Program Memorandum Carriers

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1893

SUBJECT: DMERCs - Advance Beneficiary Notices (ABNs) for "Upgrades"

Background and Policy

This Program Memorandum (PM) advises DMERCs on ABNs for billing instructions regarding **beneficiary requested** upgrades of items of DMEPOS. Federal regulations at 42 CFR 411.408, and the Medicare Carriers Manual (MCM) §7300.5.A., establishes the basis for a supplier to issue an ABN to a Medicare beneficiary. The purpose of the ABN is to inform a Medicare beneficiary, before he/she receives an item, that Medicare probably will not pay for the item on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether to accept the item for which he or she may have to pay out of pocket or through other insurance.

For purposes of this PM, the ABN is used for upgrades and applies to both assigned and unassigned claims. An upgrade is an item with features that go beyond what the physician ordered. An upgrade may include an excess component. An excess component may be an item feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature or service, which is in addition to, or is more extensive and/or more expensive than, the item or service ordered by the physician, and which is reasonable and necessary under Medicare's coverage requirements. When the supplier knows or believes that the item of DMEPOS supplied does not or may not meet Medicare's reasonable and necessary rules under the specific circumstances, it is the responsibility of the supplier to notify the beneficiary in writing through the use of the ABN, if the supplier wants to collect from a beneficiary should the item be denied.

When an upgraded item of DMEPOS has been furnished 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, an ABN may be given to the beneficiary and the signature of the beneficiary obtained for such a purpose. Optional ABN forms are available at: www.hcfa.gov/medicare/bni.htm.

NOTE: This PM does not address the issue of a physician ordering an upgrade. When a physician orders an upgrade, follow your current operating procedures and appropriate medical review.

General Instructions for the Use of the ABN for Upgrading DMEPOS Items

1. An upgrade may be from one item to another within a single HCPCS code, or may be from one code to another. When an upgrade is within a single code, the upgrade is from the item or service which the beneficiary may be furnished as medically necessary, within the range of items or services included in that code, to the more costly item or service which the beneficiary wishes to have furnished.

2. An upgrade must be within the range of items or services which are medically appropriate for the beneficiary's medical condition and the purpose of the attending physician's order. ABNs may not be used for substitution of a different item or service that is not medically appropriate for the beneficiary's medical condition for the originally ordered item/service that would have been medically appropriate for the beneficiary's medical condition. The upgraded item must still meet the intended and medical necessity purpose of the physician ordered item.

3. Using an ABN to furnish an upgraded item or service to a beneficiary, with the beneficiary being personally responsible for payment for the difference between the costs for the standard and the upgraded item/services, does not change the coverage or payment statutory provisions, rules, and instructions for the particular benefit involved; they continue to apply as if the standard item or service had been provided. (See MCM §5l02.)

4. In a case where payment would be made for the standard item or service 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. Physicians and suppliers must submit a claim for upgraded items and services using the GA modifier with the upgrade line item to indicate than an ABN signed by the beneficiary is on file, or a GZ modifier to indicate that an ABN was not signed by the beneficiary. Upgrade features must be listed in Item 19 (or as an attachment to the claim) on Form HCFA-1500 and the HAO record on the electronic claim. Once HIPAA is implemented, the NTE segment/line note should be used on the 837/40l0.

6. Denials should be medical necessity denials.

Billing Instructions – Prior to April 2002

Currently, DMERCs accept a claim with an ABN on one claim line with the GA modifier. When you review these claims, make appropriate medical review determinations in accordance with current claims processing procedures.

Billing Instructions for Dates of Service on or After April 1, 2002

Educate suppliers to bill 2 line items per claim for an upgraded item when the **beneficiary** requests an upgraded item. Both lines must be billed on the same claim.

Line 1 Bill appropriate HCPCS code for the item provided to the beneficiary with the GA or GZ modifier; with dollar amount of the upgraded item. If an upgrade was provided and an ABN is on file, the supplier must bill for the DMEPOS item provided with a GA modifier. If an upgrade was provided and there is no ABN on file, the supplier must bill for the DMEPOS item provided with the GZ modifier.

Line 2 Bill the appropriate HCPCS code for the item that was **ordered by the physician** with modifier GK with the actual charge or fee schedule amount. When upgrades are involved, the supplier must bill a second line on the same claim with the HCPCS code for the DMEPOS item ordered by the physician and 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 physician ordered/covered item (Line 2). If the upgrade is "within a code," suppliers would still bill 2 line items – use the same code on both lines, but Line 1 would have the higher dollar amount. Both lines must be billed on the same claim.

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

Systems Changes May Include:

- System to accept new GK modifier;

- The GK modifier cannot be billed alone. If GK is billed without a GA or GZ modifier on the same claim, reject the claim. There must be 2 line items on the same claim when a supplier uses the GK modifier;

- System to automatically put "N" in WOL field if claim edits for Waiver of Liability and modifier is GZ;

- When an ABN is obtained, do not count line 1 (with GA or GZ modifier) in total as medical review savings. Only the difference between line 1 and line 2 should be counted as medical review savings;

- When an ABN is obtained, do not count line 1 (with GA or GZ modifier) in total submitted charge. Only count the difference between line 1 and line 2 in the total;

- Duplicate Edit revision;

- Automated CMN duplicate revision; and

- Edits may be established to review claims containing the GA or GZ modifiers. System may deny Line 1 with the GA and GZ modifier because it is not what the physician ordered.

These claims should go through your normal medical review and post-payment reviews.

Definitions of the Modifiers That May Be Associated With The 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 – Actual item/service ordered by physician, item associated with GA or GZ modifier.

Medicare Summary Notices (MSN) and Remittance Advice (RA)

When denying claims containing the GZ modifier, use the appropriate MSN message and remittance advice (RA) to explain that the beneficiary is not liable and the provider is liable. When denying claims with the GA modifier, use the appropriate MSN message and RA to explain that the beneficiary is liable.

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 sould 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.

Provider Education

Suppliers should be educated through regular training sessions, provider bulletins, and web sites on the contents of this PM.

The *effective date for the Policy Change* is January 1, 2002.
The *effective date for Systems Changes* for this Program Memorandum PM is April 1, 2002.

The *implementation date for the Policy Change* is January 1, 2002.
The *implementation date for Systems Changes* for this PM is April 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions, please contact the appropriate Regional Office.