

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1921	Date: February 19, 2010
	Change Request 6563

Transmittal 1894, dated January 15, 2010, is being rescinded and replaced by Transmittal 1921, dated February 19, 2010 to reinstate the deletion of section 60.1.5, on the transmittal page only, which was inadvertently omitted from Transmittal 1894, but previously listed in Transmittal 1840, dated October 29, 2009. All other material remains the same.

Subject: Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)

I. SUMMARY OF CHANGES: This transmittal provides instructions regarding one new and one revised modifier for use in association with ABNs. It also provides revisions to clarify general non-covered charge instructions for institutional claims and relocates certain benefit-specific information in their associated chapters of the Claims Processing Manual.

EFFECTIVE DATE: April 1, 2010

IMPLEMENTATION DATE: April 5, 2010

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 - Provider Billing of Non-covered Charges on Institutional Claims
R	1/60.1 - General Information on Non-covered Charges on Institutional Claims
R	1/60.1.1 - Basic Payment Liability Conditions
R	1/60.1.2 - Billing Services Excluded by Statute
R	1/60.1.3 - Claims With Condition Code 21
R	1/60.1.3.1 - Provider-liable Fully Non-covered Outpatient Claims
D	1/60.1.4 - Summary of All Types of Institutional No Payment Claims
D	1/60.1.5 – General Operational Information on Institutional Non-covered Charges

R	1/60.2 - Non-covered Charges on Inpatient Bills
R	1/60.3.1 - Background on Institutional Demand Bills (Condition Code 20)
R	1/60.3.2 - Inpatient and Outpatient Demand Billing Instructions
D	1/60.3.3 - Summary of Methods for Institutional Demand Billing
R	1/60.4.1 - Outpatient Billing With an ABN (Occurrence Code 32)
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
D	1/60.4.3 - Clarifying Institutional Instructions for Outpatient Therapies Billed as Noncovered, on other than HH PPS claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments
D	1/60.4.4 - New Instructions for Noncovered Charges for Mileage on Institutional Ambulance Claims
D	1/60.4.5 - Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits
D	1/60.4.6 - Clarification of Notice Requirements Related to Billing Noncovered Charges for "Bundled" Institutional Benefits: Laboratory and Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) Examples
N	4/250.1.1 - Special Instructions for Non-covered Time Increments in Standard Method Critical Access Hospitals (CAHs)
R	5/40 - Special Claims Processing Rules for Institutional Outpatient Rehabilitation Claims
R	5/40.1 - Determining Payment Amounts
R	5/40.2 - Applicable Types of Bill
R	5/40.3 - Applicable Revenue Codes
R	5/40.4 - Edit Requirements for Revenue Codes
R	5/40.5 - Line Item Date of Service Reporting
N	5/40.6 - Non-covered Charge Reporting
N	15/30.2.4 - Non-covered Charges on Institutional Ambulance Claims

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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 Instructions

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1921	Date: February 19, 2010	Change Request: 6563
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Transmittal 1894, dated January 15, 2010, is being rescinded and replaced by Transmittal 1921, dated February 19, 2010 to reinstate the deletion of section 60.1.5, on the transmittal page only, which was inadvertently omitted from Transmittal 1894, but previously listed in Transmittal 1840, dated October 29, 2009. All other material remains the same.

SUBJECT: Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background: In Transmittal 1587 (Change Request 6136), CMS revised instructions for providers' use of Advanced Beneficiary Notices of Noncoverage (ABNs). For the first time, these instructions allowed for the use of ABNs to provide liability notices to beneficiaries on a voluntary basis for services that are excluded from Medicare coverage by statute or services for which no Medicare benefit category exists. Previously, voluntary issuance of notices in these cases used the Notice of Exclusion from Medicare Benefits (NEMB – now a retired form) or notices of the providers' own devising.

Under previous instructions, required issuance of ABNs was tied to the use of the –GA (originally defined as “Waiver of Liability on File”) modifier on the claim for the corresponding services. The advent of voluntary uses of ABNs requires changes to Medicare billing instructions and claims processing systems in order to distinguish between voluntary and required uses of ABNs. These changes are described in the requirements below. Other than the policy and processing changes described below, all other policies and processes regarding non-covered charges and liability continue as stated in Medicare Claims Processing Manual (Pub. 100-04), Ch.1, section 60 and in the requirements defined in previous change requests.

B. Policy: HCPCS level 2 modifiers have been updated in order to distinguish between voluntary and required uses of liability notices. Modifier –GA has been redefined to mean “Waiver of Liability Statement Issued, as Required by Payer Policy.” This modifier is only to be used to report when a required ABN was issued for a service. As stated in previous instructions, the –GA modifier should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges. However, Medicare systems will now deny these claims as a beneficiary liability (rather than subjecting them to possible medical review), and the beneficiary will have the right to appeal this determination.

