Guidelines For Using The New ABN Process

PROVIDING DMEPOS UPGRADES TO MEDICARE CONSUMERS

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INVACARE®

Yes, you can.™

Dear Provider,

Invacare is pleased to provide you information about the new process that allows you to provide new and expanded equipment and supply options to your Medicare consumers. The information contained in this booklet provides you with the most comprehensive information available on how to provide upgraded items to your Medicare consumers.

The new Advance Beneficiary Notice (ABN) process and federal form offer you a mechanism to provide Medicare consumers with items that more closely meet their lifestyle than the product Medicare covers for the beneficiary. In this instance, the beneficiary only pays out-of-pocket the difference between the upgraded item and the Medicare covered item (as well as the co-payment for the covered item).

Enclosed you will find the following information:

* Guidelines for Using the New ABN Process to Provide DMEPOS Upgrades to Medicare Consumers
* Some Frequently Asked Questions (FAQ)
* The ABN form, CMS-R-131-G.

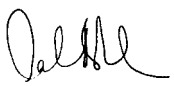
We have developed this information based upon our understanding of the intent of the Centers for Medicare and Medicaid Services (CMS), October 22, 2001 CMS instructions on using the ABN form to provide upgraded items and numerous meetings and discussions with CMS about the ABN process. CMS plans to issue additional written instructions regarding the ABN process to the carriers in January 2002.

Please log on to the Invacare web site — www.invacare.com — to download electronic versions of this material. If you have any questions about the upgrade process, we encourage you to submit questions to us directly at dtwilliams@invacare.com.

Developing these guidelines for using the ABN for consumer choice is somewhat of a privilege. We feel honored to have been given the opportunity to write these instructions and to help make it possible for you to better serve your Medicare clients. The industry will be closely watched to ensure that suppliers appropriately provide beneficiaries with the opportunity to choose to receive upgraded items. Invacare has worked a long time for this privilege, and providers should take great care to make sure that it is used judiciously.

Sincerely,

David T. Williams
Director of Government Relations
Invacare Corporation



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INTRODUCTION

Durable medical equipment suppliers can now offer upgrades to their customers who are Medicare beneficiaries on both assigned and unassigned claims. They can do this using the Advance Beneficiary Notice form and process developed by the Centers for Medicare and Medicaid Services (CMS). This document provides guidelines developed by the authors based on their best interpretation of the ABN process, meetings with CMS officials, a thorough review of the guidelines for using the ABN process for home health services that went into effect in 2000 and a review of draft Carrier Instructions developed by CMS.

Note: Information published in this brochure is not intended to be, nor should it be considered, legal advice. Readers should consult an attorney to discuss specific situations in further detail.

WHAT IS THE NEW ABN FORM?

Advance Beneficiary Notice - or ABN - is a written notice that you, a supplier, give to a Medicare beneficiary before you furnish items and services when you believe that Medicare will not pay for some or all of the items and services. If you expect that Medicare will deny payment in whole or in part for the item and services, you must advise the beneficiary before you furnish the items and services, and the beneficiary will be personally and fully responsible for the amounts that Medicare will not pay. In these cases, the beneficiary may pay "out-of-pocket," through other insurance coverage (e.g., supplemental health plan coverage). As a supplier, you are required to issue the notice using the standard federal form each time, as soon as you determine that Medicare is unlikely to pay. When you properly use an ABN, the ABN protects you from financial liability. When used to provide a beneficiary with an upgraded item, the ABN effectively notifies the beneficiary that Medicare is not likely to pay for the item, and you may bill the beneficiary for the difference between the Medicare covered item and the non-covered item.

If you, as a supplier, fail to provide a beneficiary a proper ABN when one is required, you may be liable for the amount of the items and services unless you can show that you did not and could not reasonably have been expected to know that Medicare would deny payment.

