



Manual: Reimbursement Policy

Policy Title: **Modifiers GA, GX, GY, and GZ**

Section: Modifiers

Subsection: None

Date of Origin: 5/5/2014

Policy Number: RPM036

Last Updated: 7/14/2021

Last Reviewed: 7/14/2021

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid plans.

Reimbursement Guidelines

Moda Health's policy on modifiers GA, GX, GY, and GZ varies depending on the line of business.

A. Moda Health Commercial plans:

Modifiers GA, GX, GY, and GZ are considered valid for commercial lines of business. We are prepared to process Medicare supplement claims that may have been submitted to Original Medicare with these modifiers.

In addition, non-covered screening procedure codes submitted with a screening diagnosis code and modifier GA or GX appended will deny to member liability. Modifiers GY and GZ have no effect on this process. Please refer to Moda Health Reimbursement Policy # RPM037 "Preventive Services versus Diagnostic and/or Medical Services" for complete information.

B. Moda Health Medicare Advantage plans:

1. Modifiers GA, GX, GY, and GZ are not considered valid for use with any procedure code for Medicare Advantage claims, per CMS policy. (CMS¹) Effective for claims processed or adjusted on or after April 27, 2015, any line item with modifier GA, GX, GY, and/or GZ will be denied to provider write-off. Contracted Medicare Advantage providers were notified of this processing change in writing on March 31, 2015. (Moda Health²)
2. Members may not be balance-billed for these amounts.

Do not balance bill member for:	Correct handling for Medicare Advantage per CMS:
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Do not balance bill member for:	Correct handling for Medicare Advantage per CMS:
Contracted providers, services specifically listed as noncovered in the member's Evidence of Coverage (EOC).	Arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided.
Contracted providers, for any services that are not specifically called out as noncovered in the member's Evidence of Coverage (EOC).	<ul style="list-style-type: none"> • Request an organization predetermination. • If Moda Health responds the services are not covered, then arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided.
Contracted providers, referrals to out-of-network providers. Caution: Your referral to an out-of-network provider includes authorization on behalf of Moda Health for coverage of excluded or non-covered services.	<ul style="list-style-type: none"> • Before referral, verify if the lab, or other provider is contracted with Moda Health Medicare Advantage. • If possible, refer to in-network lab or provider. • If out-of-network referral is only option, document a member financial responsibility conversation with beneficiary, and that they wish to pay cash for any non-covered services.
Out-of-network providers who accept Medicare. Services specifically listed as noncovered in the member's Evidence of Coverage (EOC).	Arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided.
Out-of-network providers who accept Medicare, for any services that are not specifically called out as noncovered in the member's Evidence of Coverage (EOC).	<ul style="list-style-type: none"> • Request an organization predetermination. • If Moda Health responds the services are not covered, then arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided.
Out-of-network providers who do not accept Medicare assignment.	<ul style="list-style-type: none"> • Do not submit claim. Moda Health Medicare Advantage cannot reimburse providers who do not accept Medicare assignment. • Arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided.

3. Applicable explanation codes.

	<u>Code</u>	<u>Description</u>
EX code(s)	514	The modifier that was billed is invalid for the procedure.
	t40	Per Medicare, use of a modifier is not typical for the billed procedure.
	u13	The modifier used is inconsistent with the procedure code.
	z52	A modifier on the line is not typical for the procedure code.
Liability		Provider
Group Code	CO	Provider Contractual Obligation
CARC	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
	<u>Code</u>	<u>Description</u>
EX code	513	Non-covered service. CMS permits network providers to bill members IF a pre-service determination was requested from Moda and was denied.
Liability		Provider
Group Code	CO	Provider Contractual Obligation
CARC	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
RARC	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

C. Medicaid plans:

Modifiers GA, GX, GY, and GZ are considered valid for Medicaid claims. Medicaid is often the secondary payer for members that are on Original Medicare. We are prepared to process secondary claims that may have been submitted to Original Medicare with these modifiers.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
CARC	=	Claim Adjustment Reason Code
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
EOB	=	Explanation of Benefits
EOC	=	Evidence of Coverage
EOP	=	Explanation of Payment
EX	=	Explanation Code
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
MAO MAOs	=	Medicare Advantage Organization(s)
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g. in context of "RPM052" policy number, etc.)

Modifier Definitions:

Modifier	Modifier Definition
Modifier GA	Waiver of Liability Statement Issued as Required by Payer Policy.
Modifier GX	Notice of Liability Issued, Voluntary Under Payer Policy.
Modifier GY	Notice of Liability Not Issued, Not Required Under Payer Policy.
Modifier GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary.

Coding Guidelines

On May 5, 2014 CMS issued a memo on "Improper Use of Advance Notices of Non-coverage" to Medicare Advantage Organizations (MAOs), Medicare Health Care Prepayment Plans, and Medicare Cost Plans. (CMS ¹) In this memo CMS instructed:

- An advanced beneficiary notice of non-coverage (ABN) is to be used for Medicare beneficiaries only.
- ABNs are not to be used for members of Medicare Advantage plans.
- Modifiers GA, GX, GY, and GZ are not for use on claims for Medicare Advantage plans.
- Instead, Medicare Advantage plans are to use the pre-service organization determination process.