A new modifier, –GX, has been created with the definition “Notice of Liability Issued, Voluntary Under Payer Policy.” This modifier is to be used to report when a voluntary ABN was issued for a service. Providers may use the –GX modifier to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute. In these cases, the –GX modifier may be reported on the same line as certain other liability-related modifiers. The –GX modifier must be submitted with non-covered charges only and will be denied by the Medicare contractor as a beneficiary liability. These changes are informational only for Medicare Part B and Durable Medical Equipment Medicare Administrative Contractors and do not impact claims processing for the Multi-Carrier System and the ViPS (Viable Information Processing System) Medicare System.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M I E R	C A R R I E R	R H I I S S	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
6563.1	Medicare systems shall automatically deny lines submitted with the -GA modifier and covered charges.						X				
6563.1.1	Medicare systems shall assign beneficiary liability to lines automatically denied due to the presence of the -GA modifier.	X		X			X				
6563.1.2	Medicare systems shall use claim adjustment reason code 50 when denying lines due to the presence of the -GA modifier.	X		X			X				
6563.2	Medicare systems shall recognize and allow the -GX modifier on claims.	X	X	X	X		X			I/OC E	
6563.3	Medicare systems shall return the claim to the provider if the -GX modifier is used on any line reporting covered charges.	X		X			X				
6563.4	Medicare systems shall allow the -GX modifier to be reported on the same line as the following modifiers that indicate beneficiary liability: -GY, -TS.						X				
6563.4.1	Medicare systems shall return the claim to the provider if the -GX modifier is reported on the same line as any of the following liability-related modifiers: -EY, -GA, -GL, -GZ, -KB, -QL, -TQ	X		X			X				
6563.5	Medicare systems shall automatically deny lines submitted with the -GX modifier and non-covered charges.						X				
6563.5.1	Medicare systems shall assign beneficiary liability to lines automatically denied due to the presence of the -GX modifier.	X		X			X				
6563.5.2	Medicare systems shall use claim adjustment reason code 50 when denying lines due to the presence of the -GX modifier.	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I 	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
6563.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
6563.1.2 and 6563.5.2	Claim adjustment reason code 50 is defined: "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

ABN Policy: Evelyn Blaemire, 410-786-1803, evelyn.blaemire@cms.hhs.gov

Program Integrity/Medical Review: Jesse Polansky 410-786-1171, jesse.polansky@cms.hhs.gov

Division of Institutional Claims Processing: Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov or Elizabeth Carmody, 410-786-5733, elizabeth.carmody@cms.hhs.gov

Division of Practitioner Claims Processing: Cynthia Thomas, 410-786-8169, cynthia.thomas@cms.hhs.gov
Division of Supplier Claims Processing: Susan Webster, 410-786-3384, susan.webster@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents (Rev.1921, 02-19-10)

60 – Provider Billing of Non-covered Charges on Institutional Claims

60.1 - General Information on Non-covered Charges on Institutional Claims

60.1.1 – Basic Payment Liability Conditions

60.1.2 – Billing Services Excluded by Statute

60.3.1 – Background on Institutional Demand Bills (Condition Code 20)

60.3.2 - Inpatient and Outpatient Demand Billing Instructions

60.4.1 –Outpatient Billing With an ABN (Occurrence Code 32)

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

60 – Provider Billing of Non-covered Charges *on Institutional Claims* (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

60.1 - General Information on Non-covered Charges on Institutional Claims (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Charges are tied to items or services described by coding on a line of a claim where they appear together. The institutional claim formats (the ANSI ACS X12 837I electronic claim transaction and the CMS-1450 [UB-04] paper claim) provide separate fields for the submission of total charges and non-covered charges.

When billing, claims submitters make a choice between submitting charges as covered, or as non-covered. When total charges are submitted and non-covered charges are not submitted, the charges for the claim line are submitted as covered. When a claim line is submitted with covered charges, the provider is seeking payment for that line. When total charges and non-covered charges submitted on a claim line are equal, the charges for that claim line are submitted as non-covered. When a claim line is submitted with non-covered charges, the provider is not seeking payment for that line and the line is denied payment by Medicare systems.

Lines submitted with covered and non-covered charges can appear together on a single Medicare claim. In rare instances, covered and non-covered charges can appear on the same line, with the exception of certain inpatient claims (see section 60.2.1). In these cases, the total charge amount is greater than the non-covered charge amount on the line.

Even when *Medicare* payment is not requested, *there can be Medicare* notice requirements that establish *financial* liability between beneficiaries and their providers. *These* liability notices, such as Advance Beneficiary Notices *of Noncoverage* (ABNs), serve to ensure that providers can shift *the financial* liability for items and services to their Medicare patients, consistent with

§1862(a)(1) and §1879 of the Social Security Act (*i.e., the Act*). See Chapter 30 of this manual for more information on financial liability and related notices.

NOTE: In this section, the term ‘provider’ may include institutional providers or suppliers and other comparable entities delivering medical items and services billed on institutional claims.

This statutory ability to shift liability only applies when billing items and services usually covered as part of established Medicare benefits. These benefits are described in law, in Title XVIII of the Act, which authorizes the Medicare Program. Other benefits not addressed in Title XVIII are known as being “statutorily excluded,” meaning Medicare is not authorized to pay for them under the Act.

Financial liability for an item or service that could be a Medicare benefit is codified in statute, along with the benefits themselves. Liability occurs when such items or services are thought to be non-covered by the Program for specific reasons also given in the Act:

- §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,
- §1879(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.

When one of these stipulated reasons will apply to a denial on an Original Medicare claim, the reason has to appear on a notice given in advance of delivery of services, and before preparation of a related claim. These notices, like an ABN, give a level of detail that allows the involved beneficiary to understand why no coverage is likely to occur in that specific circumstance.

The financial liability that remains when Medicare does not pay belongs to either providers or beneficiaries. Such determinations are made by Medicare when processing related claims. Sometimes, providers and beneficiaries make their own agreements on payment without billing Medicare, which Medicare allows them to do. More often, Medicare is billed, since resulting denials of claims, even when submitted with non-covered charges, have appeal rights under Medicare over payment. See Chapter 29 of this manual for more information on such appeals.

Appeals rights are not expected to be used for non-covered charges, certainly not with any frequency. When no amounts are in dispute since no payment is sought, appeals tend not to occur. Charges submitted as non-covered should indicate that there is an understanding shared by the involved beneficiary and provider that Medicare payment is not expected. For example, non-covered charges could be used for cosmetic surgery because both parties know this surgery is never a Medicare benefit, or statutorily excluded. The surgery may be billed to Medicare so that subsequent payers could see a Medicare denial when they require proof of denials by payers more primary in the sequence of coverage.

