Eli's Rehab Report

Reader Question: Submit Modifier -GA When ABN Exists

Question: Do we have to report modifiers -GA and -GX for all claims that we know Medicare will deny?

Texas Subscriber

Answer: Even when you know that Medicare will deny a given service, you must file a claim with the patient's carrier and append modifier -GA (Waiver of liability statement on file) to the CPT code. This tells the insurer that the patient signed an advance beneficiary notice (ABN), which explains that Medicare may not cover a particular service or procedure and notifies the patient of his or her responsibility to pay if Medicare does not. The ABN must clearly identify the service rendered and state the reason that Medicare may deny it.

Append modifier -GA only if you're billing a service that Medicare may not deem medically necessary. For instance, you administered six lumbar epidural injections to a patient over the past year the maximum number of epidurals that his carrier covers. The patient requests an additional injection for pain management. You assume his carrier will deny the service, so he signs an ABN stating that he will pay you for the service if Medicare denies it. Modifier -GA tells Medicare that you have the ABN on file, and the explanation of benefits will note that the patient is responsible for payment.

An ABN is not necessary for procedures or services that Medicare never covers (such as acupuncture, 97780-97781). But the physician may still ask the patient to sign an ABN to verify that she knows she'll have to pay for the service.

Note: Medicare updated and standardized its ABN form effective July 1, 2001 (CMS memorandum A-01-77). The ABN is a simple form that you may reproduce on your practice's letterhead. A sample ABN (OMB Approval #0938-0566, form #HCFA-R-131-G) with instructions is on the CMS Web site, http://www.cms.gov.

Some patients ask the physician to submit a claim for noncovered services so their secondary insurer will cover it. Until 2002, providers submitted such claims using modifier -GX (Service not covered by Medicare), which indicated that Medicare should issue a denial notice, thus allowing the patient to pursue payment from other, secondary insurers.

On April 26, 2001, CMS released program memorandum B-01-30 announcing that modifiers -GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) and -GZ (Item or service expected to be denied as not reasonable and necessary) would replace -GX effective Jan. 1, 2002. These new modifiers describe the reason why Medicare will not allow the service or procedure.

Append modifier -GY when billing a general program exclusion service to Medicare. Use modifier -GZ when you bill a service that doesn't pass medical-necessity edits and the physician did not obtain a signed ABN from the patient. Medicare will not automatically deny claims submitted with modifier -GZ. But the carrier may deny the claim based on other criteria such as diagnosis to procedure coding.

According to the memo, "Anytime the modifiers -GY or -GZ are used, providers and suppliers must explain why the services or supplies are being submitted" on Item 19 of the CMS 1500 form. CMS-approved examples of explanatory language include "Claim submitted to receive denial for secondary payer" or "Service performed by family member."