

Hospital Based Practitioners - Inpatient Services

***all red text is new for 11/01/2015**

Effective January 1, 2015, professional services delivered by a hospital based practitioner during the inpatient stay must be billed on a professional claim and will be reimbursed outside of the APR-DRG classification system.

This policy is an integral component of the Department of Social Service's overall hospital modernization and healthcare payment reform initiative, mandated by Section 17b-239 of the Connecticut General Statutes, as amended in 2013. Hospitals need to enroll at least one practitioner group to be able to bill for inpatient professional services, if they have not done so already. This will ensure that the hospitals will be reimbursed for their inpatient professional fees for dates of admissions January 1, 2015 and forward. Hospitals will also need to ensure their hospital based practitioners (performing providers) are enrolled in the Connecticut Medical Assistance Program (CMAP) under a participation type of Employed/Contracted by an organization.

Please refer to the hospital based practitioners workshop presentation for additional information located on the Hospital Modernization page on the Web site www.ctdssmap.com and click on "Provider Training" under "Helpful Information & Publications" on the right side of the Web page. Select "Hospital Workshop" and select "Hospital Based Practitioners Workshop 2014." Hospitals can also refer to Provider Bulletin 2014-68 "Hospital Based Practitioners - Inpatient Services" located on the Hospital Modernization page under "Provider Bulletins".

1. Will hospitals be required to enroll multiple practitioner groups?
 - A. Hospitals are required to enroll one or more practitioner groups, unless they are already enrolled as a group(s). Multiple professional groups must be enrolled when the hospital based practitioners represent multiple type and/or specialties. Please refer to the table listed below for further reference.

Practitioner Discipline	Provider Type	Provider Specialty
General Practice Medicine, Internal Medicine, Hospitalist, and all other practitioner disciplines not listed separately below	Physician Group	Select one: Hospitalist, Internal Medicine or General Practice Medicine
Family Medicine	Physician Group	Family Medicine
Pediatrics	Physician Group	General Pediatrics
OB/GYN	Physician Group	Obstetrics and Gynecology
Advanced Practice Registered Nurses (APRNs)	Advance Practice Nurse Group	Adult Health Nurse Practitioner
APRN - Pediatric	Advance Practice Nurse Group	Pediatric Nurse Practitioner
APRN – OB/GYN	Advance Practice Nurse Group	Obstetric Nurse Practitioner
APRN – Family Medicine	Advance Practice Nurse Group	Family Nurse Practitioner
Nurse Midwives	Nurse Midwives Group	Certified Nurse Midwife

2. If the hospital chooses to enroll a new practitioner group(s) using the hospital’s NPI, would they be required to make any updates to the National Provider Plan and Enumeration System (NPPES) Web site?

A. Yes. If the hospital chooses to enroll the group(s) with the same NPI that is used to submit claims for inpatient services, the hospital must contact the NPPES to add the taxonomy(s) being used for their group(s) under the hospital’s NPI.

3. Are hospitals that currently have a practitioner group(s) billing for professional inpatient services required to enroll a new practitioner group(s) under the hospital’s NPI?

B. Hospitals would only need to enroll a new practitioner group(s) if they do not have a group enrolled for their practitioner’s discipline.

4. What is the process for hospitals to enroll a practitioner(s) who is currently enrolled as an OPR only?
 - A. Practitioners that are currently enrolled as ordering/prescribing/referring (OPR) providers only will need to re-enroll with a participation type of “Employed/Contracted by an Organization” in order to be eligible for payment for services rendered.
 - B. Hospitals will need to submit an Excel spreadsheet listing these practitioners containing the following information: the practitioner’s name, NPI, AVRS ID, address and the hospital’s group AVRS ID and NPI to which the hospital wants the practitioner to be associated. The spreadsheet should be sent to ctxihospipay@dxc.com. DXC Technology will create re-enrollment ATNs and return the spreadsheet to the provider containing the ATN number for each provider. This will be returned to the hospital within 5 business days from the date the spreadsheet was received.
 - C. Re-enrollment applications that are not fully completed will result in the practitioner being **dis-enrolled** immediately from the Connecticut Medical Assistance Program (CMAP). A notice of disenrollment will be sent to the practitioner. Claims submitted for reimbursement for these dis-enrolled practitioners will be denied for services rendered after the deactivation date. Once they are deactivated, claims with these providers as ordering, prescribing or referring will also deny, including inpatient and outpatient hospital claims
5. How long will it take for the online enrollment / re-enrollment application to process?
 - A. Once the online application is completed without discrepancies it is reviewed by DXC Technology within 5 business days and then submitted to DSS. DSS’ review may take up to 10 - 12 business days.
6. Can hospitals bill for services if the hospital based practitioner(s) enrollment / re-enrollment application is pending?
 - A. No. Hospitals will need to wait until the enrollment / re-enrollment application is approved by DSS.
7. Why would a hospital based practitioner(s) be deactivated from the CMAP?
 - A. Hospital Based Practitioner(s) will be deactivated from CMAP if they do not complete their re-enrollment application by the expiration date. The provider will also be systematically dis-associated from their respective group(s).
 - B. Claims submitted for reimbursement for these practitioners will be denied for services rendered after the deactivation date. This will include inpatient or outpatient hospital claims where the practitioner is being billed as the attending or referring provider.
8. How will inpatient professional services be reimbursed?

