CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 770	**Date: September 17, 2010**
	Change Request 7106

SUBJECT: Suspension of Automatic Denial of Institutional Claims Reporting Modifier -GA

I. SUMMARY OF CHANGES: In October 29, 2009, the CMS issued Change Request (CR) 6563, Transmittal 1840, entitled "Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)", effective April 1, 2010. Transmittal 1840 was rescinded and replaced with Transmittal 1894, dated January 15, 2010. Transmittal 1894 was rescinded and replaced with Transmittal 1921 dated, February 19, 2010. This CR changed processing of institutional claims with the -GA modifier. Requirement 6563.1 of this CR directed Medicare contractors processing institutional claims to automatically deny line items submitted with the -GA modifier. Such denials have since been subsequently suspended at the direction of CMS.

EFFECTIVE DATE: *April 1, 2010
IMPLEMENTATION DATE: October 17, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENT:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 770	Date: September 17, 2010	Change Request: 7106

SUBJECT: Suspension of Automatic Denial of Institutional Claims Reporting Modifier -GA

Effective Date: April 1, 2010

Implementation Date: October 17, 2010

I. GENERAL INFORMATION

A. Background:

October 29, 2009, the CMS issued Change Request (CR) 6563, Transmittal 1840, entitled "Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)." Transmittal 1840 was rescinded and replaced with Transmittal 1894, dated January 15, 2010. Transmittal 1894 was rescinded and replaced with Transmittal 1921, dated February 19, 2010. In addition to creating the –GX modifier for use with voluntarily issued ABNs, this CR also changed processing of institutional claims with the –GA modifier, effective April 1, 2010. Requirement 6563.1, of this CR directed Medicare contractors processing institutional claims to automatically deny line items submitted with the –GA modifier.

B. Policy:

Provider concerns instigated CMS review of this transmittal. In response to those concerns and review of applicable program policies after such denials occurred, CMS instructed Medicare contractors to suspend these automatic denials until further notice, so that CMS could take another look at their appropriateness. In such review, CMS considers policies that support: existing claim coding as used in completion for submission, ABN delivery prior to receipt of medical care and claims submission, and recourse to payment decisions made while adjudicating Medicare claims for financially involved parties.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7106.1	Medicare contractors shall notify providers that services submitted with the –GA modifier on institutional claims will not be subject to automatic denial until further notice.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7106.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, Wilfried.Gehne@cms.hhs.gov and Elizabeth Carmody, Elizabeth.Carmody@cms.hhs.gov, 410-786-7533.
Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs),*** **include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.