BACKGROUND

On June 25, 2001, the Office of Management and Budget approved a new federal form that all Medicare Part B physicians and suppliers, including durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, must use to inform beneficiaries when Medicare is unlikely to pay for an item or service. The Center for Medicare and Medicaid Services[i] (CMS) developed this form and has tested it extensively with beneficiaries to ensure they can read and understand it. There is one general form for all Part B physicians and suppliers (CMS-R-131-G); laboratories have the option of using a lab-specific form (CMS- R-131-L). On October 22, 2001, CMS issued implementation instructions to the DMERCs on using the ABN form to provide upgrades. CMS expects to issue additional ABN instructions as a new chapter, Section 7310 of the Medicare Carriers Manual, by the end of 2001. Part B suppliers can use the new form to provide upgrades as of January 1, 2002.

USING THE FORM

You can download a copy of the approved form at http://www.hcfa.gov/medicare.bni.htm You cannot modify the approved form except for the two customizable boxes in which you are to insert (1) the description of items or services and (2) the reasons for expected denial. You must use a readable font such as 12-point Arial or Arial Narrow.

AN ACCEPTABLE ABN:

1. Is on the approved form CMS-R131-G;
2. Clearly identifies the item or service; and
3. Gives the reason you believe that Medicare is likely to deny payment for the item.

You should put your company name, address and telephone number at the top of the form; include your logo, if you like. Insert the patient's name and Medicare health insurance claim (HIC) number.

"ITEMS OR SERVICES" BOX

You may insert in this customizable box a description of items which you frequently furnish, with check-off boxes to identify the particular item that may be denied. Otherwise, list the specific products and services that you provided the beneficiary.

REASON FOR PREDICTING DENIAL

Your explanation for predicting likely Medicare denial must be sufficiently detailed to give the beneficiary enough information to make an informed decision about whether or not to receive the service and pay for it personally. CMS has said that simply stating "medically unnecessary" or something similar will not be sufficient. You may insert a list of reasons in the customizable "Because:" box, and use check-off boxes to indicate which reason applies in the particular circumstance.

"ESTIMATED COST" LINE

While CMS does not require you to provide the estimated cost on the form, we strongly suggest that you do so to provide the beneficiary with sufficient information to make an informed decision about whether they wish to receive the item.

THE PATIENT'S RESPONSIBILITY

The beneficiary must read the notice and choose either Option 1 (deciding to receive the items or services and be financially responsible for any amount Medicare does not pay for) or Option 2 (deciding not to receive the items or services); and sign and date the form.

NO ROUTINE NOTICES

You should not give notices routinely to beneficiaries. You should have some genuine doubt that Medicare will not make payment because of the reason you identify in the "Because:" box. Similarly, you must identify specifically the items and services for which you believe Medicare will not pay or will only partially pay for. While giving beneficiaries ABN notice routinely will be considered defective ABNs, there are limited exceptions to this rule:

1. Services which are always denied for medical necessity {e.g.: full electric beds}
2. Certain Frequency Limited Items, where Medicare has an established frequency limitation on coverage. You may routinely give ABNs to beneficiaries in these cases; however, you must accurately state the actual frequency limitation in the "Because:" box {e.g.: when beneficiary has actually reached the frequency limit in question}.

DELIVERY OF ABNs

To effectively deliver an ABN to a beneficiary:

1. You should hand deliver it.
2. If you provide notice by telephone and immediately follow-up with a mailed notice or personal visit during which the written notice is delivered in person, the telephone notice time will be the time of delivery.
3. The beneficiary must be able to understand the ABN. You are responsible for overcoming any hurdles, such as providing the notice in Spanish, Braille, or to an authorized representative if the beneficiary is not competent. If a foreign language or sign language interpreter is used, the interpreter must be independent of the provider.
4. You must notify the beneficiary sufficiently in advance of receiving the item/service so the beneficiary can make a rational, informed consumer decision. Otherwise, carriers may conclude that the beneficiary was coerced into accepting the item.

