Modifier Coding Alert

Compliance: ABNs: Make The Extra Effort To Remain In Modifier Mainstream

Modifier quartet won't affect payment, but Medicare might notice if you don't use them.

When your physician performs a service that Medicare might not cover completely, or at all, you should obtain a signed advance beneficiary notice (ABN) from the patient before performing the service. With that in hand, append one of four modifiers to your claim even though some coders might eschew this action, as Medicare only uses these modifiers for tracking purposes.

Experts recommend that you still append the modifiers, even though it doesn't affect payment consideration by Medicare. To clear up any modifier confusion your practice might have, check out this quick primer on when to use each modifier, and whether or not it requires an ABN.

GA Clears The Way To Bill Patient

According to **Steven M. Verno, CMBSI, CHCSI, CMSCS, CEMCS, CPM-MCS, CHM, SSDD,** a coding, billing, and practice management consultant in central Florida, you must issue the ABN when:

1. You believe Medicare might not cover an item or service;

2. Medicare usually covers the item or service; or

3. Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

In these situations, the payer expects you to append one of the following modifiers to the CPT® code you are reporting for the service:

- GA (Waiver of liability statement issued as required by payer policy, individual case): "Use this modifier when you issue a mandatory ABN for a service as required, and it is on file," Verno explains. You don't need to submit the ABN on GA claims, but you should have it available upon request, Verno says.
- GX (Notice of liability issued, voluntary under payer policy): "Use this modifier when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded, or is not a Medicare benefit," says Verno. In certain situations, you can also use this modifier in combination with modifier GY (see below).
- GY (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit): "Use this modifier to report that Medicare statutorily excludes the item or service; or the item or service does not meet the definition of any Medicare benefit," explains Verno. In certain situations, you can also use this modifier in combination with modifier GX.
- GZ (Item or service expected to be denied as not reasonable and necessary): "Use this modifier when you expect Medicare to deny payment of the item or service due to a lack of medical necessity, and no ABN was issued," says Verno.

Include Modifiers To Stay In The "Norm"

Despite Medicare's insistence on using the above modifiers when appropriate, some coders might wonder why they're necessary at all.

The reason: "The modifiers don't affect ... whether or not a claim is actually paid," explains **Leslie Johnson, CPC, CSFAC,** chief coding officer at PRN Advisors in Palm Coast, Fla. Though payment might not be affected, Johnson recommends using the modifiers whenever Medicare requires it or you could be identified as an outlier.

"Rules are rules. CMS is tracking every single code, and that includes the modifiers. Codes that are reported or not reported are indicative of patterns that are tracked by the data-mining systems," Johnson explains. This means that if you're not using the modifiers, you could attract the attention of Medicare auditors; further, you won't be able to bill the patient for the service.

Bottom line: Deviate from the norm one way or another, and payers could take notice, Johnson warns.