Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1820

This manualizes Program Memorandum B-01-58, Change Request 1820, dated September 25, 2001.

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-4.3 - 4-4.4 (2 pp.)	4-4.3 - 4-4.4 (2 pp.)
4508 - 4540	4-373 - 4-376.1 (5 pp.)	4-373 - 4-376 (4 pp.)

MANUALIZATION--*EFFECTIVE DATE: Not Applicable.*
IMPLEMENTATION DATE: Not Applicable

Section 4508.1, Coding for Non-Covered Services and Services Not Reasonable and Necessary, provides information on how providers and suppliers can submit claims for non-covered services.

All references to HCFA have been replaced with CMS in §§4507.1, 4508, 4509, 4509.1, 4509.2, and 4509.3.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER IV

Parenteral and Enteral Nutrition

Oral Anti-Emetic Drugs When Used as Full Replacement for Intravenous Anti-Emetic Drugs

Immunosuppressive Drugs

Vaccines

Services Provided In Health Manpower Shortage Areas

Healthcare Common Procedure Coding System (HCPCS)

Your request to add a new local code or modifier must include the following information:

- o Reason for the code/modifier (e.g., new procedure, new product, etc.);
- o Exact nomenclature or terminology requested;
- o Nearest national HCPCS code/modifier with an explanation why it cannot be used;
- o If applicable, suggested Relative Value Unit (RVU) of the new local code;
- o Expected annual billings in terms of services and charges;
- o Purpose for which the code/modifier is needed, (e.g., administrative/statistical use);
- o For modifiers only, a description of how the modifier will be used (e.g., to trigger MR, for informational purposes, to affect payment, (how it impacts payment), or for internal processing only); and
- o The RO and CO must receive written notification when local codes/modifiers are deleted and when there are changes to administrative data.

Do not pend affected claims prior to receiving a decision on the local code or modifier requested. Process the claims under a "not otherwise classified code" in the Level I or Level II code range that most closely represents the service, pending CMS CO approval/denial of your local code/modifier request.

4508. USE AND ACCEPTANCE OF HCPCS CODES AND MODIFIERS

Physicians and suppliers must use HCPCS on Form CMS-1500 (or Form CMS-1491 for ambulance claims) and when submitting EMC. The service or procedure can be further described by using 2-position modifiers contained in HCPCS.

Modifiers to HCPCS Level I codes for medicine, anesthesia, surgery, radiology, and pathology are on the HCPCS tape. Modifiers for Level II alpha-numeric codes are with the Level II codes published by CMS. Alpha-numeric and CPT-4 modifiers may be used with either alpha-numeric or CPT-4 codes. It is expected that you can accept up to (2) two-position numeric or alpha modifiers and process both modifiers completely through your system (including any manual portion) as far as payment history. It is not acceptable merely to be able to accept multiple modifiers and then drop one before complete systems processing. Dropping of a modifier leads to incomplete and inaccurate pricing profiles. At a minimum, your system must be able to carry (2) two-position modifiers in history.

Series "Q", "K" and "G" in the Level II coding are reserved for CMS use. "Q", "K" and "G" codes are temporary national codes for items or services requiring uniform national coding between one year's update and the next. If "Q", "K" or "G" codes are not converted to permanent codes in the Level I or Level II series in the following update, they will remain active until converted in the following years or you are notified to delete them. All active "Q", "K" and "G" codes at the time of update will be included on the update tape sent to you. The "K" codes are used primarily by the Durable Medical Equipment Regional Carriers.

Series "S" and Series "I" Level II codes are reserved for use by the BCBSA and the HIAA, respectively. These codes provide for reporting needs unique to those organizations.

Each State defines its own Medicaid coverage, payment, and utilization levels. CMS does not impose Medicare requirements on Medicaid programs. HCPCS simply provides a framework that can be expanded to meet everyone's needs. However, States and carriers using HCPCS must cooperate in the development and use of local codes.

If Level I and Level II codes/modifiers do not exist for services or items common to Medicare and Medicaid, a local HCPCS code/modifier in the W, X, Y or Z series may be requested. Local code/modifier requests for services common to both Medicare and Medicaid should be coordinated between the Medicare carriers and the Medicaid State agency and submitted to CMS CO for approval through the RO. Follow the procedure outlined in §4507.1 to request CMS CO approval for such codes.

Although Medicare and Medicaid program requirements are different, the two programs should, to the extent feasible, maintain consistency in use of the HCPCS codes.

