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Internal Medicine Coding Alert

Use -GY,-GZ Modifiers to Speed Medicare Denials

Many coders are confused about how to use the -GY and -GZ modifiers that CMS created in 2002 for use on claims for noncovered services and some are unaware that these modifiers are not required, as originally proposed, but instead are voluntary.

CMS says there are advantages to using the modifiers even though they are not mandatory. Using them may speed denial so you can bill secondary insurance or the patient more quickly and may also help practices avoid the appearance of fraud when they bill for multiple procedures Medicare does not cover, CMS says.

The modifiers, which were introduced in January 2002, are:

1. -GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit. Use this modifier when you expect a claim to be denied because it is excluded by statute from Medicare coverage or it does not meet all of the requirements for a particular benefit. You don't have to secure a signed advance beneficiary notice (ABN) because patients are expected to know what Medicare covers and doesn't cover.

   For example, a 67-year-old patient with no signs or symptoms of a problem comes in for a routine well visit and physical, which is excluded by law from coverage. Code the visit with the preventive medicine services code for a person of that age, 99397, and attach modifier -GY. Using modifier -GY with your claim will speed Medicare's denial.

   "Use -GY for any claim that's going to Medicare where you need a denial back so you can bill supplemental insurance or the patient," says **Judy Richardson, RN, MSA, CCS-P,** a senior consultant at Hill and Associates, a coding and compliance firm in Wilmington, N.C.

2. -GZ Item or service expected to be denied as not reasonable and necessary. Use this modifier when you expect a claim to be denied on the basis of medical necessity but and this is a key point you failed to have the patient sign an ABN.

   Perhaps the patient was not at the office and therefore you could not ask him to sign an ABN before a specimen was tested.

   Or perhaps you realized too late that you should have had the patient sign an ABN. For example, a low-risk female patient requests and undergoes an annual breast and pelvic exam, which Medicare will cover only every two years. Your office forgets to have the patient sign an ABN. Bill the service with **HCPCS G0101** (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and attach modifier -GZ. Because you failed to get a signed ABN, you will not be able to bill the exam to the patient, Richardson says.

   Modifier -GZ gives you a way to identify a claim where you would normally attach the existing -GA modifier, except you forgot or did not have the opportunity to get a signed ABN from the patient. Use modifier -GA (Waiver of liability statement on file) when you provide a service to a patient that you expect will be denied on the basis of medical necessity AND you have had the patient sign an ABN. For example, use -GA in the above scenario to report the off-year pelvic and breast exam when you remembered to have the ABN signed.

   Internists and other physicians initially balked when Medicare proposed the -GY and -GZ modifiers in April 2001 because that plan called for the modifiers to be required on claims, says **Brett Baker,** third-party payment specialist for the American College of Physicians-American Society of Internal Medicine in Washington, D.C. However, after lobbying from

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ACP-ASIM and other organizations, Medicare agreed to make use of -GY and -GZ voluntary rather than mandatory, Baker says.

Many physicians now view the modifiers as a good idea if they speed denials as Medicare promises.

"We think there's some merit to being able to facilitate those denials," Baker says.

So what happens if you don't use modifiers -GY and -GZ? If you don't use modifier -GY, Medicare says it will review your claim as it does any claim, but turnaround time may be slower than if you used the modifier.

If you fail to use modifier -GZ, Medicare will also review the claim like any other claim, but a pattern of claims for services deemed not medically necessary where no ABN has been obtained could raise suspicion of fraud. Using modifier -GZ will "greatly reduce the risk of a mistaken allegation of fraud or abuse," Medicare says.

Using the modifiers doesn't automatically guarantee a denial, Medicare says. If Medicare decides to pay a claim with modifier -GY or -GZ, the modifier is dismissed as irrelevant.

For more information on how to differentiate between the -GA, -GY and -GZ modifiers, visit http://cms.hhs.gov/medlearn/refabn.asp and click on the appropriate modifier under the "Exhibits" heading.

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