Surgery Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render professional surgical 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 surgical services, 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 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.

All inpatient admissions require inpatient notification prior to services being rendered. Professional claims will be denied if the notification to the hospital has not been obtained by the facility. It is the responsibility of the admitting practitioner and/or facility to obtain the appropriate authorization(s), as necessary. For more information, refer to the Referrals, Prior Authorizations and Notifications chapter of the CarePartners of Connecticut Provider Manual. For a list of procedures, services, and items requiring prior authorization or notification, refer to the Prior Authorization and Inpatient Notification List.

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.

Non-Physician Practitioners

Major surgical procedures billed by a non-physician practitioner (NPP) must have modifier 80, 81, 82 or AS appended to the claim line.

Compensation/Reimbursement Information

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

Assistant Surgeons, Co-Surgeons and Team Surgery

In alignment with CMS and the American College of Surgeons, CarePartners of Connecticut considers compensation for services requiring multiple practitioners when the procedure warrants. The appropriate modifier must be appended to compensate the claim

according to the services rendered. Refer to Chapter 12 of the Medicare Benefit Processing Manual for more information on claims requiring multiple practitioners.

Bariatric Surgery for Treatment of Morbid Obesity

CarePartners of Connecticut does not routinely compensate 43644, 43645, 43770, 43775, 43845-43847 (gastric restrictive procedure, with gastric bypass) when billed without a primary diagnosis of morbid obesity.

Bilateral and Multiple Surgical Procedures

CarePartners of Connecticut compensates multiple surgical procedure code(s) by paying the surgical procedure code with the CarePartners of Connecticut highest allowable compensation at 100% of the allowed amount. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50% of the allowed amount.

When a bilateral procedure code and surgical procedure code(s) are submitted together and both the bilateral and surgical procedure code(s) are eligible for multiple procedure reduction, the bilateral adjustment is applied first. The surgical procedure code(s) with the highest allowable compensation will be compensated at 100 percent after the bilateral adjustment. Other surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount, after bilateral adjustment, as appropriate.

Implantable Neurostimulator Electrode

CarePartners of Connecticut will not routinely compensate L8680 (implantable neurostimulator electrode, each) when billed with 63650 (percutaneous implantation of neurostimulator electrode array, epidural).

Photosensitive Drugs and Ocular Photodynamic Therapy

CarePartners of Connecticut does not routinely compensate 67221-67225 (destruction of localized lesion of choroids) if billed and J3396 (verteporfin) has not been billed or paid for the same date of service.

Place of Service

Procedures or services that are not appropriate to be performed in an office setting will deny. For a list of procedure codes that are not appropriate to be billed in office setting, refer to the CMS National Physician Relative Value File.

Robotic Surgical Systems

CarePartners of Connecticut does not routinely provide separate compensation for the use of a robotic surgical system (S2900).

Surgical Global Day Period

Some services are included in the global surgical package and are not considered separately payable when billed by the same provider or another provider within the same provider group (same tax ID number).

Global surgery includes all necessary services normally furnished by the surgeon or other qualified health care professionals before, during and after a surgical procedure. 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.

Split Surgical Services

Providers rendering a portion of the surgical service (pre-, intra- or post-operative) should indicate the portion of services rendered by appending the appropriate modifier. Providers will be compensated accordingly for the specific portion of services rendered.

If a surgical claim is submitted without a modifier appended, it is assumed that the same provider performed the pre-, intra- and post-operative services. Claims that do not have an appended modifier will be processed and compensated at the surgical rate.

Additional Resources

- Emergency Department Services Payment Policy
- Evaluation and Management Professional Payment Policy
- Inpatient Facility Payment Policy
- Modifiers Payment Policy
- CarePartners of Connecticut Provider Manual
- Medicare Claims Processing Manual Chapter 12, Section 40

Document History

- September 2024: Annual policy review; added Modifiers and E&M Payment Policy to Additional Resources; administrative updates
- November 2023: Annual policy review; added language to bilateral and multiple surgical procedures
- May 2021: Added claim edits for Minor Surgery: 10-Day Procedures, effective for dates of service on or after July 1, 2021
- December 2020: Policy reviewed by committee; added existing compensation information for robotic surgical assistance; consolidated global surgery compensation information; added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- January 2020: Eliminated referral requirements for in-network providers effective January 1, 2020
- August 2019: Removed reference to Claims Submission Policy (retired)
- May 2019: Added edits for nonphysician practitioners and photosensitive drugs and ocular photodynamic therapy, 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.