Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-01-30 **Date: APRIL 26, 2001**

CHANGE REQUEST 1371

SUBJECT: Deletion of the HCFA Common Procedure Coding System (HCPCS) Codes A9160, A9170, and A9190 and the GX Modifier and Replacement with New Codes and Modifiers; Status Change to HCPCS Code A9270

NOTE: CR 1370 was never released in final and has been deleted from the system. This CR now includes the issues covered in that CR.

This PM has been superceded by CR 1820.

To allow providers and suppliers to bill Medicare in order to get denials for secondary payers for non-covered items and services, the following coding changes will become effective January 01, 2002:

Deleted Codes:

A9160 – Non-covered service by podiatrist

A9170 – Non-covered service by chiropractor

A9190 – Personal comfort item, (non-covered by Medicare statute)

Deleted Modifier:

GX – Service not covered by Medicare

Status Changed to "Not Valid for Medicare"

A9270 – Non-covered item or service

Added Codes:

Q3015 – Item or service statutorily non-covered, including benefit category exclusion, (used only when no specific code available)

Q3016 – Item or service not reasonable and necessary, (used only when no specific code available)

These codes will have a type of service of 9.

Added Modifiers:

GY - Item or service statutorily non-covered

GZ - Item or service not reasonable and necessary

The new codes, Q3015 and Q3016, must be used when there is no specific code currently available to describe the item or service. If a specific code is available, it must be used. "Not Otherwise Classified" codes may not be used in these situations.

The new modifiers, GY and GZ, must be used when a specific code is available but the provider or supplier wants to indicate that the item or service is not covered or is not reasonable and necessary.

Explanatory Information To Be Included

Anytime the codes Q3015 or Q3016 are used, providers and suppliers must include a description of the services or items provided as well as an explanation of why the services or supplies are being submitted. This information is entered in Item 19 of the HCFA-1500. For the electronic format, providers and suppliers must report this information in the claims level note.

If space for additional narrative is needed, the provider or supplier must enter the qualifier "ADD" in NTE01 then enter the additional narrative in NTE02.

Anytime the modifiers GY or GZ are used, providers and suppliers must explain why the services or supplies are being submitted. This information is entered in Item 19 of Form HCFA-1500. For the electronic format, providers and suppliers must report this information in the claims level note. If space for additional narrative is needed, the provider or supplier must enter the qualifier "ADD" in NTE01, then enter the additional narrative in NTE02.

Examples of explanatory language are, "Claim submitted to receive denial for secondary payer" or "Service performed by family member". Carriers and DMERCs may specify explanatory language for providers and suppliers as necessary.

Items and Services Considered Not Reasonable and Necessary:

Medicare may cover certain items and services as reasonable and necessary under particular circumstances. These same items and services may not be covered benefits under other circumstances. When a provider or supplier furnishes either an assigned or unassigned service or item that they believe is not reasonable and necessary according to Medicare policies and regulations, the specific HCPCS code that describes the service or item furnished must be submitted along with the GZ modifier. If there is no specific code available, the provider or supplier may submit the claim using the Q3016 code. Claims submitted using the GZ modifier or the Q3016 code may not be auto-denied simply based on the code. However, the carrier may auto-deny based on other criteria such as diagnosis to procedure coding. These claims should be included in regular medical review procedures.

Statutorily Non-Covered Items or Services:

Items and services that are statutorily non-covered by Medicare, must be submitted using the specific code with the GY modifier. This includes claims submitted by chiropractors for statutorily non-covered maintenance therapy. If there is no specific code available, the provider or supplier must submit the claim using the Q3015 code. Carriers and DMERCs must program their systems to allow these claims to auto-deny.

Use of the GA Modifier with the New Codes and Modifiers:

When a service is performed or item supplied that is not reasonable and necessary under the specific circumstances, it is the responsibility of the provider or supplier to notify the beneficiary in writing through the use of the advance beneficiary notice (ABN). The provider or supplier should file the pertinent services or items on the claim with the GA modifier, waiver of liability statement on file. The GA modifier must be used in conjunction with the Q3016 or GZ modifier, not instead or in place of them.

Use a GA modifier with all assigned Part B claims where an ABN is given, and for all unassigned Part B claims for physicians' services where an ABN is given (per §1842(l) of the Social Security Act) and for durable medical equipment, prosthetics, orthotics, and supplies when an ABN is given. (See §§1834(a)(18) and 1834(j)(4) of the Act.)

If the service or supply is statutorily excluded, thus resulting in an automatic denial, neither the ABN nor the GA modifier is required. (See §§7320 and 7330 of the Medicare Carriers Manual for further information on waiver of liability.)

Provider Notification:

Notify providers and suppliers of these changes in your next regularly scheduled bulletin and on your web site. Because this Program Memorandum (PM) is not effective until January 01, 2002, a reminder should also be included in the last bulletin published for the year 2001.

The *effective date* for this PM is January 01, 2002.

The *implementation date* for this PM is January 01, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after March 31, 2002.

If you have any questions, contact your local regional office.