| CMS Manual System | Department of Health & Human Services (DHHS) |
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| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 3774** | **Date: May 12, 2017** |
| | **Change Request 10090** |

**SUBJECT: Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)**

**I. SUMMARY OF CHANGES:** The purpose of this CR is to—

1. Implement section 16006 of the 21st Century Cures Act, which allows outpatient physical therapy services furnished by physical therapists in a health professional shortage area (HPSA), a medically underserved area (MUA), or in a rural area to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective no later than June 13, 2017. The term "locum tenens," which has historically been used in the manual to mean fee-for-time compensation arrangements, is being discontinued because the title of section 16006 of the 21st Century Cures Act uses "locum tenens arrangements" to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements. As a result, continuing to use the term "locum tenens" to refer solely to fee-for-time compensation arrangements is not consistent with the law and could be confusing to the public.

2. Update Pub. 100-04, chapter 1, sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14 of CMS' internet-only manual (IOM) by changing "Carriers" to "A/B MACs Part B" and removing all references to "UPIN" (since the terms "carriers" and "UPIN" are obsolete).

3. Update sections 30.2.10 and 30.2.11 of the IOM to clarify that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period. This policy is required by section 137 of the Medicare Improvements for Patients and Providers Act of 2008.

**EFFECTIVE DATE: June 13, 2017**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 13, 2017**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 1/TOC |
| R | 1/30/2.1/Exceptions to Assignment of Provider’s Right to Payment - Claims Submitted to A/B MACs Part B |
| R | 1/30/2.10/Payment Under Reciprocal Billing Arrangements - Claims Submitted to A/B MACs Part B |
| R | 1/30/2.11/Payment Under Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements) - Claims Submitted to A/B MACs Part B |
| R | 1/30/2.13/Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for A/B MAC Part B Processed Claims |
| R | 1/30/2.14/Correcting Unacceptable Payment Arrangements |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 3774 | Date: May 12, 2017 | Change Request: 10090 |
|---|---|---|---|

**SUBJECT: Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)**

**EFFECTIVE DATE: June 13, 2017**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 13, 2017**

## I. GENERAL INFORMATION

**A. Background:** The purpose of this CR is to—

1. Implement section 16006 of the 21st Century Cures Act, which allows outpatient physical therapy services furnished by physical therapists in a health professional shortage area (HPSA), a medically underserved area (MUA), or in a rural area to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective no later than June 13, 2017. The term "locum tenens," which has historically been used in the manual to mean fee-for-time compensation arrangements, is being discontinued because the title of section 16006 of the 21st Century Cures Act uses "locum tenens arrangements" to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements. As a result, continuing to use the term "locum tenens" to refer solely to fee-for-time compensation arrangements is not consistent with the law and could be confusing to the public.

2. Update Pub. 100-04, chapter 1, sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14 of CMS' internet-only manual (IOM) by changing "Carriers" to "A/B MACs Part B" and removing all references to "UPIN" (since the terms "carriers" and "UPIN" are obsolete).

3. Update sections 30.2.10 and 30.2.11 of the IOM to clarify that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period. This policy is required by section 137 of the Medicare Improvements for Patients and Providers Act of 2008.

**B. Policy:** Section 1842(b)(6)(D) of the Act allows payment to be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if the first physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either (1) informal and reciprocal, or (2) involves per diem or other fee-for-time compensation for such services. In addition, the services must not be provided by the second physician over a continuous period of more than 60 days unless the regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days. Effective June 13, 2017, this same process will be available to Medicare-enrolled physical therapists who use substitute physical therapists to furnish outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 10090.1 | Contractors shall implement the payment policies described in IOM Pub. 100-4, chapter 1, sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14. | | X | | | | | | | |
| 10090.2 | Contractors shall accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for reciprocal billing arrangements, when submitted with the Q5 modifier. | | X | | | | | | | |
| 10090.2.1 | Contractors shall accept claims from Physical Therapists that are reported with a Q5 modifier whose descriptor references only physicians. When the descriptor is updated to include physical therapists and physicians, contractors shall accept the Q5 modifier with the updated descriptor.<br><br>NOTE: The Modifier Q5's descriptor will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update. | | X | | | | | | | |
| 10090.2.2 | Contractors shall suspend any editing that would cause physical therapist claims submitted with the Q5 modifier whose descriptor references only physicians to be denied or returned as unprocessable. | | X | | | | | | | |
| 10090.3 | Contractors shall accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for services provided by a substitute physical therapist under a fee-for-time compensation arrangement when submitted with the Q6 modifier. | | X | | | | | | | |
| 10090.3.1 | Contractors shall accept claims from Physical Therapists that are reported with the Q6 modifier whose descriptor references only physicians. When the descriptor is updated to include physical therapists and physicians, contractors shall accept the modifier with the updated descriptor.<br><br>NOTE: Modifier Q6's descriptor will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update. | | X | | | | | | | |
| 10090.3.2 | Contractors shall suspend any editing that would cause | | X | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Other |
| | | A | B | H H H | | F I S S | M C S | V M S | C W F | |
| | physical therapist claims submitted with the Q6 modifier whose descriptor references only physicians to be denied or returned as unprocessable. | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | D M E M A C | C E D I |
| | | A | B | H H H | | |
| 10090.4 | MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | X | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** David Walczak, 410-786-4475 or david.walczak@cms.hhs.gov , Fred Grabau, 410-786-0206 or frederick.grabau@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual
## Chapter 1 - General Billing Requirements

