CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3962	**Date: February 2, 2018**
	Change Request 10453

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this instruction, the Agency develops a workaround for the issue of Medicare claims that are denied due to the presence of modifiers not used by Medicare. Additionally, this instruction is implementing a change to ensure that duplicate diagnosis codes from incoming hardcopy claims are not mapped to Part B outbound 837 professional claims.

EFFECTIVE DATE: July 1, 2018; October 1, 2018 - (For VMS, the effective date is process date.)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018 - (For VMS--analysis, design, and coding completed); October 1, 2018 - (For VMS--testing, support tasks, and implementation)

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	1/60.4.2/ Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim

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

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I. GENERAL INFORMATION

A. Background: This instruction addresses two (2) issues affecting the COBA Medicare crossover process: 1) Making certain that claims with modifiers that are "not used" by Medicare are no longer denied; and 2) making certain that duplicate diagnosis codes included on incoming Medicare claims are no longer mapped to COBA crossover claims.

Currently, our Medicare Administrative Contractors (MACs) follow the guidance in the Internet Only Manual (IOM) Pub.100-04, Chapter 1, Section 60.4.2 for denying incoming Medicare claims that contain modifiers not used by Medicare. This practice is contributing to unintended negative impacts for providers as well as supplemental payers. Claims denied due to invalid modifier usage for Medicare cannot be further used for additional Coordination of Benefits (COB) payment actions. The Centers for Medicare & Medicaid Services (CMS) addresses this issue through this instruction.

Recently, it was clarified that the Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) 837 X12 claims transaction Technical Report Type 3 (TR3) Implementation Guide does not support duplication of International Classification of Diseases (ICD), Clinical Modifications (CM), version 10 (ICD-10) diagnosis codes. Medicare's front-end editing currently catches instances where duplicate ICD-10 diagnosis codes are billed. However, there is no process in place to address this situation for incoming hardcopy CMS-1500 claim forms. This instruction remedies this concern.

B. Policy: The Part B shared system shall ensure that modifiers that are valid per the established code-set but "not used" by Medicare are no longer denied as part of claims adjudication. To ensure that modifiers "not used" by Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will no longer be denied when included on Medicare claims, the DME MAC shared system shall implement a one-time process to load all Healthcare Common Procedure Coding System (HCPCS) modifiers on the annual HCPCS file not currently in its internal modifier table as "informational" modifiers. (**Note:** Currently, this internal table only includes those modifiers applicable to DME MAC claims processing.) Additionally, the DME MAC shared system shall modify the annual HCPCS file load process to ensure that changes to modifiers are applied to its internal modifier table. Lastly, the DME MAC shared system shall eliminate obsolete Part B logic within the VIPS Medicare system (VMS) that involves modifier values not currently applicable to DME MAC claims processing. Part B MACs and DME MACs shall discontinue the practice of denying claims on the basis that submitted modifiers are not used by Medicare.

As part of their routines for creating outbound 837 professional COB flat files, the Part B and DME shared systems shall ensure that diagnosis codes are not duplicated.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10453.1	The Part B shared system shall ensure that modifiers that are valid per the established code-set but "not used" by Medicare are no longer denied as part of claims adjudication.						X			
10453.1.1	To ensure that modifiers "not used" by the DME MACs will no longer be denied when included on Medicare claims, the DME MAC shared system shall implement a one-time process to load all HCPCS modifiers on the annual HCPCS file not currently in its internal modifier table as "informational" modifiers. (**Note:** Currently, this internal table only includes those modifiers applicable to DME MAC claims processing.)							X		
10453.1.2	The DME MAC shared system shall also modify the annual HCPCS file load process to ensure that changes to modifiers are applied to its internal modifier table, as specified in 10453.1.1.							X		
10453.1.3	The DME MAC shared system shall eliminate obsolete Part B logic within the VMS that involves modifier values not currently applicable to DME MAC claims processing.							X		
10453.1.4	Part B MACs and DME MACs shall discontinue the practice of denying claims on the basis that submitted modifiers are not used by Medicare.		X		X					RRB-SMAC
10453.2	As part of their routines for creating outbound 837 professional COB flat files, the Part B and DME shared systems shall ensure that diagnosis codes are not duplicated.						X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

60.4.2 - Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim

(Rev.3962, Issued: 02-02-18, Effective: 07-01-18, Implementation: 07-02-18)

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists those modifiers, many more commonly used on professional claims, for services not covered or not payable by Medicare. Modifiers not payable on professional claims are also not payable on institutional claims and will be denied if submitted on such claims. Providers are liable for these denials, UNLESS a specific modifier (see second table in this section) or indicator on the claim (i.e., occurrence code 32) specifically assigns liability to the beneficiary.

Effective with July 2, 2018, Part B MACs and DME MACs shall discontinue the practice of denying claims on the basis that submitted modifiers are "not used" by Medicare. Most of the "not used" modifiers appear in the first cell under "Non-Covered Modifiers" in the table directly below. Part A MACs already do not deny modifiers that are "not used" by Medicare because such modifiers are loaded to the Integrated/Outpatient Code Editor (I/OCE).

