Gastroenterology Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render gastroenterology 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 gastroenterology services, in accordance with the member's benefits. Anesthesia assistance for gastrointestinal endoscopic procedures may also be covered when medical necessity criteria is met.

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.

Note: Gastrointestinal procedures that are not considered preventive in nature may be subject to outpatient hospital or ambulatory surgical center cost-share amounts.

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 gastroenterology 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 noncontracting labs 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.

Colorectal Screenings

In accordance with CMS, CarePartners of Connecticut does not compensate for the following:

- Fecal occult blood tests (82270, 82274) more than once every 12 months for members over the age of 50
- Sigmoidoscopy or barium enema more than once within 48 months
- Colonoscopy or a barium enema on individuals at high risk more than once within 23 months
- Diagnostic, non- high-risk colonoscopy more than once within a 3-year period unless a colorectal cancer screening (sigmoidoscopy) has been billed in the previous 3 years

- Colorectal cancer screenings (stool-based DNA and fecal occult hemoglobin [e.g., KRAS, NDRG4 AND BMP3]) are limited to once visit within three years
- 45300, 45330, 45378, 46600 (endoscopic colorectal cancer screenings) for members less than 45 years of age on the date of service if the only diagnosis on the claim is screening for malignant neoplasm of colon.
- 45330 or 45378 (endoscopic colorectal cancer screening) for members less than 45 years of age on the date of service if the only diagnosis on the claim is constipation
- 81528 (oncology colorectal screening) for members less than 45 years of age on the date of service.
- 45381 (colonoscopy, flexible; with injection[s]) if billed with 45383-45385, 45388 or G6024 (colonoscopy)

Multiple Surgical Procedures

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

Multiple Endoscopy Procedures

Compensation for procedures subject to multiple endoscopy guidelines is based on a percentage methodology, whereby the endoscopy with the highest allowed amount is determined and secondary endoscopies are reduced by the percentage that is representative of the value of the base endoscopy.

Additional Resources

- Anesthesia Professional Payment Policy
- Surgery Professional Payment Policy

Document History

- November 2024: Annual policy review; no changes
- November 2023: Annual policy review; added compensation for multiple endoscopy procedures
- November 2022: Annual policy review
- April 2021: Updated coverage limits for diagnostic, nonhigh risk colonoscopy
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- September 2020: Policy reviewed by the committee; clarified anesthesia for gastrointestinal services may be covered when medically necessary; clarified non-preventive gastrointestinal procedures may be subject to member cost-share
- 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.