DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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/S/

FROM: Stuart Wright
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SUBJECT: Memorandum Report: *Medicare Payments for Part B Claims with G Modifiers*, OEI-02-10-00160

This memorandum report describes Medicare payments for Part B claims with G modifiers and how contractors process claims with these modifiers. Providers and suppliers use four G modifiers to indicate why claims may not be covered by Medicare. Providers file such claims when they need to document the use of services or items, or to provide information that may be required by other payers. Providers and suppliers use GA and GZ modifiers to indicate that they expect Medicare to deny the service or item as not "reasonable and necessary." For example, they may use these modifiers when they are unsure whether a beneficiary has reached a frequency limit that applies to certain services or items. Providers and suppliers use GY and GX modifiers to indicate that services or items are not covered by Medicare.

SUMMARY

In 2011, Medicare paid nearly $744 million for Part B claims with G modifiers that providers expected to be denied as not reasonable and necessary or as not being covered by Medicare. We found vulnerabilities in how Medicare pays for these claims. When processing claims, contractors often do not consider the modifiers that providers use to indicate that they expect the services or items to be denied as not reasonable and necessary. Contractors also do not always consider the modifiers that providers use to indicate that services or items are not covered by Medicare. Although contractors have checks that affect some of these claims, such as determining whether the services and items met Medicare frequency limitations, they do not specifically check for claims for which providers expect not to be paid. Further, we found that from 2002 to 2011, Medicare paid $4.1 million for claims that included inappropriate combinations of G modifiers.

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BACKGROUND

Medicare Part B covers a variety of services and items, including physician office visits, outpatient procedures, laboratory tests, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Covered services and items must be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part.[1] As discussed in more detail below, providers and suppliers use G modifiers to alert Medicare when they bill for services or items that they expect to be denied as either not reasonable and necessary (GA and GZ modifiers) or because they are not covered by Medicare (GY and GX modifiers).

In a 2009 report, the Office of Inspector General (OIG) raised concerns about the use of GA and GZ modifiers and about Medicare inappropriately paying for some claims with these modifiers. The report looked at claims for pressure-reducing support surfaces and found that Medicare paid for 72 percent of all pressure-reducing support surface claims with GA or GZ modifiers.[2] This amounted to over $4 million in potentially inappropriate payments.

GA and GZ Modifiers

Providers and suppliers use GA and GZ modifiers to bill for certain services or items that they expect to be denied as not reasonable and necessary.[3] They may use these modifiers when they are uncertain about whether a claim should be paid. For example, a provider may not know whether a beneficiary already had a particular laboratory test that Medicare covers only once a year [4] or a supplier may suspect that the beneficiary already has the item it is providing.[5] Providers and suppliers may also use these modifiers when they are certain that the claim should not be paid. For example, a provider may know that Medicare does not pay for a particular test for a beneficiary with a given condition, but because the beneficiary requests it, the provider submits the claim to Medicare for a decision.[6] The beneficiary may need Medicare to deny the claim so that it can be submitted to the beneficiary's secondary insurance.

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[1] Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A).

[2] OIG, *Vulnerabilities in Medicare Payments for Pressure Reducing Support Surfaces*, OEI-02-07-00421, December 2009.

[3] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, 20.9.1.1(E). The requirements concerning these modifiers also apply to Part B claims submitted by Part A providers. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.1, § 60.4.2.

[4] Medicare may not pay on a claim if it represents a test that exceeds a frequency limit. See CMS, *Advance Beneficiary Notice of Noncoverage (ABN): Part A and Part B*, May 2012. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf on April 1, 2013.

[5] See e.g., Noridian Administrative Services LLC, "Proper Use of GY, GA, and GZ Modifiers," *Happenings*, August 2007. Accessed at https://www.noridianmedicare.com/dme/news/bulletins/happenings/issue6_aug07.pdf on February 14, 2011.

[6] This type of claim is called a demand bill. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1, § 60.3.2(B).

