

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2148</b>	<b>Date: February 4, 2011</b>
	<b>Change Request 7228</b>

**SUBJECT: Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier**

**I. SUMMARY OF CHANGES:** This CR requires that all MACs, CERT, RACs, PSCs and ZPICs shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items with a GZ modifier shall be denied automatically and will not be subject to complex medical review.

**EFFECTIVE DATE: July 1, 2011**

**IMPLEMENTATION DATE: July 5, 2011**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	23/20.9.1.1/Instructions for Codes With Modifiers (Carriers Only)

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 2148	Date: February 4, 2011	Change Request: 7228
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**SUBJECT: Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier**

**Effective Date: July 1, 2011**

**Implementation Date: July 5, 2011**

## I. GENERAL INFORMATION

**A. Background:** Health and Human Services Office of General Counsel (HHS OGC) has provided guidance that Medicare contractors that process both institutional and professional claims have discretion to automatically deny claim line(s) items billed with the GZ modifier. The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. According to this guidance from HHS OGC, an automated edit shall be established to deny Part A and B claim line(s) items that contain a GZ modifier.

**B. Policy:** In Pub. 100-04, Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 20.9.1.1 (Instructions for Codes With Modifiers (Carriers Only)), Part E, (Coding for Noncovered Services and Services Not Reasonable and Necessary) states, “The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.”

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B  M A C	D M M A C	F I  I E R	C A R I E R	R H H I  S S	Shared-System Maintainers				Other	
		F	M	V	C							
7228-04.1	Contractors shall automatically deny claim line(s) items submitted with a GZ modifier.	X	X	X	X	X	X					CERT RAC ZPIC PSC
7228-04.2	When claim line(s) items submitted with the Modifier – GZ are denied, contractors shall use the following codes:  Group Code CO (Provider/Supplier liable) CARC 50 defined “These services are non-covered services because this is not deemed a ‘medical necessity’ by the payer.	X	X	X	X	X	X					CERT RAC ZPIC PSC
7228-04.3	Contractors shall not perform complex medical review on any claim line(s) items submitted with a GZ modifier.	X	X	X	X	X						CERT RAC ZPIC PSC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R I E R	R H H I	Shared-System Maintainers				Other	
		M A C	M A C				F I S S	M C S	V M S	C W F		
7228-04.4	<p>Contractors shall use the following MSN message:</p> <p><b>MSN Message 8.81</b></p> <p><b>English</b> If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier.</p> <p><b>Spanish</b> Si el proveedor/suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el proveedor/suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra revisión. Si usted pagó por este servicio y no recibe ninguna información sobre un reembolso en 30 días, comuníquese con su proveedor/suplidor.</p>	X	X	X	X	X	X					CERT RAC ZPIC PSC
7228-04.5	Contractors shall make all language published in their educational outreach materials, articles and on their Web sites, consistent to state all claims line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review.	X	X	X	X	X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I    	C A R R I E R	R H I   	Shared-System Maintainers				Other
						F I S S	M C S	V M S	C W F		
7228-04.6	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X	X	X	X	X					

### IV. SUPPORTING INFORMATION

**Section A: for any recommendations and supporting information associated with listed requirements, use the box below: N/A**

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

**Section B: For all other recommendations and supporting information, use this space: N/A**

### V. CONTACTS

**Pre-Implementation Contact(s):** Latesha Walker [Latesha.Walker@cms.hhs.gov](mailto:Latesha.Walker@cms.hhs.gov)  
 Andrea Glasgow [Andrea.Glasgow@cms.hhs.gov](mailto:Andrea.Glasgow@cms.hhs.gov)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

### **Section B: For *Medicare Administrative Contractors (MACs)*:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## 20.9.1.1 - Instructions for Codes With Modifiers (Carriers Only)

*(Rev. 2148, Issued: 02-04-11, Effective: 07-01-11, Implementation: 07-05-11)*

### A. General

Carriers subject all line items with identical modifiers to the CCI edit.

All line items with identical modifiers must be subjected to the CCI edit. Line items with the modifiers listed below are NOT subject to the CCI edit. However, they are subject to additional edits based on the specific use of the modifier as defined in other instructions issued by CMS.

