



Reimbursement & Coding News

February 9, 2010

Santa Clara County Medical Association/Monterey County Medical Society

How to Bill When the Doctor Is the Attending Physician for a Hospice Patient

DID YOU KNOW?...

Physicians or suppliers who routinely waive the collection of deductible or coinsurance from a Medicare beneficiary constitute a violation of the law pertaining to false claims and kickbacks.

Where a physician/supplier makes a reasonable collection effort for the payment of coinsurance/deductibles, failure to collect payment is not considered a reduction in the physician's/supplier's charge. To be considered a reasonable collection effort, the effort to collect Medicare coinsurance/deductible amounts must be similar to the effort made to collect comparable amounts from non-Medicare patients. It must also involve the issuance of a bill to the beneficiary or to the party responsible for the patient's personal financial obligations. In addition, it may include other actions, such as subsequent billings, collection letters, and telephone calls or personal contacts which constitute a genuine, rather than token, collection effort.

Source:

<http://www.cms.hhs.gov/manuals/downloads/clm104C23.pdf>

Pg. 124

Selecting the correct modifier is crucial to billing for hospice patients. Most services to hospice patients are included in the hospice payment, but a physician who has been designated by the patient as the attending physician and doesn't have a payment arrangement with the hospice can bill Part B for his or her services.

Per the Medicare Claims Processing Manual, Chap. 11, sec. 40.1.3, "When a Medicare beneficiary elects hospice coverage, he/she may designate an attending physician, who may be a nurse practitioner, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered *Medicare Part A* 'hospice services.' These *independent* attending physician services are billed *through Medicare Part B* to the *Medicare contractor*, provided they were not furnished under a payment arrangement with the hospice. The *independent* attending physician codes services with the **GV** modifier (attending physician not employed or paid under agreement by the patient's hospice provider) when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. The *Medicare contractor* makes payment to the *independent* attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service."

"Where the service is related to the hospice patient's terminal illness, but was furnished by someone other than the designated 'attending physician' [or a physician substituting for the attending physician], the physician or other provider must look to the hospice for payment."

Here are some tips to avoid denials:

- When a physician enrolls a patient in hospice and he or she elects that physician as the attending doctor, make sure the hospice informs Medicare.
- File claims for hospice patients with modifier **GV** (attending physician not employed or paid under agreement by the patient's hospice provider).
- If another doctor is covering for the attending physician, bill his or her services under the reciprocal or locum tenens rules. Use modifier GV with either **Q5** (service furnished under a reciprocal billing arrangement) or **Q6** (service by a locum tenens physician).
- If a physician treats a hospice patient for a condition **not related** to the terminal condition, submit claims to your carrier with **GW** (service not related to the hospice patient's terminal condition).

Source: Medicare Claims Processing Manual Pg. 27

<http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf>

Medicare Posts List of PECOS-Enrolled Physicians

Medicare physicians who have not updated their enrollment information in the past five years may need to fill out another application or face payment problems for ordered or referred services. The new rules that take effect April 5, authorize Medicare to reject claims if an ordering physician is not identified in Medicare's web-based PECOS system. For example, if you order X-rays, you'll need to be in PECOS or the radiologist who reads the images won't get paid. If you are not sure if you are already in the PECOS system, you may now find out via Medicare's list of enrollees posted on their website <http://www.cms.hhs.gov/MedicareProviderSupEnroll> and click on "OrderingReferringReport" on the left hand side.