Downcoding – Use of GK and GL Modifiers on Claims for Upgrades

GK and GL modifiers are used on claims for upgraded DMEPOS items. 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.

Use of the GK and GL modifiers allows the DME MAC to automate the downcoding at the time of the initial determination. The advantage to suppliers is that they will not receive a total denial at the time of initial determination. Therefore the claim will not have to be sent through the appeals process in order to be paid comparable to the least costly alternative. Some examples (not all-inclusive) of situations in which this would be used are downcoding between different types of power wheelchairs, different types of hospital beds, different type of prosthetic components, or from a bi-level positive airway pressure device to a CPAP.

The GK and GL modifiers are used and the following instructions apply only when suppliers provide an upgrade – i.e., an item that goes beyond what is covered by Medicare.

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 the beneficiary does not meet the coverage criteria specified in the medical policy for the item that is provided but does meet the criteria for a different type device, the GK or GL modifier must be used. Suppliers decide which modifier to use depending on whether or not they want to collect the difference between the submitted charge for the upgraded item and the submitted charge for the item that meets coverage criteria from the beneficiary.

**Supplier Collects Additional Charge for Upgrade – GK/GA Modifiers**

If a supplier wants to collect the difference from the beneficiary, a properly completed ABN must be obtained. If an ABN is obtained, the supplier bills the HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GA modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. **(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.

Supplier Provides Upgrade without Additional Charge – GL Modifier or GK/GZ
Modifiers

If a supplier wants to provide the upgrade without any additional charge to the
beneficiary, then no ABN is obtained. In this situation, there are two options for claim
submission:

1. If the physician has ordered the upgrade or if the upgrade is provided without
additional charge for supplier convenience, the supplier only bills the HCPCS code
for the item that meets coverage criteria with a GL modifier. The HCPCS code for
the item that is provided is not billed. The code with the GL modifier will continue
through the usual claims processing.

2. If the physician has not ordered the upgrade but it is provided at the request of the
beneficiary, the supplier bills the HCPCS code for the item that is provided (but that
does not meet coverage criteria) with a GZ modifier on one claim line and the
HCPCS code for the item that meets coverage criteria with a GK modifier on the next
claim line. (Note: The codes must be billed in this specific order on the claim.) In
this situation, the claim line with the GZ modifier will be denied as not medically
necessary with a “contractual obligation” (CO) message and the claim line with the
GK modifier will continue through the usual claims processing.

KX Modifier

If there is a requirement in a specific policy to use a KX modifier to indicate that an item
meets coverage criteria, then it is used in addition to the GK or GL modifier. For
example:

- If a power wheelchair that does not meet coverage criteria specified in the policy is
  provided and an ABN is obtained, the supplier bills the HCPCS code for the PWC
  that is provided with a GA modifier and no KX modifier on one claim line and the
  HCPCS code for the PWC that meets coverage criteria with a GK modifier and a KX
  modifier on the next claim line.
- If a supplier does not obtain an ABN and therefore provides an upgrade without any
  additional charge to the beneficiary, the supplier either (1) bills the HCPCS code for
  the item that meets coverage criteria with the GL modifier and a KX modifier or (2)
  bills the HCPCS code for the PWC that is provided with a GZ modifier and no KX
  modifier on one claim line and the HCPCS code for the PWC that meets coverage
  criteria with a GK modifier and a KX modifier on the next claim line. The specific
  situations in which the GZ/GK combination is used instead of the GL are discussed
  above.

Orders and the EY Modifier

In order to use the GK or GL modifier, the supplier must have a physician order for one
of the items. An order for either the covered or upgraded item is acceptable.
If the GK or GL modifier is used as specified in these instructions, the EY should not be used – i.e., it is not used on the GA, GK, or GL claim line. This is an exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

The supplier may not use the GK or GL modifiers if there is no physician order for either the upgraded item or the item that otherwise meets coverage criteria. In this situation, the HCPCS code for the item that is provided must be billed with an EY modifier and the claim line will be denied.

The supplier may not use the GK or GL modifiers if there is a physician order for the upgraded item but the supplier provides an item that meets coverage criteria. In this situation, the HCPCS code for the item that is provided is billed but the EY modifier should not be used. This is another exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

**Other Requirements/Instructions**

In order to use the GK or GL modifiers, the upgraded item must be within the range of items that are medically appropriate for the beneficiary’s medical condition and the purpose of the physician’s order. For example, there could be an upgrade between two different types of wheelchairs but the upgrade modifiers would not be used if a walker met a patient’s mobility needs but the beneficiary chose to obtain a wheelchair.

When using the GK or GL modifier, the supplier must specify the manufacturer and model name/number of the item that is actually furnished – i.e., the upgraded item – and describe why this item is an upgrade. This information must be included in the narrative field of the electronic claim.

Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be paid at a less costly alternative or to be denied. However, if no other edits are involved, payment would be made for the code with the GK or GL modifier.

An upgrade may be from one HCPCS code to another code or it may be from one item to another item within a single HCPCS code. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.

Refer to the CMS Internet-Only Claims Processing Manual, Publication 100-04, Chapter 20, Sections 120 and 120.1 for additional billing information.

These instructions are effective for claims with dates of service on or after April 1, 2007.
DME Upgrades
ABN and Claims Modifiers

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare coverage requirements.

<table>
<thead>
<tr>
<th></th>
<th>ABN Required</th>
<th>Required Modifier(s)</th>
<th>DMAC Payment</th>
<th>Beneficiary Pays for Upgrade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Physician orders upgrade:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Supplier provides upgrade free of charge to beneficiary</td>
<td>No</td>
<td>GL</td>
<td>R&amp;N item only (GL line)</td>
<td>No</td>
</tr>
<tr>
<td>b) Supplier bills beneficiary for upgrade</td>
<td>Yes</td>
<td>GA/GK</td>
<td>R&amp;N item only (GK line)</td>
<td>Yes</td>
</tr>
<tr>
<td>2) Patient requests upgrade:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Supplier provides upgrade free of charge to beneficiary</td>
<td>No</td>
<td>GZ/GK</td>
<td>R&amp;N item only (GK line)</td>
<td>No</td>
</tr>
<tr>
<td>b) Supplier bills beneficiary for upgrade</td>
<td>Yes</td>
<td>GA/GK</td>
<td>R&amp;N item only (GK line)</td>
<td>Yes</td>
</tr>
<tr>
<td>3) Supplier provides upgrade for supplier convenience:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Supplier provides upgrade free of charge to beneficiary</td>
<td>No</td>
<td>GL</td>
<td>R&amp;N item only (GL line)</td>
<td>No</td>
</tr>
</tbody>
</table>

GK or GL is added to HCPCS code for item that meets Medicare coverage requirements. When GK is used, GA or GZ is added to HCPCS code for item that is provided. R&N = Reasonable and necessary

For additional information, refer to CMS Internet-Only Claims Processing Manual, Publication 100-04, Chapter 20, Sections 120 and 120.1