Advanced Beneficiary Notices: Usage for Voluntary (Noncovered) Services—Medicare Only

Effective April 1, 2010, two modifiers have been updated or created, specific to Medicare claims only.

Updated Modifier

-GA: This is now defined as "Waiver of Liability Statement Issued as Required by Payer Policy" and is to be utilized when a mandatory Advanced Beneficiary Notice (ABN) is issued for a specific CPT code that is a covered service. This modifier is to be used only when an ABN is *required* for covered services and should not be reported with any other Medicare modifier.

Mandatory ABNs are required to be issued in the following circumstances: "When physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they *do have on file* an ABN signed by the beneficiary." Liability occurs when such items or services are thought to be noncovered for specific reasons (CMS):

- §1862(a)(1) on services that otherwise could be covered but which are *not* medically reasonable and necessary in the individual case at hand,
- §1862(a)(9) for custodial care which Medicare *never* covers
- §1862(g)(1) for home care given to a beneficiary who is *neither* homebound *nor* needs intermittent skilled services at home, or lastly, under
- §1879(g)(2) for hospice care given to someone *not* terminally ill

It is not anticipated that a mandatory ABN will be required in many situations in audiology. An example may be when a covered procedure does not meet the local Medicare contractor's definition of medical necessity. Guidelines for medical necessity are contained in Local Coverage Determination (LCD) policies issued by Medicare contractors.

New Modifier

-GX: This new modifier is defined as the "Notice of Liability Issued, Voluntary Under Payer Policy" and is to be utilized when a *voluntary* ABN was issued. Audiologists would utilize this modifier when there is a desire to issue a notice of non-coverage for services that are statutorily excluded such as routine evaluations, hearing aids, and related services and/or therapeutic services.

Scenario: Patient is being seen for aural rehabilitation services, which are not eligible for reimbursement by Medicare when performed by an audiologist. Although an ABN in this case is not required by regulation, some practices prefer to notify patients in all cases of noncoverage.

Existing Modifiers

-GY: "Item or service statutorily excluded or does not meet the definition of any Medicare benefit" is often used when a denial is required from Medicare in order to access a benefit from a secondary payer.

Scenario: Patient has a secondary insurance plan that covers hearing aids. In order to access this benefit, they need a denial from Medicare.

In this case, you would use both the GX (voluntary notice of noncoverage) and the GY (statutorily excluded) modifiers. In box 24D on the CMS 1500 form, you can place both the GX and the GY modifiers to indicate to Medicare that this is for an automatic denial. Some of the Medicare contractors suggest placing this note: "Denial required for secondary payor benefit" in Box 19 of the 1500 form. You will want to consult with your contractor for their specific guidance regarding explanations in Box 19.

-GZ: "Item or service expected to be denied as not reasonable and necessary." This is utilized when an ABN is not on file. Claims submitted with this modifier will not allow billing the patients for services.

Scenario: This modifier has rare applicability for audiologists, but is typically used when a patient has not signed an ABN in an emergent situation.

Reference

Centers for Medicare and Medicaid Services. (2010) *Publication 100-04, Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notice of Noncoverage (ABNs)*. http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

The information and guidance contained in this article is related specifically to Medicare Part B providers and not institutional providers.

Four Individual Vestibular Codes

With the publication of the 2010 *CPT Codebook*, an inadvertent parenthetical description resulted in disallowing the individual vestibular codes (CPT code 92541, 92542, 92544, and 92545) to be billed separately if not all four procedures were performed as part of the new bundle, CPT code 92540.

In February, the American Academy of Audiology, American Academy of Neurology, American Academy of Otolaryngology – Head and Neck Surgery, American Speech-Language-Hearing Association, Association of VA Audiologists, and the Directors of Speech and Hearing Programs in State Health and Welfare Agencies appealed to the AMA CPT Editorial Panel and the CPT Editorial Panel Executive Committee to revise the parenthetical notes in order for the individual codes to be filed individually.

At the time this article went to press, the previously mentioned organizations were actively engaged in an appeal of this decision.

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