Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Facility Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to rehabilitation, chronic care and acute care hospitals who render inpatient rehabilitation and/or LTAC 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 inpatient rehabilitation and LTAC 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.

Facilities must fax a completed inpatient notification form to the Precertification Operations Department at 857-304-6463. Facility admitting departments are responsible for notifying CarePartners of Connecticut within one business day of the member's admission.

Note: Obtaining an inpatient notification number is a condition of payment but does not guarantee authorization or coverage.

Prior to admission, the facility should make every effort to coordinate services in advance with the Utilization Management Clinician (UMC). The CM will consult with the facility to determine the member's appropriate level of care (LOC) with the facility based on clinical information presented prior to admission.

Lack of Information

CarePartners of Connecticut must receive clinical information as soon as possible, but no later than 5 p.m. the next business day following the request. CarePartners of Connecticut will deny payment of claims if the provider fails to provide required clinical information within the specified time frame. In rare circumstances, providers may be asked to provide the information in a shorter time frame.

For a complete description of prior authorization requirements, refer to the Referrals, Prior Authorizations, and Notifications chapter of the CarePartners of Connecticut Provider Manual.

Services Excluded from the Per Diem

Services excluded from the per diem must be obtained from a CarePartners of Connecticut contracting provider. Any nonemergency service that is not provided by a CarePartners of Connecticut provider will be the responsibility of the ordering facility.

Note: Disagreements with a member's LOC should be discussed directly with the UMC. Changes in LOC status must be updated in CarePartners of Connecticut's systems accordingly.

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.

- Submit a separate claim for each inpatient notification number or distinct LOP
- Special billing circumstances such as "COB-related" or "billing for denial purposes only" must be indicated on the UB-04 form in box 84/Remarks to assist in accurate claims adjudication

Revenue Code and Description

Level of Care	Service Description	Revenue Code
Level R1	Rehabilitation	0128
Level R2	Acute complex rehabilitation	0129
Level C1	Long term acute care	0120

Note: The revenue code submitted on the claim must correspond to the authorized LOC. Refer to the Inpatient Rehabilitation and LTAC Level of Care Guidelines for specific services included in each level of care listed above.

Compensation/Reimbursement Information

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

Compensation for inpatient treatment and related services corresponds to the CarePartners of Connecticut contracted rate for per diem, per case and/or other arrangements, as applicable. Refer to your current contract for details regarding inpatient compensation provisions.

Additional Resources

Prior Authorization, Notification, and No Prior Authorization Medical Necessity Guidelines

Document History

- July 2025: Annual policy review; administrative edits
- July 2024: Annual policy review; administrative edits
- September 2023: Annual policy review; administrative updates
- July 2022: Annual policy review; administrative updates
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- January 2019: Created document

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.

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.