Payment Policy | Advance Notice of Non-Coverage

EFFECTIVE DATE: 01|01|2015
POLICY LAST UPDATED: 10|05|2022

OVERVIEW

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The Advance Notice of Noncoverage (ANN), also known as an Advance Beneficiary Notice (ABN), is a written notice given by providers to a member to indicate that the service will not be covered by the member's insurance and that the member may be held liable for the cost of the service.

Medicare Advantage Plans

ANNs are not recognized for Medicare Advantage Plans, as described more fully below.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Medicare Advantage Plans

For a pre-service organization determination on behalf of a member, contact the Health Services Management Department at (401) 272-5670, extension 3012, or fax your request to (401) 272-8885. Contact the BCBSRI Behavioral Health Vendor at 1-800-274-2958.

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Not applicable

POLICY STATEMENT

Medicare Advantage Plans

An ABN is not used for items or services provided under Medicare Advantage Plans. If a provider believes a service will not be covered by the plan, the provider is expected to request a pre-service organization determination from the plan. If the provider does not request a pre-service organization determination prior to rendering the services, the provider will be liable for the cost of the services. Medicare Advantage Plan members will be held harmless. This determination on behalf of Medicare Advantage Plan members may be obtained by contacting BCBSRI or our vendor for the applicable services. See the Prior Authorization section for details.

Modifiers noted in the Coding section of this policy will not be recognized for Medicare Advantage Plans and any claim submitted with a modifier will be processed in accordance with the member's applicable benefits.

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An ANN should be given to members prior to having services that are non-covered or not medically necessary. If the member decides to proceed with the service nonetheless, the provider may submit the claim with the modifiers GA, GU, or GX as described further in the Coding section. If it is determined that the modifier was appended to a service that is covered, the claim will pay consistent with the member's benefit. In these situations, the provider is responsible for refunding any monies collected from the member for a covered service.

HCPCS modifier GA should only be used when a provider has issued an ANN and retains documentation that supports all of the following requirements:

- The service/item that is believed to be not covered or not medically necessary must be specifically listed on the ANN;
- An estimate of the cost of the service/item must be included;
- The ANN must be verbally reviewed with the member or his/her representative and any questions must be answered prior to signing;
- The ANN must be delivered far enough in advance for the member to consider the options and make an informed decision;
- A copy of the signed ANN is given to the member and the issuer must retain the original in the member's file.

HCPCS modifiers GU or GX are used for care that is typically excluded from coverage (e.g., cosmetic surgery). Modifier GU or GX can be used to provide notice of liability to the member and the claim will deny, with member liability assigned for the service.

An ANN is not to be given if a service is covered but not separately reimbursed or is considered bundled in another service as members may not be held liable for these services.

Notes: It is the provider's responsibility to review the member's applicable benefits and medical and payment policies prior to issuing an ANN. It is incorrect coding to file the modifiers noted in the Coding section routinely or when the provider does not expect a service will be denied. The member is not responsible for charges related to denials that are the provider's responsibility. Inappropriate use of the GA modifier may result in an audit of the Provider's records and subsequent corrective action.

If an ANN is not given to the member for a non-covered service, the provider is financially liable for the service/item provided to the member.

If a service/item requires preauthorization and authorization is denied, if the member elects to go forward despite the denial, then an ANN is not required as the denial notice serves as notification to the member that the service/item is not covered. In this case, the provider may submit the claim with the modifier(s) despite the lack of ANN, and the claim will deny, with member liability assigned for the service.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for the applicable instructions for appeals or coverage decisions.

CODING

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The following modifiers are applicable for ANNs/ABNs as noted in the Policy Statement Section:

- **GA –** Waiver of liability statement issued as required by payer policy, individual case
- **GU –** Waiver of liability statement issued as required by payer policy, routine notice
- **GX –** Notice of liability issue, voluntary under payer policy

Note: As set forth elsewhere in this Policy, these modifiers should not be used for Medicare Advantage Plans.

RELATED POLICIES

None

PUBLISHED

Provider Update, December 2022
Provider Update, February 2018
Provider Update, December 2017

Provider Update, January 2017
Provider Update, November 2015
Provider Update, July 2015
Provider Update, April 2011

REFERENCES:

1. Medicare.gov, Your Protections: https://www.medicare.gov/basics/your-medicare-rights/your-protections
2. Department of Health and Human Services Centers for Medicare & Medicaid Services: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf