Part B Insider (Multispecialty) Coding Alert

Understand Modifiers for Non-Covered Services

Want to bill Medicare for a service you're sure it's going to deny? You still need to append the correct modifier.

Many providers aren't clear on the difference between modifiers -GA and -GY, says **Jennifer Darling**, insurance and collection specialist with the **Center for Oncology Research & Treatment** in Dallas. Many servic- are statutorily excluded from Medicare payment, and you don't need a signed advance beneficiary notice (ABN) to bill the patient for these "non-covered services," such as a preventive well-woman exam (**CPT 99387**).

In such a case, you should use the -GY modifier, which notifies Medicare that you're aware that the service isn't covered, but you're billing simply to obtain a denial.

By contrast, you'd use the -GAmodifier when Medicare imposes time coverage limits on a service. For example, drug codes such as the chemotherapy codes have time constraints, and so do pathology and radiology services. In the case of bone density scans, you can bill them once every two years in the absence of other medical-necessity indicators.