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### Compliance Hotline

Type: <http://157.21.29.163/Compliance/>

and click on Hotline. EVMS Health Services Compliance concerns may also be sent to the EVMS Health Services Compliance Office via phone, mail or e-mail.

### Contact Us

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## Humana/CMS Diagnosis Audits

Humana is now auditing records for its Medicare Advantage members to ensure that the **diagnosis** codes reported "include all pertinent codes and accurate levels of specificity". If the Humana reviewers determine that a more specific code is supported by the record they will submit it to the Centers for Medicare and Medicaid Services (CMS). Remember that the codes selected should always be the most accurate and specific based on the documentation of the conditions addressed at the current visit.

Two of our departments have recently received requests for supporting documentation. If your department receives a request, please contact the EVMS Health Services Compliance Office before responding.

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## Signature Logs for FY 2009

Although many of our departments now use the EHR it is still necessary for us to obtain new signature logs each year which include **everyone** who will document in office charts or hospital records throughout the new year. The logs must contain the **typed name, title** and **position** of each individual as well as **his/her signature** and **initials**. Providers should sign as they do when documenting in the medical record.

All new providers and staff hired during the year must be added to the log. If your department has not already done so, please send copies of the completed logs to the EVMS Health Services Compliance Office. Original FY 2009 logs and all previous logs should be labeled as such and kept in your department for future

reference for a period of not less than 12 years.  
 Contact the EVMS Health Services Compliance Office if you have questions.

## Medicare Modifiers GA, GZ and GY

These modifiers are to be appended to the appropriate codes when billing Medicare for items or services that are not covered or may not be covered.

Modifier	GA	GZ	GY
<b>When to use</b>	When you think a service will be denied because it does not meet the Medicare program standards for medically necessary care <i>and the patient signed an ABN.</i>	When you think a service will be denied because it does not meet the Medicare program standards for medically necessary care <i>and the patient did not sign an ABN.</i>	When you think a service will be denied because it is not a Medicare benefit or because Medicare law specifically excludes it.
<b>Examples</b>	All instances in which a patient signs an ABN and services are furnished.	When you realize after furnishing the service that an ABN should have been obtained.	Routine physicals, tests in the absence of signs and symptoms and other services statutorily excluded.
<b>What happens if you use?</b>	The claim will be reviewed by Medicare and may or may not be denied. If the claim is denied the patient will be liable for payment.	The claim will be reviewed by Medicare and may or may not be denied. If the claim is denied the patient will not be liable for payment.	The claim will be denied by Medicare. This action may be quicker than if you do not use a GY modifier. The patient will be liable for all charges.
<b>What happens if you don't use?</b>	The claim will be reviewed by Medicare and may or may not be denied. If the claim is denied the patient will not be liable for payment.	The claim will be reviewed by Medicare and may or may not be denied. You may elect not to use a GZ modifier; however, there is a risk of allegation of fraud or abuse for claiming services that are not medically necessary.	The claim will be reviewed by Medicare and probably will be denied. This action may be slower than if a GY modifier had been used.