Audio Title: Hospice Related Services – Part B
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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information that health care professionals can trust.

Are you a physician submitting claims to Medicare contractors or Medicare Administrative Contactors (MACs)? Are you also submitting claims to MACs for services provided to beneficiaries who are in a hospice period of coverage? If your answer is yes to both of these questions, then you will benefit from this podcast!

Recovery Auditors are conducting automated claim reviews of medical services provided as separate services when CMS regulation or policy, or local practice dictates that they should have been billed together for Medicare beneficiaries in hospice care.

To begin, it is important for you to identify if a beneficiary is enrolled in hospice. You can ask beneficiaries or their legal representative if they are enrolled in Hospice. Be sure to document this in the beneficiary's medical record.

You should also educate beneficiaries and their families that once the beneficiaries are enrolled in Hospice, they should contact the Hospice provider to arrange for any care they need.

If the Hospice provider does not arrange the services the beneficiaries need, then the beneficiaries may be financially responsible for the services.
You should make sure that the beneficiary and his or her family is aware that the beneficiary or legal representative may revoke the election of hospice care at any time in writing.

Let the beneficiary know that in order to revoke the election of hospice care, he or she must file a document with the hospice that includes:

- A signed statement that the beneficiary revokes the election for Medicare coverage of hospice care for the remainder of that election period
- And the effective date of that revocation.

Be aware that a verbal revocation of benefits is NOT acceptable. . Revocation of the hospice election must be done in writing and a beneficiary may not designate an effective date of the revocation that is earlier than the date that the revocation is made.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, a beneficiary resumes Medicare coverage of the benefits waived when hospice care was elected.

A beneficiary may at any time elect to receive hospice coverage as long as he or she continues to meet the eligibility criteria, meaning the beneficiary is entitled to Medicare Part A and has been certified as terminally ill, with a medical prognosis of six months or less.

Now that we are finished with our background information discussion of hospice, let's move on to what you need to know when submitting claims for patients in a hospice period of coverage.

Services related to a Hospice terminal prognosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

In cases where beneficiaries are enrolled in hospice, Medicare contractors should deny any Part B services furnished on or after January 1, 2002 that are submitted without either:

- A GV modifier, meaning the attending physician is not employed or paid under arrangement by the beneficiary's hospice provider and professional services provided are related to the terminal prognosis
- Or a GW modifier, meaning the service is not related to the hospice beneficiary's terminal prognosis.

Contractors should deny services that are submitted with the GW modifier when the service is determined to be related to the terminal prognosis.

Contractors should also deny services that are submitted with the GV modifier if it is determined that the Physician services were furnished by Hospice-employed physicians and Nurse Practitioners (NP) or by other physicians under arrangement with the Hospice.

Example 1 is: A beneficiary is enrolled in Hospice and goes to a physician's office for closed treatment of a metatarsal fracture, CPT code 28470.

The resolution is: If the procedure is unrelated to the terminal prognosis (Non-Hospice related), the physician's bill should contain the GW modifier.

If this modifier is not appended, the procedure is related to the terminal prognosis and should not be reimbursed under the Part B benefit. Thus, the claim is in error, since the services are considered included with payments under the hospice benefit.

Example 2 is: The patient is listed as being on hospice starting August 1, 2010 through August 31, 2010. A provider billed CPT code 45378, a Diagnostic Colonoscopy, with no modifiers on August 3, 2010 to Part B.

The resolution is: The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice and there can be no separate reimbursement unless the service was unrelated to the terminal prognosis or the attending physician was otherwise entitled to separate reimbursement, which would be reflected by the GV modifier or the GW modifier.

MACs should also deny services that are submitted with the modifier but for which, during medical review, the service is determined to be related to the terminal prognosis.

This concludes our hospice related services podcast. To learn more about this topic:

Download the MLN Matters article number SE1321, by going to the CMS website at www.cms.gov and Search for the Medicare Learning Network.

From that page search for MLN Products.

More questions? To learn more about the hospice program and hospice related services, contact your Medicare Administrative Contractor or
visit the CMS website at www.cms.gov and search for the Medicare Learning Network. From that page, search for MLN Multimedia to view the podcast transcript.

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