- A. Professional services delivered by a hospital based practitioner are reimbursed based on the physician fee schedule. The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Program's Web site, www.ctdssmap.com. From the Home page, go to "Provider", then to "Provider Fee Schedule Download", then to the appropriate "Physician" fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open". Please refer to the Fee Schedule Instructions under "Provider Fee Schedule Download" for additional information, including rate type descriptions.
9. Can hospitals submit inpatient professional services performed by more than one performing provider on the same claim for a patient?
- A. Yes, hospitals can submit inpatient professional services for more than one performing provider on the same claim if the rendering providers are under the same group.
- B. Each performing provider listed on the claim must be currently enrolled with CMAP in order for the hospital to be reimbursed.
10. Can the newly created practitioner groups have the same Electronic Funds Transfer (EFT) as the hospital?
- A. Yes, they can have the same EFT information as the hospital.
11. How can hospitals add their new practitioner group(s) to their electronic RA to view their claims for dates of service January 01, 2015 and forward?
- A. Hospitals and trading partners can add physician group(s) to their electronic RA(s) via that trading partner's secure Web portal account. Instructions for adding a new practitioner group's AVRS ID can be found in Chapter 10, Section 10.8 of the Provider Manual. The provider manuals are located on the Web page www.ctdssmap.com by clicking on "Information", then "Publications", and scrolling down to Provider Manuals.
12. Will hospitals be required to submit outpatient and emergency department professional services on a professional claim starting for dates of service January 01, 2015 and forward?
- A. Hospitals will not be required to bill outpatient and emergency professional claims on a CMS 1500 for DOS January 1, 2015 and forward. The current billing policies and procedures in place prior to 1-1-2015 for outpatient and emergency department physicians will remain in place until further guidance is issued. Specifically, those policies and procedures will not be fully modified until the Department modernizes its outpatient hospital reimbursement methodology using Ambulatory Payment Classifications pursuant to section 17b-239(d)(2) of the Connecticut General Statutes. That change is tentatively scheduled for implementation in mid-2016. Please refer to provider bulletin 2014-88 "Billing for Emergency Department Services" for additional information.

13. Do hospitals need to affiliate Residents to their practitioner groups?

- A. No. Residents are not permitted to join practitioner groups and will not be allowed to be the performing provider on a professional claim. Hospitals can refer to provider bulletin 2014-48 “Enrollment Requirements for Residents” for additional information on enrolling residents.

14. Where should hospitals go for policy and billing guidelines?

- A. Hospitals should reference Provider Manual Chapter 7 for specific policy and regulations for practitioners, Provider Manual Chapter 8 for claims submission instructions and provider bulletins for additional information relating to physician, APRN, and nurse midwife services.

15. Should hospitals enroll a separate practitioner group for behavioral health clinicians including psychologist?

- A. No. Hospitals should not be enrolling a separate group for behavioral health clinicians since they cannot be reimbursed for services provided in an inpatient setting. Hospitals can reference Provider Manual Chapter 7 and select provider type “Behavioral Health Clinicians” for specific policy and regulations for behavioral health clinicians. Behavioral Health Clinicians groups do not include psychiatrists.

16. Can the hospitals bill for inpatient professional services performed by a psychiatrist?

- A. Yes. The department recommends that hospitals enroll a separate provider group if they have not done so already in order to receive reimbursement for inpatient behavioral health services billed on a professional claim performed by a psychiatrist. Hospitals can visit our Web site at www.ctdssmap.com then select “Provider Enrollment”. When enrolling a psychiatrist group, hospitals will need to select the application type of “Organization/Group”, select provider type “Physician Group” and specialty “Psychiatry.”

17. What are the timely filing guidelines for professional claims?

- A. There are no changes to timely filing guidelines. For HUSKY C and D benefit plans the timely filing for medical and behavioral health services is one year. For HUSKY A and B benefit plans the timely filing limits for medical services is one year, but for behavioral health services the timely filing limit is 120 days. Hospitals can reference Provider Manual Chapter 5 “Claim Submission Information” for all timely filing requirements and guidelines.