CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1142	**Date: DECEMBER 22, 2006**
	Change Request 5367

Subject: DMERC Claim Modifiers for Upgrades

I. SUMMARY OF CHANGES: DMEPOS providers/suppliers can use claims modifiers when billing for upgrades of DMEPOS items.

New/Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	20/120/DMERCs--Billing Procedures Related to Advanced Beneficiary Notice (ABN) Upgrades
R	20/120/120.1/Providing Upgrades of DMEPOS Without Any Extra Charge

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1142	Date: December 22, 2006	Change Request: 5367

SUBJECT: DMERC Claims Modifiers for Upgrades

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: DMEPOS providers/suppliers shall use claims modifiers when billing for upgrades of DMEPOS items.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5367.1	DME PSCs and DME MACs shall review claims from DMEPOS suppliers/providers.		X			X						DME PSC
5367.2	DME PSCs and DME MACs shall review claims for claims modifiers for upgrades for items of DMEPOS.		X			X						DME PSC
5367.3	When reviewing claims for upgrades, and the upgrade is within a single code, the DME PSCs and DME MACs shall review to see if the upgraded item includes features that exceed the official code descriptor for that item.		X			X						DME PSC
5367.4	When reviewing claims for upgrades DME PSCs and DME MACs shall take into account that the supplier may also be accommodating a physician order for an upgrade.		X			X						DME PSC
5367.5	DME PSCs and DME MACs shall review claims for ABNs with the beneficiary signature that holds the beneficiary liable for the additional expense for upgrades.		X			X						DME PSC
5367.6	DME PSCs and DME MACs shall		X			X						DME PSC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	review claims with ABNs to ensure that the ABN is not being used to substitute a different item or service that is not medically appropriate for the beneficiary's medical condition for the original item or service.											
5367.7	DME PSCs and DME MACs shall review claims to ensure that the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item is being used properly.		X			X						DME PSC
5367.8	DME PSCs and DME MACs shall review claims to ensure that the reasonable and necessary item/service is being associated with the appropriate GA or GZ modifier.		X			X						DME PSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
NA	

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Jesse Polansky, MD, jesse.polansky@cms.hhs.gov, 410-786-1171

Post-Implementation Contact(s):): Jesse Polansky, MD, jesse.polansky@cms.hhs.gov, 410-786-1171

VI. FUNDING

A. ***For TITLE XVIII Contractors*****, use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

120 - DMERCs – Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades

(Rev.1142, Issued: 12-22-06, Effective: 04-01-07, Implementation: 04-02-07)

This section provides the DMERCs billing instructions regarding the use of ABNs *and claims modifiers* for upgrades for items of DMEPOS.

Federal Regulations at 42 CFR 411.408 and Chapter 30 of this manual establishes the basis for a supplier to issue an ABN to a beneficiary. The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives an item, that Medicare will probably not pay for that particular item on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision on whether to accept an item for which he or she may have to pay out of pocket or through supplementary insurance.

Under existing policy, suppliers may collect from a beneficiary a payment amount greater than Medicare's allowed payment amount if the beneficiary, by signing an ABN, agrees to pay extra for a DMEPOS item because the beneficiary prefers an item with features or upgrades that are not medically necessary. This policy applies to both assigned and unassigned claims. When a beneficiary does not sign an ABN, a supplier that accepts assignment cannot hold the beneficiary liable for the cost of medically unnecessary equipment or upgrades unless there is other acceptable evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay for the medically unnecessary equipment or upgrades. With respect to unassigned claims, a signed ABN is necessary to hold the beneficiary liable.

The instructions in this section apply to situations where the ABN is being used for upgrades and applies to both assigned and unassigned claims. An upgrade is an item with features that go beyond what is *medically necessary*. An upgrade may include an excess component. *An excess component may be an item feature or service, which is in addition to, or is more extensive and/or more expensive than the item that is reasonable and necessary under Medicare's coverage requirements*. When a DMEPOS supplier knows or believes that the DMEPOS item does or may not meet Medicare's reasonable and necessary rules under specific circumstances, it is the responsibility of the supplier to notify the beneficiary in writing via an ABN if the supplier wants to collect money from a beneficiary if an item is denied.

When a supplier furnishes an upgraded item of DMEPOS and the supplier expects Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, the supplier *must* give an ABN to the beneficiary for signature for *holding the beneficiary liable for the additional expense*. Optional ABN forms are available at: http://www.cms.gov/medicare/bni/#BNINotices.