4508.1 Coding for Non-Covered Services and Services Not Reasonable and Necessary.--Effective January 1, 2002, new modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily non-covered or do not meet the definition of a Medicare benefit and items and services not considered reasonable and necessary by Medicare. The following 3 codes and one modifier were therefore deemed obsolete and were discontinued.

A9160 - Non-covered service by podiatrist
A9170 - Non-covered service by chiropractor
A9190 - Personal comfort item, (non-covered by Medicare statute)
GX - Service not covered by Medicare

A. Definitions of the GA, GY and GZ Modifiers.--The modifiers are defined below:

GA - Waiver of liability statement on file.
GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
GZ - Item or service expected to be denied as not reasonable and necessary.

B. Use of the GA, GY, and GZ Modifiers for Services Billed to Local Carriers.--The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered (as defined in the Program Integrity Manual (PIM) Chapter 1, §2.3.3.B) or is not a Medicare benefit (as defined in the PIM, Chapter 1, §2.3.3.A).

The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. (Go to www.cms.hhs.gov/medlearn/refabn.asp for additional information on use of the GA modifier and ABNs.)

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a “not otherwise classified code” (NOC) must be used with either the GY or GZ modifier.

C. Use of the GA, GY, and GZ Modifiers for Items and Supplies Billed to DMERCs.--The GY modifier must be used when suppliers want to indicate that the item or supply is statutorily non-covered (as defined in the PIM Chapter 1, §2.3.3.B) or is not a Medicare benefit (as defined in the PIM, Chapter 1, §2.3.3.A).

The GZ modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they do have on file an ABN signed by the beneficiary.

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe items or supplies, an NOC must be used with either the GY or GZ modifiers.

D. Use of the A9270.--Effective January 1, 2002, the A9270, Non-covered item or service, under no circumstances will be accepted for services or items billed to local carriers. However, in cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the A9270 must continue to be used by **suppliers** to bill **DMERCS** for statutorily non-covered items and items that do not meet the definition of a Medicare benefit.

E. Claims Processing Instructions.--At carrier and DMERC discretion, claims submitted using the GY modifier may be auto-denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

4509. HCPCS UPDATE

HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. CMS provides a tape/cartridge of updated HCPCS codes to contractors and Medicaid State agencies at least 60 days in advance of implementation.

Distribution consists of a tape/cartridge and listing of the updated HCPCS codes, file characteristics, record layout, and a listing of changed and deleted codes. CMS facilitates additions or changes to the codes/modifiers.

4509.1 Payment Concerns While Updating Codes.--The following instructions apply in situations where CMS CO does not provide pricing guidance via the Medicare Fee Schedule Database (MFSDB) for physicians' services. If a new code appears, make every effort to determine whether the procedure, drug or supply has a pricing history and profile. If there is a pricing history, map the new code to previous customary and prevailing charges or fee schedule amounts to ensure continuity of pricing.

Since there are different kinds of coding implosions and explosions, the way you apply this principle can vary. For example, when the code for a single procedure is exploded into several codes for the components of that procedure, the total of the separate customary, prevailing, relative value unit or other charge screens established for the components must not be higher than the customary, prevailing, relative value units or other charge screens for the original service. However, when there is a single code that describes two or more distinct complete services (i.e., two different but related or similar surgical procedures), and separate codes are subsequently established for each, continue to apply the payment screens that applied to the single code to each of the services described by the new codes.

If there is no pricing history or coding implosion and explosion you must make an individual consideration determination for pricing and payment of a covered service. (See §15006(B).)

Conversely, when the codes for the components of a single service are combined in a single global code, establish the payment screens for the new code by totaling the screens used for the components (i.e., use the total of the customary charges for the components as the customary charge for the global code; use the total of the prevailing charges for the components adjusted for multiple surgical rules if applicable as the prevailing charge for the global code, etc.). However, when the codes for several different services are imploded into a single code, set the payment screens at the average (arithmetic mean), weighted by frequency, of the payment screens for the formerly separate codes.

