



Supplier Education on Use of Upgrades for Multi-Function Ventilators

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Note: We revised this article to show that the policy on use of multi-function ventilators, as discussed in the “What You Need to Know” section, is a permanent change.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for ventilators, including multi-function ventilators, provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Medicare’s multi-function ventilator policy applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (namely, oxygen concentrator, cough stimulator, suction pump, and nebulizer). HCPCS code E0467 is used to describe multi-function ventilators. **Starting in April 2020, the Centers for Medicare & Medicaid Services (CMS) permanently suspended claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.**

This article also informs DME suppliers that effective immediately, you may provide and bill for multi-function ventilators described by code E0467 as an upgrade in situations where beneficiaries only meet the coverage criteria for a ventilator.

BACKGROUND

Billing instructions for suppliers are in [Chapter 20](#) and [Chapter 30](#) of the Medicare Claims Processing Manual (100-04). Key provisions of those instructions follow:

An upgrade is an item that goes beyond what is medically necessary under Medicare’s requirements. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the Local Coverage Determination (LCD), the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL. 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 a supplier wants to collect from the beneficiary for the upgraded item provided, you must obtain a properly completed Advance Beneficiary Notice (ABN). If you obtain an ABN, on one claim line you bill with a GA modifier the HCPCS code that describes the item that was provided, in this case E0467. On the next claim line, you bill with a GK modifier the HCPCS code, in this case E0465 or E0466 that describes the item that is covered based on the LCD. **(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. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line.

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary or if a physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, then no ABN is obtained. In these instances, the supplier bills with a GL modifier the HCPCS code (in this case E0465 or E0466) that describes the item that is covered based on the LCD. Also, the supplier does not bill the HCPCS code that describes the item that was provided.

If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge, no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code (in this case E0467) that describes the item that was provided. On the next claim line, the supplier bills with a GK modifier the HCPCS code (in this case E0465 or E0466) that describes the item that is covered based on the LCD. **(Note: The codes must be billed in this specific order on the claim).**

Chapter 30, Section 50.4.2 of the Medicare Claims Processing Manual requires you to obtain an ABN (where the ABN is needed) from a Fee-For-Service Medicare beneficiary or his/her representative before providing him/her with a Medicare covered item or service that may not be covered in this particular instance if you intend to collect from the beneficiary. Recipients of ABNs include beneficiaries who have Medicaid coverage in addition to Medicare (that is, dual-eligible).

The following table summarizes the billing requirements:

Requirement	Upgrade not used	Supplier provides upgrade and expects no additional payment	Supplier provides upgrade and wants beneficiary payment	Beneficiary Requests Upgrade and Supplier expects no additional payment
ABN required	N/A	NO	YES	NO
Modifier + HCPCS Codes required		GL Modifier with HCPCS E0465 or E0466 Do not use the HCPCS for upgrade item	In the following order: GA Modifier with HCPCS E0467 Next Claim line GK Modifier with HCPCS E0465 or E0466	In the following order: GZ Modifier with HCPCS E0467 Next Claim line GK Modifier with HCPCS E0465 or E0466

Remember that you will likely have financial liability for items or services if you knew or should have known that Medicare would not pay and you fail to obtain an ABN when required. In these cases, you may not collect funds from the beneficiary and you must make prompt refunds if funds were previously collected.

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 GL modifier.

ADDITIONAL INFORMATION

The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for completion are available at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
May 29, 2020	We revised this article to show that the policy on use of multi-function ventilators, as discussed in the "What You Need to Know" section, is a permanent change.
April 3, 2020	Initial article released.

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