<b>E1 - E4</b>	<b>FA</b>	<b>F1 - F9</b>	<b>TA</b>	<b>T1 - T9</b>	<b>LT</b>	<b>RT</b>
-25	-58	-59	-78	-79	LC	LD
RC	-91					

### B. Modifier “-59”

Definition - The “-59” modifier is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Rationale - Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).

Instruction - The secondary, additional, or lesser procedure(s) or service(s) must be identified by adding the modifier “-59”.

Following are examples of appropriate use of the “-59” modifier:

**EXAMPLE 1:** CPT codes describing chemotherapy administration include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session. When this is the case, using the CPT codes 96408, 96410, and 96414, the “-59” modifier (different substance) should be attached to the lesser valued technique indicating that separate agents were administered by different techniques.

**EXAMPLE 2:** When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the “-59” modifier should be attached to the initial incisional hernia repair code.

Modifier “-59” may not be used with the following codes:

77427	Radiation treatment management, five treatments
99201 - 99499	Evaluation and management services

When a provider submits a claim for any of the codes specified above with the “-59” modifier, the carrier must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.A above, carriers convey the following message on the provider remittance notice:

“The procedure code is inconsistent with the modifier used, or a required modifier is missing.” (ANSI 4)

No additional message should be conveyed on the beneficiary’s MSN.

### **C. Modifier “-91”**

**Definition** - The “-91” modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain subsequent reportable test values.

**Rationale** - Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier “-91” was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a laboratory procedure code indicates a repeat test or procedure on the same day.

**Instruction** - The additional or repeat laboratory procedure(s) or service(s) must be identified by adding the modifier “-91”.

**EXAMPLE 1:** When cytopathology codes are billed, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in the previous CPT code, e.g., 88104-88107, 88160-88162) is to be billed. If multiple services on different specimens are billed, the “-91” modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports.

### **D. Professional Component Modifier**

Modifier 26 is used when reporting the physician component of a service separately. If this modifier is used with a Column II code that is reported with a Column I code, carriers deny the Column II code with the modifier.

### **E. Coding for Noncovered Services and Services Not Reasonable and Necessary**

Effective January 1, 2002, new modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily non-covered or do not meet the definition of a Medicare benefit and

items and services not considered reasonable and necessary by Medicare. The following three codes and one modifier were therefore deemed obsolete and were discontinued.

- A9160 - Non-covered service by podiatrist
- A9170 - Non-covered service by chiropractor
- A9190 - Personal comfort item, (non-covered by Medicare statute)
- GX - Service not covered by Medicare

## 1. Definitions of the GA, GY, and GZ Modifiers

The modifiers are defined below:

- GA - Waiver of liability statement on file.
- GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
- GZ - Item or service expected to be denied as not reasonable and necessary.

## 2. Use of the GA, GY, and GZ Modifiers for Services Billed to Local Carriers

The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. (See <http://www.cms.hhs.gov/medlearn/refabn.asp> for additional information on use of the GA modifier and ABNs.)

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a “not otherwise classified code” (NOC) must be used with either the GY or GZ modifier.

## 3. Use of the GA, GY, and GZ Modifiers for Items and Supplies Billed to DMERCs

The GY modifier must be used when suppliers want to indicate that the item or supply is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they do have on file an ABN signed by the beneficiary.

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe items or supplies, an NOC must be used with either the GY or GZ modifiers.

## 4. Use of the A9270

Effective January 1, 2002, the A9270, Noncovered item or service, under no circumstances will be accepted for services or items billed to local carriers. However, in cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the A9270 must continue to be used by suppliers to bill DMERCs for statutorily non-covered items and items that do not meet the definition of a Medicare benefit.

## 5. Claims Processing Instructions

At carrier and DMERC discretion, claims submitted using the GY modifier may be auto-denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

### ***F. GZ Modifier***

*Effective for dates of service on and after July 1, 2011, contractors shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review. When claim line(s) items submitted with the Modifier GZ are denied, contractors shall use the following codes: Group Code CO (Provider/Supplier liable) and CARC 50 defined "These services are non-covered services because this is not deemed a 'medical necessity' by the payer.*

*Contractors shall use the following MSN message: **MSN Message 8.81***

### ***English***

*If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier.*

### ***Spanish***

*Si el proveedor/suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el proveedor/suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra revisión. Si usted pagó por este servicio y no recibe ninguna información sobre un reembolso en 30 días, comuníquese con su proveedor/suplidor.*