Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Locum Tenens Physicians/Fee-for-Time Compensation

Effective Date: **08/14/17**	Committee Approval Obtained: **08/14/17**	Section: **Administration**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage allows reimbursement of Fee-for-Time Compensation for substitute physicians in accordance with CMS guidelines unless provider, state or federal contracts and/or requirements indicate otherwise. Amerigroup 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, medically underserved area or rural area. Amerigroup Medicare Advantage will reimburse the member's regular physician or medical group or physical therapist for 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 sixty continuous days. Amerigroup 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.
History	• Biennial review approved and effective 08/14/17: Policy language updated • Biennial review approved and effective 04/27/15: Policy language added; policy template updated • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts
Definitions	• **Fee-for-Time Compensation:** substitute physician or physical therapist that takes over a regular physician or physical therapist's professional practice when the regular provider is absent for reasons such as illness, pregnancy, vacation or continuing medical education, and the regular provider bills and receives payment for the substitute provider's services as though they performed them; the substitute provider generally has no practice of their own and moves from area to area as needed; the regular provider generally pays the substitute provider a fixed amount per diem, with the

	substitute provider having the status of an independent contractor rather than of an employee; a regular physician or physical therapist is the provider that is normally scheduled to see a patient • **Modifier Q6:** services furnished by a substitute physician or physical therapist • **General Reimbursement Policy Definitions**
Related Policies	• Claims Submission — Required Information for Professional Providers • Modifier Usage • Reimbursement of Sanctioned and Opt-Out Providers • Scope of Practice
Related Materials	• None