UNIVERSITY HEALTHCARE ALLIANCE

CODING CORNER

HOSPICE MODIFIERS

Patients are enrolled in hospice if they are expected to pass away within the next 6 months. All care is expected to be given by the hospice care facility and may or may not be related to the patient's terminal illness.

When a patient in hospice is treated by a physician who is not paid by the hospice or for a condition unrelated to the patient's terminal condition, a modifier is required to indicate that a separate payment should be allowed.

A provider that is not paid by hospice providing care for the patient should use the appropriate E/M codes (99201-99215, 99221-99233) and POS appropriate for the status of the patient at the time of treatment.

Depending on the patient's terminal illness and related conditions, the plan of care the hospice team creates can include any or all of these services:

- Doctor services
- Nursing care
- Medical equipment, like wheelchairs or walkers
- Medical supplies, like bandages or catheters
- Prescription drugs for symptom control or pain relief
- Hospice aide and homemaker services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services
- Social work services
- Dietary counseling
- Grief and loss counseling for the patient and their family
- Short-term inpatient care for pain and symptom management
- Short term temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.
- Short-term respite care for the patient's usual caregiver can be in an inpatient respite care in a Medicare-approved facility (like a hospice inpatient facility, hospital, or nursing home). Each stay may be up to 5 days, may be received more than once, and is limited to an occasional basis.
- Any other Medicare-covered services needed to manage pain and other symptoms related to terminal illness and related conditions, as recommended by the hospice team

Modifier GV

The attending physician is not employed or paid under agreement by the patient's hospice provider.

Instructions

This modifier must be submitted when a service meets the following conditions, regardless of the type of provider:

- Service was rendered to a patient enrolled in a Hospice.
- Service was provided by a physician or non-physician practitioner identified as the patient's 'attending physician' at the time of that patient's enrollment in the Hospice program
- Submit this modifier regardless of whether the services were related to the patient's terminal condition

This modifier must *not* be used in the following situations:

- Service was provided by a physician employed by the Hospice, you may *not* submit this modifier
- Service was provided by a physician not employed by the Hospice and the physician was not identified by the beneficiary as his/her attending physician, you may *not* submit this modifier

HOSPICE MODIFIERS

Example
An independent attending physician or independent laboratory interprets the surgical pathology (88305) from a patient with a terminal illness related service. The professional component is billed to the Medicare contractor. If there is no professional component (e.g., clinical lab tests), then the Part A Hospice should only be billed.

Date of Service	Treatment	CPT/Modifier
1/14/2012	Surgical pathology (professional component)	Bill to Part B: 88305 26GV
1/14/2012	Surgical pathology (technical component)	Bill to Hospice: 88305 TC

Same rules apply for diagnostic tests		
Date of Service	**Treatment**	**CPT/Modifier**
9/25/2012	Chest x-ray (professional component)	Bill to Part B: 71010 26GV
9/25/2012	Chest x-ray (technical component)	Bill to Hospice: 71010 TC

Modifier GW
Condition not related to the patient's terminal condition

Instructions
- Submit when a service is rendered to a patient enrolled in a hospice, and service is unrelated to patient's terminal condition
- All providers must submit this when this condition applies

Claim Coding Example
Patient is on hospice for congestive heart failure and goes to the office for a toe nail trim. The procedure is unrelated. The GW modifier should be added to the CPT for the toe nail trim.

Other Payer information
Aetna indicates that Aetna Medicare members may elect to use the hospice benefit in the Original Medicare program instead of their MA HMO and PPO coverage if a waiver for election of benefits is signed prior to initiating hospice care. In this case the GV/GW modifiers are then required as indicated above.

