GZ modifier Payment Policy

Line of Business: McLaren Health Plan Medicaid, McLaren Health Advantage, McLaren Community, McLaren Medicare Advantage

Effective Date: 9/26/2026

This policy applies to claims billed with the GZ modifier. If there is a conflict between this policy and applicable federal or state laws, regulations or regulatory requirements, the applicable laws or regulations will control. Further, if there is a conflict between this policy and a provider contract, the provider contract will govern. Note – coverage may be mandated by MDHHS or CMS.

Providers are required to submit accurate claims and documentation for all services performed.

Providers must submit claims using valid code combinations required by applicable law. Claims should be coded appropriately according to industry standard coding guidelines. All claims are subject to claim edits and may be subject to further reviews by McLaren or contracted third parties. Providers are expected to promptly work with McLaren and any third parties to provide any requested information related to claim submission.

Definitions
Modifier GZ - Item or service expected to be denied as not reasonable and necessary

Modifier Reimbursement Policy
Per CMS the GZ modifier is used when the provider expects denied payment for the item or service because its not medical necessary and was not issued an Advance Beneficiary Notice of Non-Coverage (ABNs). Standard guidelines reflect the usage of modifier GZ as reporting only. To align with these guidelines effective 10/15/2026 claim lines submitted with GZ modifier shall have the charge line denial of non-covered.

Audit:

McLaren or a third party may audit or otherwise review all paid claims to ensure the integrity of the paid claims. This includes, but is not limited to coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews include clinical claim reviews and payment analytics.

Sources:

MSA Bulletin 03-15

https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder19/MSA_03-15.pdf?rev=ae89bc122dd04f8199cdd16a340089d3

MDHHS Provider Manual Pages 21-22 and Page 42 of the Billing & Reimbursement for Professionals Section.

CMS Resources

Medicare Claims Processing Manual Chapter 1 – General Billing Requirements. Page 13.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

Medicare Claims Processing Manual Chapter 23 – Fee Schedule Administration and Coding Requirements

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c23.pdf

Section 20.9.1.1.E Instructions for Codes with Modifiers

MLN Booklet Medicare Advance written Notices of Non-coverage

https://www.cms.gov/files/document/mln006266-medicare-advance-written-notices-non-coverage.pdf