NOTE: This table does not include ambulance origin and destination modifiers, which may fall into the ranges of modifiers values below, but are NOT non-covered by definition.

Source of the Modifier List	**Non-covered Modifiers**	**Claims Processing Instructions**	**Definition Source**
HCPCS Modifiers Not Covered or Not Payable by Medicare by HCPCS Definition (HCPCS Administrative Instruction)	-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -SY, -TD through -TR, -TT through -TW, -U1 through -U9, -UA through –UD, –UF through -UK	Institutional standard systems will deny all line items on all TOBs using these modifiers in all cases as part of processing claims; provider liability is assumed EXCEPT when noted as beneficiary liable in accordance with the chart below (of the total set to the left:-GY)	Use as defined by publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPPS Claims	See current OPPS instructions	Institutional standard systems accept these modifiers for processing on OPPS claims (TOBs: 12x, 13x, 14x) in accordance with HCPCS/CPT definitions	CPT numerical modifiers defined in publication of "CPT Manual" by the American Medical Association; HCPCS codes as defined by publication of HCPCS codes by CMS
Modifiers Used in Billing Ambulance Non-covered Charges	-GY, -QL, -QM* or -QN*, -TQ, alpha origin/destination modifiers*	Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x	See ambulance instructions and chart immediately below
Specific HCPCS Modifiers to Consider Related to Non-covered Charges or ABNs	-EY, -GA, -GK, -GL, -GY, -GZ, -KB,	Institutional standard systems accept some of these modifiers for processing as specified on the chart below	See chart immediately below

* These modifiers are not non-covered by definition, but rather are commonly used on non-covered lines

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats. Use of modifiers has increased in institutional billing over time, though institutional claims do not always require the use of procedure codes in addition to revenue codes.

Institutional shared systems require procedure codes to be present any time a modifier is used, whether the line is covered or not. Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as non-covered. In cases in which providers need to submit a non-covered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Non-covered item or service

Institutional shared systems will accept this code and it will be denied in all cases, since it is non-covered by Medicare by definition. Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary (i.e., -GL, -GY), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note –GA or –KB modifiers cannot be used with this code since they require covered charges. Modifiers most likely to be used with ABNs or non-covered charges or liability notices are listed below.

Table: Definition of Modifiers Related to Non-covered Charges/ABNs for Institutional Billing

Modifier	**HCPCS Modifier Definition**	**HCPCS Coverage/ Payment/ Administrative Instruction**	**Notice Requirement/ Liability**	**Billing Use**	**Payment Result**
EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; liability is provider unless other modifiers are used (-GL or -GY)	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., TOBs 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x)	When orders required, line item is submitted as non-covered and services will be denied
GA	Waiver of Liability Statement Issued, as Required by Payer Policy	None	ABN required; beneficiary liable	To signify a line item is linked to the mandatory use of an ABN when charges both related to and not related to an ABN must be submitted on the same claim	Line item must be submitted as covered; Medicare makes a determination for payment
GK	Reasonable and Necessary Item/Service Associated with a –GA or –GZ modifier	None	ABN required if –GA is used; no liability assumption since this modifier should not be used on institutional claims	Not used on institutional claims. Use –GA or –GZ modifier as appropriate instead	Institutional claims submitted using this modifier are returned to the provider

Modifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
GL	Medically Unnecessary Upgrade Provided instead of Non-Upgraded Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; beneficiary liable	Use only with durable medical equipment (DME) items billed on home health claims (TOBs: 32x, 33x, 34x)	Lines submitted as non-covered and will be denied
GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Non-covered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; beneficiary liable	Use on all types of line items on provider claims. May be used in association with modifier –GX.	Lines submitted as non-covered and will be denied
GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be non-covered by Medicare	Cannot be used when ABN or HHABN is actually given, recommend documenting records; provider liable	Available for optional use on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	Lines submitted as non-covered and will be denied
KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; if service denied in development, beneficiary assumed liable	Use only on line items requiring more than [2 or] 4* modifiers on home health DME claims (TOBs 32x, 33x, 34x)	Line item submitted as covered, claim must suspend for development
QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Mileage lines submitted as non-covered and will be denied; base rate line submitted covered

Modifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
TQ	Basic life support transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Lines submitted as non-covered and will be denied
GX	Notice of Liability Issued, Voluntary Under Payer Policy	None	Used when a provider issued an ABN on a voluntary basis; beneficiary liable	Use on all types of provider claims when a voluntary notice has been issued. May be used in association with modifiers –GY or used separately.	Lines submitted as non-covered and will be denied

* **NOTE**: Many provider systems will not allow the submission of more than two modifiers. In such cases, despite the official definition and the capacity of the Medicare systems to take in five modifiers on a line with direct EDI submission, contractors processing home health claims should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit.

All modifiers listed in the chart immediately above need to be used only when non-covered services cannot be split to entirely non-covered claims. Modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability. Inappropriate use of these modifiers may result in entire claims being returned to providers.