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FROM: Stuart Wright
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SUBJECT: Memorandum Report: *Vulnerabilities in Medicare Payments for Pressure Reducing Support Surfaces*, OEI-02-07-00421

This memorandum report provides information on vulnerabilities in Medicare payments for pressure reducing support surfaces (support surfaces). It specifically focuses on Medicare payments for claims that have GA and GZ modifiers. Suppliers use these modifiers to indicate that they expect Medicare to deny the claim as not reasonable and necessary. Suppliers may also use these modifiers to indicate that they provided an upgraded item to the beneficiary. An upgrade is a durable medical equipment (DME) item that contains a component, such as an equipment feature, that is in excess of the beneficiary's medical needs.

Staff at the Centers for Medicare & Medicaid Services (CMS) asked the Office of Inspector General (OIG) to provide information on these claims following a report issued by OIG on support surfaces.[1] In that evaluation, OIG found that 86 percent of claims for group 2 support surfaces did not meet Medicare coverage criteria in the first half of 2007, which amounted to an estimated $33 million in inappropriate payments. In response to that report, CMS staff were concerned that suppliers were incorrectly using GA and GZ modifiers on support surface claims and that Medicare was inappropriately paying for these items.

Based on an analysis of 2007 data, we found that Medicare paid for 72 percent of all support surface claims with GA or GZ modifiers. Medicare potentially inappropriately paid $4.4 million for these claims. We also found that suppliers submitted only four claims for upgrades for support surfaces in 2007, indicating that they may not be using the appropriate modifiers when providing upgrades. Further, for a number of other claims, Medicare inappropriately paid for more than one support surface for the same beneficiary on the same service date. In several

[1] OIG, *Inappropriate Medicare Payments for Pressure Reducing Support Surfaces*, OEI-02-07-00420, August 2009.

other instances, Medicare paid for a higher priced support surface, as opposed to a lower priced support surface.

BACKGROUND

Pressure Reducing Support Surfaces

Support surfaces are used for the care or prevention of pressure ulcers. A pressure ulcer, also known as a bedsore or decubitus ulcer, is an area of skin that breaks down when a person stays in one position for too long without shifting his or her weight. Pressure ulcers commonly occur among the elderly and among individuals with spinal cord injuries. Medicare pays for most support surfaces as rental items under its Part B DME benefit. In 2007, Medicare payments for all support surfaces totaled $137 million, $118 million of which was for rentals.

CMS categorizes support surfaces into three groups based on the complexity of their features. The three support surface groups have varying characteristics and include the following:

- Group 1 support surfaces are generally designed to be placed on top of standard hospital or home mattresses and include pressure pads and mattress overlays (foam, air, water, or gel). These support surfaces may be rented or purchased.

- Group 2 support surfaces, which can be special mattresses used alone or placed directly over a bedframe, include powered air flotation beds, powered pressure reducing air mattresses, and nonpowered advanced pressure reducing mattresses. These support surfaces may only be rented and are more expensive than Group 1 support surfaces.

- Group 3 support surfaces are complete bed systems, known as air-fluidized beds, which simulate the movement of fluid by circulating filtered air through silicone-coated ceramic beads. These support surfaces may only be rented and are the most expensive of the groups.

Modifiers for Services Not Reasonable and Necessary

GA or GZ modifiers can be used to bill for certain Part B items or services, including support surfaces, that are expected to be denied by Medicare as not reasonable and necessary.[2] For DME items, examples of when suppliers can use these modifiers include the following:[3]

(1) The item was not ordered by a provider who is qualified to prescribe the item.
(2) The item does not meet medical necessity criteria or frequency guidelines.
(3) The item is the same as or similar to covered items that the beneficiary is already using.

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[2] CMS added the GZ modifier and issued instructions to suppliers on how to use both the GZ and GA modifiers, effective January 1, 2002. CMS Program Memorandum, CR 1820, Transmittal B-02-020, *Coding for Non-Covered Services and Services Not Reasonable and Necessary*, March 27, 2002.

