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NGS Medicare Virtual Conference

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Billing Noncovered Charges on Outpatient Hospital Claims

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
  - Jean Roberts, RN, BSN, CPC
  - Kim Thomas, CPC

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Objectives

- Review guidelines on payment liability conditions including services excluded from Medicare coverage
- Provide guidance on applicable billing guidelines

Agenda

- Payment Liability Conditions
- Reminders
- Billing Services Applicable to Payment Condition One
- Billing Services Applicable to Payment Condition Two
- Modifiers Applicable to Noncovered Services
- Resources

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Payment Liability Conditions

Medicare Coverage

- Statutory ability to shift liability only applies to items/services usually covered as part of an established Medicare benefit per Title XVIII of the Social Security Act
  - Benefits not addressed in Title XVIII are statutorily excluded from Medicare coverage
    - Medicare not authorized to cover/reimburse

Medicare Coverage

- Financial liability occurs when items/services are not covered by Medicare due to specific sections of the SSA stated below
  - Section1862(a)(1) on services that otherwise could be covered but which are not medically reasonable and necessary in the individual case at hand
  - Section 1862(a)(9) for custodial care which Medicare never covers
  - Section 1879(g)(1) for home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home, or lastly, under
  - Section 1879(g)(2) for hospice care given to someone not terminally ill
- Beneficiary must be informed via written notice prior to receiving such services and notice must specify the reason
  - e.g.: Advanced Beneficiary Notice of Noncoverage

Best Practices

- Provider should
  - Review planned services as well as potential coverage/noncoverage for all applicable insurers
  - Determine any potential beneficiary liability and reason for anticipated Medicare noncoverage
  - Discuss planned services with beneficiary including any potential financial liability and cost estimate
  - Issue any involuntary/voluntary notice per liability determination
  - Allow beneficiary to determine whether accepting any financial liability for identified services
    - Beneficiary has right to refuse service/not accept financial liability
  - Render services per beneficiary decision and bill accordingly

Payment Liability Condition One - Three

- Only one of the following three payment liability conditions can apply to a given item or service, or to a given line of a claim
- When possible, split claims so that one of these three conditions apply per claim
  - It is understood that splitting claims is not always possible and that multiple conditions and notices may apply to a single claim
    - E.g.: claims paid under OPPS requires all services provided on the same day to be billed on the same claim with few exceptions

Payment Liability Condition One

Scenario	Payment Condition One
Description	Items and services being billed are statutorily excluded from Original Medicare coverage, meaning item(s)/ service(s) are not defined as a specific Medicare benefit per the SSA ; therefore, such services are never paid
Notification (prior to billing)	Liability notices are voluntary (i.e., voluntary ABN); for statutory exclusions, there are no required Medicare notices
Billing	Items and services may be billed as noncovered on Medicare claims
Liability	Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code their claims to transfer liability to themselves

Exclusions from Medicare Coverage

- Items/services excluded from Medicare coverage by statute
  - Not recognized as a Medicare benefit
- Examples of exclusions (there are exceptions)
  - Dental: Items/services for care, treatment, filling, removal replacement of teeth and/or structures directly supporting the teeth
  - Most foot care services and supportive devices for the feet
  - Hearing aids and examinations; eyeglasses/lens and examinations

Exclusions from Medicare Coverage

- Custodial care
- Personal comfort items
- Routine: physical checkups, eye exams, certain immunizations
- Chiropractor services
- Cosmetic surgery
- Investigational devices
- Items and services furnished by patient's immediate relatives and members of patient's household

Exclusions from Medicare Coverage

- Inpatient hospital or SNF services when not delivered directly or under arrangement by the provider
- Services related to and required as a result of services not covered
- Services and supplies denied as bundled or included in the basic allowance of another service
- Items and services the patient, another individual, or an organization has no legal obligation to pay for or furnish
- Defective equipment or medical devices covered under warranty

