# Cardiac Services Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render cardiology services to members of the CarePartners of Connecticut plans selected above. These services can be performed in various settings, such as an office or freestanding facility, and for inpatient admissions and outpatient testing performed in a contracted facility.

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

## Policy

CarePartners of Connecticut covers medically necessary cardiology 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 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.

## Compensation/Reimbursement Information

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

### CarePartners of Connecticut Reimburses

- Cardiac catheterization: Supervision and interpretation is reimbursed to one physician only (either the cardiologist or radiologist)
- Cardiac monitoring
    - Cardiac event monitors
    - Holter monitors
    - Interpretation of an ECG/EKG associated with Holter or cardiac event monitor
    - Trans-telephonic transmission of post-symptomatic electrocardiograms
- Cardiac Rehabilitation: For members with established coronary artery disease or unusual potentially serious risk factors, when medically necessary and ordered by PCP or contracted specialist

- Cardiac stress tests:
    - Components, when the service is limited to supervision only, tracing only, or interpretation and reporting only
    - Drug stressors used in conjunction with a stress test when billed with the appropriate HCPCS code
    - Global reimbursement when the services include treadmill or bicycle exercise, continuous EKG monitoring and/or pharmacological stress with supervision, and interpretation and reporting
- Cardiac surgery
- Electrocardiograms (ECG/EKGs); multiple per day
- External counterpulsation (ECP) services
- Inpatient cardiology services according to facility contracted rates and methodologies
- Surgical day care services according to facility contracted rates and methodologies
- Transcatheter repair of congenital heart defects
- Transfer of a member from one facility to another for cardiac catheterization or other procedure

### CarePartners of Connecticut Does *Not* Reimburse

- Interpretation and report of electrocardiogram when billed with an evaluation and management service
- Electrocardiograms (ECGs) when billed in an office setting with a screening or general routine exam for members age 18-65
- Rhythm electrocardiogram services when billed with routine electrocardiogram services (also applies to interpretation and report only services)
- Cardiac catheterization when billed with a percutaneous coronary procedure when another cardiac catheterization has been billed in the previous week by any provider
- Automatic implantable cardiac defibrillator (AICD) monitoring services when billed more than once within three months when the diagnosis is Presence of automatic (implantable) cardiac defibrillator
- External MCT (CPT 93228-93229) or external patient activated ECG event recording (CPT 93268-93272) when billed more frequently than once in a six-month period
- A complete transthoracic echocardiography if the same complete echocardiography has been billed within 90 days with the same diagnosis
- Duplex scans of extracranial arteries if billed in an office setting for members age 18 and older on the date of service (DOS), unless a diagnosis of carotid artery stenosis symptom is also present
- Cardiac stress tests (CPT 93015-93018) or stress echocardiography testing (CPT 93350) for members age 15 or older on the DOS and the only diagnosis is for a general routine exam or screening for cardiovascular disorders
- Stress tests billed more frequently than once within a six-month period

### Coding

This code table may not be all inclusive

| Code | Description |
|---|---|
| 0480-0489 | Use to bill for outpatient cardiology services |
| 0943 | Other therapeutic services; Cardiac Rehabilitation. CPT/ HCPCS code required; itemized services by date |

### Other Information

- When billing multiple EKGs on the same day, bill on one line using a total count
- When submitting EKG recordings/rhythm strips over a 30-day period, use the last date of tracing; claims submitted with a date range may deny for itemization

## Additional Resources

- Evaluation and Management Professional Payment Policy
- Imaging Services Payment Policy
- Nurse Practitioner and Physician Assistant Payment Policy
- Outpatient Payment Policy
- Outpatient Facility Payment Policy
- Surgery Professional Payment Policy
- Transplant Facility Payment Policy

## Document History

- June 2024: Policy document created to support existing billing and reimbursement guidelines

## 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.