Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUESTS 1893, 1894, and 2084

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter III	3-1 – 3-1.1 (2 pp.)	3-1 – 3-1.1 (2 pp.)
3012 – 3012.1 (Cont.)	3-16.11 – 3-16.15 (5 pp.)	3-16.11 (1 p.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 18, 2003*
IMPLEMENTATION DATE: July 18, 2003

Section 3012, Durable Medical Equipment Regional Carriers (DMERCS) - Billing Procedures Related to Advanced Beneficiary Notice (ABN) Upgrades, is being added to manualize Program Memoranda (PMs) B-01-64, (Change Request 1893) B-01-68, and B-02-029 (Change Request 2084).

Section 3012.1, Providing Upgrades of DMEPOS Without Any Extra Charge, is being added to manualize PM B-01-68 (Change Request 1894).

These PMs provided operational instructions regarding the use of ABNs for upgrades to item of durable medical equipment, prosthetics, orthotics, and supplies.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER III
CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

Section

Electronic Media Claims

Special Optional Requirements for Immunosuppressive Drugs:

Inpatient facilities (e.g., hospitals) are responsible for providing all drugs a beneficiary needs while the beneficiary is an inpatient in the facility.

The DMERCs make payment for immunosuppressive drugs for beneficiaries who receive a covered organ transplant and who meet all other Medicare coverage criteria for immunosuppressive drugs once the patient has returned to their home. Suppliers are required to obtain a properly completed DMERC Information Form (DIF) prior to submission of claims for immunosuppressive drugs for use in the home.

It is reasonable to expect that a pharmacy, knowing the patient is going to be discharged, may want to obtain a DIF for the patient up to 2 days prior the date the patient will be discharged. Similarly, the supplier may operate by mail-order, and may wish to put the drugs in the mail 2 days prior to the date a patient will be discharged, so that the drugs will be at the patient's home when they return.

Under normal circumstances, the date of service listed on the claim must be the date the supplier actually delivered or mailed the item. However, under the circumstance described above, the systems will, appropriately, reject the claim with a date of service listed as being prior to the patient's date of discharge, because the hospital remains responsible for the provision of immunosuppressive drugs while the beneficiary is still an inpatient.

Therefore, in this situation, the pharmacy may enter the date of discharge as both the initial date on the DIF form and as the date of service on the first claim it submits for the beneficiary after the beneficiary is discharged. Note that this is an optional, not mandatory, process. If the pharmacy does not want to obtain the DIF or dispense the immunosuppressive drugs prior to the beneficiary's date of discharge from the hospital, they may wait for the beneficiary to be discharged before doing so, and follow all applicable Medicare and DMERC rules for immunosuppressive drug billing (e.g., the date of service will be the date of delivery).

Note that the following conditions apply:

1) The facility remains responsible for all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay. The pharmacy must not receive separate payment for immunosuppressive drugs prior to the date the beneficiary is discharged.

2) The pharmacy must not obtain the DIF or mail or otherwise dispense the drugs any earlier than 2 days before the patient is discharged. It is the pharmacy's responsibility to confirm the patient's discharge date if they choose to take advantage of this option.

3) The pharmacy must not submit a claim for payment prior to the beneficiary's date of discharge.

4) The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient hospital or skilled nursing facility) that does not qualify as the beneficiary's home.

3012. DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCS) - BILLING PROCEDURES RELATED TO ADVANCED BENEFICIARY NOTICE (ABN) UPGRADES

This section provides the DMERCs billing instructions regarding the use of ABNs for **beneficiary requested** upgrades for items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

Federal Regulations at 42 CFR 411.408 and the Medicare Carriers Manual (MCM) §7300.5.A establish 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 the physician ordered. 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 or service the physician ordered, and which 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 may give an ABN to the beneficiary for signature for such a purpose. Optional ABN forms are available at: http://www.cms.gov/medicare/bni/#BNINotices.

NOTE: The policies and billing procedures in this section do not apply to physician ordered upgrades. When a physician orders an upgrade, DMERCs must follow their current operating and medical review procedures.

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 upgrade is from the item or service which the beneficiary may be furnished as medically necessary, within the range of items or services that code includes, to the more costly item or service which the beneficiary wishes to receive.

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 that the physician originally ordered. 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. DMERCs must continue to apply such rules as if the supplier had provided the item or service the physician ordered.

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.

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 **item that the physician ordered** with the actual charge of fee schedule amount of 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 physician ordered 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.

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-Actual item/service ordered by physician, item associated with GA or GZ modifier

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.

3012.1 Providing Upgrades of DMEPOS Without Any Extra Charge.--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.

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 only include 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.