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***(Rev. 3774, 05-12-17)***

**Transmittals for Chapter 1**

30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to *A/B MACs Part B*

30.2.11 - *Payment Under_Fee-For-Time Compensation* Arrangements *(formerly referred to as Locum Tenens Arrangements)* - Claims Submitted to *A/B MACs Part B*

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for A/B MAC *Part B* Processed Claims

### 30.2.1 - Exceptions to Assignment of Provider's Right to Payment – Claims Submitted to A/B MACs

***(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)***

**A. Payment to Government Agency**

Medicare payment for the services of a provider is not made to a governmental agency or entity except when payment to the governmental agency or entity is permissible under the other listed reassignment exceptions, e.g., where the agency is the employer of the physician.

**B. Payment Pursuant to Court Order**

The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §30.2.

**C. Payment to Agent**

The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions in §30.2.4.

**D. Payment to Employer**

The *A/*B MAC *Part B* may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for his services. (See §30.2.6.)

**E. Payment for Services Provided Under a Contractual Arrangement**

The *A/*B MAC *Part B* may make payment to an entity enrolled in the Medicare program for services provided by a physician or other person under a contractual arrangement with that entity. The services may be furnished on or off the premises of the entity submitting the claim. Both, the entity submitting the claim and receiving payment and the physician or other person under contract are subject to certain program integrity requirements. (See §30.2.7.)

**F. Payment for Anti-Markup Tests**

The *A/*B MAC *Part B* may pay a physician (or a physician's medical group) or other supplier for the TC or PC of diagnostic tests (other than clinical diagnostic laboratory tests) that the physician or other supplier contracts an independent physician, medical group, or other supplier to perform. The anti-markup payment limitation applies when the performing physician or other supplier does not meet the criteria for sharing a practice with the billing physician or other supplier. The contracting physician, physician's group, or other supplier must accept as payment in full the lower of: (a) the acquisition price; (b) the submitted charge for the service; or (c) the fee schedule amount. (See §30.2.9, of this chapter, for additional information on the anti-markup payment limitation.)

**G. Payment Under Reciprocal Billing Arrangements**

The *A/*B MAC *Part B* may pay the patient's regular physician for *physicians'* services *and services furnished incident to such services that are* provided to *the regular physician's* patients by another physician on an occasional reciprocal basis *and certain other requirements are met*. *Also, in the case of outpatient physical therapy services furnished by physical therapists in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area, the A/B MAC Part B may pay the patient's regular physical therapist for such services that are provided to his/her patients by another physical therapist on an occasional reciprocal basis and certain other requirements are met.* (See §30.2.10.)

**H. Payment Under *Fee-For-Time Compensation* Arrangements *(formerly referred to as Locum Tenens Arrangements)***

The *A/*B MAC *Part B* may pay the patient’s regular physician for *physicians'* services *and services furnished incident to such services that are provided by* a *substitute* physician during the absence of the regular physician where the regular physician pays the *substitute* on a per diem or similar fee-for-time basis, and certain other requirements are met. *Also, in the case of outpatient physical therapy services furnished by physical therapists in a HPSA, a MUA, or a rural area, the A/B MAC Part B may pay the patient’s regular physical therapist for such services that are provided by a substitute physical therapist where the regular physical therapist pays the substitute on a per diem or similar fee-for-time basis, and certain other requirements are met.* (See §30.2.11.)

