

# White Paper

## How to Bill for Locum Tenens Services

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CompHealth understands the importance of capturing every available revenue dollar for physician services, including those performed by locum tenens physicians (both replacement and supplemental). If you utilize temporary physician services and don't bill for them, you are leaving money on the table.

### Where do I start?

Start by asking yourself a few simple questions, and then follow the flowchart contained in this document. First, determine whether you need replacement or supplemental physician services. Replacement services are used when your regular physician is unavailable to provide services, typically for 60 days or less. Supplemental services are used when you are looking to grow your practice and need the services of a physician in addition to your current staff. Due to Medicare restrictions, if you need a replacement provider for more than 60 days, you will typically follow the same procedure as when supplemental services are needed. Once you have determined your exact need, simply follow the recommended guidelines for the type of services needed.

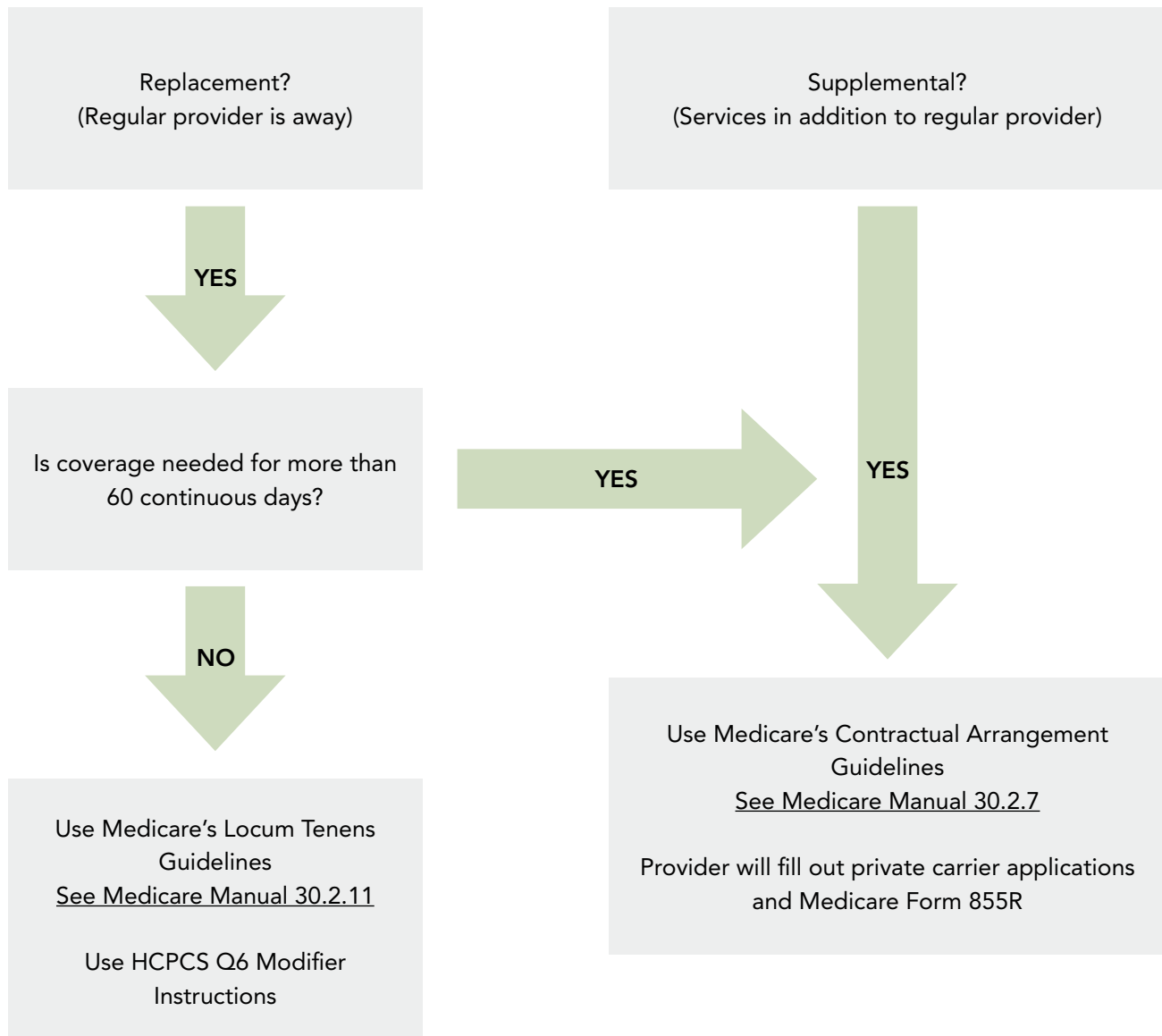
What about private payers and Medicaid? Many private payers and State Medicaid programs follow Medicare guidelines, but it's a good rule to verify each program independently. Your CompHealth team can make billing recommendations to you once you provide some basic information about your patient population.