[3] See, e.g., Noridian Administrative Services LLC, "Proper Use of GY, GA, and GZ Modifiers," *Happenings*, August 2007. Available online at https://www.noridianmedicare.com/dme/news/bulletins/happenings/issue6_aug07.pdf. Accessed on August 10, 2009.

(4) The safety or effectiveness of the item in the home setting has not been established.
(5) The item is experimental or investigational.

Suppliers use the GA modifier when they have a signed Advance Beneficiary Notice of Noncoverage (ABN) on file.[4] The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives specified items or services, that Medicare certainly or probably will not pay for the item or service on that particular occasion.[5] A beneficiary may sign the ABN and indicate on the form that he or she accepts liability for the item or service and may need to pay out-of-pocket or through other insurance if Medicare denies payment.[6] In contrast, suppliers use the GZ modifier when they expect that the claim will be denied as not reasonable and necessary, but do not have an ABN on file.[7] In these cases, if Medicare denies the claim as not reasonable and necessary, the beneficiary cannot be held liable for the cost of the item.

Upgrades

An upgrade is a DME item that contains a component, such as an equipment feature, that is in excess of the beneficiary's medical needs.[8] The supplier may choose to provide an upgrade to the beneficiary free of charge, perhaps for the supplier's own convenience. The supplier may also charge the beneficiary for an upgrade, perhaps because the upgrade was requested by the beneficiary. In the case of support surfaces, a Group 1 support surface can be upgraded to a Group 2 or Group 3 support surface, or a Group 2 support surface can be upgraded to a Group 3 support surface.

When a supplier provides an upgraded DME item, it must use certain modifiers on the claim to indicate that such an upgrade occurred. If the supplier is providing the upgrade free of charge, the supplier submits a claim for the item that the beneficiary qualifies for and adds a GL modifier to the claim.[9] If the supplier wants to obtain payment for the upgrade, the supplier submits two line items on the claim: the first line item is for the upgraded item and the second line item is for the item that the beneficiary actually qualifies for. The supplier adds a GA or GZ modifier to the

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[4] CMS Program Memorandum, CR 1820, Transmittal B-02-020, *Coding for Non-Covered Services and Services Not Reasonable and Necessary*, March 27, 2002. In 2007, the ABN was known simply as the Advance Beneficiary Notice. See Form No. CMS-R-131-G, June 2002.

[5] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 30 - Financial Liability Protections," §40.3 (October 1, 2003). The Financial Liability Protection provisions of the Social Security Act protect beneficiaries and healthcare providers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 30 - Financial Liability Protections," §10 (October 1, 2003).

[6] The beneficiary could also indicate on the ABN that he or she chooses not to receive the item or service. See Form No. CMS-R-131-G that was in effect in 2007. In addition, CMS revised the ABN in March 2008 to provide an additional option to indicate that a beneficiary would pay for the item or service and the supplier would not bill Medicare. See Form No. CMS-R-131.

[7] CMS Program Memorandum, CR 1820, Transmittal B-02-020, *Coding for Non-Covered Services and Services Not Reasonable and Necessary*, March 27, 2002.

[8] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," § 120 (as of Rev. 1142; effective April 1, 2007).

[9] Ibid.

first line item to indicate that it expects the claim for the upgrade to be denied as not reasonable and necessary. The supplier adds a GK modifier to the second line item to indicate that the item is associated with the GA or GZ modifier and is reasonable and necessary.[10] When an upgrade is not medically necessary, Medicare should deny the first line item and allow the second line item.[11]

Claims Processing and Program Safeguard Activities

CMS contracts with four Durable Medical Equipment Medicare Administrative Contractors (DME MAC) that are responsible for processing and paying all DME claims. CMS may provide instruction to DME MACs to process certain claims for review or denial. Currently, there is no claims processing instruction to DME MACs for how to process claims with either a GA or a GZ modifier.[12, 13]

METHODOLOGY

This analysis focuses on all Part B claims for Group 1, 2, and 3 support surfaces with a date of service in 2007. We obtained the universe of support surface claims from CMS's National Claims History file. Multiple line items may be billed within a single claim. For the purposes of this report, we refer to a line item as a claim. In total, there were 197,145 denied claims and 504,848 allowed claims.

