Transplant Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to inpatient transplant facilities who render 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 organ and stem cells transplants 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.

When the transplant recipient is a member, the following services related to the procurement of the organ or stem cells from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- Evaluation and preparation of the donor
- Surgical intervention and recovery services when those services relate directly to donating the organ or stem cells to the member.

Per Medicare requirements, all heart, heart-lung, liver, intestinal, kidney and pancreas transplants must be performed at a Medicare-approved facility. To determine if a facility is Medicare-approved to perform a particular service, refer to the following CMS information:

- Heart, heart-lung, lung, liver, and intestinal transplants
- Kidney and pancreas transplants

Not all in-network providers who perform these services are Medicare-approved. CarePartners of Connecticut does not routinely compensate for services rendered at a non-Medicare-approved facility and contracted providers cannot hold the member liable for these services. Refer to the Medicare-Approved Facilities List for additional information.

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.

All inpatient admissions require inpatient notification prior to services being rendered, except for urgent or emergency care. Admitting practitioners and facilities are responsible for notifying CarePartners of Connecticut, following the procedures outlined in the Notifications chapter of the CarePartners of Connecticut Provider Manual and in accordance with the following time frames:

- Elective admissions must be reported no later than five business days prior to admission.
- Urgent or emergency admissions must be reported by 5 p.m. the next business day following admission.

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 revenue code 0811 (organ acquisition, live donor) or 0812 (organ acquisition, cadaver donor) for all solid organ transplants.

Compensation/Reimbursement Information

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

CarePartners of Connecticut currently uses the Medicare DRG as established by CMS to assign a DRG to an inpatient claim.

If a member terminates with CarePartners of Connecticut while receiving inpatient services, CarePartners of Connecticut is responsible for the entire admission until the member is discharged.

Additional Resources

Inpatient Facility Payment Policy

Document History

- October 2024: Annual policy review; removed link for LVRS, bariatric surgery, CAS with embolic protection, and VAD as destination therapy as no longer relevant
- September 2023: Annual policy review; administrative updates
- September 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 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- August 2019: Committee review; clarified referral, authorization and notification requirements
- 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.