- What is the payer breakdown?
  - % of Medicare/Medicaid patients?
  - % of private payer patients?
- Who are the main insurance carriers?

With this information, your CompHealth team will help you determine the best course of action to capture revenue for your replacement or supplemental physician services.

## Locum Tenens Billing Flowchart - Medicare

\*Many private payers and state Medicaid programs follow Medicare guidelines closely. Please contact your client representative for information related to specific carriers/states.



**Section 30.2.7** of the Medicare manual covers billing for Supplemental Physician Services. It allows a carrier to make payments to your group for services performed by a supplemental physician who has a contractual arrangement to see your patients. There are two safeguard requirements that must be met before a claim can be paid in this type of arrangement:

1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
2. The person furnishing the service has unrestricted access to claims submitted by an entity for services provided by that person.

When using services performed under a contractual arrangement, the supplemental provider will complete the necessary applications to bill for services with each of your private carriers, and the Medicaid program for your state. Additionally, the provider will complete Medicare's Form 855R to allow your practice to bill Medicare for his/her services. A provider may have billing rights assigned to multiple practices/groups, and the same form is used to rescind billing privileges once an assignment is completed.

**Section 30.2.11** of the Medicare manual covers billing for Locum Tenens Services. It allows a practice to bill for temporary physician services during the absence of a regular physician who normally would have been scheduled to see a patient. For this type of reimbursement to take place, the regular physician arranges coverage for no longer than 60 continuous days, and then enters HCPCS code modifier Q6 after the procedure code during the billing process.

Text from Sections 30.2.7 and 30.2.11 of the Medicare Manual is on the following pages.

## **30.2.7 - Payment for Services Provided Under a Contractual Arrangement - Carrier Claims Only**

A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished.

Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment. The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:

1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
2. The person furnishing the service has unrestricted access to claims submitted by an entity for services provided by that person.

## **30.2.11 - Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers** (Rev. 1486, Issued: 04-04-08, Effective: 01-01-08, Implementation: 05-05-08)

### **A. Background**

It is a longstanding and widespread practice for physicians to retain substitute physicians who take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them.

The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than an employee. These substitute physicians are generally called "locum tenens" physicians.

Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. Thus, beginning January 1, 1995, a regular physician may bill for the services of a locum tenens physicians. A regular physician is the physician who normally is scheduled to see a patient. Thus, a regular physician may include physician specialists (such as a cardiologist, oncologist, urologist, etc.).

## B. Payment Procedure

A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- The regular physician is unavailable to provide the visit services;
- The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject to the exception noted below; and
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a locum tenens physician) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) or NPI when required to the carrier upon request.

**EXCEPTION:** In accordance with section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE), enacted on December 29, 2007, the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces has been extended for services furnished from January 1, 2008 through June 30, 2008. Thus, under this law, a physician called to active duty may bill for substitute physician services from January 1, 2008 through June 30, 2008 for longer than the 60-day limit.

If the only substitution services a physician performs in connection with an operation are postoperative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

## C. Medical Group Claims Under Locum Tenens Arrangements

For a medical group to submit assigned and unassigned claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements of subsection B must be met. For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the locum tenens physician is considered paid by the regular physician. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 60 days. The group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q6 after the procedure code. Until further notice, the group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required on block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the requirements of subsection A for payment for locum tenens physician services. Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term "regular physician" includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.