For the first part of our analysis, we determined the proportion of all claims that had a GA or GZ modifier that Medicare denied and the proportion of these claims that Medicare allowed. We then calculated the total amount Medicare potentially inappropriately paid for these claims. For the second part of our analysis, we determined the number of sets of claims in which Medicare paid for two or more support surfaces for the same beneficiary on the same service date.[14] We excluded claims that had a GA or GZ modifier from this analysis to keep this part of the analysis

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[10] Suppliers must give an ABN to a beneficiary prior to furnishing an item or service when they expect Medicare to reduce the level of payment because part of the item or service is not reasonable and necessary. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 30- Financial Liability Protections," § 50.7.5 (as of Rev. 1; effective October 1, 2003).

[11] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," § 120 (as of Rev. 1142; effective April 1, 2007).

[12] The only claims processing instructions provided to DME MACs for Part B claims with GA or GZ modifiers is to treat a claim as unprocessable if the supplier added both a GA and GZ modifier to the same claim line item. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, "Ch. 23 - Fee Schedule Administration and Coding Requirements," §§ 20.9.1.1 (as of Rev. 1; effective October 1, 2003).

[13] CMS recently provided additional instructions to contractors on the use of modifiers associated with ABNs for Part A claims submitted by institutional providers. Beginning in April 2010, Part A claims with a GA modifier will be automatically denied as a beneficiary liability. In addition, Medicare created a new GX modifier for providers to indicate that they voluntarily provided an ABN to the beneficiary for a service or item that is not covered under the Medicare statute. Part A claims with a GX modifier will be automatically denied as a beneficiary liability. See CMS, Pub 100-04 Medicare Claims Processing, CR 6563, Transmittal 1840, *Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage*, October 29, 2009.

[14] There is one situation in which a supplier could potentially order two different replacement parts for a Group 1 support surface at the same time. We did not include these sets of claims in our analysis.

distinct from the first. For these sets of claims, we considered the amount that Medicare paid for the lower priced support surface to be appropriate and any higher priced support surfaces to be inappropriate. Finally, we identified additional sets of claims in which Medicare paid for a higher priced support surface and denied a lower priced support surface for the same beneficiary on the same service date. If these were for upgrades, Medicare should have only paid for the lower priced support surface, as opposed to the higher priced support surface. To identify these claims, we matched the allowed and denied claims by beneficiary and service date. For each set of claims, we calculated the difference between the higher priced support surface and the lower priced support surface as the amount that Medicare potentially inappropriately paid for these claims.

For these analyses, we took a conservative approach by only including claims that had the same service date because there could be legitimate reasons for a beneficiary to rent two support surfaces on different dates during a month. For example, a beneficiary may rent one support surface, have an unexpected hospital stay, and return home needing a different support surface in the same month.

We also determined whether the claims in our analysis were associated with the same supplier based on the supplier's business name. We obtained each supplier's business name from the National Supplier Clearinghouse. Using the supplier's business name allowed us to combine all of a supplier's branch locations.[15]

In addition, we looked at the frequency of GA and GZ modifiers in a sample of support surface claims that we reviewed for medical necessity in a previous evaluation.[16] We analyzed these data to determine the number of claims with GA or GZ modifiers that did not meet Medicare coverage criteria.

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

In 2007, Medicare Paid for 72 Percent of Support Surface Claims With GA or GZ Modifiers, Amounting to $4.4 Million in Potentially Inappropriate Payments in 2007

Suppliers use the GA and GZ modifiers when they expect that Medicare will deny the claim as not reasonable and necessary. In 2007, suppliers submitted a total of 21,145 support surface claims with GA or GZ modifiers. Of these claims, Medicare denied only 28 percent (5,893 claims) and paid the remaining 72 percent (15,252 claims). Medicare potentially inappropriately paid $4.4 million for these claims in 2007.

