CMS Announces New ABN Modifiers

In 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the use of the revised Advance Beneficiary Notice of Non-coverage (ABN) form, CMS-R-131. This form replaced the general ABN (CMS-R-131-G), laboratory ABN (CMS-R-131-L), and Notice of Excluded Medicare Benefits (CMS-20007) forms and combined them into one document. Prior to the issuance of the revised ABN form, the Notice of Excluded Medicare Benefits form was voluntary. Now, the CMS-R-131 form is used for both voluntary and mandatory ABNs. Providers are permitted to voluntarily issue liability notices to patients for items or services excluded from Medicare by statute or where no Medicare benefit category exists such as personal comfort items, cosmetic care, and custodial care. In contrast, a mandatory ABN must be issued if an item or service that is usually covered by Medicare is likely to be denied due to the lack of medically necessity for the beneficiary’s specific condition.

In order to distinguish between the two types of ABNs, CMS announced two Healthcare Common Procedure Coding System (HCPCS) Level II modifiers related to ABN. Effective April 1, 2010, providers are instructed to report Modifier GA for mandatory and Modifier GX for voluntary ABNs. CMS encourages providers to notify their billing staff of the recent changes in ABN modifiers to ensure proper coding, billing, and reimbursement.

How to use ABN Modifiers?

Modifiers GA and GX were created to differentiate between mandatory and voluntary ABNs. Modifier GA has been redefined as “waiver of liability statement issued as required by payer policy” and should be used when a mandatory ABN was issued to a beneficiary. Billing staff should not report Modifier GA with any other liability-related modifier such as GZ (item or service expected to be denied as not reasonable and necessary); EY (no doctor’s order on file); GL (medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN); GX (notice of liability issued, voluntary under payer

1 Although, it is voluntary to provide an ABN for items or services that are statutorily excluded or lack a Medicare benefit category, a facility’s conditions of participation may require the provider to inform the beneficiary of non-coverage.


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Modifier GX is defined as a “notice of liability issued, voluntary under payer policy” and should be used when a voluntary ABN is issued to a beneficiary. This modifier may be reported on the same line as liability-related modifiers GY and TS. However, Modifier GX may not be reported in combination with liability-related modifiers EY, GA, GL, GX, KB, QL, or TQ.

When CMS receives a claim with Modifier GA or GX, the Medicare system automatically denies the claim lines reporting the modifiers. CMS claims processing system will issue claim adjustment reason code 50 “these are non-covered services because this is not deemed a ‘medical necessity’ by the payer” which will shift the financial liability of the non-covered items or services to the beneficiary who has the option to appeal.

How to Submit Claims with Non-covered Charges?

CMS has specific billing rules when filing claims for non-covered charges. The billing rules differ for inpatient and outpatient claims. Billing staff should comply with the following in order to submit accurate claims.

Inpatient Claims
In the event covered and non-covered items or services are furnished during an inpatient stay, CMS’ claims processing system is not able to differentiate between procedure codes that are covered versus those that are not covered. This claims processing limitation can affect the assignment of the Medicare Severity Diagnosis Related Group (MS-DRG) on an inpatient claim and can result in improper payment. Therefore, CMS recently revised its billing policy for non-covered services on an inpatient claim.

Effective April 1, 2010 “hospitals must only seek payment for covered services by removing non-covered procedure codes and related charges from the payable Type of Bill (TOB) 11X”2 (where X does not equal zero). If a hospital would like to bill non-covered procedures and its associated non-covered charges, the provider may report the codes and charges on a no-pay claim, TOB 110.3 Further, if an ABN was provided to a beneficiary for non-covered items or services, the provider must maintain documentation.

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2 CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 1 sec. 60.2.1-Billing for Non-covered Procedures in an Inpatient Stay.

3 It should be noted that TOB X and TOB 110 must have the same State Cover Period (from and through date) for the same beneficiary.
Outpatient Claims

If a beneficiary chooses to receive non-covered items or services and a valid ABN has been obtained prior to delivery of the non-covered item or service, the billing personnel must conduct the following when submitting an outpatient claim:

- Append modifier GA or GX to the non-covered items or services;
- Maintain documentation indicating that an ABN was issued;
- State the date the ABN was signed by the beneficiary in association with the occurrence code; and
- Report occurrence code 32 and the accompanying date multiple times if more than one ABN is associated to a single claim for services that must be bundled or billed on the same claim.

It is important to note that CMS requires providers to maintain proper documentation despite the different billing rules for inpatient and outpatient claims. Furthermore, although CMS does not require providers to submit the ABN notice when filing a claim, this information must be immediately available upon request.

Take Home Message

Overall, understanding the nuances of ABN coding and billing is challenging. However, billing staff should reference the diagram below to ensure proper billing with ABN modifiers.
Diagram 1: ABN Flowchart.

When to issue an ABN?

Mandatory ABN

You must issue an ABN when an item or service is expected to be denied by Medicare because it is medically unnecessary.

Voluntary ABN

You may provide an ABN when items or services are excluded from Medicare coverage by statute.

What modifier should be used?

Modifier GA

1. Modifier GA cannot be used with any other liability related modifier.
2. Modifier GA should be submitted with covered charges.

Modifier GX

1. Modifier GX can be used with liability-related modifiers GY and TX.
2. Modifier GX cannot be used with liability-related modifiers: EY, GA, GL, GX, KB, QL, or TL.

What are the rules?

You must issue an ABN when an item or service is expected to be denied by Medicare because it is medically unnecessary.

You may provide an ABN when items or services are excluded from Medicare coverage by statute.

1. Modifier GA cannot be used with any other liability related modifier.
2. Modifier GA should be submitted with covered charges.

1. Modifier GX can be used with liability-related modifiers GY and TX.
2. Modifier GX cannot be used with liability-related modifiers: EY, GA, GL, GX, KB, QL, or TL.
Official Resources


CMS, Medicare Claims Processing Manual, CMS 100-04, Ch. 1 sec. 60. Provider Billing for Non-covered Charges on Institutional Claims.