Program Memorandum Carriers

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

Transmittal B-01-68 **Date: OCTOBER 31, 2001**

CHANGE REQUEST 1894

SUBJECT: Providing Upgrades of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Without Any Extra Charge

Background

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 Advance Beneficiary Notice (ABN), agrees to pay extra for a DMEPOS item because the beneficiary prefers a DMEPOS 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.

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain instances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price as 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 as 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 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 payment amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

Billing Instructions for January 1, 2002

When a supplier decides to furnish an upgraded DMEPOS item but to bill Medicare and the beneficiary for a non-upgraded item, the supplier should bill for the non-upgraded item and not the upgraded item. No modifier should be used to indicate that an upgraded item was furnished in place of the non-upgraded item. However, the upgraded item should be described in Item 19 (or as an attachment to the claim) on Form HCFA-1500 and the HAO record on the electronic claim. You should process the claim for the non-upgraded item as if the beneficiary actually received the non-upgraded item. A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the non-upgraded item. These billing instructions will be implemented effective January 1, 2002, and be replaced with new billing instructions effective April 1, 2002.

Billing Instructions for April 1, 2002

When a supplier decides to furnish an upgraded DMEPOS item but to bill Medicare and the beneficiary for a non-upgraded item, the supplier should bill for the non-upgraded item rather than for the item actually furnished. The claim should only include the charge for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by modifier GL – Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN.

In Item 19 of the 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.

Contractors are to pay based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage 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.

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

For items accompanied with a GL modifier, use MSN message 8.51- You are not liable for any additional charge as a result of receiving an upgraded item.

Separate Instructions for when there is an Extra Charge for an Upgrade

A separate PM will be issued to provide instructions on the use of ABNs when a supplier decides to hold the beneficiary responsible for paying for the difference between the cost of a non-upgraded item and the cost of a medically unnecessary upgrade.

The effective date for the policy is January 1, 2002.

The implementation date for systems changes 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, contact Hillory Wiggin at 410-786-4484.