# Part B Insider (Multispecialty) Coding Alert

## Advance Beneficiary Notices: Know These 4 Categories of Noncovered Services

**Sometimes it can be hard to determine what's considered 'noncovered.'**

As most Part B practices are aware, Medicare will cover only a limited number of certain procedures per patient in a given period, and when you think a particular service won't be covered, it's advance beneficiary notice (ABN) time. But some practices are puzzled about which services are subject to Medicare coverage and which aren't. Although Medicare coverage varies from state to state, there are some services that are routinely excluded. Read on to find out more.

Medicare will not cover a procedure just because it has a CPT® code. Some services are statutorily excluded from coverage, while others are covered only once every year or two (for instance, an ob-gyn's pelvic exam).

There are four categories of items and services that are not covered under the Medicare program, according to the Medicare publication Items and Services That Are Not Covered Under the Medicare Program. These categories are as follows:

**1. Services and supplies that are not medically reasonable and necessary.** These include screening tests for which the beneficiary has no symptoms.
**2. Non-covered items and services.** These include personal comfort items such as radios and televisions, eyeglasses, hearing aid exams, or cosmetic surgery.
**3. Services and supplies that have been denied as bundled or included in the basic allowance of another service.** For example, these include physician standby services or telephone calls to and from the beneficiary.
**4. Items and services reimbursable by other organizations and furnished without charge.** This includes services that should be covered under automobile or workers' compensation insurance, among other insurers.

**Modifiers Explain ABN Status**

You should accompany any ABN claim with the correct code modifier so Medicare's EOB will properly outline when the patient has to pay.

The existing ABN modifiers are:

**GA** □ Waiver of liability statement issued, as required by payer policy, individual case.

Use modifier GA when you've issued an ABN because you expect Medicare to deny the service as not medically necessary. This might include tests ordered without a payable diagnosis code or those ordered more frequently than covered.

**Example:** A physician orders a screening Pap smear (P3000), but the patient does not remember when she last had the test. Because Medicare covers only one Pap test every second year unless the physician suspects cervical abnormalities, you should get the patient to sign an ABN acknowledging that she will have to pay for the test if she has had a Pap smear within the last two years.

**GY** □ Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.

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By law, Medicare excludes some medical treatments, such as many screening tests and you might want to inform patients of this fact. Although you're not required to issue an ABN, for excluded procedures, doing so is a courtesy to the patient and may help you get paid. When you report modifier GY in these cases, Medicare will generate a denial notice that the patient can use to seek payment from secondary insurance  helping the physician avoid unpaid claims.

**Example:** A patient requests a hearing aid (for example, V5244). Medicare does not pay for hearing aids, but the patient's secondary insurer provides coverage. The physician has the patient sign an ABN and appends modifier GY to V5244 to demonstrate he is aware Medicare does not cover the service.

**GX**  Notice of liability issued, voluntary under payer policy: You'll use modifier GX if a service or item is statutorily excluded but you did give the patient an ABN to sign.

**GZ**  Item or service expected to be denied as not reasonable and necessary. Modifier GZ indicates that you did not issue an ABN when you should have. Therefore you cannot bill the patient when Medicare denies payment.

So why use GZ if you still won't get paid? Because you'll reduce the risk of fraud or abuse allegations when filing claims that are not medically necessary.

**Example:** A physician orders prothrombin time (85610, Prothrombin time) for a patient diagnosed with unspecified Gram-negative septicemia (038.40). The lab doesn't issue an ABN but discovers before billing that Medicare's PT national coverage determination only covers the test for unspecified septicemia (038.9). Expecting a denial, the lab bills 85610-GZ.

Be forewarned, however, that modifier GZ claims might be subject to complex medical reviews, which can slow claims and create logjams in your billing processes. However, CMS has a policy to deny those claims instantly.

**In black and white:** "Effective for dates of service on and after July 1, 2011, contractors shall automatically deny claim line(s) items submitted with a GZ modifier," states Transmittal 2148. Your explanation of benefits will list the denial codes CO (Provider/supplier liable) and 50 (These services are non-covered services because this is not deemed a 'medical necessity' by the payer).

**Plan ahead:** Don't force yourself to resort to modifier GZ. Have a policy in place to collect ABNs before the procedure or service has been provided, when you think the service will be denied because it doesn't meet the Medicare's medical necessity requirements.