Keystone First
Family of Health Plans

Locum Tenens

Reimbursement Policy ID: RPC.0064.PA01

Recent review date: 12/2025

Next review date: 12/2027

Keystone First VIP Choice reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First VIP Choice may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement for locum tenens physicians. Locum tenens is a Latin phrase that means "to hold the place of, to substitute for." When a practitioner is expected to be absent for a period of time, he or she may arrange for practice coverage by a locum tenens physician for no longer than 60 days. The regular physician will generally pay the substitute physician a fixed amount per diem as an independent contractor rather than as an employee.

Exceptions

N/A

Reimbursement Guidelines

Reimbursement for services provided by a locum tenens physician is based on the claim. The locum tenens physician does not submit a claim. The regular physician submits a claim under the fee-for-time compensation arrangement using his/her own national provider identifier (NPI), appending the modifier -Q6 (service furnished by a locum tenens physician) to the procedure code(s). Services furnished under a locum tenens arrangement are not eligible for reimbursement after 60 consecutive days. Modifier -Q5 is submitted when a physician covers for another physician within the same group.

Definitions

Locum Tenens
Locum tenens physicians are contracted physicians who substitute for a physician who has left the practice, or who is temporarily unavailable (e.g., on medical leave, on vacation).

Modifier -Q5
A procedure code modifier used for billing when services are furnished by a substitute physician under a reciprocal billing arrangement.

Modifier -Q6
A procedure code modifier used for billing of services for a locum tenens physician. It is intended to be used when a physician is away for an extended period of time and arranges for a locum tenens or substitute physician to provide services to their patients in their place.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1486CP.pdf.
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding Keystone First VIP Choice Clinical Policies.
VII. Applicable Keystone First VIP Choice provider manual reference.
VIII. CMS Medicare program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

12/2025	Reimbursement Policy Committee Approval
11/2025	Biennial policy review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
11/2023	Reimbursement Policy Committee Approval

08/2023	Removal of policy implemented by Keystone First VIP Choice from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section