Billing Hospice Physician and Nurse Practitioner (NP) and Physician Assistant (PA) Services (Related to Terminal Diagnosis)

Are services for Face-to-Face (F2F) Encounter? PA cannot perform F2F.
- YES → Is F2F the only service provided?
  - YES → F2F is not billable.
  - NO → Are services for professional component?
- NO → Are services for professional component?

Are services for professional component?
- YES → Is physician/NP/PA employed by, under contract with (physician only option) or a volunteer of the hospice?
  - YES → Are services provided by a physician?
    - YES → Hospice bills HHH MAC for physician's services. For the professional component of a technical service, include CPT modifier 26 and remarks. Services reimbursed lesser of actual charge or 100 percent of Medicare Physician Fee Schedule amount.
  - YES → Are services provided by an NP/PA?
    - YES → Is NP/PA the patient's attending physician?
      - YES → Hospice bills HHH MAC for NP/PA's services. For the professional component of a technical service, report HCPCS GV and CPT 26 modifiers and include remarks. Services reimbursed lesser of actual charge or 85 percent of Medicare Physician Fee Schedule amount.
      - NO → Hospice cannot bill services provided by a hospice employed NP/PA who is not the attending physician. Reimbursement included in hospice daily rate.
  - NO → Is physician/NP/PA an independent attending physician/NP/PA?
    - YES → Physician bills A/B MAC with HCPCS GV modifier. Physician reimbursed 80 percent of Medicare reasonable charge. RHC physicians may be a hospice attending physician, but must bill using their own Part B provider number. This is not an RHC service and cannot be billed by RHC.
    - NO → Patient care provided by a physician/NP/PA who is not employed by, under contract with or a volunteer of the hospice, and is not the attending physician, is not covered under the Hospice benefit and cannot be billed to the HHH MAC. Services billed to the A/B MAC by a nonattending physician will be denied.
- NO → Are services for technical component?
  - YES → Hospice cannot separately bill. Reimbursement included in hospice daily rate. Hospice pays physician for services from daily rate.
  - NO → Are services to establish, review or update the Plan of Care?
    - YES → Hospice cannot separately bill. Reimbursement included in hospice daily rate.

Special Notes:

1. NPs and PAs as attending physicians must be permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law).
2. Effective January 1, 2019, PAs are recognized as designated hospice attending physicians.

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When appropriate, physician/NP/PA services can be billed on an **initial hospice claim** (81X or 82X), along with the levels of care and discipline visits. If the physician/NP/PA services are not included on the initial hospice claim, an **adjustment claim** (817 or 827) can be submitted to add the services.

Initial Hospice Claim (81X or 82X) with Physician/NP/PA Services	Adjustment Claim (817 or 827) to Add Physician/NP/PA Services	
	Using Fiscal Intermediary Standard System (FISS)	Using Paper UB-04 or 5010 Software
1. Bill all usual field locators (FLs) 2. In FL42 (Revenue Code), enter 0657 3. In FL43 (Description), enter *Physician Services* or *Nurse Practitioner Services* 4. In FL44 (HCPCS/Rates), enter appropriate HCPCS code for the service provided. For NP/ PA services, also include HCPCS modifier *GV*. For the professional component of a technical service, include CPT modifier 26 (and remarks in FL 80). 5. In FL45 (Service Date), enter date the physician/ NP/PA's service was provided 6. In FL46 (Service Units), enter appropriate units 7. In FL47 (Total Charges), enter appropriate charge for physician/ NP/PA's services 8. Total the Total Charge column (FL47, on the 0001 revenue code line), **including** the physician/NP/PA's services	1. Choose FISS option 03 (Claims Correction) 2. Choose FISS option 35 (Hospice Adjustments) 3. Enter your NPI in the *NPI* field 4. Enter HIC/MBI number for the patient's claim you are adjusting in the *MID* field 5. If you are a hospital-based hospice, change your type of bill (TOB) to 82. If you are not hospitalbased, leave the TOB as 81. 6. Press Enter to access claims matching your criteria. Tab to select the claim needing adjustment. 7. In the COND CODES field on FISS Page 01, enter claim change reason code *D9* 8. In the REV field on FISS Page 02, enter 0657 below the 0001 line 9. In the HCPC field on FISS Page 02, enter appropriate HCPCS code for service provided. For NP services, also include HCPCS modifier GV 10. In the TOT UNIT and COV UNIT fields on FISS Page 02, enter appropriate units 11. In the TOT CHARGE field on FISS Page 02, enter appropriate charges. **Reminder:** The TOT CHARGE field on the 0001 line must also be updated to reflect the additional services. 12. In the SERV DATE field on FISS Page 02, enter date the physician/NP/ PA's service was provided 13. In the ADJUSTMENT REASON CODE field on FISS Page 03, enter RM 14. On FISS Page 04, enter remarks indicating reason for adjustment	Bill all usual field locators (FLs) as billed on original claim **except**: 1. In FL4 (TOB), enter TOB ending in 7 (e.g., 817 or 827) 2. In FL18-28 (Condition Code), enter claim change reason code *D9* 3. In FL64, enter Document Control Number (DCN) of claim being adjusted. The DCN can be found on your remittance advice or by viewing MAP171D of FISS Page 02 of the original processed claim. 4. In FL42 (Revenue Code), enter 0657 in addition to the original revenue codes 5. In FL43 (Description), enter *Physician Services* or *Nurse Practitioner Services* 6. In FL44 (HCPCS/Rates), enter appropriate HCPCS code for service provided. For NP/PA services, also include HCPCS modifier GV 7. In FL45 (Service Date), enter date the physician/ NP/PA's service was provided 8. In FL46 (Service Units), enter appropriate units being billed in addition to the original units 9. On the subtotal line (0001) in FL42, total the Total Charge column (FL47) **including** the physician/NP/PA's services 10. In FL80 (Remarks), add a remark indicating adjustment to add physician/NP/PA services

NOTE: For physician services unrelated to terminal diagnosis, the physician bills the claim with a *GW* HCPCS modifier and is reimbursed by the A/B MAC.

Resources

CMS Medicare Benefit Policy Manual, Chapter 9, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

CMS Medicare Claims Processing Manual, Chapters 11, 12, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

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