GA Modifiers: Beginning in January 2002, Medicare required providers and suppliers to use the GA modifier for claims they expect to be denied as not reasonable and necessary for which they have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary. One of the purposes of the ABN is to inform the beneficiary that Medicare certainly or probably will not pay for the service or item on that occasion. The GA modifier may be used only if a beneficiary signed an ABN indicating that he or she accepts liability for the cost of the service or item if Medicare does not pay for it. Medicare prohibits the routine use of ABNs. However, it does allow for certain exceptions, such as when a service or item has a frequency limit on coverage.[7] For example, laboratories may routinely use ABNs because Medicare places frequency limitations on many laboratory services and laboratories may not be able to determine whether a beneficiary has already exceeded the limit for a test.

GZ Modifiers: Beginning in January 2002, Medicare required providers and suppliers to use the GZ modifier for claims they expect to be denied as not reasonable and necessary for which they do not have an ABN on file.[8] In these cases, if Medicare denies the claim as not reasonable and necessary, the beneficiary cannot be held liable for the cost of the service or item. Table 1 provides the definitions of GA and GZ modifiers for Part B claims.

Table 1: Definitions of GA and GZ Modifiers for Part B Claims

Modifier	Definition
GA	Service or item is not considered reasonable and necessary; ABN is on file
GZ	Service or item is not considered reasonable and necessary; ABN is not on file

Source: CMS, Medicare Claims Processing Manual, Pub. No. 100-04, ch. 23, § 20.9.1.1(E).

GY and GX Modifiers

Beginning in January 2002, Medicare allowed providers and suppliers to use the GY modifier to indicate that a service or item is not covered by Medicare, either because it is statutorily excluded (e.g., hearing aids) or does not meet the definition of any Medicare benefit (e.g., surgical dressings that are used to clean or protect intact skin).[9] Because Medicare does not cover these services or items, the beneficiary is liable for payment. No ABN is required with the GY modifier. The provider or supplier may use this modifier when a beneficiary needs Medicare to deny the claim so that it can be submitted to the beneficiary's secondary insurance.

In April 2010, Medicare established the GX modifier. It indicates that a service or item is statutorily excluded and that the provider or supplier voluntarily gave the beneficiary an

[7] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 30, §§ 40.3.6 and 40.3.6.4(C).
[8] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, § 20.9.1.1(E).
[9] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, § 20.9.1.1(E). The requirements concerning these modifiers also apply to Part B claims submitted by Part A providers. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.1, § 60.4.2.

ABN.[10] In 2010, Medicare provided instructions to contractors to automatically deny Part A claims with the GX modifier for noncovered charges.[11] Medicare has not issued similar instructions for Part B claims. Table 2 provides the definitions of GY and GX modifiers.

Table 2: Definitions of GY and GX Modifiers for Part B Claims

Modifier	Definition
GY	Service or item is statutorily excluded or does not meet the definition of any Medicare benefit; ABN is not required.
GX	Service or item is statutorily excluded and the provider or supplier voluntarily notified the beneficiary with an ABN.

Source: CMS Program Memorandum, CR 1820; CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, § 20.9.1.1(E).

Medicare Part B Claims Processing

CMS contracts with Medicare Administrative Contractors (MAC) to process and pay Part B claims.[12] These contractors also apply claims processing "edits"—i.e., system checks—to prevent improper payments; conduct medical reviews and data analyses of claims; and conduct outreach and education to providers. Edits flag a claim for automatic denial or for contractor review to ensure that the claim is appropriate.

CMS provides contractors with various instructions about how to process claims with G modifiers. CMS required contractors to automatically deny claims with GZ modifiers for services or items that were provided on or after July 1, 2011.[13] Currently, CMS does not have any specific instructions for claims with GA modifiers, except for those submitted with both a GA and GZ modifier; CMS instructs contractors to treat such claims as unprocessable.[14] For claims with GY modifiers, CMS allows contractors to deny these claims at their discretion. Finally, CMS has not issued instructions for processing Part B claims with GX modifiers. See Table 3.

Table 3: Processing Instructions for Part B Claims With G Modifiers

Modifier	Processing Instructions
GA	Claims with both a GA and a GZ modifier for the same service or item should be treated as unprocessable.
GZ	Effective July 1, 2011, GZ claims must be automatically denied.
GY	Effective January 2002, claims with GY modifiers may be automatically denied at the discretion of the MACs.
GX	No instructions.