USING THE ABN FORM TO PROVIDE AN UPGRADED ITEM

The ABN process provides suppliers the opportunity to provide beneficiaries with items that better meet their needs than the base item that Medicare will cover. In general, the beneficiary must agree at the outset to pay the difference between the Medicare covered item and the non-covered item. The ABN form provides written documentation that the beneficiary agrees to be personally financially liable for that amount. In addition, the upgrade process is designed to be used for items that are appropriate for the beneficiary's medical condition and are within the purpose of the physician order. Upgrades may be from one item to another within the HCPCS code, or may be from one code to another. For example, a beneficiary may want a wheelchair that is more lightweight or has more deluxe features than the standard Medicare covered wheelchair. In contrast, the ABN process cannot be used to upgrade from a walker to a wheelchair.

Therefore, suppliers may use the ABN process to provide Medicare beneficiaries with "upgraded" items, and collect from the beneficiary the difference between the Medicare covered item and the upgraded item. While CMS had issued a proposed rule over a year ago to implement the DME upgrade provision, CMS will not issue a final rule and instead has advised us that suppliers should use the new ABN form to provide beneficiaries with upgraded items. In fact, CMS included in its draft carrier instructions an explanation that in the case of upgraded medical equipment, the ABN form must identify the expected partial denial, and must clearly identify in "Items and Services:" box the item with a specific description of the "excess component(s)" for which the supplier expects denial, and must also state in the "Because:" box the reason that the supplier expects Medicare to deny payment for the specified "excess component(s)"[ii].

When a beneficiary selects Option 1 on the ABN, indicating that he or she wants to receive the item/services, use the GA modifier on the 1500 claim form in item 24d, inserting the dollar amount of the upgraded item. The GA modifier indicates that the supplier furnished an ABN and it is on file in the supplier's office. The GA modifier also documents the supplier's expectation that Medicare will either not pay the claim in whole or only partially cover the claim. For claims with dates of service on or after April 1, 2002, you must bill two line items per claim for an upgraded item. On the first line, bill as above. On line two, bill the item that the physician ordered with the GK modifier, with the actual charge or fee schedule amount.

Finally, remember that you should use the ABN process to provide beneficiaries with an upgraded item when the beneficiary desires the upgrade item. You should not engage in any tactics that would be deemed to be coercive. State consumer protection laws will apply to protect beneficiaries from these kind of unscrupulous acts.

EXAMPLES

Following are examples of how suppliers can use the ABN process to provide an upgraded item to a beneficiary. In general, you should follow the rule that you submit a claim to the DMERC for the item actually delivered to the beneficiary.

The GA modifier on the 1500 claim form tells the DMERC that you have a signed ABN form on file in which the beneficiary has acknowledged that Medicare is likely not to pay in whole or in part for the item/services, and you may bill the beneficiary for the amount that Medicare does not pay. For claims dates of service on or after April 1, 2002, suppliers must also identify on the 1500 claim form the standard item with a GK modifier to indicate that it is the actual item ordered by the physician, and the actual charge or fee schedule amount for the standard item.

EXAMPLES

Semi-electric Bed to Full-electric Bed

A beneficiary who meets the medical necessity criteria for a semi-electric bed (E0260, E0261, E0294, E0295) may wish to upgrade to a full-electric bed (E0265, E0266, E0296, E0297) for the caregiver's convenience.

1. Establish that the beneficiary and/or the caregiver desires to pay out-of-pocket the difference between the Medicare fee schedule amount for the covered semi-electric bed and the Medicare fee schedule amount for the full-electric bed.

2. You must insert on the ABN form the expected partial denial, and you must clearly identify in the "Items and Services:" box the item with a specific description of the "excess component(s)" for which you expect denial. You must also state in the "Because:" box the reason that you expect Medicare to deny payment for the specified "excess component(s)."

3. Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the semi-electric bed.

4. If the beneficiary chooses Option 1 on the ABN form, provide the full-electric bed and submit the HCFA-1500 claim form for the full-electric bed, making sure you insert the "GA" modifier in item 24d. (For claims with dates of service on or after April 1, 2002, bill on line 2 the standard item with the GK modifier.)

