Outpatient Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

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

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

Policy

CarePartners of Connecticut covers medically necessary services performed in an outpatient setting, 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.

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.

Immunoglobulin

Pre-administrative-related services for the IV infusion of immunoglobulin need to be reported with the appropriate immunoglobulin injection code for the same encounter. Refer to the CMS Transmittals/Memos/Publications for additional information.

Modifier 59 Subsets

CMS has established four HCPCS modifiers to define subsets of modifier 59, used to define a "distinct procedural service." These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. For more information, refer to CMS.

CarePartners of Connecticut accepts either a modifier 59 or a more selective modifier as correct coding, and the compensation currently applied to modifier 59 will be applied to modifiers XE, XS, XP and XU. For additional information refer to CMS.

Global Surgery

Global surgery includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. Global surgery applies only to surgical procedures that have post-operative global periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. Global surgery includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-day and 90-day global surgeries related to the primary procedure. Refer to the AMA CPT Manual for additional information.

Professional, Technical and Global

- Outpatient facilities should only bill for the technical component of a procedure and not the global or professional component.
- Only services that have a professional and technical component may be billed with modifiers 26 and TC, respectively.

Once Per Lifetime

National and regional CMS policies indicate certain procedures or services that can only be done once in a patient's lifetime. In general, these procedures involve the removal of some organ in the body, such as the thyroid gland, the tonsils or the stomach, or a service such as initial use of home INR monitoring. If one of these codes is billed more than once for a patient, the subsequent service will be denied.

Procedure Codes

Age/Gender

Edits have been developed that support correct coding based on the definition or nature of a procedure code, or combination of procedure codes and are limited to the treatment of a specific age, age group or gender. In order for a claim to be processed correctly, the procedure codes and the age and/or gender of the patient must agree.

Bundling

Edits may bundle procedures based on the appropriateness of the code selection.

Deleted Codes

Deleted procedure codes are defined as procedure codes that have been valid at some point in the past, but have since been deleted by a governing entity. All procedure codes are assigned an effective date and a termination date by their governing entities. If the procedure code is invalid for the date of service then the procedure will either be mapped to the updated procedure code, if there is one, or denied if one does not exist.

Separate Procedures

The description for many CPT codes includes a parenthetical statement that the procedure represents a “separate procedure” (e.g., the procedure should not be reported when it is performed in conjunction with, and related to, a major service). However, if the separate procedure is carried out independently from, or is unrelated to, the major procedure, then the separate procedure may be reported with the appropriate modifier.

Add-On Codes

Add-on codes are not compensated if the primary procedure code is not submitted on the same date of service. Add-on codes pertain to services performed in conjunction with a primary procedure and should never be reported as stand-alone services. If the primary procedure is not allowed, then the add-on code will also not be allowed.

Compensation/Reimbursement Information

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

CarePartners of Connecticut has adopted CMS’s differential compensation for office and facility-based services, replacing CarePartners of Connecticut’s standard facility fee reduction. Refer to the provider’s current contract for details regarding outpatient compensation provisions.

Abrasion Arthroplasty

CarePartners of Connecticut does not separately compensate for procedure code 29879 (arthroscopy of knee with abrasion arthroplasty) when billed with procedure code 29880 or 29881 (arthroscopy of knee with meniscectomy).

Ambulatory EEG Monitoring

CarePartners of Connecticut does not compensate for ambulatory EEG when a resting EEG has not been billed on the same day or within the previous 12 months.

Anatomical Modifiers

CarePartners of Connecticut does not routinely compensate for procedures that are billed without a required anatomical modifier.

Antepartum Care

CarePartners of Connecticut does not routinely compensate for the following:

- Global delivery codes if the provider has billed antepartum care in the last 8 months
- Antepartum services billed with a date of service up to one week following a delivery

Billing for Established Patients in a Facility

CarePartners of Connecticut does not compensate for a new patient visit when any service has previously been billed within the last three years.

Bundled Services

CarePartners of Connecticut does not compensate for bundled services performed in an outpatient hospital setting, as they are included in the facility payment.

Cervical Cancer Screening

CarePartners of Connecticut does not routinely compensate for cervical or vaginal screening services for a female patient less than 21 years of age when the only diagnosis is a screening diagnosis code.

CarePartners of Connecticut does not routinely compensate cervical or vaginal screening services for a female member 21 years of age or older when the only diagnosis is a screening diagnosis code and any of these screening services has been reported in the previous 13 months.

CarePartners of Connecticut does not routinely compensate cervical or vaginal screening services for a female member 21 years of age or older on the date of service if the only diagnosis is a screening diagnosis code and any of these screening services has been reported in the previous three years.