Source: CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, § 20.9.1.1(E)(5) and (F).

[10] CMS, CR 6563, Transmittal 1921, *Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)*, February 19, 2010.
[11] Ibid., Requirement Number 6563.5.
[12] During the period of our review, CMS was transitioning the claims processing workload of other contractors—such as carriers and fiscal intermediaries—to the MACs.
[13] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 23, § 20.9.1.1(F).
[14] Ibid., ch. 1, § 20.9.1.1(E)(5).

METHODOLOGY

This study is based on an analysis of all Part B claims, including DMEPOS claims, with GA, GZ, GX, and GY modifiers for calendar year 2011. It is also based on structured interviews with staff at CMS and selected claims processing contractors.

Analysis of Part B claims. Using CMS's National Claims History File and Standard Analytical File, we analyzed all Part B claims with GA, GZ, GX, or GY modifiers from 2011.[15] We determined the number of claims with each of these modifiers, the number and percentage of these claims that Medicare paid, and the total amount Medicare paid for these claims. We also analyzed the services or items that were billed on these claims. We determined the types of services or items that had the largest numbers of paid claims and the amounts Medicare paid for each of these services or items.

Next, we analyzed the number of paid claims that included inappropriate combinations of G modifiers. We did this analysis for all Part B claims with GA, GZ, GX, or GY modifiers from 2002 to 2011. We looked for combinations that represent inappropriate scenarios, such as when one modifier indicates that a service or item is not reasonable and necessary and the other modifier indicates that Medicare does not cover the service or item. For the purposes of this report, we use "providers" to refer to both providers and suppliers.

Interviews with CMS staff and selected contractors. We conducted structured interviews with staff at CMS and selected claims processing contractors about how they use G modifiers. We also asked staff at each contractor whether they have any claims processing edits specific to claims with G modifiers and under what circumstances they review these claims. During the period of our review, CMS was transitioning the claims processing workload of other contractors, called carriers, to the MACs. For this review, we interviewed staff at the 13 MACs; these contractors processed 78 percent of all paid 2011 claims with G modifiers.[16] We conducted these interviews in September 2011.

Standards

This inspection was conducted in accordance with the *Quality Standards for Inspection and Evaluation* approved by the Council of the Inspectors General on Integrity and Efficiency.

[15] All analyses for GX are for the period from April 1, 2010—the date the GX modifier became effective—to December 31, 2011.

[16] The carriers processed the remaining 22 percent of claims.

RESULTS

In 2011, Medicare paid nearly $744 million for Part B claims that providers expected to be denied as not reasonable and necessary or as not being covered by Medicare

Medicare paid for 16.5 million Part B claims with GA, GZ, GX, and GY modifiers. Most of these claims (98 percent) were submitted with GA modifiers. Another 2 percent of claims were submitted with GZ modifiers. Less than 1 percent of claims were submitted with GY and GX modifiers. See Table 4.

Table 4: Part B Claims With G Modifiers, 2011

Modifier	Number of Paid Claims	Percentage of Paid Claims With G Modifiers	Total Amount Paid
GA	16,165,721	97.7%	$727,224,448
GZ	352,735	2.1%	$14,240,381
GY	9,081	0.1%	$1,043,755
GX	16,914	0.1%	$1,360,584
Total	**16,544,451**	**100%**	**$743,869,168**

In contrast to their processing of GA modifiers, almost all contractors reported having edits specific to GZ modifiers. Providers use GZ modifiers to indicate that they expect Medicare to deny a service or item as not reasonable and necessary and that they do not have an ABN on file. As previously noted, beginning in July 2011, CMS required contractors to automatically deny claims with GZ modifiers. While 12 contractors that we interviewed reported having edits to automatically deny claims with GZ modifiers, the remaining contractor did not. This contractor noted that it had other edits that affect some claims with GZ modifiers, such as edits to check that services and items met Medicare coverage requirements, but that it did not automatically deny all claims with GZ modifiers, as required.

In 2011, Medicare paid for 26 percent of claims submitted with GZ modifiers, totaling $14.2 million. Almost all of these claims were for services or items provided before July 2011.[18] As noted previously, CMS required contractors to automatically deny claims with GZ modifiers for service or items provided on or after July 1, 2011. About three-quarters of the paid claims with GZ modifiers were for laboratory tests.

