

**NOTICE OF RULE ADOPTION—FINAL RULE**

**STATE OF MISSISSIPPI  
OFFICE OF THE GOVERNOR  
DIVISION OF MEDICAID**

Miss. Division of Medicaid  
c/o Bob M. Dent, Staff Officer  
Robert E. Lee Building  
239 N. Lamar Street  
Suite 801  
Jackson, MS 39201-1399  
(601) 359-6120  
<http://www.dom.state.ms.us>

Specific Legal Authority Authorizing the promulgation of  
Rule: Miss Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the  
Proposed Rule :  
Provider Policy Manual Section 55.09

**Date Rule Proposed:**

**Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:**  
AP 2006-54. Provider Policy Manual Section 55.09 creates the subsection regarding Physician -  
Locum Tenens/Reciprocal Billing Arrangements.

The Agency Rule Making Record for this rule including any written comments received during the comment period and the record of any oral proceeding is available for public inspection by contacting the Agency at the above address.

An oral proceeding was held on this rule:

Date:  
Time:  
Place:

An oral proceeding was not held on this rule.

The Agency has considered the written comments and the presentations made in any oral proceedings, and

This rule as adopted is without variance from the proposed rule.

This rule as adopted differs from the proposed rule as there are minor editorial changes which affect the form rather than the substance of the rule.

The rule as adopted differs from the proposed rule. The differences however are:  
Within the scope of the matters in the Notice of Proposed Rule Adoption, the logical outgrowth of the contents of the Notice of Proposed Rule Adoption and the comments submitted in response thereto, and  
The Notice of Proposed Rule Adoption provided fair warning that the outcome of the proposed rule adoption could be the rule in question.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Effective Date of Rule: November 1, 2006

Executive Director

Signature and Title of Person Submitting Rule for Filing

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 11/01/06</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Physician</b>	<b>Section: 55.09</b>	
	<b>Pages: 3</b>	
<b>Subject: Locum Tenens/Reciprocal Billing Arrangement</b>	<b>Cross Reference:</b>	

### **Locum Tenens Arrangement**

In a "locum tenens" arrangement, the regular physician retains a substitute physician to take over his/her practice during an absence. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

The patient's regular physician can submit a claim and receive payment for covered 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:

1. The regular physician is unavailable to provide the services; and
2. The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis; and
3. The Medicaid beneficiary has arranged or sought to receive services from the regular physician; and
4. The substitute physician does not provide the services to the Medicaid beneficiary over a continuous period of longer than 60 days; and
5. The regular physician keeps on file a record of each service provided by the substitute physician and makes the record available to DOM and/or its representatives upon request; and
6. The regular physician identifies the services as substitute physician services by entering HCPCS modifier Q6 (service furnished by a locum tenens physician) after the procedure code in item 24D of the CMS 1500 claim form; and
7. The locum tenens physician must be an enrolled Mississippi Medicaid provider with a valid Mississippi Medicaid provider number. When billing locum tenens services, the regular physician should place the locum tenens provider number in 24K on the CMS-1500 claim form.
8. It shall be the responsibility of the regular physician to ensure that the locum tenens physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

### **Medical Group Claims Under Locum Tenens Arrangements**

For a medical group to submit claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements listed above 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 still be considered a member of the group until a permanent replacement is obtained. The group must enter in item 24D of the CMS-1500 claim form the HCPCS modifier Q6 after the procedure code. The group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available upon request by DOM and/or its representatives. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) in block 24K 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 for payment of locum tenens

---

---

arrangements. 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.

### **Reciprocal Billing Arrangement**

A reciprocal billing arrangement is used when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

Under the reciprocal billing arrangements, the patient's regular physician may submit the claim and receive Medicaid benefits for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

1. The regular physician is unavailable to provide the services; and
2. The Medicaid beneficiary has arranged or sought services from the regular physician; and
3. The substitute physician does not provide the services to a Medicaid beneficiary over a continuous period of longer than 60 days; and
4. The regular physician keeps on file a record of each service provided by the substitute physician and makes the record available to DOM and/or its representatives upon request; and
5. The regular physician identifies the services as substitute physician services by entering in item 24D of the CMS 1500 claim form HCPCS modifier Q5 (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code; and
6. The substitute physician must be an enrolled Mississippi Medicaid provider with a valid Mississippi Medicaid provider number.
7. It shall be the responsibility of the regular physician to ensure that the substitute physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

### **Medical Group Claims Under Reciprocal Billing Arrangements**

The requirements of this section 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.

For a medical group to submit claims for the covered visit services of a substitute physician who is not a member of the group, the requirements listed above (1 – 5) must be met. The medical group must enter in item 24D of the CMS-1500 claim form HCPCS modifier Q5 after the procedure code. The medical group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to DOM and/or its representatives upon request. In addition, the medical group physician for whom the substitute services are furnished must be identified by his/her provider identification number (PIN) in block 24K of the appropriate line item.

For an independent physician to submit claims for the substitution services of a physician who is a member of a medical group, the requirements listed above (1-5) must be met. The independent physician must enter in item 24D of the CMS-1500 claim form HCPCS modifier Q5 after the procedure code. The independent physician must keep on file a record of each service provided by the substitute medical group physician, associated with the substitute physician's UPIN, and make this record available to DOM and/or its representatives upon request. 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 for

---

---

reciprocal billing arrangements.

### **Continuous Period of Covered Visit Services**

A continuous period of covered visit services begins with the first day on which the substitute physician provides covered visit services to patients of the regular physician, and it ends with the last day on which the substitute physician provides these 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, 2006, and returns to work on September 4, 2006. A substitute physician provides services to patients of the regular physician on July 2, 2006, and at various times thereafter, including August 30<sup>th</sup> and September 2<sup>nd</sup>, 2006. The continuous period of covered visit services begins on July 2<sup>nd</sup> and runs through September 2<sup>nd</sup>, a period of 63 days. Since September 2<sup>nd</sup> 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 which the substitute physician provided on his/her behalf in the period July 2<sup>nd</sup> through August 30<sup>th</sup>.