Payment Liability Condition One

- Ensure beneficiary informed service would be billed as noncovered and patient would be financially liable
  - Ensure a clear specific reason for Medicare noncoverage was conveyed to beneficiary and documented
- When beneficiary is informed of noncoverage of service the medical record must include documentation
- ABN not required if patient elects to receive services excluded from Medicare by statute
  - ABN may be used for voluntary notification purposes

Voluntary ABN

- Voluntary use of the ABN is allowed, but not required for certain services to serve as courtesy/forewarning of impending financial obligation
  - Beneficiary not asked to choose option box or sign notice
- Voluntary ABN can be issued for care that is
  - Statutorily excluded (Social Security Act [SSA] Section 1862) from coverage; or
  - Fails to meet technical benefit requirement (SSA Section 1861)

Payment Liability Condition Two

Scenario	Payment Condition Two
Description	Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider
Notification (prior to billing)	Liability notices are required • i.e.: expedited determination notice, ABN
Billing	Billing of such items and services can vary, and can depend on the ability to segregate into covered and noncovered portions (if both exist)
Liability	For any services that are not paid by Medicare itself, properly notified beneficiaries are usually liable for resulting denials

Not Reasonable/ Not Medically Necessary

- Provider determines service typically covered by Medicare not medically reasonable/necessary
- Examples of item(s)/service(s) not reasonable/ medically necessary
  - Experimental/investigation or only for research
  - Custodial care
  - Not covered for specific diagnosis(s) or treatment
  - Not covered per Local and/or National Coverage Determination
  - Considered not safe/effective

Not Reasonable/ Not Medically Necessary

- Frequency limited items/services
  - Preventive service exceeding frequency limitation
- Hospice patient not terminally ill
- Does not meet home health requirements
  - Not confined to home, intermittent skilled care not medically necessary
- Outpatient therapy exceeding the threshold and provider determines does not qualify for exception
  - Beneficiary received physical therapy and at some point physician/therapist determines therapy is no longer reasonable necessary due to no further improvement anticipated - services considered maintenance – beneficiary requests to continue PT

Payment Liability Condition Two

- Provider must issue ABN when services reduced or terminated and thought to be not covered
  - Delivery of ABN can permit shift of liability
- Provider must issue ABN to beneficiary before services are delivered
  - Failure to issue ABN when required means provider will not be able to shift liability to beneficiary
- When mandatory ABN issued patient records must be documented
- Example: Provider determines physical therapy no longer medically necessary (met all goals) but beneficiary wants to continue PT

Routine ABN Notice Prohibition

- Routine use not effective
  - Routine – issue ABN when no specific identifiable reason to believe Medicare will not pay
- Provider must have some doubt that Medicare will make payment
- Routinely issued = defective notice

Routine ABN Prohibition – Exceptions

1. Services always denied for medical necessity – NCD provides service never reasonable and necessary
2. Experimental items and services
3. Services where Medicare established statutory or regulatory frequency limitation on coverage or frequency limitation on coverage based on NCD/LCD
4. DME/Medical equipment related

Delivery Requirements

- ABN considered to be effective when
  - Delivered to capable recipient by suitable notifier
  - Issued appropriate, fully completed ABN form
  - Delivered in person (if possible)
  - Provided far enough in advance – patient considers all options
  - Explained in full – patient questions answered
  - Signed by recipient

Alternate Options for Delivery

- Should be delivered in person and prior to rendering noncovered service
- When in person delivery not possible, provider may deliver ABN via
  - Telephone contact
  - Mail
  - Secure fax
  - Internet email

Beneficiary Changes Their Mind After Signing

- Notifier should
  - Request that beneficiary annotate original signed ABN
  - Annotation must include clear indication of new option and beneficiary's signature/date
    - If unable to present in person, annotate ABN reflecting new choice and immediately send copy for beneficiary's signature and date