Contractors also do not always consider modifiers that providers use to indicate that services or items are not covered by Medicare

Providers use GY modifiers to indicate that either a service or item is statutorily excluded (e.g., eyeglasses) or that it does not meet the definition of any Medicare benefit (e.g., surgical dressings that are used to clean or protect intact skin rather than to cover an actual wound). Medicare gives contractors the discretion to automatically deny claims with GY modifiers. Eleven of the thirteen contractors we interviewed automatically denied these claims, while two contractors did not. One of these contractors reported that, instead of automatic denial, it had an edit in place that flags these claims for review. The other contractor reported that it had other edits that affect some claims with GY modifiers, such as edits to check that services and items met Medicare coverage requirements.

In 2011, Medicare paid for less than 1 percent of claims with GY modifiers, totaling $1 million. As shown in Table 4, the majority of paid claims with GY modifiers (87 percent) were for DMEPOS. Most of these claims were for accessories for prosthetics and orthotic devices. The next most common claims with GY modifiers were for enteral and parenteral nutrition; ambulance services; and drugs, such as vitamin B12 injections.

[18] CMS paid for 0.10 percent of GZ claims for services or items provided on or after July 1, 2011, totaling $66,441 in payments.

Table 5: Top Categories of Paid Part B Services and Items With GY Modifiers, 2011

Service or Item Category	Number of Paid Claims with GY Modifiers	Percentage of Paid Claims with GY Modifiers	Total Amount Paid
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	7,892	87%	$624,560
Enteral and Parenteral Nutrition	783	9%	$251,067
Ambulance	177	2%	$30,478
Drugs (e.g., certain injections, including vitamin B12 and Ranibizumab)	130	1%	$108,729
Other Services and Items*	99	1%	$28,920

Source: OIG analysis of CMS claims data, 2012.
* This includes several service and item categories that each accounted for 0.1 percent or less of all paid claims with GY modifiers.

Providers use GX modifiers to indicate that the service or item is statutorily not covered by Medicare and they voluntarily notified the beneficiary with an ABN that he or she is liable for the claim. Medicare established the GX modifier in April 2010 for Part A claims. Medicare has not given instructions to contractors on how to process Part B claims with the GX modifier.[19]

In 2011, Medicare paid for 11 percent of claims submitted with GX modifiers, totaling $1.3 million.[20] In 2011, almost a third of the paid claims with GX modifiers were for imaging services, while 21 percent were for laboratory tests. Another 13 percent were for chiropractic services.

Further, Medicare paid $4.1 million for Part B claims that included inappropriate combinations of G modifiers from 2002 to 2011

With the exception of a GX modifier paired with a GY modifier, all other combinations of G modifiers on the same claim are inappropriate. From 2002 to 2011, Medicare paid $4.1 million for claims submitted with inappropriate G modifier combinations. Claims that contained both a GA and GY modifier made up the vast majority of these claims, totaling $3.9 million in payments. Claims with this combination indicate that the provider expects that the service or item is not reasonable and necessary and that it is not covered by Medicare.

Medicare paid $89,973 for claims with the combination of a GA and GZ modifier. Including both modifiers is contradictory and indicates that the provider expects that claim to be denied as not reasonable and necessary and either provided an ABN (GA) or did not provide an ABN (GZ). Because contractors must automatically deny claims that include both GA and GZ modifiers, it is unclear why Medicare paid for these claims.

[19] CMS instructs contractors to automatically deny Part A claims with GX modifiers. See Requirement Number 6563.5 in CMS, CR 6563, Transmittal 1921, *Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)*, February 19, 2010.
[20] This only includes Part B claims submitted with GX modifiers for service dates on or after April 1, 2010, the date CMS first allowed providers to use the GX modifier under its current definition.

CONCLUSION

This memorandum report describes Medicare payments for Part B claims with G modifiers and how contractors use these modifiers in their claims processing.