*Claims which are rejected by the Medicare contractor or are returned to the provider (or RTP'ed) can be corrected and re-submitted, permitting a **payment** determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but **they can NEVER appeal RTP'ed claims. Rejections may be apparent on remittances for claims submitted with administrative errors, but beneficiaries cannot be held liable for items and services that were never properly billed to Medicare.***

In contrast, denied claims can never be resubmitted, since they are in fact the result of official payment determinations made by Medicare. As mentioned, such determinations can be appealed.

60.1.1 – Basic Payment Liability Conditions

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

With any service delivered, providers must decide which one of the following three conditions apply in order **both** to properly inform Medicare beneficiaries of their potential liability for payment, **and later to bill for this payment.** *The concepts used in making these decisions are displayed in the following table*

TABLE 1:

<i>MEDICARE SCENARIO</i>	<i>Payment 'CONDITION 1'</i>	<i>Payment 'CONDITION 2'</i>	<i>Payment 'CONDITION 3'</i>
<i>DESCRIPTION</i>	<i>Items and services being billed are statutorily excluded from Original Medicare coverage, meaning it is not defined as a specific Medicare benefit defined in the Act; therefore, it is never paid.</i>	<i>Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider (see applicable reasons in 60.1 above).</i>	<i>Items or service is presumed to be a Medicare benefit and can be paid.</i>
<i>NOTIFICATION (Prior to billing)</i>	<i>Liability notices are <u>voluntary</u> (i.e., ABN); for statutory exclusions, there are no required Medicare notices.</i>	<i>Liability notices are <u>required</u> (i.e., expedited determination notice, ABN).</i>	<i>Liability notices, mandatory or voluntary, are never used in advance of such billing.</i>
<i>BILLING</i>	<i>Items and services may be billed as</i>	<i>Billing of such items and services can vary,</i>	<i>Items and services are billed as</i>

	<i>non-covered on Medicare claims.</i>	<i>and can depend on the ability to segregate its covered and non-covered portions (if both exist).</i>	<i>covered.</i>
LIABILITY <i>(displayed on MSNs or remittances)</i>	<i>Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code their claims to transfer liability to themselves.</i>	<i>For any services that are not paid by Medicare itself, properly notified beneficiaries are usually liable for resulting denials.</i>	<i>If Medicare doesn't pay itself as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy.</i>

NOTE: *Only one of these conditions can apply to a given item or service, or to a given line of a claim.*

To the extent possible in billing *Medicare*, providers should split claims so that one of these three conditions holds true for all *items and services* billed on a single claim. *Consequently*, no more than one type of beneficiary notice on liability *would* apply to a single claim. This approach should improve understanding of potential liability for all parties and speed processing of the majority of claims.

EXCEPTION: Cases may occur where multiple conditions apply and multiple notices may be necessary:

- (A) Claims paid under the outpatient prospective payment system (OPPS); the OPPS requires all services provided on the same day to be billed on the same claim (*see §170 of Chapter 4 of this manual*), with few exceptions as already given in OPPS instructions (i.e., claims using *any of the following 3* condition codes: 21, 20, *which are also discussed below in this chapter, and G0*);
Or:
- (B) Claims using certain *claim coding*:
 - occurrence span codes on inpatient claims,
 - modifiers used to differentiate multiple conditions *that* apply *to different lines on the same claim*.

These issues are *discussed further in subsequent sections of this chapter. More information on each payment condition listed in the table above follows in this section.*

Payment Condition 1. There is no required notice if beneficiaries elect to receive services that are excluded from Medicare by statute. This is understood as:

- not being part of a Medicare benefit, or
- not covered for another reason that a provider can define, but that would not relate to potential denials under §§1879 *or* 1862 (a) of the Act (*listed above in 60.1*).

If written notification of potential liability for statutory exclusions is desired *to aid beneficiaries, even though not required by Medicare*, the ABN may be used for *such* voluntary notification purposes. *Explanation of this use* can be found at the Centers for Medicare and Medicaid Services (CMS) Web site:

- www.cms.hhs.gov/medicare/bni/ ; *and*
- Chapter 30 of this manual, Financial Liability Protections.

Any other situations in which a patient is informed a service is not covered should also be documented *in patient records*, making clear the specific reason *a* beneficiary was told a service would be billed as non-covered.

Payment Condition 2. Providers **must** supply a liability notice if *payment for* services delivered to a Medicare beneficiary *are* to be reduced or terminated following delivery of the *same or similar* covered *services, and those services* are thought not to be covered *at all specifically for one of the reasons listed* under §1862 (a) of the Act. *Delivery of such notices can permit a shift of* liability under §1879. Providers must give these notices *to beneficiaries* before services are delivered for which *the beneficiary* may be liable. Failure to provide such notices when required means *a* provider will not be able to shift liability to *a* beneficiary. *As a result, the liability must be assumed by the provider.* When a *mandatory* notice is given, patient records should be documented.

Aside from liability requirements of the Act, applicable Conditions of Participation (COPs) MAY also require a provider to inform a beneficiary of payment liability. This must be done BEFORE delivering services not covered by Medicare, IF the provider intends to charge the beneficiary for such services. *This is the case with the COPs applicable to home health agencies.* In addition to what may be required by the COPs, providers are advised to respect Medicare beneficiaries' right to information as described *in Medicare publications targeted to beneficiaries (e.g. "Medicare and You")*.