Beneficiary Refuses to Complete or Sign

- Notifier should
  - Annotate original copy indicating refusal – may list witness to refusal
  - Consider not furnishing service unless that not an option
  - Provide patient copy of annotated ABN

Liability

- Beneficiary
  - Issued properly written and delivered ABN and agrees to pay may be held liable
- Provider
  - Provider will be liable if knew or should have known that Medicare would not pay and fails to issue ABN when required or issues defective ABN
- **Note:** Beneficiary relieved from liability if he/she does not receive proper notice when required

Emergency/Urgent Situation

- Must not issue ABN in medical emergency or when beneficiary is under duress
- ABN issued in ER may be appropriate in some cases
  - Is beneficiary medically stable with no emergent health issues?
- When EMTALA applies, no ABN should be issued
  - May reconsider if beneficiary is capable after completion of medical screening exam and stabilization of any emergency medical condition

Period of Effectiveness/Repetitive or Continuous Noncovered Care

- ABN may remain effective up to one year as long as no other triggering event occurs
  - New triggering event = new ABN must be issued
- Allegations of improper or incomplete notices will be investigated by MAC
  - If ABN is found to be improper or incomplete – patient will not be held liable

Payment Liability Condition Three

Scenario	Payment Condition Three
Description	Items or service is presumed to be a Medicare benefit and can be paid
Notification (prior to billing)	Liability notices, mandatory or voluntary, are never used in advance of such billing
Billing	Items and services are billed as covered
Liability	If Medicare doesn't pay as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy

Payment Liability Condition Three

- Condition three occurs when providers billing for what they believe to be covered services
  - No ABN requirements for this condition
  - Noncovered charges are not involved
  - Denials may result from processing
- Billing options
  - Bill services with covered charges

Reminders

Liability Conditions for Bundled Services

- Bill entire bundled service as covered as long as part of bundled service is certain to be covered/ medically necessary
  - If entire bundle certain to be noncovered, should be billed as noncovered
  - Must never split bill portions of bundled service
- ABN must apply to all of bundled service or to none of it
  - Full bundled service must be billed as noncovered or none of it

Obligation to Bill Medicare

- Providers are required to
  - Obtain insurance information prior to providing services
    - Should use the CMS Questionnaire, or a questionnaire that asks similar types of questions
    - Submit any MSP information to the MAC using condition and occurrence codes on the claim
  - Bill Medicare for all covered services provided
  - If provider believes a service that is typically covered by Medicare is not reasonable and necessary for a specific patient, then an ABN must be issued
- Additional information: Your Billing Responsibilities

Obligation to Bill Medicare

- Medicare beneficiary has the right to request all services be billed to Medicare
  - Whether never covered/excluded or not reasonable/ medically necessary
- If ABN issued, beneficiary has right to request claim submission to Medicare for official payment decision
  - Patient must receive service described in ABN and choose option one in order to request Medicare claim submission

Reminder: Refunds Due to Beneficiary

- Provider must refund monies to the beneficiary in a timely manner when
  - Provider collects payment from a beneficiary and Medicare subsequently
    - Pays all or part of claim previously paid for by the beneficiary/ representative or
    - Medicare determines the provider is liable
- Provider should make this refund in a timely manner even if they are appealing the claim(s)
- Refunds are considered prompt/timely when made within
  - 30 days of the Medicare denial OR
  - 15 days after a determination on an appeal if an appeal is made

Reminder

- Noncovered service does not have a specific, valid, CPT or HCPCS code
  - Bill service with HCPCS code A9270 (noncovered item or service)
  - Use “Remarks” to identify the service billed with A9270

Reminder

- Only one of three payment liability conditions can apply to a given item or service, or to a given line of a claim
- When possible, split claims so that one of these three conditions apply per claim
  - It is understood that splitting claims is not always possible and that multiple conditions and notices may apply to a single claim
    - E.g.: Claims paid under the OPPS requires all services provided on the same day to be billed on the same claim with few exceptions