Colonoscopy and Cologuard

CarePartners of Connecticut does not routinely compensate for the following:

- 45330 or 45378 for a member who is less than 50 years of age on the date of service and the only diagnosis on the claim is constipation
- 45300, 45330, 45378, 46600 (endoscopic colorectal cancer screening) for a member who is less than 45 years of age on the date of service and the only diagnosis on the claim is screening for malignant neoplasm of colon
- 81528 (oncology colorectal screening) if billed and the member is less than 50 years of age on the date of service

CMS Coverage Rules

CarePartners of Connecticut does not routinely compensate for the following:

- Services billed prior to the effective date of FDA approval
- Wound care management services performed by a physical, occupational or speech therapist if billed by the outpatient facility
- Electrical stimulation for wound healing or ambulation training for a spinal injury if performed at home or in an assisted living or custodial care facility. Refer to CMS for additional information.
- Imaging agents billed without the appropriate imaging procedures. Refer to the Regional CMS Policy (Local Coverage Determination) for additional information.

Drug and Biological Policies

For information on drug and biological policies, refer to the Drugs and Biologicals Payment Policy.

Electroencephalogram (EEG)

CarePartners of Connecticut does not routinely compensate for the following:

- 95950, 95951, 95953, 95956 (24-Hour EEG monitoring) or 95957 (EEG for epileptic spike analysis) when billed in any combination greater than three days.

- 95957 (EEG for epileptic spike analysis) when billed on same date of service as 95951, 95953, or 95956 (Monitoring for localization of cerebral seizure focus).
- 95950, 95951, 95953 or 95956 (24-Hour EEG Monitoring) if billed without a requisite diagnosis.

Endometrial Biopsy for Infertility

CarePartners of Connecticut does not routinely compensate 58100 or 58110 (endometrial biopsy) if the only diagnosis on the claim is infertility or infertility encounter.

Frequency Policies and Descriptions

CarePartners of Connecticut sets frequency limits on certain outpatient procedures based on medical necessity. The following are policies that fall within frequency limitations:

Policy	Description
Bone Density	Bone density studies are covered once every 24 months.
Care Plan Oversight	CarePartners of Connecticut does not compensate for care plan oversight when reported separately under the end stage renal disease (ESRD) benefit when ESRD services have been paid for the month. Refer to the CMS Transmittals/Memos/Publications.
Colorectal Screening	In accordance with CMS, CarePartners of Connecticut does not compensate for: • Fecal occult blood tests more than once every 12 months for patients over the age of 50. • A sigmoidoscopy or barium enema more than once within 48 months. • A colonoscopy or a barium enema on individuals at high risk more than once within 23 months. • A colonoscopy more than once within a 10-year period.
Home Health	CarePartners of Connecticut compensates for physician recertification for Medicare-covered home health services under a home health plan once every 60 days. Refer to the CMS Transmittals/Memos/Publications.
Lipid Panel Testing	CarePartners of Connecticut does not compensate for a lipid panel test more than two times within a 365-day period. Refer to the CMS Internet Only Manual.
Mammograms	CarePartners of Connecticut will compensate for screening mammography once a year for all patients over age 39. If a breast condition is discovered at that time or during the year, then additional diagnostic mammography would be covered.
Nebulizers	CarePartners of Connecticut will not compensate for a 90-day pharmacy dispensing fee when billed more often than every 83 days. CarePartners of Connecticut will not compensate for a 30-day pharmacy dispensing fee when billed more often than every 23 days.

Global Surgery

CarePartners of Connecticut does not routinely compensate for E&M services performed by the facility, as they are included in the global fee for the procedure. Refer to the CMS Outpatient Prospective Payment System for additional information.

Home Prothrombin Time/INR Monitoring for Anticoagulation Management

CarePartners of Connecticut does not routinely compensate additional units of G0249 (home prothrombin time [INR]) when greater than three units have been billed within a three-month period.

Impacted Cerumen Removal

CarePartners of Connecticut will not routinely compensate removal of impacted cerumen (69209, 69210 or G0268) if billed without a diagnosis of impacted cerumen.

Intraoperative Neurophysiology Monitoring (IOM)

CarePartners of Connecticut does not routinely compensate continuous intraoperative neurophysiology monitoring (95940, 95941 or G0453) unless the place of service billed is 19 (outpatient hospital-off campus), 21 (inpatient hospital), 22 (outpatient hospital-on campus) or 24 (ambulatory surgical center).

Intravenous

CarePartners of Connecticut does not routinely compensate for IV infusion or injections when billed with neuromuscular studies, as they are considered to be included in the performance of neuromuscular studies.