Required Notices for Condition 2. Over time, there have been different types of *liability* notices, *used* in different settings for specific types of *services*:

- (1) *Notices of Noncoverage* have been given to eligible inpatients receiving, or *those* previously eligible for, non-hospice services covered under Medicare Part A (types of bill (TOB) 11x, 18x, 21x, and 41x) *when* services at issue no longer met coverage guidelines; for *example, when* exceeding the number of covered days *allowed* in a spell of illness *for a specific Medicare benefit.*
 - a. In hospitals, these notices *have been* known as Hospital Issued Notice of Non-coverage (HINNs) or hospital notices of non-coverage (*in the past this hospital use was the exclusive use of the term 'notice of non-coverage), and*

- b. In Skilled Nursing Facilities (SNFs), they may *have been* known as Sarrassat notices, *denial letters or the specific notice called “SNFABN.”*

Current CMS policy on *these benefits, and claims seeking payment for them*, can also be found at:

TABLE 2:

<i>BENEFIT</i>	<i>INTERNET ON-LINE MANUAL</i>
<i>Inpatient Hospital</i>	<i>100-02, Benefit Policy, Chapter 1,</i>
<i>“</i>	<i>100-04, Claims Processing, Chapter 3;</i>
<i>SNF. (Part A Paid)</i>	<i>100-02, Benefit Policy, Chapter 8,</i>
<i>“</i>	<i>100-04, Claims Processing, Chapter 6.</i>

- *Overall, for these and other Original Medicare benefits, see Chapter 30 of this manual, 100—04, for information on financial liability notices.*
- *All Medicare manual instructions are accessible at the following Web site:*

www.cms.hhs.gov/manuals/

(2) ABNs, when:

- (a) Overall medical necessity of a recognized Medicare benefit is in doubt, under §1879 and §1862 (a) of the Act, or
- (b) *Items and services that were* previously covered *are* to be reduced *in payment or* terminated, *creating financial* liability, or
- (c) The setting is a hospital or SNF, *but their inpatient* specific forms are not applicable: ABNs are used for certain *outpatient services or services covered under Part B delivered in a SNF or hospital; also, HH not under a plan of care, or*
- (d) CORF, or
- (e) Hospice services, which alone among services *discussed here, are* paid under Part A.

NOTE: *ABNs can refer to a specific notice format but here is used as a general term including notices used for other benefits such as HHABNs, which are used exclusively for home health.*

Another form of notice, known as an expedited determination notice, can be simultaneously delivered with Medicare liability notices like ABNs, since both types of notices can be involved in terminations of services. Expedited determination notices are primarily intended to convey information about impending discharge, or termination of services, not liability, which is the focus of notices like ABNs.

Expedited determination notices apply to the following Medicare providers:

- *Inpatient Hospital,*
- *Skilled Nursing Facilities (SNFs),*
- *Hospices,*
- *Home Health Agencies, and*

- *Comprehensive Outpatient Rehabilitation Facilities (CORFs).*

These providers are required to give a specific type of notice when all services they are providing, or Medicare payment for those services, terminate. These notices are described at the following locations:

- *www.cms.hhs.gov/medicare/bni/ ; and*
- *2005 Transmittal R594CP, which will be placed in Chapter 30 of this manual, Financial Liability Protections, and in the interim is found at:*
 - *<http://www.cms.hhs.gov/Transmittals/> .*

Payment Condition 3. This condition *occurs when* providers are billing for what they believe to be covered services as covered services. There are no notice requirements for this condition, and non-covered charges are not involved *when submitting such claims, though denials may result from processing.*

Billing follows notification, so providers should remember that in all payment conditions the notices described above would be delivered to the beneficiary before a claim is submitted to Medicare.

The following table summarizes and supplements the information in this subsection:

TABLE 3:

CONDITION	Type of Provider/Type of Bill	Liability Notice
Payment [Liability] Condition 1, <i>No Medicare notice required and liability expected</i>	All providers when service known not to be covered by Medicare	<i>Voluntary</i> notice ONLY , <i>provider expects to receive no Medicare payment.</i>
Payment [Liability] Condition 2, <i>Medicare notice IS required and liability expected</i>	Inpatient only, <i>Part A paid</i> (TOBs: 11x, 18x, 21x, 41x)	Notice of Non-Coverage or comparable form <i>required.</i>
Payment [Liability] Condition 2, <i>Medicare notice IS required and liability expected</i>	Home Health (HH) services under a HH plan of care and paid through the HH prospective payment system (PPS) only (TOBs 32x and 33X)	HHABNs (Form CMS-R-296) <i>required.</i>
Payment [Liability] Condition 2, <i>Medicare notice</i>	All providers and services IF , <ul style="list-style-type: none"> • <i>Hospice</i> • Part B <i>paid services</i> not previously listed above 	ABN (Form CMS-R-131) <i>required .</i>

<i>IS required and liability expected</i>	for Condition 2; includes laboratories or providers billing lab tests only (revenue codes 30x, 31x and 92x)	
Payment [Liability] Condition 3, <i>No Medicare notice required and no liability expected</i>	All providers	No notice requirement, <i>provider expects to receive payment from Medicare.</i>

Providers must decide which payment condition and notice requirement is appropriate to the billing situation in each case. Based on this decision, providers will then apply certain billing instructions as that described in the remainder of this section.

60.1.2 – Billing Services Excluded by Statute

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The billing instructions in this subsection apply to payment condition 1.

Medicare will not pay for services excluded by statute, *meaning that Title XVIII of the SSA either:*

- *does not describe the items and services in question as all or part of a covered Medicare benefit, or*
- *describes, but excludes, such items and services from coverage.*

Examples of such services are given to beneficiaries in the “Medicare and You” handbook.

These services can be billed to Medicare as non-covered on institutional claims.

Items and services excluded by statute cannot necessarily be recognized in specific procedure or diagnosis codes. For example, *in some cases*, a given code may be covered as part of a given *Medicare* benefit, but under other cases, when no benefit *exists*, the same code would not be covered *by Medicare*. For claims submitted to *Medicare contractors*, these services *that are not Medicare benefits* may be:

(A) Not submitted to Medicare at all (*see A, immediately below*),

(B) Submitted as non-covered line items, or

(C) Submitted on entirely non-covered claims.