## 30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to *A/B MACs Part B*

***(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)***

**A. *General requirements applicable to all Reciprocal Billing Arrangements***

*Under section 16006 of the 21st Century Cures Act, a Medicare-enrolled physical therapist may use a substitute physical therapist to furnish outpatient physical therapy services in a HPSA, a MUA, or a rural area under a reciprocal billing arrangement on or after June 13, 2017.*

The patient's regular physician *or physical therapist* may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services which the regular physician *or physical therapist* arranges to be provided by a substitute physician *or physical therapist* on an occasional reciprocal basis, if:

- The regular physician *or physical therapist* is unavailable to provide the services;
- The Medicare patient has arranged or seeks to receive the services from the regular physician *or physical therapist*;
- The substitute physician *or physical therapist* does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the *following* exception*: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a reciprocal billing arrangement for longer than the 60-day limit*; and
- The regular physician *or physical therapist indicates that* the services *were provided by* a substitute physician *or physical therapist under a reciprocal billing arrangement* meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS code Q5 modifier (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*) after the procedure code. The regular physician *or physical therapist* must keep on file a record of each service provided by the substitute physician *or physical therapist along with* the substitute physician *or physical therapist's* NPI, and make this record available to the *A/B MAC Part B* upon request.

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as services *furnished by a substitute physician*.

A physician *or physical therapist* may have reciprocal *billing* arrangements with more than one physician *or physical therapist*. The arrangements need not be in writing.

*With respect to physicians, t*he term "**covered visit service"** includes 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.

*With respect to physical therapists, the term "**covered visit service**" means outpatient physical therapy services furnished in a HPSA, a MUA, or a rural area. HPSAs and MUAs are designated by the Health Resources & Services Administration (HRSA). To determine if an area is a HPSA or an MUA, visit HRSA's website at https://www.hrsa.gov. A rural area is any area that is outside of a Metropolitan Statistical Area or a Metropolitan Division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget, or the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. To determine if an area is rural, consult the*

*Crosswalk of Counties to Core-Based Statistical Areas in the most current Inpatient Prospective Payment system final rule. Any area that is not designated as urban in the crosswalk is rural.*

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician or *physical therapist* provides covered visit services to Medicare Part B patients of the regular physician *or physical therapist*, and ends with the last day the substitute physician or *physical therapist* provides services to *such* patients before the regular physician *or physical therapist* returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician *or physical therapist* or are furnished by some other substitute physician *or physical therapist* on behalf of the regular physician *or physical therapist*. A new period of covered visit services can begin after the regular physician *or physical therapist* has returned to work.

**EXAMPLE:** The regular physician *or physical therapist* goes on vacation on June 30, and returns to work on September 4. A substitute physician *or physical therapist* provides services to Medicare Part B patients of the regular physician *or physical therapist* on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician *or physical therapist* is not entitled to bill and receive direct payment for the *services furnished August 31 through September 2*. The substitute physician *or physical therapist* must *either* bill for the *services furnished August 31 through September 2* in his/her own name *and billing number or reassign payment to the person or group that bills for the services of the substitute physician or physical therapist*. The regular physician *or physical therapist* may, however, bill and receive payment for the services that the substitute physician *or physical therapist* provides on behalf *of the regular physician or physical therapist* in the period July 2 through August 30.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

*A/B MACs Part B should inform physicians and physical therapists of the compliance requirements when billing for services of a substitute physician or physical therapist. The physician or physical therapist notification should state that, in entering the Q5 modifier, the regular physician or physical therapist (or the medical group or physical therapy group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician or physical therapist identified in a record of the regular physician or physical therapist which is available for inspection, and are services for which the regular physician or physical therapist (or group) is entitled to submit the claim. A/B MACs Part B should include in the notice that penalty for false certifications may include civil or criminal penalties for fraud, or administrative penalties including revocation of the physician's or physical therapist's Medicare billing privileges, right to receive payment, or to submit claims or accept any assignments. The revocation procedures are set forth under 42 CFR 424.535 and in the Medicare Program Integrity Manual (Pub. 100-8).*

*If a line item includes the code Q5 certification, A/B MACs Part B assume that the claim meets the requirements of this section in the absence of evidence to the contrary. A/B MACs Part B need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the Q5 certifications by a particular regular physician or physical therapist may not be valid.*