5. Invoice and collect from the beneficiary the difference and the co-pay on a monthly basis

6. Maintain a paper copy of the original signed ABN form in the event of a DMERC audit.

7. Give a complete and legible copy of the form to the beneficiary.

Ostomy Supplies: Beneficiary Wishes to Purchase Additional Amounts

A beneficiary wishes to pay out-of-pocket for five skin barriers (A4362 Skin barrier; solid, 4 x 4 or equivalent) in addition to the 10 that Medicare will pay for per month.

1. Establish that the beneficiary and/or the caregiver desires to pay out-of-pocket the difference between the Medicare fee schedule amount for the covered 10 skin barriers per month and the non-covered additional five skin barriers.

2. You must insert on the ABN form the expected partial denial, and you must clearly identify in the "Items and Services:" box the item with a specific description of the "excess component(s)" for which you expect denial. You must also state in the "Because:" box the reason that you expect Medicare to deny payment for the specified "excess component(s)."

3. Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the 10 skin barriers (A4362).

4. If the beneficiary chooses Option 1 on the ABN form, provide 15 skin barriers and submit the HCFA-1500 claim form for the 15 skin barriers (A4362), making sure you insert the "GA" modifier in item 24d. (For claims with dates of service on or after April 1, 2002, bill on line 2 the standard item with the GK modifier.)

5. Invoice and collect from the beneficiary the amount for the additional five skin barriers.

6. Maintain a paper copy of the original signed ABN form in the event of a DMERC audit.

7. Give a complete and legible copy of the form to the beneficiary.

i. The Health Care Financing Administration was renamed the Centers for Medicare and Medicaid Services on June 15, 2001.
ii. See draft CMS implementing instructions for ABNs, draft section 7310 of the Medicare Carriers Manual. 7310.5.C

FREQUENTLY ASKED QUESTIONS

WHAT IS AN UPGRADE?

An "upgrade" is when a beneficiary wants to receive a product that is more deluxe, or has more features, or more closely fits his or her lifestyle than the product that Medicare will cover for the beneficiary based upon the beneficiary's medical needs. At the same time, the beneficiary only pays out-of-pocket the difference in cost between the two items. An upgrade may be from one item to another within the HCPCS code, or may be from one code to another. In the absence of this upgrade option, the beneficiary would have to receive the upgraded item on a non-assigned basis, pay up front the entire cost of the upgraded product, and wait for Medicare to reimburse for the base Medicare covered product.

WHAT KINDS OF PRODUCTS DOES THE UPGRADE APPLY TO?

Beneficiaries can upgrade to any product that is generally within (a) the range of items that are medically appropriate for the beneficiary's medical condition and (b) consistent with the purpose of the physician's order. For example, a consumer may want to upgrade from a lightweight wheelchair to an ultra-lightweight wheelchair, from a semi-electric bed to a full-electric bed. In contrast, a beneficiary cannot upgrade from a cane to a wheelchair. The upgrade process applies to all Medicare Part B items and services, including durable medical equipment, prosthetics, orthotics, medical supplies, parenteral and enteral nutrition, and surgical dressings.

WHAT IS AN ADVANCE BENEFICIARY NOTICE?

The ABN – or Advance Beneficiary Notice – is a new federal form that you must use whenever you have reason to believe that Medicare will not pay in full or in part for the item the supplier provides to the beneficiary. The ABN provides written notice to the beneficiary that he or she will be financially liable for the amount that Medicare does not pay. There will be situations that you will have to use the ABN form that are not for upgrades.

HOW DO I GET THE NEW FEDERAL ABN FORM?

You can download the form from the CMS website at http://www.hcfa.gov/medicare/bni.htm. The form is identified by its number: CMS-R-131-G.

WHOSE CHOICE IS IT TO UPGRADE?

