Program Memorandum Carriers

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

Transmittal B-02-020 **Date: MARCH 27, 2002**

This Program Memorandum re-issues Program Memorandum B-01-58, Change Request 1820 dated September 25, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1820

SUBJECT: Coding for Non-Covered Services and Services Not Reasonable and Necessary

The information in this CR supercedes all information found in CR 1371, Transmittal B-01-30, 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.

This Program Memorandum (PM) provides an explanation on the use of the new GY and GZ modifiers. These 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. It also provides an explanation on the use of the GA modifier. The new modifiers will become effective January 1, 2002, with the annual HCPCS update. The Q3015 and Q3016 described in CR 1371 will not be implemented.

Discontinued Codes/Modifier

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

New Modifiers

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.

Clarification on Use of A9270

HCPCS code A9270, Non-covered item or service, will remain an active code and valid for Medicare. A processing note will be added to the HCPCS file that states, "Only for use on bills submitted by DMEPOS suppliers."

Use of the GA, GY, and GZ Modifiers for Services Billed to Carriers

The new 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 new 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.

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.

The A9270 will no longer be accepted for services or items billed to carriers.

Use of the GA, GY, and GZ Modifiers for Items and Supplies Billed to DMERCs

The new GY modifier must be used when suppliers want to indicate that the item or supply 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 new 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, a NOC must be used with either the GY or GZ modifiers.

In cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the HCPCS code A9270 must be used by suppliers to bill for statutorily non-covered items and items that do not meet the definition of a Medicare benefit.

Carriers and DMERCs

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.

Explanatory Information To Be Included on Claims

Anytime a NOC code is used, providers and suppliers must include a description of the services or items provided. This information must be entered in item 19 on the Form HCFA-1500 or submitted as an attachment. For electronic claims, 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.

Provider Notification

Notify providers and suppliers of these changes in your next regularly scheduled bulletin and on your Web site.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2002.

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