*When A/B MACs Part B make Part B payment under this section, they determine the payment amount as though the regular physician or physical therapist provided the services. The identification of the substitute physician or physical therapist is primarily for purposes of providing documentation to verify upon audit that the services were actually furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician or physical therapist.*

***B. Requirements applicable to* Physician Medical Group *or Physical Therapy Group* Claims Under Reciprocal Billing Arrangements**

*In order f*or a medical group *or physical therapy group* to submit claims *in the name of the regular physician or physical therapist* for the services of a substitute physician *or physical therapist*, the *substitute physician or physical therapist may not have reassigned his or her right to Medicare payment to the group through a CMS-855R reassignment enrollment form approved by the A/B MACs Part B and the* following requirements must be met:

- The regular physician *or physical therapist* is unavailable to provide the services;
- The Medicare patient has arranged or seeks to receive the services from the regular physician *or physical therapist*; and
- The substitute physician *or physical therapist* does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception*: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a reciprocal billing arrangement for longer than the 60-day limit*.

Services are billed for *the* entity as follows:

- The medical group *or physical therapy group* must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q5 after the procedure code.
- The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q5 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.
- A record of each service provided by the substitute physician *or physical therapist* must be kept on file *along* with the substitute physician's *or physical therapist's* NPI. This record must be made available to the *A/B MAC Part B* upon request.
- In addition, the medical group physician *or group physical therapist on whose behalf the* services *were* furnished *by a substitute* must be identified by his/her NPI in block 24J of the appropriate line item.

On claims submitted by *a* group, the group physician *or group physical therapist* who actually performed the service must be identified in the manner described in §30.2.13, with one exception. *When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5 modifier may be used* ***by the designated attending physician*** *to bill for services related to a hospice patient's terminal illness that were performed by another group member.*

## 30.2.11 - Payment Under *Fee-For-Time Compensation* Arrangements *(formerly referred to as Locum Tenens Arrangements)* - Claims Submitted to *A/B MACs Part B*

***(Rev. 3774, 05-12-17, Effective:06-13-17, Implementation: 06-13-17)***

### A. Background

It is a longstanding practice for *a* physician to retain *a* substitute physician to take over *his/her* professional practice when the physician *is* absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for *such* physician *(the regular physician)* to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician *often* has no practice of his/her own and *may* move from area to area as needed. The regular physician generally pays the substitute physician *on* a per diem *or other fee-for-time compensation basis* with the substitute physician having the status of an independent contractor, rather than of an employee*, of the regular physician*.

A regular physician *or physical therapist* is the physician *or physical therapist who* is normally scheduled to see a patient. *A* regular physician may include *a* physician specialist (such as a cardiologist, oncologist, urologist, *hospitalist,* etc.).

*Under section 16006 of the 21st Century Cures Act, a Medicare-enrolled physical therapist may use a substitute physical therapist to furnish outpatient physical therapy services in a HPSA, a MUA, or a rural area under a fee-for-time compensation arrangement on or after June 13, 2017.*

**B.** *General requirements applicable to all Fee-For-Time Compensation Arrangements*

A patient's regular physician *or physical therapist* may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services of a *substitute* physician *or physical therapist*, if:

- The regular physician *or physical therapist* is unavailable to provide the services;
- The Medicare beneficiary has arranged or seeks to receive the services from the regular physician *or physical therapist*;
- The regular physician *or physical therapist* pays the *substitute* for his/her services on a per diem or similar fee-for-time basis;
- The substitute physician *or physical therapist* does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the *following* exception: *A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a fee-for-time compensation arrangement for longer than the 60-day limit;* and
- The regular physician *or physical therapist indicates that* the services *were provided by* a substitute physician *or physical therapist under a fee-for-time compensation arrangement* meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished *under a fee-for-time compensation 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*) after the procedure code.

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as services *furnished by a substitute physician*.