It is always the beneficiary who has the option to receive, or not, an upgraded item. Suppliers should not engage in any coercive tactics to "persuade" a beneficiary to choose an upgraded product. Remember, state consumer protection laws apply.

WHAT HAPPENED TO CMS (FORMERLY HCFA) APRIL 2000 PROPOSED REGULATION IMPLEMENTING THE UPGRADE PROVISION IN THE BALANCED BUDGET ACT OF 1997?

The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) issued a proposed regulation in April 2000 implementing the Balanced Budget Act of 1997 upgrade provision. At the same time, however, CMS was developing a new federal ABN form for all Part B physicians and suppliers. Since the objectives of the two processes were the same (informing the beneficiary that Medicare might not pay for certain items based upon the beneficiary's condition), CMS decided to streamline the upgrade process by explicitly allowing suppliers to use the ABN process to provide beneficiaries with an upgrade option.

WHAT IF MOST OF MY MEDICARE CUSTOMERS WANT TO UPGRADE? WILL THE DMERC SCRUTINIZE MY CLAIMS?

While you should not routinely issue ABNs to beneficiaries as a general business practice, if the majority of your Medicare customers want to upgrade to a better item, it is appropriate for you to issue these beneficiaries an ABN to inform them of their potential financial liability. The DMERC will be examining whether the ABNs you issue contain a specific reason why you believe Medicare will not pay (either in whole or in part) for the item you provide the beneficiary. Therefore, if you have a genuine doubt that Medicare will pay for the item, you should issue an ABN to the beneficiary, regardless of how many that turns out to be.

IS THE ABN FORM USED BY OTHER PROVIDERS?

Yes. This ABN form applies to all Medicare Part B physicians and suppliers, including laboratories. Whenever a Part B physician or supplier has reason to believe that Medicare will not pay in full or in part for items or services that a physician has ordered/prescribed, the physician/supplier must use the ABN form to inform the beneficiary before the items/services are provided to the beneficiary. Therefore, this new federal form will become familiar to beneficiaries as they encounter it with various physicians and suppliers.

CAN A PROVIDER CHARGE MORE FOR LIQUID OXYGEN AND BILL THE DIFFERENCE TO A BENEFICIARY WHO SIGNS AN ABN? WHAT ABOUT TRAVELING OXYGEN?

No. Home oxygen therapy is reimbursed on a modality neutral basis. The Medicare allowable amount is the same regardless of modality (liquid, gas cylinder or concentrator). Providers are also required to provide a reasonable supply of oxygen in cylinders to insure the safety of the beneficiary and the continuation of therapy in the event of a power failure and for and to be used when they are away from the base unit.

However, concentrator systems that fill an unlimited number of cylinders for portable use, and pulse-dose conservation devices that extend the life of portable systems constitute functional enhancements of the basic/covered benefit. As such, the additional costs for these devices may be charged to the beneficiary if they have been fully informed of the enhancement and voluntarily sign an ABN.

CAN WE UPGRADE WITHIN HCPCS CODES?

Yes, CMS states in its October 22, 2001 instructions, "An upgrade may be from one item to another within a single HCPCS code, or may be from one code to another."

WHAT ABOUT USING THE UPGRADE PROCESS FOR DUAL ELIGIBLE PATIENTS?

The ABN process applies only to business transactions between Medicare beneficiaries and providers. Patients who are dually eligible for Medicare and Medicaid are not affected by the ABN process.

WHAT ARE SOME EXAMPLES OF THE PROCESS FOR PROVIDING UPGRADES?

a. Semi-electric Bed to Full-electric Bed.

A beneficiary who meets the medical necessity criteria for a semi-electric bed (E0260, E0261, E0294, E0295) may wish to upgrade to a full-electric bed (E0265, E0266, E0296, E0297) for the caregiver's convenience.

