

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

Providers are responsible for submission of accurate claims requests. This reimbursement policy is intended to ensure that you are reimbursed based on the code that correctly describes the procedure performed. This and other reimbursement policies may use CPT, CMS or other coding methodologies from time to time. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.

This information is intended to serve as a resource regarding the reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to enrollees as legislative mandates, the provider contract documents, and the enrollee's benefit coverage documents, may supplement or in some cases supersede this policy. Finally, systems logic or set up may prevent the loading of this policy onto different claims platforms in exactly the same way; however, we strive to minimize these variations.

ACN Group Inc. (OptumHealth Physical Health), may modify this policy from time to time by publishing a new version of the policy on its Website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.

Modifier –GZ Policy	
Type	Reimbursement
Number	0050
Approved by	
Reimbursement and Technology Committee Quality Improvement Committee	
Approval Date	
August 9, 2007 October 11, 2007	
Description	
This policy describes OptumHealth Physical Health methodology and requirements for the reimbursement of services appended by modifier -GZ.	
Audience	
Targeted Population	This policy applies to all Medicare products, all network and non-network health care professionals. This includes non-network authorized and percent of charge contract providers.* <i>*Fee schedule/provider contract/client contract may supersede.</i>
Policy	
Policy Statement	Modifier -GZ: Item or Service Expected to be Denied as Not Reasonable and Necessary

Description: This Level II modifier is typically used in claims submitted for Medicare reimbursement, when an item or service is expected to be denied as not reasonable and necessary, and an ABN was not signed by the enrollee.

Guidelines: The modifier -GZ should be used when a health care provider expects a service or supply to be denied because it does not meet coverage criteria, and advance notice has *not* been provided to the enrollee. The enrollee is *not* responsible for services and supplies that are denied as not meeting benefit coverage criteria, when the Billing Acknowledgement Form has not been documented.

Edit Sources

OptumHealth Physical Health sources its Physical Medicine and Rehabilitation and Chiropractic CPT code payment policy methodology to methodologies used and recognized by third party authorities. The sources used to determine if a CPT code is reimbursable are:

American Medical Association. *Current Procedural Terminology (CPT) Professional Edition*, 2010

Centers for Medicare and Medicaid (CMS) National Coverage Policy and current Centers for Medicare and Medicaid (CMS) Policy Manual(s) <http://www.cms.hhs.gov>

Grider DJ. *Coding With Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*, 2006; AMA Press

Background Summary

A modifier provides the means by which the reporting health care practitioner can indicate that a CPT descriptor code (service or procedure), which has been performed, has been altered by a specific circumstance or in some way *without changing the definition of the CPT code*. Modifiers increase the specificity of certain CPT codes.

CPT code modifiers are comprised of two digits, either numeric (Level I; AMA) or alphabetic (Level II; CMS), and are listed after a procedural code by a hyphen e.g., 98943-51. Modifiers are typically recorded in Section 24 (D) on the CMS-1500 form.

Modifiers have two different applications: (1) to identify circumstances that significantly alter a service or procedures where reimbursement will be affected; and (2) for informational purposes without impact on reimbursement. For the purposes of this policy, the applications of select Level I (AMA) and Level II (CMS) modifiers have been assessed for their impact on reimbursement determinations.

CPT coding modifiers are used to communicate that something is *atypical* about a particular claim. Circumstances where the use of a modifier include, if the service: (a) has been increased or decreased; (b) has both a professional and technical component; (c) only part of the service was performed; (d) an independent or adjunctive procedure was performed; (e) if unusual events occurred; and (f) is expected to be denied as not appropriate and/or necessary.

Definitions

Current Procedural Terminology (CPT) Codes	A set of codes, description and guidelines intended to describe the procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code.
CPT Modifiers	These are two digit (numeric or alphabetic) codes that are appended to CPT codes to properly identify a procedure or service has been altered due to specific circumstances, and the procedure or service was not changed in its definition or code.

References and Resources

References

1. American Medical Association. *Current Procedural Terminology (CPT) Professional Edition, 2010*
2. Centers for Medicare and Medicaid Services (CMS), *Medicare Benefit Policy Manual, Chapter 15* <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>
3. Grider DJ. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*, 2nd edition, 2006; www.ama-assn.org
4. American Chiropractic Association (ACA), Professional Resources, Clinical (Medical) Documentation: The Key to Reimbursement for Chiropractic Claims http://www.amerchiro.org/content_css.cfm?CID=1080
5. 2009 Chiropractic Coding Solutions Manual. American Chiropractic Association; Arlington, VA
6. *ChiroCode DeskBook*, 18th ed., 2010. <http://www.chirocode.com>

History/Updates

Approval Date:	Revision History: 10/9/08, 2/26/09, 4/8/10
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