Billing Services Applicable to Payment Condition One

Billing: Payment Liability Condition One

- Billing options
  - Do not submit to Medicare
  - Submit as noncovered line item
    - May use applicable liability modifier, e.g. GY modifier
  - Submit on entirely noncovered claim
    - Condition code 20 “Demand Denial”
    - Condition code 21 “Insurance Denial”

Demand Bill: Condition Code 20

- Report CC 20 in situations where issuing ABN not appropriate and beneficiary demands Medicare determination
  - Charges related to CC 20 billed as noncovered
    - TOB frequency = 0 when all charges billed as noncovered
  - Unrelated covered charges are allowed
    - TOB as applicable
  - OC 32 and/or CC 21 cannot be billed with CC 20
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1 General Billing Requirements, Section 60

Insurance Denial: Condition Code 21

- Report CC 21 for Medicare denial to use when billing secondary or other insurances
  - Submit services on a claim with CC 21 showing all charges as noncovered (total charges = noncovered charges)
  - Report CC 21; no modifier; TOB frequency = 0
  - No services are in dispute by beneficiary
  - Billing for denial
- CMS IOM Publication100-04, *Medicare Claims Processing Manual,* Chapter 1 General Billing Requirements, Section 60

Billing Services Applicable to Payment Condition Two

Payment Liability Condition Two

- Proper issuance of advanced Beneficiary Notice of Noncoverage
  - Billing: Submit covered charges with Occurrence code 32
    - GA modifier (waiver of liability issued as required) used on line(s) applicable to ABN
- No (or Improper) issuance of ABN when required
  - Billing: Submit noncovered charges with GZ modifier (Item /service expected to be denied - ABN not obtained/not valid)

Claim for Mandatory ABN

- Report OC 32 with date mandatory ABN issued
  - Services related to ABN are billed with covered charges
  - If multiple ABNs were issued, bill multiple OC 32s
- Report GA modifier when applicable
  - GA modifier (Waiver of Liability Statement on file, as Required by Payer Policy) used when only some services on claim relate to mandatory ABN
    - Do not report the GA modifier with any other liability-related modifier
- Normal billing regulations apply

Claim for Mandatory ABN

- When billing for mandatory ABN related services, other covered and noncovered services may be included on the claim
  - Use OC 32 and GA modifier (with covered charges) to identify services related to ABN but do not include any other liability-related modifier(s)
- Medicare system determines coverage/liability for claims/lines submitted with OC 32 and/or modifier GA (charges billed as covered)
  - Claim may suspend for review
- Medicare systems assign beneficiary liability to claims
  - CARC 50 - “These are noncovered services because this is not deemed a medical necessity”

Delivery Guidance During COVID-19 Public Health Emergency

- COVID-19 PHE institutional care ABN delivery flexibilities for beneficiaries in isolation
  - Delivery
    - Hard copies of notices may be dropped off with patient by any hospital worker able to enter room safely; or
    - Notice delivery may be made via telephone or secure email to off site beneficiary representatives
    - If hard copy cannot be dropped off, notices to beneficiaries may also delivered via email (if available in isolation room)
  - Contact phone number should be provided for patient to ask questions, if person delivering notice unable to answer

Delivery Guidance During COVID-19 Public Health Emergency

- Notices must be annotated with circumstances of delivery, including person delivering notice via telephone and time of the call, or when and to where email sent
- CMS Special Edition MLN Matters® Article: *SE20011 Revised: Medicare FFS Response to the PHE on COVID-19*

Modifiers Applicable to Noncovered Services

Modifiers

- Submit with covered charges
  - GA – waiver of liability statement on file – line item is linked to a valid ABN (occurrence code 32 must be included on claim)
- Submit with noncovered charges
  - GX – Item/service statutorily not covered by Medicare - voluntarily ABN issued – beneficiary liable
  - GZ – Item/service expected to be denied as not reasonable/medically necessary – required ABN was not issued (provider liable)
  - GY – item/service statutorily excluded or does not meet definition of any Medicare benefit (beneficiary liable)

