Advance Beneficiary Notice (ABN) Modifiers GA, GX, GY and GZ

Medicare Only

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

The Advanced Beneficiary Notice (ABN) serves to inform the patient that Medicare may not cover a particular service and that the patient may be responsible for its payment.

To ensure smooth claims processing and billing for non-covered services, the following modifiers are not mandatory according to Medicare but are beneficial:

- GA: Valid and signed ABN on file for a service not medically necessary
  - Medicare considers the claim for medical necessity.
  - If Medicare finds a claim or portion of it not medically necessary, Medicare assigns this as patient liability.
  - Offers patient's appeal rights.
- GX: Valid and signed ABN on file for a service not included in Medicare's benefits.
  - Medicare does not review medical necessity.
  - Medicare assigns patients liability.
  - Offers patient's appeal rights.
- GY: ABN is optional for statutorily excluded items or services.
  - Medicare does not review medical necessity.
  - Medicare assigns patients liability.
- GZ: No ABN on file, but Medicare requires one to change patient liability.
  - Medicare does not review medical necessity.
  - Medicare assigns provider liability.
  - Offers patient's appeal rights.

By utilizing these modifiers appropriately, you can facilitate clean claims processing and billing procedures related to non-covered services.

Reimbursement Guidelines

Molina Healthcare requires proper documentation of medical necessity and valid diagnosis codes for the reimbursement of specific procedures. Charges submitted without supporting evidence of medical necessity or the correct diagnosis codes will not be factored into the final calculation for claim payment.

To understand the coverage guidelines, limitations, and criteria for medical necessity, please consult:
CMS Claims Processing Manual, Chapter 1, Section 60

And CMS Claims Processing Manual, Chapter 30, Section 50

Claims that are not billed accurately may be denied or subject to potential recovery. Rates for reimbursement are determined based on the appropriate fee schedule or the provider contract agreement.

Molina Healthcare reserves the right to review all claim payments and recover any overpaid amounts identified based on contractual rates.

Supplemental Information

Definitions

Term	Definition
ABN	Advanced Beneficiary Notice

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	10/23/2023	
Revised Date	12/12/2024	Updated template, verified links

References

State/Agency	Document Name/Description	Link/Document
AAFP	Medicare non-covered services	AAFP Medicare non-covered services
CMS	PUB 100-04 Medicare Claims Processing	CMS.gov R1921CP CMS.gov R2148cp, Section E
Capture billing	Commonly used Medicare modifiers – GA, GX, GY, GZ	Medicare modifiers (GA, GX, GY, GZ)
Noridian	Medicare modifiers GA, GX, GY, GX	Noridian - Medicare - Modifier GA Noridian - Medicare - Modifier GX Noridian - Medicare - Modifier GY Noridian - Medicare - Modifier GZ

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*