

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11029	Date: September 29, 2021
	Change Request 12357

Transmittal 10907, dated August 10, 2021, is being rescinded and replaced by Transmittal 11029, dated, September 29, 2021 to revise business requirement 12357.1 removing the CG modifier. All other information remains the same.

SUBJECT: Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

I. SUMMARY OF CHANGES: This change request implements the GV modifier for both RHCs and FQHCs to report on claims when billing for hospice attending physician services furnished by certain RHCs or FQHC practitioners during a patient’s hospice election.

EFFECTIVE DATE: January 1, 2022

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/Table of Contents
N	9/60/60.6/RHCs and FQHCs for Billing Hospice Attending Physician Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11029	Date: September 28, 2021	Change Request: 12357
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SUBJECT: Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

EFFECTIVE DATE: January 1, 2022

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 3, 2022

I. GENERAL INFORMATION

A. Background: Prior to January 1, 2022, RHCs and FQHCs were not authorized under the statute to serve in the role of a hospice attending physician. However, a physician, Nurse Practitioner (NP), or Physician Assistant (PA) who worked for an RHC or FQHC could provide hospice attending physician services during a time when they were not working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement). The physician, NP, or PA would bill for these services under Part B using their national provider identifier.

Section 132 of the Consolidated Appropriations Act, 2021 amended section 1834(o) of the Act and added a new section 1834(y) to the Act, to provide the authority for both FQHCs and RHCs, respectively, to receive payment for hospice attending physician services.

B. Policy: Beginning January 1, 2022, an RHC or FQHC can bill and receive payment under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), respectively, when a designated attending physician employed by or working under contract with the RHC or FQHC furnishes hospice attending physician services (as described in section 1812(d)(2)(A)(ii) of the Act) during a patient's hospice election.

Therefore, beginning January 1, 2022, to receive the RHC AIR or payment under the FQHC PPS, the RHC or FQHC must report the GV modifier (attending physician not employed or paid under arrangement by the patient's hospice provider) when a physician, NP, or PA employed by or working under contract with an RHC or FQHC furnishes hospice attending physician services to a beneficiary that has elected hospice.

RHCs must report the GV modifier on the claim line for payment (that is, along with the CG modifier) each day a hospice attending physician service is furnished.

FQHCs must report the GV modifier on the claim line with the payment code each day a hospice attending physician service is furnished.

When the RHC/FQHC furnishes a hospice attending physician service that has technical component, the provider furnishing the technical component would go to the hospice for payment as discussed in the Medicare Claims Processing Manual at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf>.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F M V C	I C M W	S S S F			
12357.1	<p>Medicare contractors shall bypass hospice overlap edits when the TOB is 71X or 77X and a service line contains modifier 'GV' during a hospice election period.</p> <p>NOTE: For 71X TOBs: If a line contains modifier GV, all the services with the same LIDOS should be bypassed from the hospice edit.</p> <p>For 77X TOBs: If the line contains G0466, G0467, G0468, G0469 or G0470 and modifier GV, all the service lines with the same LIDOS should be bypassed from the hospice edit.</p>									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC			D M E	C E D I					
		A	B	H H H			M A C				
12357.2	<p>MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.</p>	X									

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov , Tracey Mackey, Tracey.Mackey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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(Rev. 11029, Issued:09-29-21)

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60.6 - RHCs and FQHCs for Billing Hospice Attending Physician Services

60.6 - RHCs and FQHCs for billing Hospice Attending Physician Services
(Rev. 11029, Issued: 09-29-21, Effective:01-01-22, Implementation:01-03-22)

Effective for services furnished on or after January 1, 2022, RHCs or FQHCs can bill and receive payment under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), when a designated attending physician employed by or working under contract with the RHC or FQHC furnishes hospice attending physician services during a patient's hospice election.

RHCs must report a GV modifier on the claim line for payment (that is, along with the CG modifier) each day a hospice attending physician service is furnished.

FQHCs must report a GV modifier on the claim line with the payment code (G0466 – G0470) each day a hospice attending physician service is furnished.

The hospice attending physician services are subject to coinsurance and deductibles on RHC claims and only coinsurance on FQHC claims.