1. Establish that the beneficiary and/or the caregiver desires to pay out-of-pocket the difference between the Medicare fee schedule amount for the covered semi-electric bed and the Medicare fee schedule amount for the full-electric bed.
2. You must insert on the ABN form the expected partial denial, and you must clearly identify in the "Items and Services:" box the item with a specific description of the "excess component(s)" for which you expect denial. You must also state in the "Because:" box the reason that you expect Medicare to deny payment for the specified "excess component(s)."
3. Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the semi-electric bed.
4. If the beneficiary chooses Option 1 on the ABN form, provide the full-electric bed and submit the HCFA-1500 claim form for the full-electric bed, making sure you insert the "GA" modifier in item 24d. ▸ insert Ⓐ
5. Invoice and collect from the beneficiary the difference between the monthly rental amount for the Medicare covered item and the upgraded item. (You must bill the beneficiary on a monthly rental basis for capped rental items).
6. Maintain a paper copy of the original signed ABN form in the event of a DMERC audit.
7. Give a clear and legible copy to the beneficiary.

b. A High Strength, Lightweight Wheelchair (K0004) to an Ultra-lightweight Wheelchair (K0005).

This is the one item we have identified in which the upgraded item is in a different payment category than the medically necessary item. In this circumstance, CMS has indicated that if payment for the standard item is on a rental basis, then the supplier must furnish the upgrade on a rental basis.

1. Establish that the beneficiary desires to pay out-of-pocket the purchase price difference between the Medicare fee schedule amount for the covered High Strength, Lightweight Wheelchair (K0004) and the Ultra-lightweight Wheelchair (K0005).
2. You must insert on the ABN form the expected partial denial, and you must clearly identify in the "Items and Services:" box the item with a specific description of the "excess component(s)" for which you expect denial. You must also state in the "Because:" box the reason that you expect Medicare to deny payment for the specified "excess component(s)."
3. Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the high strength lightweight wheelchair (K0004).
4. If the beneficiary chooses Option 1 on the ABN form, provide the ultra-lightweight wheelchair (K0005) and submit the HCFA-1500 claim form for the K0005, making sure you insert the "GA" modifier in item 24d. ▸ insert Ⓐ
5. Invoice and collect from the beneficiary the purchase price difference in the Medicare fee schedule for the K0004 and K0005.
6. Maintain a paper copy of the original signed ABN form in the event of a DMERC audit.
7. Give a clear and legible copy to the beneficiary.

Ⓐ▸ For claims with dates of service on or after April 1, 2002, bill on line 2 the standard item with the GK modifier.

c. Ostomy Supplies: Beneficiary Wishes to Purchase Additional Amounts

A beneficiary wishes to pay out-of-pocket for five skin barriers (A4362 Skin barrier; solid, 4 x 4 or equivalent) in addition to the 10 that Medicare will pay for per month.

1. Establish that the beneficiary and/or the caregiver desires to pay out-of-pocket the difference between the Medicare fee schedule amount for the covered 10 skin barriers per month and the non-covered additional five skin barriers.

2. You must insert on the ABN form the expected partial denial, and you must clearly identify in the "Items and Services:" box the item with a specific description of the "excess component(s)" for which you expect denial. You must also state in the "Because:" box the reason that you expect Medicare to deny payment for the specified "excess component(s)."

3. Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the 10 skin barriers (A4362).

4. If the beneficiary chooses Option 1 on the ABN form, provide 15 skin barriers and submit the HCFA-1500 claim form for the 15 skin barriers (A4362), making sure you insert the "GA" modifier in item 24d.
   ▸ insert Ⓐ

5. Invoice and collect from the beneficiary the amount for the additional five skin barriers.

6. Maintain a paper copy of the original signed ABN form in the event of a DMERC audit.

7. Give a clear and legible copy to the beneficiary.

ARE THESE GUIDELINES GOING TO CHANGE WHEN CMS PUBLISHES FURTHER ABN INSTRUCTIONS IN JANUARY 2002?