A. Medicare does not require procedures excluded by statute to be billed on institutional claims UNLESS:

- (1) Established *Medicare* policy requires either all services in a certain period, covered or non-covered, be billed together so that all such services can be bundled for payment consideration

(i.e., procedures provided on the same day to beneficiaries under OPPS), or

(2)

Billing is required for reasons other than payment (i.e., *when utilization days must be charged in inpatient settings where the benefit itself is limited in duration, such as the 100 day limit of Part A payment for a SNF stay*); or

(3)

A beneficiary requests Medicare be billed *so* that the *item or service* in question will be reviewed by Medicare *to make an official payment determination* (more on demand billing in §60.3 in this chapter).

- B. To submit *statutory exclusions* as non-covered line items on claims with other covered services, *modifiers like –GY can be used* on non-covered *line items*.
- C. To submit statutory exclusions on entirely non-covered claims, use condition code 21, a claim-level code, signifying all charges that are submitted on that claim are non-covered charges.

60.1.3 - Claims With Condition Code 21

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Condition code 21 can be employed to indicate no payment claims are being submitted for other reasons in addition to *those mentioned in section 60.1.2.* above:

- At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare to facilitate payment by subsequent insurers (ex., statutory exclusions outside Original Medicare benefits, such as most self-administered drugs). *This is payment condition 1. These claims are referred to as no-payment claims.*
- With an HHABN in special cases (see Chapter 10, §60, of this manual). *This is payment condition 2.*

General Billing Instructions for No Payment Claims with Condition Code 21 (Other than HH PPS).

No payment claims are sometimes referred to as “billing for denial”. *They are submitted with condition code 21, which is defined by the National Uniform Billing Committee as “billing for denial notice.”*

The following instructions for use of condition code 21 are applicable to all bill types, other than HH PPS claims.

- All charges must be submitted as non-covered;
- No modifiers signifying *beneficiary or provider liability are necessary*;

- Frequency code 0 (zero) must be used in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;
- Total charges must equal the sum of non-covered charges;
- Basic required claim elements must be completed; and
- Statement dates should conform to simultaneous claims for payment, if any.

Non-covered charges billed on these claims, when not rejected, will be denied. Medicare beneficiaries will always be liable for these claims. Such denials can only be overturned on appeal.

If claims do not conform to these requirements, they will be returned to providers *for correction and resubmission*. However, in the case of *claims with statement dates that overlap with other claims*, the incoming overlapping claim using condition code 21 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

60.1.3.1 – Provider-liable Fully Non-covered Outpatient Claims *(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)*

Originally with the creation of the ability of outpatient institutional providers to submit non-covered charges, only two types of fully non-covered claims were permitted: (1) No payment claims using condition code 21, or (2) Demand bills (see 60.3 below in this chapter).

However, based on input from both *Medicare contractors* and providers, CMS recognized the need for entirely non-covered claims that *were provider-liable*. *This meant a new billing method was necessary, as* no payment claims with condition code 21 are never provider liable, and *liability* on demand bills cannot be assured until after review/adjudication by Medicare. A primary example of this need is a case in which a provider has failed to provide an ABN when required *under payment condition 2*, and chooses to accept all liability for services billed as non-covered.

Therefore, entirely non-covered outpatient claims are also allowed when billed with all non-covered charges, as long as either:

- (1) There are no indicators of liability on the claim at the claim or line level *preventing* the shared system *from defaulting* to hold providers liable on all denied line items; or
- (2) All indicators at the claim or line level *show* provider, not beneficiary, liability.

An example of such an indicator is the -GZ modifier, which is often used in the case where a provider fails to give an ABN. In both cases, these line items, all submitted as non-covered, will be denied *as provider liable*.

60.2 - Non-covered Charges on Inpatient Bills

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a non-covered level of care and end with a covered level (within the same month for SNF billing), only one claim is required for both the non-covered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no payment. These bills must correctly reflect provider and beneficiary liability (see Chapter 6, §40.6.4 of this manual) For inpatient hospital PPS claims that cannot be split into covered and non-covered periods, hospital providers can submit occurrence span code 77 *to represent* provider-liable non-covered periods, and occurrence span code 76 for beneficiary-liable non-covered periods.

These procedures must be followed for Part A inpatient services (TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (religious non-medical health care institutions—RNHCI)), *but the list that follows is* not required for inpatient Part B claims:

- All charges submitted as non-covered;
- Frequency code 0 (zero) *must* be used in the third position of the type of bill (TOB) form locator of the original claim (i.e., not adjustment or cancellation)

NOTE: If providers do not submit no payment claims with this frequency code, the *shared* systems may already act to change the frequency code to 0 or return the claim to the provider.

- Total charges *must* equal the sum of non-covered charges;
- Basic required claim elements must be completed;

NOTE: Units are not required when reporting non-covered days on SNF *claims or* Inpatient Rehabilitation claims.

Claims that do not conform to these requirements will be returned to providers. For SNFs, occurrence code 22 should also be used on *benefits exhaust* claims when SNF care is reduced to a non-covered level and benefits had previously been exhausted (see Chapter 6, section 40.7 in this manual).

Current instructions for inpatient no payment claims are found in the following locations:

TABLE 4:

BENEFIT	INTERNET ON-LINE MANUAL
<i>Inpatient Hospital</i>	<i>100-02, Benefit Policy, Chapter 1</i>
<i>“</i>	<i>100-04, Claims Processing, Chapter 3, §40.4, Chapter 3 (Inpatient Hospital) on no payment claims</i>
<i>SNF (Paid from Part A)</i>	<i>100-02, Benefit Policy, Chapter 8</i>

“	<i>100-04, Claims Processing, Chapter 6, §40.8, Chapter 6 (Inpatient SNF) on no payment claims</i>
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60.3.1 – *Background on Institutional Demand Bills (Condition Code 20)*
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Demand bills are both a principle and a mechanism of Medicare. The principle goes back to the founding of the Program, reflected in the protection of the rights of the Program’s beneficiaries being among the first sections of Title XVIII. The principle assures that beneficiaries have the right to demand that Medicare be billed for the services provided to them, whether or not that billing provides Medicare payment. By assuring claims are sent to and processed by Medicare, permitting official payment decisions to be made, beneficiaries retain the right to appeal payment decisions made on those claims, when they believe need to use that right exists.