CarePartners of Connecticut does not compensate for puncture aspiration of a hydrocele when billed with hernia, hydrocele, spermatic cord, and varicocele repairs as the puncture aspiration is considered part of hernia, hydrocele, spermatic cord and varicocele repairs.

CarePartners of Connecticut does not routinely compensate for the introduction of an intravenous needle or catheter when billed with a venipuncture, as the introduction of an intravenous needle or catheter is included in a venipuncture.

Lung Cancer Screening with Low Dose Computed Tomography

CarePartners of Connecticut does not routinely compensate G0296 (counseling visit to discuss need for lung cancer screening), or G0297 (low-dose CT scan (LDCT) for lung cancer screening) when billed and the diagnosis is not personal history of tobacco use/personal history or nicotine dependence, cigarettes.

Modifiers Inappropriate for Professional Claims

CarePartners of Connecticut does not routinely compensate any procedure billed with modifier 27, 73, 74 or CA if billed by or on behalf of a professional provider.

Nerve Conduction Studies and Electromyography for Radiculopathy

CarePartners of Connecticut does not routinely compensate for the following:

- Needle electromyography (95860-95864) when billed without a nerve conduction study (95905) and the only diagnosis on the claim is radiculopathy.
- Nerve conduction study (95907-95913) when billed without a needle electromyography (95885, 95886) and the only diagnosis on the claim is radiculopathy.

Neurophysiology Evoked Potential (NEP) Studies

CarePartners of Connecticut does not routinely compensate auditory evoked potentials and responses (92585, 92586) or somatosensory evoked potential studies (95925-95929, 95938 or 95939) if billed without a requisite diagnosis.

Obstetrical Ultrasounds

CarePartners of Connecticut does not routinely compensate 76801 or 76802 (pregnant uterus ultrasound services) if 76801 or 76802 has been billed in the past three months.

CarePartners of Connecticut compensates for ultrasound codes that involve multiple gestations when accompanied by one of the diagnoses for multiple gestations. Certain diagnoses, by definition or nature of the diagnoses, are limited to the treatment of one gender and/or age. CarePartners of Connecticut will deny a claim when the gender and/or age of the member do not match the definition of the diagnosis.

Orthopedic Injections

CarePartners of Connecticut does not routinely compensate the following orthopedic injections if billed without a required diagnosis, per CMS policy:

- 20526 (injection, therapeutic, carpal tunnel)
- 20527 (injection, enzyme, palmar fascial cord)
- 20550 (injection[s]; single tendon sheath, or ligament, aponeurosis)
- 20551 (injection[s]; single tendon origin/insertion)
- 20612 (aspiration and/or injection of ganglion cyst[s] any location)

Preadmission Testing

CarePartners of Connecticut 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

Code	Description
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

Pressure Ulcer Stage Codes

CarePartners of Connecticut does not routinely compensate for pressure ulcer stages if billed without a pressure ulcer.

Procedure-Age Consistency

CarePartners of Connecticut does not routinely compensate for procedures submitted that are inconsistent with the member's age, based on the nature or indication for the procedure.

Subcutaneous or Intramuscular Injection

CarePartners of Connecticut does not routinely compensate for the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids.

Trigger Point Injections

CarePartners of Connecticut does not routinely compensate any combination of trigger point injections (20552, 20553) if billed more than three times in a 90-day period day period at the same anatomic site.

Urinary Catheter for Incontinence

CarePartners of Connecticut does not routinely compensate catheter insertion (51702, 51703) if the only diagnosis on the claim is urinary incontinence.

Vascular Diagnostic Studies

CarePartners of Connecticut does not routinely compensate for duplex scan of extracranial arteries, study if billed in an office setting unless the member is over 18 years of age and a carotid artery stenosis symptom diagnosis is also present on the claim.

Venipuncture

CarePartners of Connecticut does not routinely compensate for 36410 (venipuncture, age 3 years or older) if billed without a covered diagnosis.

Additional Resources

- Drugs and Biologicals Payment Policy
- Ambulatory Surgical Center Payment Policy
- Inpatient Facility Payment Policy
- Laboratory and Pathology Payment Policy
- Observation Services Facility Payment Policy
- CarePartners of Connecticut Provider Manual
- Bilateral and Multiple Surgical Procedures Professional and Facilities Payment Policy
- Modifier Payment Policy

Document History

- November 2023: Annual policy review; administrative updates
- February 2023: Annual code updates
- September 2022: Annual policy review; administrative changes
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- August 2019: Removed reference to Claims Submission Policy
- May 2019: Added claim edits for electroencephalograms, impacted cerumen removal, intraoperative neurophysiology monitoring, and neurophysiology evoked potential studies, effective for dates of service on or after July 1, 2019
- 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.