CMS' ABN instructions will likely contain additional and consistent information on using the ABN form. In any event, CMS staff has remained constant and clear on these points:

- A properly executed Advance Beneficiary Notice associated with a reasonable effort by the provider to serve their customer shall not in itself expose the provider to any legal challenges.

- A provider should use the ABN process when supplying a product or service for which they have a reasonable expectation of non-coverage or partial coverage if they wish to exercise their right to bill the beneficiary for any uncovered balance.

- A Medicare beneficiary has a right to request deluxe (or more functional) equipment, supplies or services than that which is prescribed by their physician and/or that which is normally considered medically necessary under existing Medicare coverage guidelines and payment policies.

NOTE: Invacare will be maintaining an ongoing list of Frequently Asked Questions (FAQ) on upgrades, which will be featured on the Washington Update page of its website, www.invacare.com. If you have a question on the use of patient-directed upgrades, please e-mail them to the following address: dtwilliams@invacare.com. (No phone calls, please.) The questions will be researched and answers will be posted in this feature within 72 hours. This will also be the place to look for clarifying information from CMS and/or the DMERC on the ABN/Upgrade process. Providers are encouraged to check Invacare's website regularly.

NOTE: These FAQ have been developed by the authors based on their understanding of the intent of the Centers for Medicare Services, conversations with CMS staff and a review of instructions developed by CMS for the use of Advance Beneficiary Notices in the Medicare Part A program for home health services that were effective in 2000. The authors also reviewed the October 22, 2001, Implementation Instructions, and a preliminary draft of additional Carrier Instructions prepared by CMS staff.

Ⓐ On the 1500 form, suppliers must also identify the standard item, with a different (yet to be identified) modifier to indicate that it is the actual item ordered by the physician, and the fee schedule amount for the standard item.

***(A)* Notifier(s):**

***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)***_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)***_____ below.

(D) _____	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)***_____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D)***_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)***_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the ***(D)***_____listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

April 2007

DME Upgrades, ABNs and Claims Modifiers

GK and GL modifiers are used on claims for upgraded DMEPOS items. An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it.

Use of the GK and GL modifiers allows the DME MAC to automate the downcoding at the time of the initial determination. The advantage to suppliers is that they will not receive a total denial at the time of initial determination. Therefore the claim will not have to be sent through the appeals process in order to be paid comparable to the least costly alternative. Some examples (not all-inclusive) of situations in which this would be used are downcoding between different types of power wheelchairs, different types of hospital beds, different type of prosthetic components, or from a bi-level positive airway pressure device to a CPAP.

The GK and GL modifiers are used and the following instructions apply **only** when suppliers provide an upgrade – i.e., an item that goes beyond what is covered by Medicare.

The descriptions of the modifiers are:

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

GL Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If the beneficiary does not meet the coverage criteria specified in the medical policy for the item that is provided but does meet the criteria for a different type device, the GK or GL modifier must be used. Suppliers decide which modifier to use depending on whether or not they want to collect the difference between the submitted charge for the upgraded item and the submitted charge for the item that meets coverage criteria from the beneficiary.

Supplier Collects Additional Charge for Upgrade – GK/GA Modifiers

IntegriGuard
Getting results. Making a difference.
Medical Review Subcontractor to EDS
2301 North 117 Avenue, Suite 200, Omaha, NE 68164
Phone: 402.498.2319 Fax: 402.498.2306
www.edssafeguardservices.eds-gov.com

If a supplier wants to collect the difference from the beneficiary, a properly completed ABN must be obtained. If an ABN is obtained, the supplier bills the HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GA modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. (**Note: The codes must be billed in this specific order on the claim.)** In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing.

Supplier Provides Upgrade without Additional Charge – GL Modifier or GK/GZ Modifiers

If a supplier wants to provide the upgrade without any additional charge to the beneficiary, then no ABN is obtained. In this situation, there are two options for claim submission:

1. If the physician has ordered the upgrade or if the upgrade is provided without additional charge for supplier convenience, the supplier only bills the HCPCS code for the item that meets coverage criteria with a GL modifier. The HCPCS code for the item that is provided is **not** billed. The code with the GL modifier will continue through the usual claims processing.