The mechanism of demand billing is the process by which providers submit claims that beneficiaries have requested be sent to Medicare. Specific procedures were developed over time to accomplish such billing, and these procedures also became known as demand billing.

A. Demand Billing Procedures

“Traditional demand bills” is a term *used* to encompass the only *administrative* billing option *that existed* for demand bills before the ABN *was used*. *These bills used* condition code 20 to indicate a beneficiary has requested billing for a service, even though the provider of the service *may have* advised the beneficiary *that* Medicare *was* not likely to pay for this service. That is, there *was* some dispute as to whether a service *was* covered or not, *leading for a need for Medicare to review the claim and make a formal payment decision*. *If* there *was* no dispute, billing a no payment claim or other options for non-covered charges *would* be more *efficient and* appropriate.

In the past, traditional demand billing was not always consistent or used by all providers. There was no *uniform* notice requirement *across Medicare benefits*. *Such instructions as existed* required 100 percent of specific types of demand bills to be suspended for manual review (inpatient SNF/home health, TOBs 21x, 32x, 33x), and required the provider to submit additional documentation for development to determine the medical justification for the service(s) in question.

B. Advent of Liability Notices for Outpatient Benefits

This changed once liability notices related to outpatient benefits, ABNs, were created. *If* an ABN *was* given, special billing requirements *applied*, and traditional demand billing *was* NOT used. *Now*, only in cases when the ABN is NOT given, services for which coverage is questioned are submitted as non-covered using traditional demand billing. *This traditional demand billing* process is now open to all provider types, inpatient and outpatient.

Even though there are no notice requirements with *traditional* demand bills, providers are always encouraged to advise beneficiaries when they may be liable for payment before delivering such

services, and may be required to do so by applicable COPs. In such cases, providers should also document their records that such advice has been given.

Demand billing is resource intensive for the Medicare program, and affects the timeliness of payment determinations, which should prevent conscientious providers from abusing this mechanism when there is no true doubt as to coverage/payment. Routine billing of covered services *and* billing of non-covered charges should *both* be used as appropriate when coverage/payment is not believed to be in doubt *instead of demand billing*. *Liability notices* are not needed if a triggering event *requiring their delivery, such as those for an ABN*, does not occur. Beneficiaries retain appeal rights when these other billing mechanisms are used, *even though no liability notice is delivered*.

60.3.2 - Inpatient and Outpatient Demand Billing Instructions **(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)**

A. Scope of this Subsection

The instructions in this subsection apply to demand bills other than for HH PPS and apply with some modification for Part A SNF services. Demand bills for those services are subject to special instructions that are cited below.

1. HH PPS Demand Bills. There are special instructions for HH PPS demand bills. Such special instructions must be followed if:

- (a) An HHABN is required, or
- (b) If a beneficiary requests demand billing when receiving care from a home health agency (HHA) in an HH PPS episode. Instructions for such bills can be found at:
 - §50 of Chapter 10 (Home Health) of the Medicare Claims Processing Manual; and
 - Note these HH PPS demand bills use frequency code 9.

2. SNF Demand Bills. There are special instructions *relating to collection of funds from patients* for inpatient Part A SNF demand bills, which can be found in Chapter 30, §70 *of the Medicare Claims Processing Manual*. *In all other respects, the instructions below apply to SNF Part A services also.*

B. General Instructions

Inpatient and outpatient providers are required to submit demand bills using condition code 20 when requested by beneficiaries. *Billing with condition code 20* is ONLY in case when an ABN is not given/not appropriate for billing *related to doubtful liability* (for ABN instructions, see §60.4.1 below). *Medicare contractors* perform review of *demand bills with condition code 20, to assure compliance with codified Medicare* medical necessity, coverage and payment liability *policy*.

Other covered services may appear on *demand bills*, but not other non-covered charges, as all non-covered charges on demand bills will be considered in dispute and in need of review. Allowing covered and non-covered services to come in on demand bills will allow all services

provided in the statement covers period to be billed *simultaneously*, though payment of the covered services will be delayed by the review and development of the non-covered charges *when not split to a separate claim*. For this reason, providers should break out demand billed services to separate claims for discrete time periods with all non-covered charges whenever possible. *Demand bills* must contain at least one non-covered charge, *the coverage of which is* at issue, *when the Medicare contractor receives them from the provider*, or claims with condition code 20 will be returned to the provider.

No payment bills using condition code 21 are only used for services that are not in dispute, as opposed to non-covered charges on demand bills. *Therefore, Condition Code 21 claims can be simultaneously submitted with such bills.*

No claims *seeking payment and submitted* with all *covered charges* may be submitted *by the same provider* simultaneously with *a demand bill for the same beneficiary*. This restriction is required because some services on demand bills may be found covered upon review. If *such overlapping claims with covered services are* received, the incoming claim will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

Providers should be aware CMS may require development of any non-covered charge on traditional demand bills. *Such* services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

C. Final Summary

In summary, other general requirements for demand bills are:

- Condition Code 20 must be used;
- All charges associated with Condition Code 20 must be submitted as non-covered;
- All non-covered services on the demand bill must be in dispute;
- At least one non-covered line must appear on the claim *related to the services in dispute*;
- Unrelated covered charges are allowed on the same claim;
- Unrelated non-covered charges not in dispute, if any, would be billed on a no payment claim using Condition Code 21;
- Frequency code zero should be used if all services on the claim are non-covered;
- *Occurrence code* 32 (i.e., ABN) *is* NEVER submitted on a claim *using condition code 20*; and
- Basic required claim elements must be completed.

