BlueCross BlueShield of North Carolina MEDICARE

November 2023

Usage of Liability Modifiers

Please note, this communication applies to Healthy Blue + Medicare[SM] (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

The Centers for Medicare and Medicaid Services (CMS) has provided specific guidance regarding the usage of the following modifiers:

Modifier	Description
GA	Waiver of Liability statement issued as required by payer policy.
GX	Notice of Liability issued, voluntary under payer policy.
GY	Item or Service Statutorily Excluded, does not meet the definition of any Medicare benefit.
GZ	Item or service expected to be denied as not reasonable and necessary.

It has been determined that these modifiers were used inappropriately for Medicare Advantage (MA) members. Examples include:

- The member has an enhanced or supplemental benefit above what original Medicare covers and one or more of the above modifiers are applied to the claim:
    - For example, office calls billed by a chiropractor and the service is an enhanced benefit under the member's Medicare Advantage health plan.
- The item/service is a covered benefit but one or more of the above modifiers is applied to claim:
    - For example, **911** ambulance calls:
        - CMS guidance states that if the call is in accordance with a prudent layperson's definition of *emergency medical condition*, regardless of the final diagnosis.

An Advance Beneficiary Notice (ABN) is a written notice given to an original Medicare beneficiary by a provider (including physicians, practitioners, durable medical equipment (DME) companies, laboratories, etc.) when they believe that Original Medicare will deny some or all of the services or items because of medical necessity or the frequency of the service; however, the ABN is optional when original Medicare never covers a service or item. When a provider obtains an ABN along with the original Medicare requirements, the provider may indicate that they have obtained an ABN by billed with modifier GS, GX, GY and/or GZ. As

NCBCBS-CR-040519-23-CPN39023 November 2023

published in the *Medicare Claims Processing Manual*, Chapter 30, Section 50, the ABN is provided to original Medicare beneficiaries for the above scenarios and is not used for items or services provided/denied under the MA program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). Under the MA program, MA members and their providers have the option to obtain a coverage decision prior to obtaining the item or service. This request for a pre-service coverage review is known as a request for an organizational determination. Because a MA member can obtain a pre-service coverage decision through the pre-service organizational determination process, the use of the ABN for MA members is not appropriate. This means that the liability modifiers that denote that there is an ABN on file is not appropriate for MA members.

Providers (contracted and non-contracted providers as well as members) have the ability to request an organizational determination (prior authorization) prior to providing an item or service to determine if the item or service will be covered under the member's health plan benefits. Once an organizational determination has been made, if a denial is warranted, an Integrated Denial Notice (IDN) will be sent to the member and provider. This document provides important appeal rights guaranteed to the member.

If the service is denied, the member will be better informed to choose if they would still like to obtain the item or service at their own expense. Claims are not processed based on the **G** modifier, but rather on the benefit of the service rendered.