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Part B Insider (Multispecialty) Coding Alert

Enrollment: Review 3 FAQs to Ensure You Know When a New Provider Should Start Seeing Patients

If a provider starts too soon, you could be giving away free services.

Following last week's announcement that CMS will start denying enrollment applications for practices that owe back payments to Medicare, many Part B practices have generated additional enrollment questions. Knowledge of enrollment specifications is essential, because if you don't provide the new provider's credentialing info to your payers before he starts seeing patients, you actually lose money, upset patients, and possible face fraud charges before you see any benefits.

Take a look at these expert answers to three credentialing frequently asked questions to make sure you are equipped to face the challenge of how to bill for the provider's services to both new and established patients who visit him at your practice.

1. Can We Bill Retroactively?

When you can bill for a new physician's services depends on when you're able to get him credentialed. You'll also need to know the differences between the payers you'll be reporting the services to, because they do not all follow the same policies.

For Medicare, you're allowed to bill 30 days retroactively. Regardless of when the provider starts with your practice, you'll only be able to retroactively bill Medicare for services your physician rendered up to 30 days prior to the date he received his Medicare credentialing status.

Pitfall: In the past you had a full 27-month window during which you could retroactively bill. That changed in 2009.

How it works: Suppose you hire a new physician who recently applied for Medicare status but has not yet received his credentials. He sees several patients each day over a three-month period, at the end of which he receives his credentials.

You'll only be able to retroactively bill for the work the physician performed during the final 30 days prior to his credentialing. The other two months of work are not billable.

You can no longer just bill Medicare while waiting for your credentialing approval, unless the services were performed 30 days prior to the Medicare approval. Unfortunately, you have no way of knowing when your approval will happen; it's a guessing game.

Note that you'll count back 30 days from the physician's application date, not the Medicare approval date. So the sooner you get the application in, the better.

The date depends on how you're submitting the application as well. If you submit the application via the Provider Enrollment, Chain, and Ownership System (PECOS), you have 30 days from the day you submitted the enrollment application to the Medicare carrier. If you file a paper application, the filing date is the day the carrier receives your application in the mail, however. Don't start counting from the day you put the application in your mailbox.

Private payer difference: Check with the individual payer as the rules vary. Some may give you an effective date for when you can start billing. Most payers will not take claims from dates of service prior to the date when they approved the physician as a credentialed paneled participating physician with their plan.

2. Can We Just Use Another Provider's NPI?

While it may be tempting, you should not bill services under another provider while you're waiting for the new physician's credentialing. You should not use another credentialed doctor's national provider identifier (NPI) on the new doctor's claims to get paid for services the new physician performs before being credentialed. Doing this is considered fraud since your practice would be saying that Doctor A performed a service that Doctor B actually provided.

Either avoid having the new physician see patients until the Medicare credentials come through, or have the physician see only patients who are self-pay or who have insurance that allows you to bill before credentialing.

Myth: You can just report the new doctor's service under an existing physician's ID number and append the locum tenens modifier to it, right?

Reality: No way. Locum tenens is designed to represent services performed "in the absence of the regular physician," according to chapter 1 of the Medicare Claims Processing Manual. Practices that simply report the new physician's service as if it was performed by a locum tenens doctor, are going against the original intent of the locum tenens rules.

Some practices may even say they heard the advice about billing this way at a conference. But you have to go back to the original source chapter 1 of the Medicare Claims Processing Manual which indicates that locum tenens applies to cases where the regular physician is absent due to illness, pregnancy, vacation, or continuing medical education.

Plus: One of the stipulations of locum tenens is that you pay the doctor taking over for you on a per-diem basis. So if you're just billing a new physician as a locum tenens, not only are you billing incorrectly but you've made a mistake in your payment structure as well.

When you have a legitimate locum tenens situation, you append modifier Q6 (Service furnished by a locum tenens physician) to all of the temporary doctor's claims and bill under the NPI of the physician the locum is replacing. Also, you should include the NPI of the temporary doctor in box 23 on the CMS-1500 billing form. But you cannot do this to get around credentialing issues.

3. What is the Best Way to Ensure We Get Paid?

In the future, you may want to allow your office more time when trying to credential a new physician.

The process can take 90 days or even longer, according to Medicare. Experts recommend that you initiate this process as far in advance of your new physician's starting date as you can (once you have all the necessary information such as the state license and DEA number) two months ahead of time, if not more.

If you act early, you'll have the necessary credentials in place when the physician starts seeing patients and you won't have to hassle with delayed payments.

The wisest way to handle the credentialing is to start long before the provider comes on board. If you wait until the doctor arrives, then it presents issues for the patients and the practice. If patients have insurance, they want to use it. If the physician is not credentialed, seeing the patients on a cash basis is the only option.

Tip: Try to arrange a new physician's starting date several months after his hire date to allow your billing office sufficient

time to get everything in order.

Alternative: If a patient needs to see the new physician before that physician is credentialed, you can take the self-pay route, if the patient is willing.

Best bet: Focus on getting the physician credentialed, and once the applications are in, then you can look at letting the physician start seeing patients.