Part B Insider (Multispecialty) Coding Alert

MYTHBUSTER: Clarification--Avoid Making Alphabet Soup Out of Modifiers GV and GW

Hospice participation is growing, so make sure you know how to bill for it

If you-re billing Medicare for hospice charges, it's time to get your modifiers straight, or you could face denials.

The Insider-s Vol. 8, No. 36 included a reader question entitled, -Don't Forget Modifiers for Hospice Patients.- The answer to this question noted that the attending physician for the hospice patient should append modifiers GV and GW, and that the non-attending physician should use modifiers Q5 and Q6, but this is incorrect, notes **Jean Acevedo, LHRM, CPC, CHC, PCS**, of **Acevedo Consulting, Inc.**

-The GV and GW modifiers are a common source of confusion,- she says. The definitions of the modifiers follow:

- GV--Attending physician not employed or paid under arrangement by the patient's hospice provider (this has nothing to do with whether the patient is being seen for her terminal illness as alluded to in the article)

- GW--Service not related to the hospice patient's terminal illness.

-One of the most common hospice misconceptions is that once a patient is in hospice, a physician cannot bill for any services,- Acevedo says. -This is a widespread problem.-

Reality: When a patient goes into hospice care, he elects an attending physician for hospice purposes. -If that physician is a community-based doctor and not a hospice employee, that physician bills Part B for his or her care of the patient related to the hospice diagnosis,- Acevedo explains. -That physician must, however, add modifier GV to the claim to show he isn't paid by the hospice.-

When GW applies: Suppose the patient has an attending physician for his hospice care, but requires a different physician to address a problem not related to the hospice diagnosis. For instance, the patient is under hospice care due to cancer, so the attending physician is an oncologist. But the patient experiences diabetes- related complications and requires an endocrinologist. -In that case, the endocrinologist will bill Medicare for his or her services with modifier GW appended,- Acevedo says.

Alternate scenario: Suppose a doctor is not the hospice patient's attending physician, but sees the patient regarding the terminal illness anyway. In this case, the hospice would pay the physician directly, and the physician would not bill the insurer.

Example: A patient has terminal cancer and a primary care physician is her attending doctor at the hospice. The patient's cancer progresses to the point that palliative chemotherapy would help ease symptoms, so an oncologist sees the patient to address the chemotherapy. In this case, the hospice will pay the oncologist directly, Acevedo advises. -The hospice should be consulted in advance, and if it's really something that will ease the patient's pain, they-ll pay for it,- she says.

Modifiers Q5 and Q6: -These modifiers would never be used for a physician in the same practice,- Acevedo says. -If the attending physician is out of town and a covering doctor is filling in, they would bill locum tenens and append modifiers GV and Q5 to tell the insurer, -I-m not contracted with the hospice, and by the way, if you ask for my records for this encounter, you-ll find proof that the doctor covering for me was seeing the patient.--

Hospices often don't struggle to collect payment the same way that physician practices do. -The hospice benefit actually includes very few impediments to the hospice being paid,- Acevedo says. And chances are that Medicare will keep treating hospices well, following a recent study that discovered that hospice care provides -significant- savings to Medicare.

The **Duke University** study, -What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the U.S. Medicare Program,- was released Nov. 7 and notes that hospice care reduced Medicare spending by an average of $2,309 per person compared to -normal care, which typically includes expensive hospitalizations near death.- Hospice care has increased from 7 percent of Medi-care patients in 1990 to almost 30 percent in 2006.

-Often, hospice is used for a relatively short time, but we found that patients who use the benefit for the last seven to eight weeks of life maximize cost savings to the program,- said primary author **Don Taylor** of Duke's **Sanford Institute of Public Policy** in a press release.