## Anthem and Its Absurd GY Modifier Policy

This recent interpretation defies common sense.

BY PAUL KESSELMAN, DPM

loot orthotics are rarely covered by Medicare. This is designated using the GY (Patient Responsibility) modifier. Correctly using the GY modifier results in the claim being processed by Medicare for purposes of "rejection only" and the subsequent forwarding of these claims to the secondary insurer (if there is one) for further processing. Theoretically, the secondary insurer will then either reject the claim (kicking it back to the patient) when there is no coverage, or pay the claim should there be benefits for the services in question (e.g., foot orthotics).

Most insurance carriers strip the GY modifier off of the electronic EOMB received from Medicare. This is done ostensibly because the secondary carriers accept the fact that they are receiving claims which were sent primarily to Medicare for "reject" processing and that they (the secondary) are for the services they cover which Medicare does not (gap coverage). The secondary carriers thus process and pay claims in full, subject to their own coverage parameters and not Medicare's, therefore ignoring the payment modifiers sent to the primary carrier.

According to Medicare, claims for foot orthotics (L3000-L3030) for Medicare-eligible patients should therefore be sent first to the DME MAC with a GY and LT or RT modifier and then are automatically forwarded to the secondary carrier. In the case of Federal retirees, these are most often sent to Anthem (and their subsidiaries) in most areas of the country. The process

seemed to work well up until October 2015, because Anthem recognized that they provided "gap" insurance for services and procedures not covered by Medicare (in this case for retirees from Federal government agencies). They further recognized the requirement(s) of Medicare providers to first submit these claims to Medicare in order for Medicare to initially reject these claims (as non-covered patient responsibility services) and then would process them

ity) must be amended to the HCPCS codes. They have further stated that if no payment modifier is used, the claim will be rejected as non-process-able, with no forwarding of the claim to the secondary carrier. Lastly, both Anthem and Medicare have insisted that they have no power to evoke change or influence the other's policies.

This has created a Ping-Pong effect for both the provider and beneficiary. If you submit the claim with

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in accordance with their secondary contract parameters.

Sometime after October 2015, Anthem carriers (e.g., Blue Cross Federal) began a policy of strictly interpreting the GY modifier for themselves as well. Thus, Anthem is now also rejecting these claims, despite their beneficiaries having gap coverage written into their contracts for non-Medicare-covered services, including foot orthotics, hearing aids, etc.

Medicare insists that any claim for a Medicare beneficiary (regardless if covered or not) must first be submitted to them, regardless of coverage or exclusion. They further stated that one payment modifier or another (KX-Attesting to coverage parameters being met) or GY (patient responsibilthe KX modifier and do this on a regular basis, you would be, at a minimum, following an abusive billing pattern. At the worst, you could be charged with a fraudulent billing pattern. If you submit the claim appropriately to Medicare with the GY modifier, Anthem (or its subsidiaries) will likely not pay the claim.

Directly charging your patient, who has secondary coverage if you are a contracted provider of services for that carrier, could be considered a violation of your contract with that insurance provider.

Anthem has also suggested by-passing the DME MAC contractors altogether. The DME MAC has said that is a violation of Anthem's con-

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tract with CMS to provide "gap" insurance and additionally is a HIPAA code set violation for the provider as well.

Expanding the discussion from foot orthotics to other medical services, it is easy to see how many providers (and patients) may fall into this trap of no carrier taking responsibility for payment, despite contracts suggesting otherwise. Anthem can (and has) included other non-Medicare covered services in this ping pong denial of claims, including but not limited to: hearing aids, eye glasses, routine foot care, plastic surgery, Lasik, non-covered physical therapy, and many more.

As we approach fall 2016, this is no longer a theoretical issue but a real crisis for podiatrists, audiologists, plastic surgeons, physical therapists, and anyone who provides non-covered services to Medicare beneficiaries who may be covered by their secondary carrier.

Beneficiaries and/or their formal employers are paying an additional amount for coverage which "gaps" what Medicare provides, yet they are still being denied coverage for these services. Several Anthem supervisory officials (including a medical director), despite multiple promises to respond back to the author and several colleagues, has failed to do so. Similar stories are being heard from other health-care professionals and their representative associations.

Is Anthem actually committing a conspiracy to pur-

posefully commit theft of services by denying payment for services which are covered under their coverage parameters? While one should leave the formal legal response to that question to those with a law degree, it is readily apparent that if one pays for coverage for specific services and the carrier provides a coverage decision for coverage, yet refuses to pay (and in fact sets up a network of policies to purposefully deny coverage), that suggests they have failed in their fiduciary responsibilities to the beneficiary and/or the provider. Do I hear class action law suit here?

In some parts of the country, this has created a real crisis for both providers and beneficiaries, particularly where

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there is a high concentration of Federal retirees who have Medigap coverage. It is now time to take out the "big guns". Our patients must be enlisted to become their healthcare providers' partners as part of the solution. Patients should be asked to contact their local, state, and Federal legislators on this issue. Practices are encouraged to do the same. Patients should also be contacting their State Insurance Departments and State Attorney General's Health care Fraud bureaus (and possibly their local chapter of the U.S. Department of Labor).

By the time you read this article, hopefully APMA has met with other professional associations having similar problems to strategize a solution, or Anthem has finally somehow resolved this issue. The latter is less likely.

It is readily apparent that the rationale for Anthem's policy change in October 2015 must be identified (it apparently was not because of ICD-10). Second, it is important to understand who the parties were at Anthem who were empowered to make this policy change. Having identified these two findings has been quite elusive and remains the source at beginning to solve this crisis for not only podiatrists but for all providing non-covered Medi-

care services. Interestingly, many non-Anthem affiliated carriers (UHC and others) have continued to process these types of claims without any issues. This again begs the question: why has Anthem behaved in a manner inconsistent with other large insurance carriers? PM



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