CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS**
Transmittal 1486	**Date: April 4, 2008**
	Change Request 5985

SUBJECT: Exception to 60-Day Limit on Substitute Physician Billing Arrangements for Physicians Called to Active Duty in the Armed Forces Reserves

I. SUMMARY OF CHANGES: Section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007", signed on December 29, 2007, extended the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces for services furnished from January 1, 2008 through June 30, 2008.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

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	1/30.2.10/Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers
R	1/30.2.11/Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1486	Date: April 4, 2008	Change Request: 5985

SUBJECT: Exception to 60-Day Limit on Substitute Physician Billing Arrangements for Physicians Called to Active Duty in the Armed Forces Reserves

Effective Date: January 1, 2008

Implementation Date: May 5, 2008

I. GENERAL INFORMATION

A. **Background:** The President signed the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE) on December 29, 2007. Section 116 of this legislation (Public Law 110-173) extended the exception to the 60-day limit on substitute physician billing for physicians being called to active duty in the Armed Forces for services furnished from January 1, 2008 through June 30, 2008. Section 116 of Public Law 110-173 extended the accommodation of physicians ordered to active duty in the Armed Forces, enacted by Public Law 110-54, by striking "January 1, 2008" and inserting "July 1, 2008". Essentially, both legislative acts allow a physician being called to active duty to bill for the services furnished by a substitute physician for longer than the 60-day limitation.

B. Policy: Sections 30.2.10 and 30.2.11 of the CMS Internet-only Manual in Publication 100-04, Chapter 1, General Billing Requirements, state that a patient's regular physician may bill for services furnished by a substitute physician, either on a reciprocal or locum tenens basis, when the regular physician is unavailable to provide the services. Both the law at section 1842(b)(6)(D)(iii) of the Social Security Act and the manual instructions cited above state that the services of the substitute physician are not to be provided over a continuous period of longer than 60 days. Both legislative acts described in the background section above allow a physician being called to active duty in the Armed Forces to bill for services furnished by a substitute physician for longer than the 60-day limitation.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5985.1	The contractor shall extend the exception to the 60-day limit for physicians being called to active duty to bill for services furnished by substitute physicians from January 1, 2008 through June 30, 2008.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5985.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 one week of the availability of the provider education article. In addition, the provider education article shall be included in the Contractors 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			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): David Walczak (410) 786-4475

Post-Implementation Contact(s): David Walczak (410) 786-4475

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers

(Rev. 1486, Issued: 04-04-08, Effective: 01-01-08, Implementation: 05-05-08)

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

- The regular physician is unavailable to provide the visit services;
- The Medicare patient has arranged or seeks to receive the visit services from the regular physician;
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days *subject to the exception noted below*; and
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS code Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering the unique physician identification number (UPIN) or NPI when required on the form and cross-referring the entry to the appropriate service line item(s) by number(s). Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request.

EXCEPTION: *In accordance with section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE), enacted on December 29, 2007, the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces has been extended for services furnished from January 1, 2008 through June 30, 2008. Thus, under this law, a physician called to active duty may bill for substitute physician services furnished from January 1, 2008 through June 30, 2008 for longer than the 60-day limit.*

If the only substitution 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 substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

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.

"Incident to" services furnished by staff of a substitute physician or regular physician are covered if furnished under the supervision of each.

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician provides covered visit services to Medicare Part B patients of the regular physician, and ends with the last day the substitute physician provides services to these patients before the regular physician 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 are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

EXAMPLE: The regular physician goes on vacation on June 30, and returns to work on September 4. A substitute physician provides services to Medicare Part B patients of the regular physician 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 is not entitled to bill and receive direct payment for them. The substitute physician must bill for these services in his/her own name. The regular physician may, however, bill and receive payment for the services that the substitute physician provides on his/her behalf 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. Physician Medical Group Claims Under Reciprocal Billing Arrangements

The requirements of this section generally do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician 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.

For a medical group to submit assigned and unassigned claims for the covered visit services of a substitute physician who is **not** a member of the group and for an independent physician to submit assigned and unassigned claims for the substitution services of a physician who **is** a member of a medical group, the following requirements must be met:

- The regular physician is unavailable to provide the visit services;

- The Medicare patient has arranged or seeks to receive the visit services from the regular physician; and

- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days.

Substitute billing services are billed for each entity as follows:

- The medical group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q5 after the procedure code.

- The independent physician must enter in item 24 of Form CMS-1500 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 must be kept on file and associated with the substitute physician's UPIN or NPI when required. This record must be made available to the carrier upon request.

- In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required in block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are treated as independent physicians for purposes of applying the requirements of this section.

Carriers should inform physicians of the compliance requirements when billing for services of a substitute physician. The physician notification should state that, in entering the Q5 modifier, the regular physician (or the medical group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician identified in a record of the regular physician which is available for inspection, and are services for which the regular physician (or group) is entitled to submit the claim. Carriers should include in the notice that penalty for false certifications may be civil or criminal penalties for fraud. The physician's right to receive payment or to submit claims or accept any assignments may be revoked. The revocation procedures are set forth in §40.

If a line item includes the code Q5 certification, carriers assume that the claim meets the requirements of this section in the absence of evidence to the contrary. Carriers need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent

postpayment findings that indicate that the certifications by a particular physician may not be valid.
When carriers make Part B payment under this section, they determine the payment amount as though the regular physician provided the services. The identification of the substitute physician is primarily for purposes of providing an audit trail to verify 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.

30.2.11 - Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers

(Rev. 1486, Issued: 04-04-08, Effective: 01-01-08, Implementation: 05-05-08)

A. Background

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are 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 he/she performed them. The substitute physician generally has no practice of his/her 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. These substitute physicians are generally called "locum tenens" physicians.

Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. Thus, beginning January 1, 1995, a regular physician may bill for the services of a locum tenens physicians. A regular physician is the physician that is normally scheduled to see a patient. Thus, a regular physician may include physician specialists (such as a cardiologist, oncologist, urologist, etc.).

B. Payment Procedure

A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- The regular physician is unavailable to provide the visit services;
- The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;

- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days *subject to the exception noted below*; and

- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a locum tenens physician) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) or NPI when required to the carrier upon request.

EXCEPTION: *In accordance with section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE), enacted on December 29, 2007, the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces has been extended for services furnished from January 1, 2008 through June 30, 2008. Thus, under this law, a physician called to active duty may bill for substitute physician services from January 1, 2008 through June 30, 2008 for longer than the 60-day limit.*

If the only substitution 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 substitution services.

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

C. Medical Group Claims Under Locum Tenens Arrangements

For a medical group to submit assigned and unassigned claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements of subsection B must be met. For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the locum tenens physician is considered paid by the regular physician. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 60 days. The group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q6 after the procedure code. Until further notice, the group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required on block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the requirements of subsection A for payment for locum tenens physician services. Compensation paid by the group to

the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term “regular physician” includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.