A. General Instructions for the Use of ABNs for Upgrading DMEPOS Items

1. An upgrade may be from one item to another within a single Heath Insurance Common Procedure Coding System (HCPCS) code, or may be from one HCPCS code to another. When an upgrade is within a single code *the upgraded item must include features that exceed the official code descriptor for that item.*

2. The upgrade must be within the range of items or services that are medically appropriate for the beneficiary's medical condition and the purpose of the physician's order. ABNs may not be used to substitute a different item or service that is not medically appropriate for the beneficiary's medical condition for the original item or service. The upgraded item must still meet the intended medical purpose of the item the physician ordered.

3. Use of an ABN to furnish an upgraded item or service, with the beneficiary being personally responsible for the difference between the costs of the standard and upgraded item or service, does not change coverage or payment rules, statutory provisions, or manual instructions for the particular benefit involved.

4. In cases where the DMERCs would make payment for the item the physician ordered on a rental basis, the supplier must furnish the upgrade on a rental basis.

5. A supplier furnishing an upgrade and using an ABN must submit a claim and include information on the claim that identifies the upgrade features. Suppliers must submit a claim for upgraded items and services using the GA modifier on the upgraded line item to indicate that the beneficiary signed an ABN. Suppliers must list upgrade features in Item 19 or as an attachment to the claim for paper claims. For electronic claims, suppliers must use the HA0 record prior to implementation of the Health Insurance Portability and Accountability Act (HIPAA) electronic standards. Upon implementation of HIPAA, suppliers must use the NTE segment/line note on the 837 electronic claim format.

6. Denials should be based on medical necessity.

B. Billing Instructions:

Suppliers must bill 2 line items for upgraded DMEPOS items where the beneficiary requests an upgrade. Suppliers must bill both lines on the same claim in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item the supplier actually provided to the beneficiary with the dollar amount of the upgraded item. If the supplier has a properly obtained ABN on file signed by the beneficiary, use the GA modifier. If the supplier did not properly obtain an ABN signed by the beneficiary, use the GZ modifier.

Line 2: Bill the appropriate HCPCS code for the *reasonable and necessary* item with the actual charge *for* the item. Use the GK modifier.

Suppliers should bill their full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the *reasonable and necessary* item (Line 2). If the upgrade is within a code, suppliers still bill 2 line items, using the same code on both lines, but Line 1 would have the higher dollar amount.

Suppliers must bill both lines on the same claim in sequential order. Line 1 and the associated Line 2 should follow each other.

DMERCs must return/reject applicable assigned claims that have invalid ABN upgrade information using appropriate messages. If the claim is unassigned, DMERCs must issue a denial.

C. Definitions of Modifiers that May be Associated with ABNs

GA - Waiver of Liability (expected to be denied as not reasonable and necessary, ABN on file)

GZ - Item or Service not Reasonable and Necessary (expected to be denied as not reasonable and necessary, no ABN on file)

GK - *Reasonable and necessary* item/service associated with GA or GZ modifier

D. Medicare Summary Notice (MSN) and Remittance Advice (RA)

MSN 36.01: Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review. ANSI Code M38

MSN 36.02: It appears that you did not know that we would not pay for this service so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things 1) A copy of this notice, 2) Your provider's bill, and 3) A receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility. (ANSI Code M25)

MSN 8.51: You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.

Use the following messages when denying claims due to invalid ABN upgrade information:

MSN 8.53: This item or service was denied because the upgrade information was invalid.

MRN N108: This item/service was denied because the upgrade information was invalid.

120.1 - Providing Upgrades of DMEPOS Without Any Extra Charge

(Rev.1142, Issued: 12-22-06, Effective: 04-01-07, Implementation: 04-02-07)

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain circumstances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price they would charge for a non-upgraded item. The reason for this may be that a supplier prefers to carry only higher level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products. Also, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines. *The supplier may also be accommodating a physician order for an upgrade.*

Policy

Suppliers are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary that they would charge for a non-upgraded item. This policy allows suppliers to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds what the non-upgraded item that Medicare considers to be medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

Billing Instructions

When a supplier decides to furnish an upgraded DMEPOS item but to charge Medicare and the beneficiary for the non-upgraded item, the supplier must bill for the non-upgraded item rather than the item the supplier actually furnished. The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the following modifier:

GL - Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN

In Item 19 of a paper claim, or as an attachment, the supplier must specify the make and model of the item actually furnished, that is, the upgraded item, and describe why this item is an upgrade. For electronic claims, suppliers must use the HA0 record prior to implementation of the HIPAA electronic standards. Upon implementation of HIPAA, suppliers must use the NTE segment/line note on the 837 electronic claim format.

Contractors are to pay based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage and payment requirements. A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the non-upgraded item but not for the upgraded item.

MSN Message:

For items accompanied with a GL modifier, use:

MSN 8.51:	You are not liable for any additional charge as a result of receiving an upgraded item.