In 2011, Medicare paid nearly $744 million for Part B claims with G modifiers. We found that vulnerabilities exist in how Medicare pays for these claims. When processing claims, contractors often do not consider the modifiers that providers use to indicate that they expect the services or items to be denied as not reasonable and necessary. Contractors also do not always consider the modifiers that providers use to indicate that services or items are not covered by Medicare. Although contractors have checks that affect some of these claims, such as determining whether the services and items met Medicare frequency limitations, they do not specifically check for claims providers expect not to be paid. Further, we found that Medicare paid $4.1 million for claims that included inappropriate combinations of G modifiers from 2002 to 2011.

CMS needs to address the vulnerabilities presented in this report. We are aware that CMS developed a GU modifier for providers to use on claims for items and services for which the routine use of ABNs is appropriate, such as for services that are subject to frequency limitations. This is one way to address the problem in that it would allow providers to use the GA modifier solely for other items and services that they expect to be denied. CMS would then need to instruct contractors to automatically deny or review claims with GA modifiers before paying them. To date, however, CMS has not issued any instructions about the GU modifier or how contractors should process these claims. CMS needs to either issue such instructions or develop other methods of addressing these program vulnerabilities.

In addition, CMS needs to ensure that all contractors are following its instructions to automatically deny claims with GZ modifiers. CMS also needs to instruct contractors to automatically deny claims with GY modifiers and ensure that contractors follow these instructions. Further, CMS should decide whether to implement the GX modifier for Part B claims, since providers are already using it. Lastly, CMS should ensure that contractors do not pay for claims with inappropriate combinations of G modifiers. OIG will continue to monitor claims with G modifiers and will undertake a review in the future if it appears that CMS has not addressed the problems presented in this report.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-10-00160 in all correspondence.

APPENDIX A

Categories of Paid Part B Services and Items with GA Modifiers, 2011

Service or Item Category	Number of Paid Claims with GA Modifiers	Percentage of Paid Claims with GA Modifiers	Total Amount Paid
Laboratory tests	8,321,058	51.5%	$125,730,915
Chiropractic	2,420,242	15.0%	$78,382,437
Standard imaging	1,157,186	7.2%	$97,088,523
Minor procedures	1,065,797	6.6%	$54,151,802
Office visits	728,031	4.5%	$38,226,312
Other drugs	448,512	2.8%	$85,072,111
Other tests	398,379	2.5%	$18,110,098
Other durable medical equipment (DME)	210,823	1.3%	$20,278,913
Echography/ultrasonography	198,300	1.2%	$29,801,792
Immunizations/vaccinations	184,297	1.1%	$4,187,908
Prosthetic/orthotic devices	173,895	1.1%	$29,453,648
Ambulatory procedures	143,505	0.9%	$10,166,348
Advanced imaging	142,215	0.9%	$54,802,485
Specialist	122,787	0.8%	$11,393,247
Eye procedure	105,538	0.7%	$16,944,745
Wheelchairs	78,337	0.5%	$8,083,403
Endoscopy	58,991	0.4%	$16,502,566
Oxygen and supplies	41,824	0.3%	$4,801,681
Imaging/procedure	33,978	0.2%	$1,872,673
Hospital beds	23,859	0.2%	$ 2,473,447
Oncology	13,555	0.1%	$1,170,745
Anesthesia	12,346	0.1%	$1,740,967
Other	12,403	0.1%	$827,033
Ambulance	11,921	0.1%	$2,499,763
Medical/surgical supplies	11,633	0.1%	$694,633
Chemotherapy	10,374	0.1%	$2,775,061
Enteral and parenteral	9,729	0.1%	$3,710,177
Hospital visit	6,575	0.0%	$751,710
Undefined codes	5,186	0.0%	$535,047
Major procedure	6,393	0.0%	$4,233,264
Drugs administered through DME	3,875	0.0%	$ 316,977
Dialysis services	1,381	0.0%	$181,084
Nursing home visit	1,480	0.0%	$140,068
Home visit	1,268	0.0%	$116,189
Emergency room visit	47	0.0%	$6,505
Hearing and speech services	1	0.0%	$171
Total	**16,165,721**	**100%***	**$727,224,448**

Source: Office of Inspector General analysis of Centers for Medicare & Medicaid Services claims data, 2012.

*The rows do not sum to the total due to rounding.