Liability Modifier: Modifier GX

- GX modifier (Notice of Liability Issued, Voluntary Under Payer Policy) – used to report voluntary ABN issued
  - Applies to services excluded from Medicare coverage by statute
- Lines with GX modifier must be submitted with noncovered charges only
- Medicare systems allow modifier GX to be reported on same line as modifier GY (service statutorily excluded)
- Claim denied as beneficiary liable

Liability Modifier: Modifier GZ

- Provider expects denial due to lack of medical necessity
  - GZ modifier indicates ABN was not issued for services
  - Submit charges as noncovered
  - Provider will be liable for services billed with GZ modifier
- NGS will not perform complex Medical Review and will automatically deny claim line(s) submitted with CARC 50/Group Code CO

FYI

- Applicable to all liability modifiers discussed today as well as those included in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1 General Billing Requirements, Section 60.4.2 table "Definition of Modifiers Related to Non-covered Charges/ABNs for Institutional Billing"
  - Liability modifiers are required when noncovered services cannot be split into entirely noncovered claims
  - Provider liability modifiers cannot be used on entirely noncovered claims where there are some services that are beneficiary liable

Resources

Resources: Did you know?

- Inpatient hospitals use Hospital Issued Notice of Noncoverage (HINN)
  - **HINN 1** – Preadmission/Admission HINN: Use before an entirely noncovered stay
  - **HINN 10** – Notice of Hospital Requested Review (HRR): Use for FFS and Medicare Advantage Program (Part C) patients when requesting Quality Improvement Organization (QIO) discharge decision review without provider agreement
  - **HINN 11** – Noncovered Service(s) during Covered Stay: Use for non-covered items and services during an otherwise covered stay
  - **HINN 12** – Noncovered Continued Stay: Use with the Hospital Discharge Appeal Notices to inform patients of their noncovered continued stay potential liability

Resources: Did You Know?

- HINN CMS IOM Publication100-04, *Medicare Claims Processing Manual*, Chapter 30 Financial Liability Protections, Sections 80, 110.5, 200.2, 240, 500
- FFS and MA MOON
- Hospitals and CAHs are required to provide a MOON to Medicare beneficiaries informing them that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH)
  - CMS IOM Publication100-04, *Medicare Claims Processing Manual*, Chapter 30 Financial Liability Protections, Section 400 "Part A Medicare Outpatient Observation Notice"

Resources

- Beneficiary Notices Initiative (BNI)
  - FFS ABN Form and Instructions
- CMS Internet-Only Manuals
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 30 - Financial Liability Protections
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1 - General Billing Requirements, Section 60 - Provider Billing of Non-covered Charges on Institutional Claims
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16 - General Exclusions From Coverage
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18 – Preventive and Screening Services

Resources

- CMS MLN® Booklet
  - *Medicare Advance Written Notices of Noncoverage*
  - *Items and Services Not Covered Under Medicare*
- CMS MLN® Educational Tool: *Advance Beneficiary Notice of Non-coverage Interactive Tool*
- CMS CR7228: Auto Denial of Claims Submitted With a GZ Modifier

NGS Resources

- Outpatient OT and PT Services Billing Guide
- Billing Medicare for a Denial – Condition Code 21
- Medicare Coverage Exclusion: Dental Services
- Refunds Due to Beneficiaries by Providers
- Capable Recipients for the Advance Beneficiary Notice of Noncoverage

Resources: Did You Know

- Medicare contractor requests for medical records should include a copy of any applicable ABN
  - Mandatory ABN requested as part of ADR on all claims undergoing complex medical record review (including TPE)
- Face validity assessment of ABN shall be done if claim determined not to be reasonable and necessary
  - Per CR6988 and CR10909

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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