Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Expect Denials? Use Modifiers -GY and -GZ

Question: What are the -GY and -GZ modifiers, and how should I use them?

Oregon Subscriber

Answer: You should attach modifiers -GY and -GZ to procedure codes Medicare doesn't cover.

Use modifier -GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) when Medicare will deny the claim because either Medicare doesn't cover the service or the claim doesn't meet the carrier's requirements for a particular benefit.

For example, a 41-year-old patient reports for a routine well visit with no symptoms of a problem. Because Medicare excludes well visits from coverage, you should code the visit with the preventive medicine services code for a person of that age (99396, Periodic comprehensive preventive medicine...; 40-64 years) and attach modifier -GY.

You do not need an advance beneficiary notice (ABN) for the claim, because Medicare excludes the service from coverage.

The -GY modifier is not mandatory, but Medicare fast-tracks -GY claims to denial -- and the faster your office receives the denial, the faster you can bill the patient or secondary insurance for the balance.

Use modifier -GZ (Item or service expected to be denied as not reasonable and necessary) when you expect that Medicare will deny a service as medically unnecessary and the office does not have a signed ABN on file.

Example: A female patient reports for an annual breast and pelvic exam, telling the internist it has been 28 months since her last exam. However, records from her previous physician indicate that it has been 22 months since her last exam, and Medicare will only pay for the procedure once every 24 months. Report G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and attach modifier -GZ to show that your office failed to get a signed ABN on file.

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