"MAOs ... should ... follow the process for issuing a notice of a denial of coverage in accordance with 42 CFR §§ 422.568 and 422.572." (CMS ¹)

“You should only provide ABNs to beneficiaries enrolled in Original (Fee-For-Service) Medicare.” (CMS ³)

Cross References

- A. “Preventive Services versus Diagnostic and/or Medical Services .” Moda Health Reimbursement Policy Manual, RPM037.

References & Resources

1. CMS. “Improper Use of Advance Notices of Non-coverage.” Health Plan Management System (HPMS) Archive, CMS. May 5, 2014. [See Attachment 1 at end of this list.](#)
2. Moda Health. ABN Provider Notification Letter. March 31, 2015. [See Attachment 2 at end of this list.](#)
3. CMS. “Advance Beneficiary Notice of Noncoverage (ABN).” Medicare Learning Network. ICN 006266: August 2014. May 2015. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf.

Background Information

Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code.

CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service

- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Attachment 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-
26 Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

DATE: May 5, 2014

TO: Medicare Advantage Organizations, Medicare Health Care Prepayment Plans, and Medicare Cost Plans

FROM: Arrah Tabe-Bedward
Director, Medicare Enrollment & Appeals Group

Danielle R. Moon, J.D., M.P.A.
Director, Medicare Drug & Health Plan Contract Administration Group

SUBJECT: Improper Use of Advance Notices of Non-coverage

The Medicare Enrollment & Appeals Group (MEAG) and Medicare Drug & Health Plan Contract Administration Group (MCAG) have received reports of Medicare Advantage organizations (MAOs) issuing notices to enrollees that advise of non-coverage for an item or service that do not comply with the requirements for such notices set forth under the organization determination process at 42 CFR Part 422, Subpart M. The notices being used by MAOs appear to be based on, and similar in purpose and content to, the advanced beneficiary notice of non-coverage (ABN) used in the Original Medicare program. Such notices are not applicable to the Medicare Advantage program, and are not appropriate for use by an MAO with respect to its enrollees. MAOs sending such notices should immediately cease this practice and instead follow the process for issuing a notice of a denial of coverage in accordance with 42 CFR §§ 422.568 and 422.572.

Original Medicare ABN notices were established in order to allow a Medicare beneficiary to find out whether a service is covered by Medicare without having to receive services, and then submit a claim for reimbursement for the costs of such services. By their own terms, the ABN requirements in the statute and regulations do not apply in the Medicare Advantage context. This is because a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services. Specifically, section 1852(g)(1)(A) requires MA organizations to “have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization. . .is entitled to receive a health

care service under this section.” The regulations at 42 CFR §§ 422.568 and 422.572 set forth rules that apply to this determination procedure. These rules must be followed when an MAO is making a determination of coverage, including the requirements applicable to the notice required upon making such a determination. Because these regulations are incorporated by reference for cost plans and HCPPs, the foregoing analysis applies to such plans as well.

Under the procedures at issue, when an MAO or cost plan or HCPP wishes to inform an enrollee that a service is not covered or that payment is denied, in whole or in part, the decision is an organization determination under 42 CFR § 422.566(b) and the appropriate notice must be used. See <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html> (notice for denials of payment and coverage). This is reflected in the self-referral provision, at 42 CFR § 422.105(a), which states that when an enrollee receives an item or service of the plan that is covered upon referral or pre-authorization by a contracted provider, the enrollee cannot be financially responsible for more than the normal cost-sharing if the enrollee correctly identified himself or herself as an enrollee of the plan to the contracted provider prior to receiving the item or service. This limitation on liability under § 422.105(a) applies unless the contracted provider can show that the enrollee received prior notice that the item or service would only be covered if further action was taken by the enrollee. Such prior notice is the issuance of an organization determination. The enrollee’s request for services from a contracted provider, whether such services are from that provider or from another provider in connection with a referral, is a request for an organization determination being made to an MAO representative. If the requested item or service is furnished to the enrollee, the furnishing of the item or service is a favorable organization determination made on behalf of the MAO. If the provider does not furnish the item or service (or does not make a referral) because the provider believes the item or service may not be covered, the contracted provider must advise the enrollee to request a pre-service organization determination from the MAO or the provider can request the organization determination on the enrollee’s behalf.

This long-standing CMS policy is reflected in Chapter 4, section 170, of the Medicare Managed Care Manual. Section 170 of Chapter 4 states, in part, that services and referrals a contracted provider gives are considered plan-approved unless “notice is provided to the enrollee that the services will not be covered.” MAOs appear to be misinterpreting this statement to mean that providing an advance notice to an enrollee that an item or service is non-covered (i.e., providing a notice outside of the organization determination process) is a permissible means of holding the enrollee financially responsible for the cost of an item or service provided by a contracted provider or a non-contracted provider on the basis of a referral from a contracted provider. However, these ABN-like notices are not compliant with the MA organization determination requirements.

