CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11095	**Date: October 29, 2021**
	Change Request 12357

Transmittal 11029, dated September 29, 2021, is being rescinded and replaced by Transmittal 11095, dated, October 29, 2021 to revise business requirement 12357.1 and add new business requirements 12357.2, 12357.2.1, 12357.3 and 12357.3.1. 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: 11095	Date: October 29, 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
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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			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12357.1	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. NOTE: For 71X TOBs: If a line contains modifier GV, all the services with the same LIDOS should be bypassed from the hospice edit. 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. **NOTE:** This business requirement will be implemented in the January 2022 release.								X	
12357.2	Medicare contractors shall create a line level reject to assign for 71X and 77X TOBs when the line item date of service (LIDOS) does not equal the LIDOS that contains modifier GV and the services are during a hospice election period for dates of service on or after 01/01/2022. For 71X TOBs: If a line contains modifier GV, all the services with the same LIDOS should bypass the edit. 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 bypass the edit. The Medicare contractor shall ensure: • Trailer 43 with a DISP								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	"CR" is returned on the detail line (s) subject to the new edit. • The edit is overrideable on the detail line. • The edit will not set if the detail line contains non-covered charges. **NOTE**: This business requirement will be implemented in an off quarter release, prior to the April 2022 release.									
12357.2.1	Medicare contractors shall modify edit '7010' to bypass TOB 71x or 77x when modifier GV is present for Dates of Service on or after 1/1/2022. If modifier GV is not present, CWF shall continue to set edit '7010' with the current process.								X	
12357.3	Medicare contractors shall accept the new overrideable line level reject edit from CWF.					X				
12357.3.1	Medicare contractors shall use the following ANSI information when rejecting TOBs 71X and 77X with the new edit: Group code: CO CARC: B9 Patient is enrolled in a Hospice	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12357.4	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.	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:

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):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev. 11095, 10-29-21)

Transmittals for Chapter 9

60.6 - RHCs and FQHCs for Billing Hospice Attending Physician Services

60.6 - RHCs and FQHCs for billing Hospice Attending Physician Services
(Rev. 11095, Issued: 10-29-21, 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.