2. If the physician has not ordered the upgrade but it is provided at the request of the beneficiary, the supplier bills the HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GZ modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. (**Note: The codes must be billed in this specific order on the claim.)** In this situation, the claim line with the GZ modifier will be denied as not medically necessary with a "contractual obligation" (CO) message and the claim line with the GK modifier will continue through the usual claims processing.

KX Modifier

If there is a requirement in a specific policy to use a KX modifier to indicate that an item meets coverage criteria, then it is used in addition to the GK or GL modifier. For example:

- If a power wheelchair that does not meet coverage criteria specified in the policy is provided and an ABN is obtained, the supplier bills the HCPCS code for the PWC that is provided with a GA modifier and no KX modifier on one claim line and the HCPCS code for the PWC that meets coverage criteria with a GK modifier and a KX modifier on the next claim line.

- If a supplier does not obtain an ABN and therefore provides an upgrade without any additional charge to the beneficiary, the supplier either (1) bills the HCPCS code for the item that meets coverage criteria with the GL modifier and a KX modifier or (2)

bills the HCPCS code for the PWC that is provided with a GZ modifier and no KX modifier on one claim line and the HCPCS code for the PWC that meets coverage criteria with a GK modifier and a KX modifier on the next claim line. The specific situations in which the GZ/GK combination is used instead of the GL are discussed above .

Orders and the EY Modifier

In order to use the GK or GL modifier, the supplier must have a physician order for one of the items. An order for either the covered or upgraded item is acceptable.

If the GK or GL modifier is used as specified in these instructions, the EY should not be used – i.e., it is not used on the GA, GK, or GL claim line. This is an exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

The supplier may not use the GK or GL modifiers if there is no physician order for either the upgraded item or the item that otherwise meets coverage criteria. In this situation, the HCPCS code for the item that is provided must be billed with an EY modifier and the claim line will be denied.

The supplier may not use the GK or GL modifiers if there is a physician order for the upgraded item but the supplier provides an item that meets coverage criteria. In this situation, the HCPCS code for the item that is provided is billed but the EY modifier should not be used. This is another exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

Other Requirements/Instructions

In order to use the GK or GL modifiers, the upgraded item must be within the range of items that are medically appropriate for the beneficiary's medical condition and the purpose of the physician's order. For example, there could be an upgrade between two different types of wheelchairs but the upgrade modifiers would not be used if a walker met a patient's mobility needs but the beneficiary chose to obtain a wheelchair.

When using the GK or GL modifier, the supplier must specify the manufacturer and model name/number of the item that is actually furnished – i.e., the upgraded item – and describe why this item is an upgrade. This information must be included in the narrative field of the electronic claim.

Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be paid at a less costly alternative or to be denied. However, if no other edits are involved, payment would be made for the code with the GK or GL modifier.

An upgrade may be from one HCPCS code to another code or it may be from one item to another item within a single HCPCS code. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.

Refer to the CMS Internet-Only Claims Processing Manual, Publication 100-04, Chapter 20, Sections 120 and 120.1 for additional billing information.

These instructions are effective for claims with dates of service on or after April 1, 2007.

DME Upgrades
ABN and Claims Modifiers

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare coverage requirements.

	ABN Required	Required Modifier(s)	DMAC Payment	Beneficiary Pays for Upgrade
1) Physician orders upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
2) Patient requests upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GZ/GK	R&N item only (GK line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
3) Supplier provides upgrade for supplier convenience:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No

GK or GL is added to HCPCS code for item that meets Medicare coverage requirements.
When GK is used, GA or GZ is added to HCPCS code for item that is provided.
R&N = Reasonable and necessary

For additional information, refer to CMS Internet-Only Claims Processing Manual, Publication 100-04, Chapter 20, Sections 120 and 120.1