4509.2 Payment, Utilization Review (UR) and Coverage Information on CMS Tape File.--The tape/cartridge that you receive for your annual update of HCPCS contains fields for payment, UR, and coverage information to assist in developing front-end screens. Coverage information is not all inclusive, but should be used mainly as a guide in establishing your own review limits. Establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. Assure that your system processes claims in accordance with CMS policies and procedures, including changes which may occur between HCPCS updates. Where CMS determines that nationally uniform temporary codes/modifiers are needed to implement policy/legislation between HCPCS updates, the codes/modifiers, definitions and policy are issued by CO as Level II codes/modifiers prefixed with "Q" or "K" or "G". Questions may arise in updating that require you to refer to a physician's or supplier's pricing history. Therefore, keep an electronic backup of HCPCS for the two prior years with linkages to pricing profiles. Perform required computer analysis as necessary.

HCPCS terminology seldom includes a place of service designation. Where place of service affects pricing, obtain it from the place of service field on Form CMS-1500.

4509.3 Deleted HCPCS Codes/Modifiers.--Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 1994, but received by you in 1995, should contain codes/modifiers valid in 1994 and be processed using the prior year's pricing files.

Claims for services furnished in the current year which are billed using codes/modifiers deleted by the most recent HCPCS update can be processed with these deleted codes/modifiers for a 3 calendar month "grace period" after each HCPCS update. The grace period applies to claims received prior to April 1 of the current year which contain dates of service for the current year and are billed using the prior years HCPCS code (which is now a deleted code for the current year). Price and pay for deleted codes during their grace period by using the prior year's rate, updated by the applicable update methodology. Allowances provided directly by CMS (e.g., the Medicare fee schedule database (MFSDB) clinical diagnostic lab fee schedules include the deleted codes and are already updated by CMS to reflect the correct grace period fees for deleted codes. For services paid under the reasonable charge methodology during the grace period, compute updated customary and prevailing charges for the deleted codes (e.g., for the 1995 update use actual charge data from July 1, 1993, through June 30, 1994, to compute 1995 customary and prevailing charges for deleted codes) and perform the required inflation indexed charge (IIC) calculations.

Include the following message on the providers remittance notice when, prior to April 1, you receive an assigned claim which includes a deleted HCPCS code for a service furnished in the current year:

> "The procedure code you submitted is obsolete. We processed the claim using the submitted code, but beginning April 1, all services billed with obsolete procedure codes will be rejected."

Do not use any special EOMB messages in this situation.

Reject services for deleted codes received on or after April 1 (i.e., after expiration of the three month grace period). If there are other services on the same claim that are valid codes, process those line items for coverage and payment determinations. Advise physicians/suppliers and beneficiaries when a service billed under a deleted code is rejected.

"The procedure code you submitted is obsolete. We processed the claim using the submitted code, but beginning April 1, all services billed with obsolete procedure codes will be rejected."

Do not use any special EOMB messages in this situation.

Reject services for deleted codes received on or after April 1 (i.e., after expiration of the three month grace period). If there are other services on the same claim that are valid codes, process those line items for coverage and payment determinations. Advise physicians/suppliers and beneficiaries when a service billed under a deleted code is rejected.

For assigned services received on or after April 1, which are billed using deleted HCPCS codes, reject the line item and include the following message on the provider remittance notice:

"Beginning April 1, Medicare no longer recognizes this procedure code. Please resubmit a claim for this service using a valid procedure code."

Include message 9.23 on the beneficiary EOMB whenever the provider remittance message above is generated for deleted codes that are rejected.

For unassigned services received on or after April 1, which are billed using deleted HCPCS codes, reject the service and generate EOMB message 9.22 for each deleted code rejected on the claim.

4540. CLAIMS REVIEW AND ADJUDICATION PROCEDURES

A. HCPCS Release.--Inform physicians and suppliers when the new HCPCS becomes available and the effective date in your claims processing system. Level III codes/modifiers should be shared with the Medicaid State agency in the carrier's jurisdiction.

Advise any physician/supplier who requests a copy of HCPCS that codes/modifiers contained in the AMA's CPT-4 (current version) may be obtained from the AMA. The HCPCS Level II codes/modifiers (alpha-numeric A-V) are available from the GPO and NTIS. (See §4501.) Supply the current HCPCS local codes/modifiers (alpha-numeric W-Z) since you are the only source. Inform physicians/suppliers that all codes/modifiers contained in the current version of the HCPCS will be recognized and processed unless they have been deleted or are indicated as not valid for Medicare. However, caution them that code/modifier recognition does not imply that a service is covered by Medicare, or, where it is, does not imply that the payment level will be different from other services of a similar nature.

B. Fee Schedule for Diagnostic Clinical Laboratory Services, Radiology and DME.--(See §4620 for Data Exchange to Fiscal Intermediaries and Status Code "C" Indicator.)