Statutorily Non-covered Services FAQs

What is a statutorily non-covered service?
Services excluded from Medicare coverage by statute. Some statutory excluded services include:

- Eye refractions with the Medicare covered vision exam.
- Hearing aids
- Custodial care
- Routine dental services
- Routine vision services
- Service not provided within the United States.

When could a statutorily excluded service be covered under the member plan?
Medicare Advantage Plans may choose to offer some benefits to members in addition to the covered Medicare Part A and Part B benefits, these are called Supplemental Benefits. A supplemental benefit is an item or service not covered by original Medicare. Supplemental Benefits are usually offered through a contracted vendor network and are generally not covered under the standard Provider Contracts. Your Provider Contract and the member's Evidence of Coverage should be checked or contact the Provider Service Department for more information.

What does a member and/or provider needs to do for statutorily non-covered services?
CMS considers a contracted provider an agent of the Medicare Advantage Plan. Contracted Providers are held liable of ensuring proper notification in accordance with CMS guidelines has been met.

- If a service is never covered by the plan ***and*** the plan's Evidence of Coverage (EOC) provided to the member is clear that the service or item is not covered, the EOC has provided notification that the service is non-covered. This means the member could be held liable for the never covered service or item. We do however ask the contracted providers to contact the Medicare Advantage plan with any questions or to obtain a formal Notice of Denial of Medical Coverage letter (NMDC). The contracted provider may submit the claim with a GX and GY modifier (see below for modifier information).
- If a service could be covered by the plan and the plan's Evidence of Coverage (EOC) provided to the member is either unclear or may be covered under a Supplemental Benefit (e.g. supplemental benefits, such as routine vision, routine hearing and routine dental), the member will need to follow the guidelines of that benefit as per the EOC (e.g. obtain from the supplemental benefit vendor directly)

*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.

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What if a provider/member still wants the service?

- If a member would like to receive the statutorily excluded service, they will need to be notified in advance of the non-coverage and provided with a Plan specific Notice of Denial of Medical Coverage.

- The contracted provider can call the Provider Service Department and ask for a *Notice of Denial of Medical Coverage* letter to be issued. The letter will be issued to the member with a copy sent to the provider via fax.

- The purpose of the letter is to advise the member the service is not covered (non-covered item or service) , they are liable for payment and gives their appeal rights.

- By CMS guidelines, the Medicare Advantage Organization/health plan has to issue the letter. We are not permitted to provide a letter template to providers to issue to the member/ their patient.

- If the Notice of Denial of Medical Coverage letter is not given to the MA member regarding a non-covered service, the claim may be denied and the provider will be held financially responsible.

- The Notice of Denial of Medical Coverage letter will help ensure that a claim for non-covered care from a contracted provider is processed accurately.

May an Advanced Beneficiary Notice be issued for Medicare Advantage?

No, CMS prohibits the use of the ABNs for Medicare Advantage members. CMS guidance advises the Medicare Advantage Plans to have their contracted providers use the Notice of Denial of Medical Coverage letter (pre-determination denial).

Source: Pub 100-04; Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf

Section 50.3 – ABN Scope

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. *It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).* The ABN is used to fulfill both mandatory and voluntary notice functions.

When may a member and/or provider be responsible for the service?

CMS considers a contracted provider **an agent of the Medicare Advantage Plan**. Contracted Providers are held liable of ensuring proper notification in accordance with CMS guidelines has been met. All claims received from contracted providers not following these guidelines will be denied to the provider and the Medicare member cannot be held financially liable. This is a CMS Medicare Advantage protection for the Medicare member. If there is any doubt about

whether a service is not covered, please seek a coverage determination (the Notice of Denial of Medical Coverage letter) from the Medicare Advantage plan.
The liability assignment will depend on certain factors.

1. When a claim is billed with the appropriate G modifier.

2. When a Notice of Denial of Medical Coverage Letter has been issued prior to the service rendered. The Notice of Denial of Medical Coverage letter should be submitted with the claim. File the claim the same way as it is done today, when filing claims with documentation attached.

Note: Claims should be submitted for all services rendered even if a Notice of Denial of Medical Coverage Letter has been issued to the member. If the member would like to appeal any denial for a service that has been rendered, a claim with appropriate modifiers will need to be submitted.

When the member and/or provider contacts Customer Service for the Notice of Denial of Medical Coverage Letter, the following information should be provided.

- Member ID including prefix
- Date of Service
- Member's Name and DOB
  - Servicing provider/ TIN
    - Ordering Physician/address /TIN
  - Servicing Facility/address/TIN
    - Fax number for the Servicing provider
    - CPT Code(s)
    - Diagnosis

Note: The Notice of Denial of Medical coverage letter is mailed to the member and faxed to the provider.

How has Amerigroup Community Care* configured the G modifiers when used for statutorily excluded services?

Modifier	Meaning	Use
GA	*indicates that it is expected that Medicare will deny a service as not reasonable and necessary*	Not appropriate on statutorily excluded services
GX	*the item or service is statutorily non-covered or is not a Medicare benefit*	Use for statutorily excluded services The contracted provider is to submit the claim with a GX and GY modifier.
GY	*the item or service is statutorily non-covered or is not a Medicare*	Use for statutorily excluded services when a Notice of Non-Coverage has been issued

	*benefit and **proper notification has been secured***	The contracted provider is to submit the claim with a GX and GY modifier.
GY	*the item or service is statutorily non-covered or is not a Medicare benefit and **proper notification has NOT been secured***	Use for statutorily excluded services when the EOC is clear that the item is never covered
GZ	*indicates that it is expected that Medicare will deny a service as not reasonable and necessary with no advanced notice*	Not appropriate on statutorily excluded services

Source: Pub 100-04; Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

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