CarePartners of Connecticut
MEDICARE ADVANTAGE

Observation Services Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to facilities who render observation 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 (up to 48 hours) medically necessary observation services when providers adhere to all the following:

- Render observation care in an acute inpatient hospital
- Use industry-standard criteria
- Obtain appropriate notification and authorization requirements as per the member's benefits

Definition

As defined by CMS, observation care is a well-defined set of specific, clinically appropriate services, which allows reasonable and necessary time to evaluate, stabilize and treat a member before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation is considered appropriate for, but not limited to:

Abdominal pain	Croup	Gastroenteritis	Sepsis
Asthma	Concussion	Migraine headache	Syncope
Back pain	Dehydration	Pneumonia	Upper limb closed fracture or dislocation
Bronchitis	Drug overdose	Renal colic/calculus	
Chest pain	False labor	Seizure	

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.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Prior authorization is not required for observation services. However, notification is required for services that require inpatient admission beyond observation. The admitting provider or facility should submit inpatient notification at the time it is determined that an inpatient level of care is needed.

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.

The following table lists CarePartners of Connecticut's claim submission instructions for observation services that result in an inpatient admission:

Observation services resulting in an inpatient admission	How to submit
Observation and inpatient admission (same day)	• Submit observation and inpatient services on the same claim
Observation and inpatient admission (next day) Option 1 – Same claim	• Submit the observation charge (revenue code 0762) on the inpatient claim • Submit inpatient admit date as admission date (not observation date) in order to correspond with inpatient notification
Observation and inpatient admission (next day) Option 2 – Two claims	• Submit one claim for observation and one claim for inpatient admission • Do not submit revenue code 0762 on the inpatient claim

- Submit observation services that are a result of ED or SDC/minor operating room (OR) services on the same claim
- Submit revenue code 0762 with HCPCS G0378 and G0379, as appropriate on the UB-04 form or 837I
- Submit units to indicate hours of observation on the same claim line when billing G0378
- Submit G0379 with a count of 1 when applicable.

Compensation/Reimbursement Information

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

Observation services are generally expected to last 48 hours; however, in certain instances, CarePartners of Connecticut may consider outpatient observation services spanning more than 48 hours.

Services Rendered	Comments
Observation	Observation only
Surgical day center (SDC)/outpatient procedure and observation	Observation services are included in compensation for the SDC/outpatient procedure and will not be compensated separately
Emergency department (ED) and observation	ED services are included in the payment for observation services[1]
Observation and inpatient admission (same day)	Observation services are included in the compensation for the inpatient admission
Observation and inpatient admission (prior days) for a facility with a non-DRG arrangement	Both observation and inpatient services will be covered when observation services are billed with a date prior to the inpatient admission
Observation and inpatient admission (prior days) for a DRG event	Observation services are included in the compensation for the inpatient admission

Additional Resources

- Emergency Department Services Payment Policy
- Inpatient Facility Payment Policy
- Obstetrics/Gynecology Professional Payment Policy
- Outpatient Payment Policy
- Medicare Benefit Policy Manual, Chapter 6, Section 20.6

[1] ED and observation services are packaged under APC pricing methodology for Senior Products claims. APC pricing methodology is only for facilities that are priced under the OPPS system.

Document History

- July 2023: Annual policy review; added footnote to clarify billing under APC pricing methodology for ED and observation services; added payment policies to Additional Resources; administrative updates
- November 2023: Annual policy review; administrative updates
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- July 2020: Clarified existing compensation policy when ED and observation services are billed on the same day
- 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.