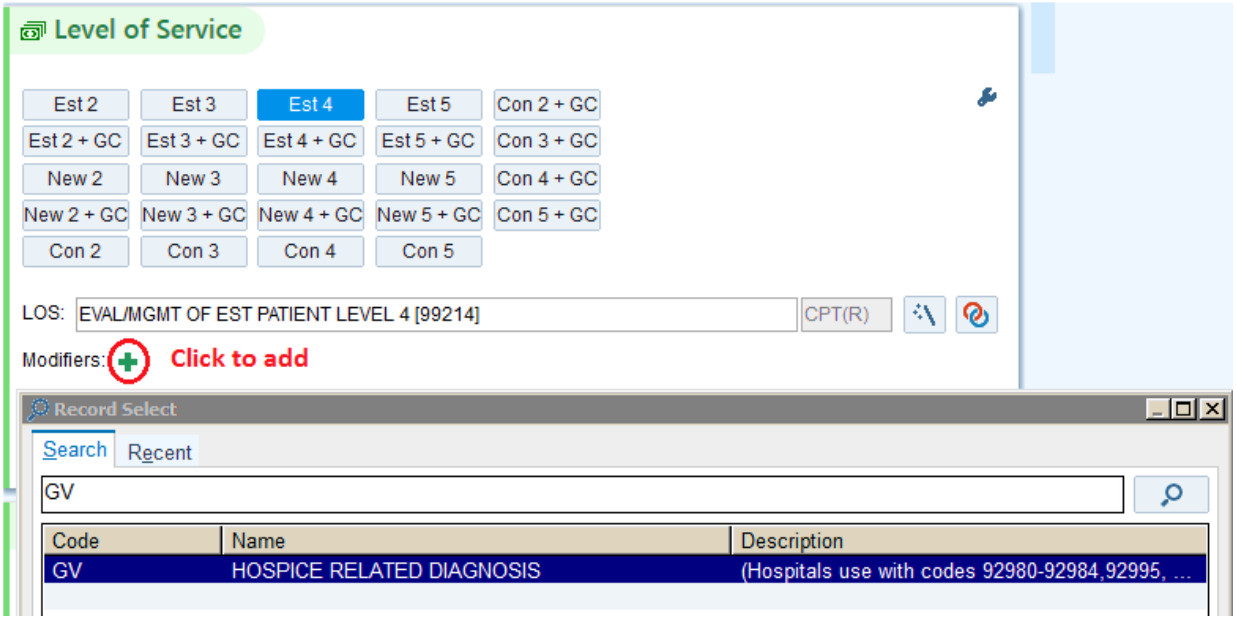
Cigna does not indicate that these modifiers are required, but they will be accepted if reported.

Blue Shield CA indicates that modifiers GW and GV should be used when appropriate according to the Medicare Carriers Manual Change Request 1910.

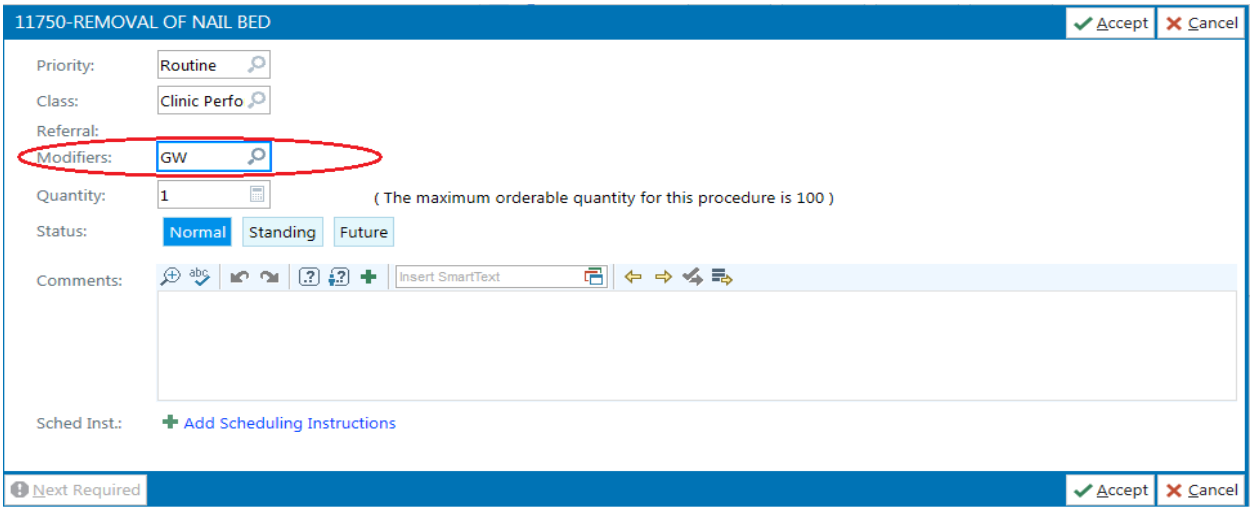
Blue Cross CA has no indication regarding these modifiers.

Medi-Cal follows CMS rules regarding use of these modifiers.

Level of Service



Orders



Resources:

- https://med.noridianmedicare.com/web/jeb/topics/modifiers/gw
- https://med.noridianmedicare.com/web/jeb/topics/modifiers/gv
- CMS Internet Only Manual (IOM) *Medicare Claims Processing Manual*, Publication. 100-04, Chapter 11, Section 40
- https://www.medicare.gov/coverage/hospice-care
- http://www.aetna.com/healthcare-professionals/documents-forms/office-manual-hcp.pdf
- https://www.hcms.org/uploadedFiles/Harris_County_Medical_Society/Practice_Resources/Payers/Commercial_Payers/HCPCS_Level_II_Modifiers.pdf
- https://www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/provider/StreamDocumentServlet?fileName=PRV_4-19_IPP_Manual_Section4.pdf

Other Resources:

- https://www.texmed.org/Template.aspx?id=27782
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241070/
- https://oig.hhs.gov/oei/reports/oei-02-06-00224.pdf