

## Hospital Based Practitioners - Outpatient Services FAQ

Hospitals will be reimbursed outside of the Outpatient Prospective Payment System (OPPS) for their outpatient professional services starting for dates of service July 1, 2016 and forward. 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 create a practitioner group(s) and to make sure their hospital based practitioners are enrolled in the Connecticut Medical Assistance Program (CMAP).

If the hospital has already enrolled a hospital based practitioner group as directed by Provider Bulletin 2014-68 "Hospital Based Practitioners - Inpatient Services" they are not required to enroll another separate group. The hospital can bill for professional services in an inpatient or outpatient setting (starting on or after dates of service July 1, 2016) under the same hospital based practitioner group.

Please submit your practitioner group enrollments no later than May 31, 2016 to be enrolled by July 1, 2016. This will ensure that the hospital based practitioner groups will be reimbursed for their outpatient professional fees for dates of service July 1, 2016 and forward. Hospitals will also need to ensure their hospital based practitioners are currently enrolled in the Connecticut Medical Assistance Program (CMAP) as performing providers. Claims will be submitted under the hospital based practitioner groups with the performing provider entered as the rendering provider.

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](http://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 2016." Hospitals can also refer to Provider Bulletin 2016-06 "Hospital Based Practitioners - Outpatient Services" located on the Hospital Modernization page under "Provider Bulletins" for more detailed instructions on enrollment.

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.

<b>Provider Discipline</b>	<b>Can enroll in the following Provider Group Type</b>	<b>With this Provider Specialty</b>
General Practice, Emergency Medicine, Hospitalist, and all other provider disciplines not listed separately below *	Physician Group	<b>Select one:</b> Hospitalist, Internal Medicine or Emergency Medicine
Family Medicine	Physician Group	Family Medicine
Pediatrics	Physician Group	General Pediatrics or Pediatric Emergency Medicine
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
Behavioral Health Clinicians and Psychologist	Behavioral Health Clinician Group	LCSW, LADC, LMFT, LPC and Psychology
Nurse Midwives	Nurse Midwives Group	Certified Nurse Midwife
Pathologist	Physician Group	Pathology
Psychiatry	Physician Group	Psychiatry

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 outpatient 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 to bill for outpatient services on or after July 1, 2016?

A. Hospitals would only need to enroll a new practitioner group(s) if they do not have a group enrolled for their provider’s type. The hospital based practitioner group can bill inpatient services and for outpatient services (effective on or after dates of service 7/1/16) under the same group.

4. What is the process for hospitals to enroll a practitioner(s) who is currently enrolled as an ordering/prescribing/referring (OPR) only?

A. Practitioners that are currently enrolled as 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. All hospitals will receive a blank excel spreadsheet from DXC Technology listing these practitioners containing columns for 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 filled out and sent to [ctxixhosppay@dxc.com](mailto:ctxixhosppay@dxc.com). DXC Technology will create re-enrollment ATNs and return the spreadsheet to the hospital containing the ATN number for each practitioner. This will be returned to the hospital within 5 business days from the date the spreadsheet was received.
  
- C. Once an ATN number is received the practitioner may proceed with the re-enrollment process via the Provider Re-enrollment Wizard, by going to [www.ctdssmap.com](http://www.ctdssmap.com). From the home page, click on the “Provider” tab, and click on “Provider Re-enrollment.” The provider’s NPI and assigned ATN will need to be entered into the designated fields. The application will be auto-populated with information currently on file for the provider. Information that is no longer valid should be updated as part of the application process.

Here is an example of how the spreadsheet should look when sending it back to DXC Technology:

Providers Name	NPI	AVRS ID	Address	Hospital’s Group NPI	Hospital’s Group AVRS ID
Hospital Paul	1234567890	003240324	195 Scott Swamp Road Farmington, CT 06032	199999999	0080000001
Peter Tasker	1111111111	008000000	55 Farmington Ave Hartford, CT 06014	199999999	0080000004

- 5. How will the hospitals be able to determine if the hospital based providers are an Ordering/Prescribing/Referring (OPR) provider?
  - A. To assist hospitals in determining which hospital based providers are currently enrolled as an OPR provider a list of all individual providers including those enrolled with an OPR only designation, will be e-mailed monthly to the hospitals. Please email [ctxixhosppay@dxc.com](mailto:ctxixhosppay@dxc.com) if you would like to receive this provider list. Emails should have a contact name of the person you wish to receive the list, their phone number and email address and the hospital NPI.
  
- 6. 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.
  
- 7. Can Hospital based providers 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.
  - B. Hospitals will be reimbursed outside of the Outpatient Prospective Payment System (OPPS) for their outpatient professional services on or after July 1, 2016. As noted in PB 2016-06, hospitals must enroll their practitioner groups and submit enrollments no later than May 31, 2016. This will ensure that hospitals will be reimbursed for their outpatient professional services on and after July 1, 2016. If the hospital has already enrolled a practitioner group as directed by Provider Bulletin 2014-68, they are not required to enroll a separate group for outpatient professional billing for dates of service on or after July 1, 2016. Practitioners and their associated groups must comply with all regulations, policies, billing requirements and procedures applicable to their provider type. New groups that are being submitted for enrollment, as well as individuals that are being added to existing groups cannot bill their professional outpatient services on the CMS 1500 until implementation of OPPS.
8. Can hospital based practitioner group submit outpatient professional services performed by more than one performing provider on the same claim for a patient?
- A. Yes, hospital based practitioner groups can submit outpatient 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 based practitioner group to be reimbursed.
9. How can hospitals add their new practitioner group(s) to their electronic RA to view their claims for dates of service July 01, 2016 and forward?
- A. Hospitals and trading partners can add practitioner 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](http://www.ctdssmap.com) by clicking on "Information", then "Publications", and scrolling down to Provider Manuals.
10. 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.
11. How will outpatient professional services be reimbursed?
- A. Most professional services delivered by a hospital based provider are reimbursed based on the physician fee schedule. The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Program's (CMAP) Web site, [www.ctdssmap.com](http://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. Refer to provider bulletin 2016-06 "Hospital Based Practitioners - Outpatient Services" for information on services that are not covered.

12. Can the hospital physician practitioner groups bill for outpatient professional behavioral health services?
  - A. Most outpatient behavioral health services in the Hospital setting are considered an all-inclusive service; therefore, they must be billed on the UB-04 by the Hospital and the professional fees should not be submitted separately. The only behavioral health services that will be reimbursed separately are: a) Emergency Department evaluation provided by licensed clinical social worker (LCSW), psychiatrists, psychiatric APRNs or psychologist and b) the professional component of electroshock treatment billed by psychiatrists or psychiatric APRNs. The professional services will be paid based on the applicable provider fee schedule, which can also be accessed on the CMAP website, following the directions above, with the exception of selecting the psychologist fee schedule or the BH Clinician for reimbursement of LCSW services.
  
13. Where should hospital based practitioner groups go for policy and billing guidelines?
  - A. Practitioners and their associated groups must comply with all regulations, policies, billing requirements and procedures applicable to their provider type. Hospital based practitioner groups should reference Provider Manual Chapter 7 for specific policy and regulations for each applicable provider type, Provider Manual Chapter 8, for claims submission instructions for each applicable provider type, Chapter 11 for step by step guide for Other Insurance and Medicare billing instructions for CMS-1500 paper claim submissions and ASC X12N Health Care 837P format and also provider bulletins for additional information relating to physician, APRN, physician assistant, nurse midwife, psychologist and behavioral health clinician services.