Medicare Filing Requirements for **Upgrades with Modifiers**

Filing requirements as discussed below for **Upgrades with Modifiers,** only apply to **ASSIGNED** claims. If an item is not approved for upgrade, such as L8000/Bras, the item is filed **UNASSIGNED.** The member pays for the item upfront, the claim is filed UNASSIGNED, for the full amount charged. No modifiers are required and the member is reimbursed directly by Medicare and her supplemental or secondary insurance.

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.

Upgrades that do not meet the coverage criteria in the applicable Local Coverage Determination (LCD) will not be paid in full (eg: L8031 and L8035 are upgrades for the L8030 but they will not be paid in full; they will be paid at the L8030 rate.) The supplier can still obtain partial payment (in this example the L8030 rate will be paid) 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 Advance Beneficiary Notice of Noncoverage (ABN)

If a supplier wants to collect from the beneficiary for the upgraded item provided, a properly completed ABN must be obtained. When an ABN is obtained, claim line one is billed with a GA modifier and the HCPCS code that describes the item that was **provided**. The next claim line is billed with the GK modifier and the HCPCS code 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. **The supplier may charge their "usual and customary" fee for the upgraded item that is provided.**

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary, then no ABN needs to be obtained. When the supplier decides to provide the upgraded item at no 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, the supplier bills with a GL modifier and the HCPCS code that describes the item that is **covered** based on the LCD. In this situation, 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 needs to be obtained. On the first claim line, the supplier bills with a GZ modifier and the HCPCS code that describes the item that was **provided**. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is **covered** based on the LCD. **(Note: The codes must be billed in this specific order on the claim.)**

Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits for Medicare purposes. Some modifiers cause automated pricing changes, while others are used to convey information only. They are not required on all HCPCS codes; however, if required and not submitted, the claim will deny as unprocessable.

Most DMEPOS fall into the following categories: Capped Rental, Frequent and Substantial Servicing DME, Inexpensive or Routinely Purchased DME, Oxygen and Oxygen Equipment, Prosthetics and Orthotics and Customized DMEPOS.

Modifier	Brief Description
GA	Waiver of Liability (ABN) statement on file
GK	Actual item/service ordered by physician, item associated with GA or GZ modifier
GZ	Item or service expected to be denied as not reasonable or necessary (items submitted with GZ are automatically denied and not subject to complex medical review)

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