Reimbursement Policy

Subject: **Locum tenens Physicians/Fee-for-Time Compensation**	
Policy Number: **G-06063**	Policy Section: **Administration**
Last Approval Date: **08/15/2022**	Effective Date: **08/15/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ny**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives to minimize delays in policy

NYBCBS-CR-RP-045008-23 November 2023

implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem Medicare Advantage allows reimbursement of locum tenens/ Fee-for-Time Compensation for substitute physicians in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines unless provider, state, or federal contracts and/or requirements indicate otherwise.
Anthem Medicare Advantage also allows reimbursement for Fee-for-Time Compensation for substitute physical therapists performing outpatient physical therapy services in a health professional shortage area (HPSA), medically underserved area (MUA), or rural area.

Anthem Medicare Advantage will reimburse the member's regular physician or medical group, or physical therapist or all covered services provided under Fee-for-Time Compensation during the absence of the regular provider in cases where the regular provider pays Fee-for-Time Compensation on a per diem or similar fee-for-time basis.

Reimbursement to the regular physician or medical group or physical therapist is based on the applicable fee schedule or contracted/negotiated rate. Fee-for-Time Compensation services may not be provided to a member for longer than a period of 60 continuous days.
Anthem Medicare Advantage will allow Fee-for-Time Compensation reimbursement for a continuous period of longer than 60 days for substitute physicians and physical therapists when the regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces. Services included in a global fee payment are not eligible for separate reimbursement when provided by a locum tenens provider.

A member's regular physician or medical group or physical therapist should bill the appropriate procedure code(s) identifying the service(s) provided by the substitute provider with a Modifier Q6 appended to each procedure code.

Related Coding
Standard correct coding applies

Policy History	
08/15/2022	Biennial review approved: policy template updated

04/21/2020	Biennial review approved: minor administrative updates
08/14/2017	Biennial review approved: policy language updated
04/27/2015	Biennial review approved: policy language added: policy template updated
01/01/2015	Initial policy approved and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract

Definitions	
Locum tenens/Fee-for-Time Compensation	Substitute physicians who take over a regular physician's professional practice when the regular physician is 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 the regular physician performed them. The substitute physician generally has no practice of their 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 of an employee. A regular physician is the physician who is normally scheduled to see a member.
Modifier Q6	Services furnished by a locum tenens physician
General Reimbursement Policy Definitions	

Related Policies and Materials
Claims Submission – Required information for Professional Providers
Modifier Usage
Sanctioned and Opt-Out Providers
Scope of Practice