*With respect to physicians, the term "**covered visit service**" includes 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.*

*With respect to physical therapists, the term "**covered visit service**" means outpatient physical therapy services furnished in a HPSA, a MUA, or a rural area. HPSAs and MUAs are designated by HRSA. To determine if an area is a HPSA or an MUA, visit HRSA's website at https://www.hrsa.gov. A rural area is any area that is outside of a Metropolitan Statistical Area or a Metropolitan Division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget, or the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. To determine if an area is rural, consult the Crosswalk of Counties to Core-Based Statistical Areas in the most current Inpatient Prospective Payment system final rule. Any area that is not designated as urban in the crosswalk is rural.*

*A "**continuous period of covered visit services**" begins with the first day on which the substitute physician or physical therapist provides covered visit services to Medicare Part B patients of the regular physician or physical therapist, and ends with the last day the substitute physician or physical therapist provides services*

*to such patients before the regular physician or physical therapist returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or physical therapist or are furnished by some other substitute physician or physical therapist on behalf of the regular physician or physical therapist. A new period of covered visit services can begin after the regular physician or physical therapist has returned to work.*

***EXAMPLE:*** *The regular physician or physical therapist goes on vacation on June 30, and returns to work on September 4. A substitute physician or physical therapist provides services to Medicare Part B patients of the regular physician or physical therapist on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician or physical therapist is not entitled to bill and receive direct payment for the services furnished August 31 through September 2. The substitute physician or physical therapist must either bill for the services furnished August 31 through September 2 in his/her own name and billing number or reassign payment to the person or group that bills for the services of the substitute physician or physical therapist. The regular physician or physical therapist may, however, bill and receive payment for the services that the substitute physician or physical therapist provides on behalf of the regular physician or physical therapist in the period July 2 through August 30.*

The requirements for the submission of claims under *fee-for-time compensation* arrangements are the same for assigned and unassigned claims.

*A/B MACs Part B should inform physicians and physical therapists of the compliance requirements when billing for services of a substitute physician or physical therapist. The physician/physical therapist notification should state that, in entering the Q6 modifier, the regular physician or physical therapist (or the medical group or physical therapy group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician or physical therapist identified in a record of the regular physician or physical therapist which is available for inspection, and are services for which the regular physician or physical therapist (or group) is entitled to submit the claim. A/B MACs Part B should include in the notice that penalty for false certifications may include civil or criminal penalties for fraud, or administrative penalties including revocation of the physician's or physical therapist's Medicare billing privileges, right to receive payment, or to submit claims or accept any assignments. The revocation procedures are set forth under 42 CFR 424.535 and in the Medicare Program Integrity Manual (Pub. 100-8).*

*If a line item includes the code Q6 certification, A/B MACs Part B assume that the claim meets the requirements of this section in the absence of evidence to the contrary. A/B MACs Part B need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the Q6 certifications by a particular regular physician or physical therapist may not be valid.*

*When A/B MACs Part B make Part B payment under this section, they determine the payment amount as though the regular physician or physical therapist provided the services. The identification of the substitute physician or physical therapist is primarily for purposes of providing documentation to verify upon audit that the services were furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician or physical therapist.*

**C. *Requirements applicable to Physician* Medical Group *or Physical Therapy Group* Claims Under *Fee-For-Time Compensation* Arrangements**

*In order f*or a medical group *or physical therapy group* to submit claims *in the name of the regular physician or physical therapist* for the services *of a substitute physician or physical therapist*, the *substitute physician or physical therapist may not have reassigned his or her right to Medicare payment to the group through a CMS-855R reassignment enrollment form approved by the A/B MACs Part B and the* following requirements must be met:

- *The regular physician or physical therapist is unavailable to provide the services;*
- *The Medicare patient has arranged or seeks to receive the services from the regular physician or physical therapist; and*
- *The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a fee-for-time compensation arrangement for longer than the 60-day limit.*

*For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the substitute is considered paid by the regular physician or physical therapist. Also, a physician or physical therapist who has left the group and for whom the group has engaged a substitute as a temporary replacement may bill for the temporary physician or physical therapist for up to 60 days. The term "regular physician or physical therapist" includes a physician or physical therapist who has left the group and for whom the group has hired the substitute as a replacement.*

*Services are billed for the entity as follows:*

- *The medical group or physical therapy group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q6 after the procedure code.*
- *The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q6 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.*
- *A record of each service provided by the substitute physician or physical therapist must be kept on file along with the substitute physician's or physical therapist's NPI. This record must be made available to the A/B MACs Part B upon request.*
- *In addition, the medical group physician or group physical therapist on whose behalf the services were furnished by a substitute must be identified by his/her NPI in block 24J of the appropriate line item.*

## 30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for A/B MAC *Part B* Processed Claims

***(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)***

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

**A General**

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses the current ASC X12 professional claim billing format or Form CMS-1500 to submit claims to Medicare A/B MACs *Part B*. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ASC X12 837 location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For electronic claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

**B Provider Identification Numbers**

The entity's NPI, when required, is entered in block 33a. Each physician who performs services for a patient must be identified on the Form CMS-1500 claim in block 24J for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician *or physical therapist* under a reciprocal or *fee-for-time compensation substitute* billing arrangement, the *"*performing*"* physician *or physical therapist identified on the claim form* is the *regular* physician *or regular physical therapist who is a* member of the entity.)