Claims not meeting these requirements will be returned to providers.

60.4.1 –*Outpatient* Billing with an ABN (Occurrence Code 32) ***(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)***

The billing instructions in this subsection apply to payment condition 2.

If an ABN is given, the billing procedures in this subsection must be used, rather than traditional demand billing. Using an ABN is frequently required, and is also allowed on a voluntarily basis when a provider sees fit. It is used more often than traditional demand billing.

Claim level coding

When a provider determines the beneficiary's services for certain benefits should be terminated, the provider must follow the ED instruction requirements located at section 150.3 below. If the beneficiary chooses to receive non-covered services after the date the provider believes covered services are terminated, the provider must also issue an ABN to the beneficiary.

In using the ABN, beneficiaries select *only* one option *on the ABN notice prior to billing, after they have been told that the provider anticipates* Medicare will not cover a service.

Claims, *other than HHPPS claims*, billed in association with an ABN never use condition code 20 or 21, and will be returned to providers if received *with those codes. Instead, the claims:*

- Must use occurrence code 32 to signify all services on the claim are associated with one particular ABN given on a specific date, unless the use of modifiers makes clear that not every line on the claim is linked to the ABN;
- Must provide the date the ABN was signed by the beneficiary in association with the occurrence code;
- *Must use occurrence code 32* and the accompanying date multiple times if more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim;
- Must submit all ABN-related services as covered charges (note –GA modifier exception, below); and
- Must complete all *the same* basic required claim elements as comparable claims for covered services.

Providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN.

If claims using occurrence code 32 remain covered, they will be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the *Medicare contractor* will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

Line level coding

The –GA modifier is used when provider must bill *some* services *which are* related and some *which are* not related to a ABN on the same claim. *The –GA modifier* is used when both covered and non-covered service appear on *an* ABN-related claim. *Occurrence code 32 must still be used on claims using the –GA modifier, so that these services can be linked to specific ABN(s). In such cases, only the line items using the –GA modifier are considered related to the ABN and must be covered charges, other line items on the same claims may appear as covered or non-covered charges.*

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. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

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.

TABLE 5:

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 <u>Not Covered</u> or <u>Not Payable</u> 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, <i>-SY</i> , -TD through -TR, <i>-TT</i> through -TW, -U1 through -U9, -UA through -UD, <i>-UF through -UK</i>	<i>Institutional</i> 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, -TS)	Use as defined by publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPSS Claims	See current OPSS instructions	<i>Institutional</i> standard systems accept these modifiers for processing on OPSS 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

Source of the Modifier List	Non-covered Modifiers	Claims Processing Instructions	Definition Source
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, -TS	<i>Institutional</i> 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, -TS), 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 6:

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

Mod- ifier	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, -GY, or -TS)	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 <i>Issued, as Required by Payer Policy</i>	None	ABN required; beneficiary liable	To signify a line item is linked to <i>the mandatory use of an</i> 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	<i>Reasonable and Necessary Item/ Service</i> 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 <i>institutional</i> claims	<i>Not used on institutional claims.</i> Use –GA or –GZ modifier as appropriate instead	<i>Institutional</i> claims submitted using this modifier <i>are</i> returned to the provider

Mod- ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GL	Medically Unnecessarily Upgrade Provided instead of <i>Non-Upgraded Item</i> , 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 <i>on home health claims</i> (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. <i>May be used in association with modifier -GX.</i>	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

Mod- ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-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
-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
-TS	Follow-Up Service	Not payable by Medicare	No notice requirement, unless COPs require, recommend documenting records; beneficiary liable	Use on all types of provider claims when services are billed as non-covered for reasons other than can be established with other coding/modifiers (i.e., -GY) when the beneficiary is liable for other documented reasons. <i>May be used in association with modifier -GX.</i>	Lines submitted as non-covered and will be denied
-GX	<i>Notice of Liability Issued, Voluntary Under Payer Policy</i>	<i>None</i>	<i>Used when a provider issued an ABN on a voluntary basis; beneficiary liable</i>	<i>Use on all types of provider claims when a voluntary notice has been issued. May be used in association with modifiers -GY or -TS or used separately.</i>	<i>Lines submitted as non-covered and will be denied</i>

* **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.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPTS)

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250.1.1 – Special Instructions for Non-covered Time Increments in Standard Method Critical Access Hospitals (CAHs)

250.1.1 – Special Instructions for Non-covered Time Increments in Standard Method Critical Access Hospitals (CAHs)

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

CAHs sometimes bill outpatient therapy services using HCPCS that by definition give specific time increments like those discussed in Chapter 5, sections 20 and 40. However, standard method CAHs are not subject to payment on a fee basis under the Medicare Physician Fee Schedule, therefore these CAHs should follow the instructions below if there is a need to bill non-covered increments.

When HCPCS codes required for reporting do not specify an increment of billing in their definition (i.e., 15 minute intervals), the unit for the line item is 1, and CAHs should follow the general instructions given for billing non-covered charges in Chapter 1, section 60, either by the line item or on no payment claims.