Our Manual guidance in Chapter 4, section 170 means the notice provided as part of the organization determination processes set forth at 42 CFR §§ 422.566 – 422.576 is necessary for an MAO to deny coverage or payment. With respect to properly notifying enrollees regarding matters of non-coverage, MAOs are prohibited from circumventing the organization determination process. The use of non-compliant advance notices of non-coverage by MAOs diminishes the enrollee protections that are part of the organization determination process. In circumstances where there is a question

whether or not the plan will cover an item or service, the enrollee has the right to request an organization determination. If coverage is denied, the plan must provide the enrollee with a standardized written denial notice (form CMS-10003) that states the specific reasons for the denial and informs the enrollee of his or her appeal rights. Unless a plan notifies an enrollee that an item or service will not be covered by issuing standardized denial notice CMS-10003, the MAO has not complied with the applicable regulations in 42 CFR Part 422, subpart M; the failure to provide a compliant denial to the enrollee means that the

enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider. To enhance understanding of and compliance with these requirements, CMS plans to issue clarifications to Chapter 4 of the Medicare Managed Care Manual, consistent with this memorandum.

Any concerns an MAO may have with the provision or referral of services should be addressed under its contractual arrangements with its network providers, not by going outside of the organization determination process and related notice requirements that protect beneficiaries.

As noted above, MAOs that are currently issuing advance notices of non-coverage outside of the organization determination process are to immediately cease from doing so. Continuation of this practice may result in compliance action. Plans that have questions regarding this memorandum should contact their account manager.

Attachment 2

March 31st, 2015

Dear contracted provider,

We've recently learned that some of our contracted providers may still be using the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form for enrollees on Moda Health Medicare Advantage (MA) plans. If you or your clinic, hospital or organization is still using the ABN for MA members, we ask that you please stop this process immediately. A bulletin released by the Centers for Medicare and Medicaid Services (CMS) on May 5, 2014, explained that the use of the ABN only applies to Original Medicare beneficiaries and should not be used for MA enrollees. We have attached the CMS memo for your reference.

We've also included information that we hope will clear up any confusion you may have about the improper use of the ABN.

ABN is prohibited for Medicare Advantage enrollees

An ABN is a written notice given to an Original Medicare beneficiary by a physician, provider or supplier (including laboratories) when he or she believes that Original Medicare will deny some or all of the services or items because of medical necessity or the frequency of the service; however, the ABN is optional when Medicare never covers a service. When a provider obtains an ABN along with Original Medicare requirements, the provider may indicate that he or she obtained an ABN by billing with GA, GX, GY or GZ modifiers.

Medicare Advantage Program

Under the Medicare Advantage (MA) program, MA enrollees have the option to obtain a coverage decision prior to obtaining the item or service. This request for a pre-service coverage review is known as a request for a pre-service organization determination. The MA plan will review the request for a pre-service organization determination and issue either an approval or denial based on its review of the requested item or service. A request for a pre-service organization determination may be made by either the provider or member. It should include any medical information that the requestor would like considered by the MA plan during the review.

Original Medicare

Under Original Medicare, a beneficiary does not have the option to request a pre-service determination of coverage. The CMS developed the ABN to address this inability to obtain a coverage decision prior to receiving services and ensure that beneficiaries are informed of the possibility of financial responsibility on services that may not be covered by Original Medicare. Because a MA enrollee can obtain a pre-service coverage decision through the pre-service organization determination process, the use of the ABN for MA enrollees is not appropriate. Likewise, the modifiers (GA, GX, GY, and GZ) that signal a provider obtained an ABN are not appropriate on claims submitted to plans for MA enrollees.

Use pre-service organization determination for MA members

If you provide items or services to Moda Medicare Advantage plan members, please request an organization determination prior to performing services that are either unlikely to be covered or will not be covered by the Moda Medicare Advantage plans. While either the enrollee or the provider can request this, we encourage our contracted providers to use our current structure for requesting a pre-service organization determination on the enrollee's behalf. Moda will review these organization determination requests and issue notices to both the member and requesting provider to let them know if the item or service has been approved or denied. If a service is denied, our MA members will be better informed to choose if they would still like to obtain the service at their own expense. If a member chooses to proceed with the service or at their own expense after exhausting the appeals process or deciding not to pursue an appeal, the member and provider may enter into a private fee arrangement for the denied services or items. At that point, contracted providers are not required to submit claims for Moda MA members for services or items supplied under these private fee arrangements to Moda for processing. Please note that these private fee arrangements may only occur after the pre-service organization determination process is completed.

Going forward, please use the pre-service organization determination process in place of either issuing ABNs or including ABN-specific modifiers on services or items supplied to MA members. This will ensure that we are compliant with Federal Medicare regulations and guidelines.

To request a pre-service organization determination for MA members

If you want to call: 503-243-4496 or 800-258-2037

If you want to fax: 855-637-2666

Questions?

We're here to help! Please call our Provider Relations team toll-free at 877-299-9062 or email us at providerrelations@modahealth.com.

We appreciate your cooperation in helping us fulfill these important requirements.

Together, we can be more. We can be better.

Sincerely,

Your Moda Health Provider Relations Team