A Primer for Billing for Temporary and Locum Tenens Physicians

Since professional and facility fee billing for medical providers has become increasingly complex, the prospect of taking on the billing function for locum tenens physicians may seem daunting. Fortunately, the majority of hospitals have the necessary billing systems in place to accomplish this function. The complexity of billing for locum tenens can be minimized using the following best practices.

Step One: Aggregate Physician Information

Physicians are required to have an active medical license from the state in which they are providing medical services, as well as a Drug Enforcement Agency (DEA) number, National Provider Identifier (NPI) and Unique Physician Identification Number (UPIN). These are used to identify the physician within all payer systems. Medicare and Medicaid provider numbers are also critical pieces of information, and it will take time to credential the physician if he or she does not already have these numbers.

Step Two: Perform Inventory of Major Managed Care Payers

Each payer requires the enrollment of every physician who is providing services at your facility longer than sixty days continuously. This process requires the completion of an application to each payer and will require copies of valid Medicare, Medicaid, NPI and UPIN numbers with each submission. Beware of the time limitations related to the consolidation of hospitals and physician groups in your market.

If the physician is serving as a temporary replacement for an existing physician and is serving less than sixty days continuously, then you can utilize the Q6 modifier to temporarily credential the replacement physician under the existing physician’s payer information for Medicare and most major commercial payers. If the existing physician is absent for more than 60 days, a new temporary replacement physician can serve for an additional 60 days. Also, if the existing physician returns but then must leave again, the 60-day clock starts over. The only case in which there is not a 60-day limit is when a physician is on active military duty.

Step Three: Acquiring the Patient Encounter Data

The complexity of billing for facility and professional services is directly correlated to the quality, accuracy and timeliness of capturing the patient encounter information. This patient encounter information includes but is not limited to:

- Patient demographics, including date of birth, address, referral, pre-authorization data and insurance card information
- Diagnosis and procedure codes for the current condition and procedures that are being performed on the patient as ordered by the physician

Billing is not a back end process. Billing for professional fees is aggregating accurate data that the hospital must have to bill and collect for its facility fees. Submitting clean and accurate claims on the front end is more effective than attempting to gather this information from a claim denial.
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Step Four: Billing the Claim

Once you have the physician, payer and encounter data, this information should be posted into your billing system. Electronic claim filing is preferred because (a) an electronic receipt will ensure you have proof of timely filing requirements for the payer and (b) any claim rejects (pre-adjudicated payer rejections) can be identified and resolved. Most claim rejects are the result of (a) bad provider or encounter information or (b) incorrect electronic claim formats. These are relatively easy items to repair and eliminate with the front-end registration and electronic claims process.

Step Five: Collecting the Claim

There is a significant financial reason to bill and ultimately collect the payment for the medical services rendered by your physicians. As an underlying rule, there are only three outcomes to a claim within 45 days from the date of service. These outcomes are:

- Paid
- Denied
- No Response

In simple terms,
(a) A claim is either paid partially or in full, achieving a balance due of $0.00, or
(b) a claim is denied by the payer, or
(c) a claim is neither paid nor denied.

A claim paid in full is evidence that you have successfully improved the financial results of your health system. If a claim is partially paid, then the balance is owed by another payer, and a secondary submission is required, or a balance is owed by the patient. Please note that this secondary submission process is relatively easy, and its success is directly correlated to the quality, accuracy and timeliness of the patient and physician encounter data. The process of submitting a partially paid claim is the same as the original claim.

If a claim is denied, then using a denial analysis report will provide you with the directions to seek actions to resubmit the claim for payment from the insurance company or patient. The ultimate tool that provides you with a complete view of the billing cycle of your physicians is a denial analysis. A denial analysis is a report that should be utilized by your existing billing department to determine what part of a claim is denied for payment and why.

This report is generated from your traditional payment posting process and recording of the explanation of benefits (EOB), whereby the payer states the reason(s) for not making a payment. Today, over 50 percent of claim denials result from inaccurate patient data. The largest secondary component for claim denial results from missing information that would justify the medical necessity of the service.
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No-response claims generally represent a low percentage of claims and are indicative of some process issues that result from internal electronic claim submission, lack of payer responsiveness and/or physician/payer credentialing. Resubmitting a claim for these no-response claims to get a payer response is generally an effective method to rule out issues from the responsible payer. The other root causes of a no-response claim are associated with internal billing process issues that can be identified and minimized with traditional billing reporting.

Summary

Billing and collection of a medical claim, whether a facility charge or physician charge, requires accurate patient and encounter data from the date of service. There is little reason to be intimidated by the professional services billing process since it aligns nicely with the billing function of the hospital and offers significant financial opportunities for the employed, temporary or locum tenens physician. The key to professional fee billing is recognizing the sequential nature of the billing process and the direct correlation of billing success to the accuracy, quality and timeliness of the physician data, whether the physician is a temporary hire, permanent hire or locum tenens solution.

About John R. Thomas

John R. Thomas serves as president and chief executive officer of MedSynergies. Mr. Thomas has been with MedSynergies since its inception in 1996 as senior vice president and managing director of development. While at MedSynergies, Mr. Thomas has held prior executive positions such as senior vice president and chief financial officer and has been a member of the board of directors since 1999.

About MedSynergies, Inc.

MedSynergies partners with health care organizations and physicians to align their operations by providing revenue cycle management, practice management, consulting services, business process analysis and software integration solutions. Leveraging its knowledge and experience in hospital-physician alignment, MedSynergies improves processes, optimizes technology and builds on trusted patient relationships, enabling hospitals and physician practices to offer quality health care. Founded in 1996, MedSynergies is privately held and headquartered in Irving, Texas. MedSynergies currently partners with hospitals and health networks and serves more than 5,600 providers across the United States.