**C Payment Records**

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, A/B MACs *Part B* transmit the performing physician's NPI when required on the Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

**D Outpatient Physical Therapy or Speech-Language Pathology Claims**

Clinics that have been certified to provide outpatient physical therapy or speech-language pathology services to outpatients also use the ASC X12 837 professional claim format, or the CMS-1500 claim form for billing the A/B MAC *Part B*.

## 30.2.14 - Correcting Unacceptable Payment Arrangements

***(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)***

**A. Disseminating Information**

From time to time, A/B MACs must disseminate through professional relations media information regarding the prohibition in §30.2.

**A/*B* MACs *Part A***

The following language may be used by A/*B* MACs *Part A* or adapted for this purpose:

The Medicare law prohibits us from paying benefits due a provider to another person or organization under an assignment, power of attorney, or any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a provider's benefits (in the provider's name) to a billing or collection agent, if:
  - The agent receives the payment under an agency agreement with the provider;
  - The agent's compensation is not related in any way to the dollar amounts billed or collected;
  - The agent's compensation is not dependent upon the actual collection of payment;
  - The agent acts under instructions which the provider may modify or revoke at any time; and
  - The agent, in receiving payment, acts only in the providers' behalf.
- CMS may pay the providers' benefits in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction.

A provider should notify us immediately if:

- CMS has been mailing its benefits to the address of another person or organization;
  - The provider has given that other person or organization power of attorney or other advance authority to negotiate its benefit checks; and
  - None of the above exceptions that would permit payment to another person or organization apply in the provider's case.

A provider which hereafter enters into or continues such a prohibited payment arrangement may have its participation in the program terminated and its right to receive assigned payment for physician services revoked.

***A/*****B** ***MACs Part B and*** **DME MACs**

A*n A/*B *MAC Part B and* DME MAC may use or adapt the following language for notification:

The Medicare law prohibits us from paying benefits due a physician or other supplier of health care items and services, to another person or organization, under a reassignment or power of attorney or under any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

  - CMS may pay a physician's or supplier's employer under the terms of his/her employment.
  - CMS may pay a hospital, clinic, or other facility for services furnished by the physician or supplier in the facility, in accordance with the physician's or supplier's agreement with the facility.

- CMS may pay a group practice prepayment plan, prepaid health plan, or
- HMO for services of physicians and suppliers associated with the plan.
  - CMS may pay a physician, medical group, or other supplier for the technical component (TC) or professional component (PC) of diagnostic tests (other than clinical diagnostic tests) that are subject to the anti-markup payment limitation.
  - CMS may pay the patient's regular physician *or physical therapist* for services provided to his/her patients by another physician *or physical therapist* on an occasional, reciprocal basis
  - CMS may pay the patient's regular physician *or physical therapist* for services of a *substitute* physician *or physical therapist* during the absence of the regular physician *or physical therapist* where the regular physician *or physical therapist* pays the *substitute* on a per diem or similar fee-for-time basis.
  - CMS may pay a physician's or supplier's benefits in his/her name to a billing or collection agent, e.g., a medical bureau, if:
    - The agent receives the payment under an agency agreement with the physician or supplier;
    - The agent's compensation is not related in any way to the dollar amounts billed or collected;

- The agent's compensation is not dependent upon the actual collection of payment;
- The agent acts under instructions which the physician or supplier may modify or revoke at any time; and
- The agent, in receiving the payment, acts only on the physician's or supplier's behalf.

- CMS may pay a physician's or supplier's benefits in accordance with a reassignment established by, or pursuant to the order of, a court of competent jurisdiction.

A physician or supplier should notify us immediately if:

- CMS has been mailing his/her benefits to the address of another person or organization;
- The physician has given that other person or organization power of attorney or other advance authority to negotiate the physician's benefit checks; and
- None of the above exceptions which would permit payment to another person or organization apply in his/her case.

A physician or other eligible recipient of assigned payment who hereafter enters into or continues such a prohibited payment arrangement may have the right to receive assigned payment revoked.