Several of the outpatient therapy HCPCS codes, however, are defined in specific time increments, and units reported on line items should be consistent with these definitions. In such cases, when both covered and non-covered increments are provided in the same visit on the same date of service, CAHs should bill as follows:

- Report covered and non-covered units in separate line items, even when part of the same visit, with one line item for all covered and non-covered increments in a visit, and another for all non-covered increments in that same visit;*
- Use ABN-related modifiers when appropriate to explain non-coverage and payment liability of specific lines (i.e., -GY, see Chapter 1, section 60 for details on these modifiers);*
- Do not report non-covered line items that are part of a partially covered service on a separate no payment claim (i.e., using condition code 21). Instead, always report them on the same claim with the separate lines for the covered portion of the service. No payment claims received for the same date, same beneficiary, same provider and same*

therapy service as a for-payment claim will be rejected. A distinct reason code will make providers aware of the reason for the rejection, and they can correct their billing to have covered and non-covered portions of the same service on the same claim;

- *Do not report non-covered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits (i.e., where all increments are non-covered and there are no covered charges for the line item, since these line items are either part of an already counted partially covered visit, or an entirely non-covered visit); and*
- *Never split a single increment into a covered and non-covered portion.*

Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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40.1 - Determining Payment Amounts

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Institutional outpatient rehabilitation claims are paid under the Medicare Physician Fee Schedule (MPFS). Medicare contractors should see [§100.2](#) for details on obtaining the correct fee amounts.

40.2 – Applicable *Types of Bill*

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The appropriate *types of bill for submitting outpatient rehabilitation services, and* requiring HCPCS coding *to ensure payment under the MPFS* are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 83X.

40.3 - Applicable Revenue Codes

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services

0430 - Occupational Therapy Services

0440 – Speech-*language* pathology services

0470 - Audiology

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - Edit Requirements for Revenue Codes

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare contractors edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, *Medicare contractors* do not edit the matching of revenue code to *certain* HCPCS codes or edit to limit provider reporting to only those HCPCS listed in *section 20*.

40.5 - Line Item Date of Service Reporting

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Medicare contractors will return claims that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

40.6 – Non-covered Charge Reporting

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Institutional outpatient therapy claims may report non-covered charges when appropriate according to the instructions provided in of this manual. Outpatient therapies billed as non-covered charges are not counted toward the financial limitation described above, when that limitation is in effect, unless the charges are subject to review after they are submitted and found to be covered by Medicare. Modifiers associated with non-covered charges that are presented in Chapter 1, section 60 can be used on claim lines for therapy services, in addition to the use of modifiers –GN, –GO and –GP.

Medicare Claims Processing Manual

Chapter 15 - Ambulance

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30.2.4 - Non-covered Charges on Institutional Ambulance Claims

30.2.4 – Non-covered Charges on Institutional Ambulance Claims (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare law contains a restriction that miles beyond the closest available facility cannot be billed to Medicare. Non-covered miles beyond the closest facility are billed with HCPCS procedure code A0888 (“non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility”). These non-covered line items can be billed on claims also containing covered charges. Ambulance claims may use the –GY modifier on line items for such non-covered mileage, and liability for the service will be assigned correctly to the beneficiary.

The method of billing all miles for the same trip, with covered and non-covered portions, on the same claim is preferable in this scenario. However, billing the non-covered mileage using condition code 21 claims is also permitted, if desired, as long as all line items on the claims are non-covered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. Such billings are more likely to be submitted on entirely non-covered claims using condition code 21. This scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

Another scenario in which billing non-covered mileage to Medicare may occur is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. The –QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and the line is submitted with covered charges. The –QL modifier should also be used on the accompanying mileage line, if submitted, with non-covered charges. Submitting this non-covered mileage line is optional for providers.

Non-covered charges may also apply if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit non-covered charges, if the provider bills Medicare at all (it is not required in such cases). These non-covered charges are unallowable, and should not be considered in

settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants policy since October 1983, supported by Federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations.

Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress’s intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Medicare requires the use of the –TQ modifier so that CMS can track the instances of the subsidy scenario for non-covered charges. The –TQ should be used whether the subsidizing entity is governmental or voluntary. The –TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case, since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges when the entity providing the subsidy never charges another entity/primary payer, should be submitted as non-covered charges, they may contact their FI about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. FIs have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

Mileage Scenario	HCPCS	Modifiers*	Liability	Billing	Remit. Requirements	MSN Message
<i>STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.</i>	<i>A0888 on line item for the non-covered mileage</i>	<i>-QM or -QN, origin/destination modifier, and -GY unless condition code 21 claim used</i>	<i>Beneficiary</i>	<i>Bill mileage line item with A0888 –GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no –GY required, claim will be denied</i>	<i>Group code PR, reason code 96</i>	<i>16.10 “Medicare does not pay for this item or service”; OR, “Medicare no paga por este artículo o servicio”</i>
<i>Beneficiary</i>	<i>Most</i>	<i>–QL unless</i>	<i>Pro-</i>	<i>Bill mileage line item</i>	<i>Group</i>	<i>16.58 “The</i>

<i>dies after ambulance is called</i>	<i>appropriate ambulance HCPCS mileage code (i.e., ground, air)</i>	<i>condition code –21 claim</i>	<i>vider</i>	<i>with –QL as non-covered, line item will be denied</i>	<i>Code CO, reason code 96</i>	<i>provider billed this charge as non-covered. You do not have to pay this amount.”; OR, “El proveedor facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”</i>
<i>Subsidy or government owned Ambulance, Medicare NEVER billed***</i>	<i>A0888 on line item for the non-covered mileage</i>	<i>-QM or –QN, origin/destination modifier, and -TQ must be used for policy purposes</i>	<i>Provider</i>	<i>Bill mileage line item with A0888, and modifiers as non-covered, line item will be denied</i>	<i>Group Code CO, reason code 96</i>	<i>16.58 “The provider billed this charge as non-covered. You do not have to pay this amount.”; OR, “El proveedor facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”</i>

** Current ambulance billing requirements state that either the –QM or –QN modifier must be used on services. The –QM is used when the “ambulance service is provided under arrangement by a provider of services,” and the –QN when the “ambulance service is provided directly by a provider of services.” Line items using either the –QM or –QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these lines items will process to completion. Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, and are not non-covered by definition.*

*** This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.*

****If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.*

Medicare systems may return claims to the provider if they do not comply with the requirements in the table.