MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Flu Season is upon us! CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (*Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.*) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to ***http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*** on the CMS website.

MLN Matters® Number: MM6563 | **Related Change Request (CR) #: 6563**

Related CR Release Date: October 29, 2009 | **Effective Date: April 1, 2010**

Related CR Transmittal #: R1840CP | **Implementation Date: April 5, 2010**

Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)

Provider Types Affected

Physicians, hospitals and other providers, and suppliers who bill Medicare fiscal intermediaries (FI) or A/B Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6563, from which this article is taken, announces recent instructions for the use of modifiers in association with Advance Beneficiary Notices (ABN). Specifically, effective April 1, 2010, two HCPCS level 2 modifiers have been updated to distinguish between voluntary, and required, uses of liability notices. Those modifiers are:

- Modifier – GA has been redefined to mean "Waiver of Liability Statement Issued as Required by Payer Policy," and should be used to report when a required ABN was issued for a service.
- A new modifier (-GX) has been created with the definition "Notice of Liability Issued, Voluntary Under Payer Policy" and is to be used to report when a

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voluntary ABN was issued for a service.

Make sure that your billing staffs are aware of these ABN modifier changes.

Background

In Change Request 6136 (*Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage*) released September 5, 2008, CMS revised instructions for providers in the use of ABNs. Prior to these instructions, providers who voluntarily issued patients notices announcing that particular services were either excluded from Medicare coverage by statute, or were services for which no Medicare benefit category exists, used the Notice of Exclusion from Medicare Benefits form (NEMB – now a retired form) or notices that they developed themselves.

With these revised instructions, providers for the first time were allowed to use ABNs to voluntarily provide such notices. (You can read the MLN Matters® article associated with this CR by going to ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf*** on the Centers for Medicare & Medicaid Services (CMS) website.)

CR 6563, from which this article is taken, announces that two HCPCS level 2 modifiers have been updated to allow the voluntary uses of liability notices to be distinguished from the required uses. Specifically, modifier –GA has been redefined to mean "Waiver of Liability Statement Issued as Required by Payer Policy." It should only be used to report when a required ABN was issued for a service, and should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges. Please note that Medicare systems will now deny institutional claims submitted with modifier –GA as a beneficiary liability (rather than subjecting them to possible medical review), and the beneficiary will have the right to appeal this determination. Medicare processing of professional claims with this modifier is not changing.

In addition, a new modifier, -GX, has been created with the definition "Notice of Liability Issued, Voluntary Under Payer Policy" which should be used to report when a voluntary ABN was issued for a service. You may use the –GX modifier to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute, and in these cases, you may report it on the same line as certain other liability-related modifiers. Please note that the –GX modifier must be submitted with non-covered charges only, and your FI or A/B MAC will deny the claim as a beneficiary liability.

You should be aware of some details in the use of these modifiers.

- -GA Modifier:
  - Medicare systems will automatically deny lines submitted with the -GA modifier and covered charges on institutional claims;

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  - Medicare systems will assign beneficiary liability to claims automatically denied when the –GA modifier is present; and
  - Medicare will use claim adjustment reason code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer.) when denying lines due to the presence of the –GA modifier.
- -GX Modifier
  - Medicare systems will recognize and allow the –GX modifier on claims, but will return your claim if the –GX modifier is used on any line reporting covered charges;
  - Medicare systems will allow the –GX modifier to be reported on the same line as the following modifiers that indicator beneficiary liability: -GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit), -TS (Follow-up service);
  - Medicare systems will return your claim if the –GX modifier is reported on the same line as any of the following liability-related modifiers: -EY (no doctor's order on file), -GA, -GL (medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN), -GZ (item or service expected to be denied as not reasonable and necessary), -KB (Beneficiary requested upgrade for ABN, more than four modifiers identified on claim), -QL (Patient pronounced dead after ambulance is called), -TQ (basic life support transport by a volunteer ambulance provider);
  - Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the -GX modifier and non-covered charges, and will assign beneficiary liability to claims automatically denied when the –GX modifier is present.

Final Note: Other than the policy and processing changes described in CR 6563, all other policies and processes regarding non-covered charges and liability continue as stated in the Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) and in the requirements defined in previous change requests.

Additional Information

You can find more information about billing for services related to voluntary uses of Advance Beneficiary Notices of Noncoverage (ABNs) by going to CR 6563, located at ***http://www.cms.hhs.gov/Transmittals/downloads/R1840CP.pdf*** on the CMS website. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) as an attachment to that CR.

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If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at ***http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*** on the CMS website.

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