substance Use Facility Payment Policy for additional information.

Additional Resources

- DRG Validation of Inpatient Hospitals (Medical Claims Review) Policy
- Emergency Department Services Payment Policy
- Hospice Services Payment Policy
- Inpatient and Intermediate BH/SUD Facility Payment Policy
- Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Facility Payment Policy
- Observation Facility Payment Policy
- Obstetrics/Gynecology Professional Payment Policy
- Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy
- Skilled Nursing Facility Payment Policy

Document History

- October 2024: Annual policy review; administrative edit
- September 2023: Annual policy review; administrative updates
- February 2023: Annual code updates; moved preadmission testing code table previously located in the Outpatient Facility Payment Policy
- October 2022: Annual policy review; administrative updates
- January 2021: Reviewed by committee; added definition of DRG, removed inpatient notification submission channels and referred to the CarePartners of Connecticut Provider Manual; removed “never events” language and linked to Serious Reportable Events Payment Policy in Additional Resources
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- November 2020: Added condition code 40 billing requirement for members being transferred to another facility, in accordance with CMS requirements
- 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.