PUBLICATION

"Locum Tenens" Physical Therapist – Does the Change Provide Sufficient Relief?

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CMS recently published guidance to implement Section 16006 of the 21st Century Cures Act, effective June 13, 2017, which allows physical therapists providing services to Medicare beneficiaries to utilize "locum tenens" arrangements in the same manner as physicians who have been allowed to provide such services. CMS's guidance, "Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)" is found in Transmittal 3774 to the Medicare Claims Processing Manual.

There is, however, a significant difference between the rules for physicians and physical therapists, because Section 16006 does not authorize the use of these coverage arrangements in all geographic areas, as is the case for physicians. Rather, with respect to physical therapists, the use is restricted to:

- Practice locations in a Medicare identified health professional shortage area (HPSA), medically underserved area (MUA) or rural area. Section 30.2.10 of Chapter 1 of the Medicare Claims Processing Manual includes information to determine if a practice location is in one of these identified areas. The inclusion of a geographic area under the Medicare rules must be distinguished from other identified underserved areas, such as a state's listing of Medicaid-identified areas of need.

The term "locum tenens" is being replaced and CMS's guidance includes specific provisions for "Reciprocal Billing Arrangements" and "Fee-For-Time Compensation Arrangements." Reciprocal Billing Arrangements include situations in which the regular physical therapist's patients are treated by another physical therapist on an occasional and reciprocal basis, such as two private practitioners who provide leave coverage for each other. Fee-For-Time Compensation Arrangements, which were formerly referred to as "Locum Tenens Arrangements," include situations in which the regular physical therapist's patients are treated by another physical therapist on a per diem or similar fee-for-time basis when the regular physical therapist is absent, such as when taking leave for vacation, illness or pregnancy. The substitute physical therapist "often has no practice of his/her own and may move from area to area as needed." This does not include, for example, using a newly hired physical therapist as a substitute for a regular physical therapist who is leaving the practice. Absent coverage for military leave, these coverage arrangements are limited to a 60-day time period. Modifiers are utilized to distinguish services provided under these types of coverage arrangements. Specifically,

- Claims are submitted with the Q5 modifier to confirm a Reciprocal Billing Arrangement and the Q6 modifier to confirm a Fee-For-Time Compensation Arrangement. CMS reports that the Q5 and Q6 modifier descriptors will be amended to include physical therapists and MACs have been instructed to suspend any edit that would deny a claim for physical therapy services with either modifier.

Physical therapy practices that plan to utilize "Reciprocal Billing Arrangements" and/or "Fee-For-Time Compensation Arrangements" should understand all the requirements of these coverage arrangements. In addition to making the requirements available to the staff, therapy practices located within a Medicare identified HPSA, MUA or rural area should consider establishing policies and procedures that set forth the practice's use of and billing for these coverage arrangements. In amending its manual guidance, CMS cautioned physical

therapists of the risks for non-compliance, including civil or criminal penalties for fraud or administrative penalties, including a billing privilege revocation.

Baker Donelson Comments: Non-compliance can result from failure to ensure that all requirements have been followed or failure to include the applicable modifier on the claim. As CMS cautioned, the risk of non-compliance can be significant. CMS has the authority to revoke billing privileges based on a "pattern or practice" of submitting claims with claims errors, which CMS has further qualified could be as few as three claims.