Internal Medicine Coding Alert

Billing: Use These Reciprocity Rules When Your Physician Is Away

Know the dos and don'ts of reciprocal billing.

Every practice has its procedures for provider absences. But do you know you have options when your internist goes on vacation or is sidelined by an unexpected illness?

Do you use a locum tenens agreement? Or do you use reciprocal billing, which allows visits to be "provided by a substitute physician or physical therapist on an occasional reciprocal basis" under a Medicare arrangement?

Whichever you use, we've put together some dos and don'ts to help you determine the most beneficial way for your practice to operate when your regular physician isn't able to provide for his or her patients.

Do Make Sure You Know CMS Guidelines ...

Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians, describes reciprocal billing this way: "Suppose a physician, Dr. A, goes on vacation and arranges for a colleague in town, Dr. B, to provide services in his absence. Under a reciprocal billing arrangement," Moore continues, "Dr. A can bill for the services Dr. B provided to Dr. A's patients while Dr. A was on vacation."

The guidelines for such an arrangement can be found in Chapter 1 - General Billing Requirements - section 30.2.10 - Payment Under Reciprocal Billing Arrangements - of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf). Highlights include the following key components of reciprocal billing:

- The regular physician is unavailable to provide the service;
- The patient has arranged, or seeks to receive, the service from the regular physician;
- The substitute only provides services to Medicare patients for no more than a period of 60 consecutive days; and
- The regular physician submits the claim for the services using HCPCS modifier Q5 (Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area).

... and Know This Exception if Your Physician Is on Active Duty

Should your physician be called to active duty in the Armed Forces, Centers for Medicare & Medicaid Services (CMS) guidelines waive the 60-day limit to reciprocal billing, and you may bill for services furnished under the arrangement for longer than the time otherwise allowed by the regulations.

Do Use Modifier Q5 ...

Any claims filed with Medicare for services provided by a substitute physician or physical therapist while a reciprocal billing arrangement is in effect need to be accompanied by modifier Q5.

The agreement indicated by modifier Q5 indicates to Medicare that your physician has submitted the service for payment under his or her National Provider Identifier (NPI), and that your physician will be receiving the payment for it. The limitation to services in a health professional shortage area, a medically underserved area, or a rural area only applies to outpatient physical therapy services provided by a substitute physical therapist. There is no such limit on services provided by a substitute physician.

... But Don't Use Modifier Q6

Though they may look familiar, there is a huge difference between modifiers Q5 and Q6 (Service furnished under a fee-for-time compensation arrangement ...). As **Jan Blanchard, CPC, CPMA**, pediatric solutions consultant at Vermont-based PCC, puts it, "the difference between the modifiers is that Q6 is applicable to locum tenens [a Latin term meaning "one holding a place"] arrangements more than the federally qualified arrangement for which Q5 is used."

Moore agrees, noting that "to use this code, the absent physician must pay the substitute physician on a per diem or another fee-for-time arrangement." He goes on to suggest that "a physician might employ a locum tenens physician to cover her practice while on maternity leave or military deployment."

Of course, either method of substituting for your absent provider is acceptable. Just make sure you don't confuse the two.

Do Include These Services ...

For physicians, CMS defines covered visit services as "not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as 'incident to' the physician's services."

In other words, as Blanchard and Moore point out, most primary care services a substitute physician provides on behalf of your doctor are covered under a reciprocal billing arrangement. Additionally, the service can be provided incident-to by a medical staff member other than the physician, providing the physician is present and your practice bills the service under the NPI number associated with your own physician or practice.

... But Don't Identify This Service

Finally, the guidelines stipulate that the only service performed under a reciprocal billing arrangement you would not identify as such is a postoperative service performed by the substitute physician that is "furnished during the period covered by the global fee."

So, if your provider performed an excision documented by 11400-11471, then the substitute re-dressed the wound as a part of the normal postoperative care covered during the 10-day global period assigned to these services, you do not have to identify this as a service furnished by the substitute.