Payment Policy | Fee-for-Time Compensation Arrangements (Former Title: Locum Tenens)

EFFECTIVE DATE: 07|17|2012
POLICY LAST UPDATED: 03|04|2026

OVERVIEW
This policy documents Blue Cross & Blue Shield of Rhode Island's (BCBSRI) administrative guidelines for Fee for Time Compensation Arrangements, or substitute physicians/providers.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
The member's physician/provider may bill BCBSRI and receive payment for the substitute physician/provider's services as though the member's regular physician/provider performed them when these procedures are followed. In all cases the participating physicians/providers are responsible for compliance under their contract. BCBSRI does not permit subcontracting. ~~and~~ Physician/provider agreements state:

A regular physician/provider may bill for the services of a substitute physician/providers if:

- The regular physician/provider is unavailable to provide the visit services;
- The regular physician/provider pays the substitute physician/provider for his/her services and guarantees that members are not charged for services, except as would have been allowed by the regular physician/provider (e.g. allowed member cost sharing);
- The regular physician/provider has notified BCBSRI in writing of the intent to use a substitute physician/provider;
- The regular physician/provider identifies the substitute physician/provider and submits proof via email to Database.Credentialing@bcbsri.org that the substitute physician/provider is licensed in the state of practice, carries liability insurance consistent with BCBSRI requirements, and possesses training/board certification in the same field as the regular physician/provider;
- The regular physician/provider documents agreement that the substitute physician/provider may not charge members for services or report services to BCBSRI in any other manner than as outlined in these policies;
- The substitute physician/provider does not provide the visit services over a continuous period of longer than 60 days; and
- The regular physician/provider identifies the services as substitute physician/provider services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a substitute physician/provider) after the procedure code.

Services of non-physician practitioners, or Advance Practice Providers (e.g., CRNAs, NPs and PAs) may not be billed under fee-for-time compensation arrangements. See Related Policy, Advance Practice Providers. A regular physician/provider is defined in this case as MDs or DOs. A regular physician/provider may include a physician specialist such as a cardiologist, oncologist or urologist.

If the only substitution services a physician/provider performs in connection with an operation are postoperative services furnished during the global period, these services need not be identified on the claim as substitution services. Services that are inclusive of the global payment are not separately reported.

Blue Cross may terminate this Agreement for cause if the physician subcontracts with another provider to render services on behalf of the physician/provider under this Agreement.

1. A substitute physician/provider may file for reimbursement when the provider that they are acting as is a participating provider with BCBSRI.
2. The use of a substitute physician/provider by a participating provider is limited to 60 days per 12-month period. A substitute physician/provider providing services for more than 60 days must be contracted and credentialed by BCBSRI.
3. The contracted physician/provider is responsible for the substitute physician/provider adhering to all contractual and other requirements and is subject to sanction for failure to do so.
4. All arrangements for substitute physician/provider use shall be approved by BCBSRI before implementation.
5. Failure to follow these procedures when using a substitute physician/provider or other provider constitutes subcontracting and is a contractual violation and cause for termination.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable benefits/coverage.

BACKGROUND

Centers for Medicare and Medicaid Services (CMS) has indicated that the term "locum tenens," which has historically been used in the Medicare Claims Processing Manual to mean fee-for-time compensation arrangements, was 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 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.

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/provider) to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician/provider often has no practice of his/her own and may move from area to area as needed. The regular physician/provider generally pays the substitute physician/provider on a per diem or other fee-for-time compensation basis with the substitute physician/provider having the status of an independent contractor, rather than of an employee, of the regular physician/provider.

CODING

Claims for services rendered by a substitute physician/provider are submitted under the regular contracted physician/provider's name and Tax Identification (ID) number. Modifier Q6 must be appended to each procedure code, signifying that the service was rendered by a substitute physician/provider.

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

Use of modifier Q6 by the regular physician/provider certifies that the covered visit services furnished by the substitute physician/provider are identified in the record of the regular physician/provider, which is available for inspection, and are services that the regular physician/provider is entitled to submit.

RELATED POLICIES

Advance Practice Providers (APPs)

PUBLISHED

Provider Update, April 2026
Provider Update, August 2021
Provider Update, April 2020
Provider Update, January 2019
Provider Update, February 2018
Provider Update, June 2013

REFERENCES

BCBSRI Physician/Provider Agreements
Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual – Chapter 1
Centers for Medicare and Medicaid Services (CMS). CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 3774.
MLN Matters Number MM10090. Changes to the Payment Policies for Reciprocal Billing and Fee-for-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements). May 12, 2017.

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.