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[15] We did not analyze the data by suppliers' National Provider Identifiers because suppliers were not required to use these identifiers until May 2007.

[16] OIG, *Inappropriate Medicare Payments for Pressure Reducing Support Surfaces*, OEI-02-07-00420, August 2009.

The 15,252 paid claims represented 3 percent of all paid support surface claims in 2007. Almost all of these claims had a GA modifier (15,211 claims), whereas 41 claims had a GZ modifier. See Table 1. These claims were from all four DME MAC regions. However, 11 percent of these claims were submitted by a single supplier.

Table 1: Claims with GA or GZ modifiers

	Number of claims	Potential inappropriate payments
Claims with GA modifiers	15,211	$4,355,780
Claims with GZ modifiers	41	$30,031
Total	**15,252**	**$4,385,811**

Source: OIG analysis of pressure reducing support surface claims, 2009.

In addition, in our sample of support surface claims that we reviewed for medical necessity, we found that 13 claims in our sample of 387 had a GA modifier.[17] Of these, 11 did not meet Medicare coverage criteria. Specifically, five were medically unnecessary, four were completely undocumented, and two were insufficiently documented to determine medical necessity. The remaining two claims met Medicare coverage criteria.

Suppliers Submitted Few Claims With Modifiers Indicating That They Provided Upgrades

Suppliers can use GA and GZ modifiers with a GK modifier on an associated claim to indicate that they provided an upgrade to the beneficiary. In 2007, suppliers submitted only four claims with GA or GZ modifiers that had a second claim with a GK modifier. Medicare paid all four of these claims appropriately by reimbursing only the second claim. Since this was relatively uncommon, it could mean that some of the claims with GA or GZ modifiers were, in fact, for upgrades in which supplier did not include a GK modifier on an associated claim.

For a Number of Other Claims, Medicare Inappropriately Paid for More Than One Support Surface for the Same Beneficiary on the Same Service Date

Medicare should pay for only one support surface for the same beneficiary on the same service date. For 145 sets of claims, Medicare paid for two support surfaces within the same group for the same beneficiary on the same service date. For another four sets of claims, Medicare paid for three support surfaces for the same beneficiary on the same service date. As shown in Table 2, most of these sets of claims were for Group 1 support surfaces. In total, these sets of claims amounted to $39,380 in inappropriate payments.

[17] None of the claims in this sample had a GZ modifier.

Table 2: Sets of claims for two or more support surfaces within the same group for the same beneficiary

	Sets of claims	Inappropriate payments
Sets of claims for two or more Group 1 support surfaces	106	$7,587
Sets of claims for two or more Group 2 support surfaces	42	$29,027
Sets of claims for two or more Group 3 support surfaces	1	$2,766
Total	**149**	**$39,380**

Source: OIG analysis of pressure reducing support surface claims, 2009.

In addition, for 31 sets of claims, Medicare paid for both a Group 1 and a Group 2 support surface for the same beneficiary on the same service date. See Table 3. For three other sets of claims, Medicare paid for both a Group 2 and a Group 3 support surface. Medicare should not have paid for two support surfaces for the same beneficiary on the same service date. If these claims were for upgrades, Medicare should have only paid for the lower priced support surface, unless the higher priced surface was found to be medically necessary. In total, these sets of claims amounted to $29,405 in inappropriate payments in 2007.

Table 3: Sets of claims for two different groups of support surfaces for the same beneficiary

	Sets of claims	Inappropriate payments
Sets of claims for Group 1 and Group 2 support surfaces	31	$20,551
Sets of claims for Group 2 and Group 3 support surfaces	3	$8,854
Total	**34**	**$29,405**

Source: OIG analysis of pressure reducing support surface claims, 2009.

In Several Other Instances, Medicare Paid for a Higher Priced Support Surface, as Opposed to a Lower Priced Support Surface

For another 91 sets of claims, Medicare paid the claim for a higher priced support surface and denied one or more claims for a lower priced support surface that was for the same beneficiary on the same service date. As shown in Table 4, for 64 sets of claims, Medicare paid for a Group 2 support surface and denied one or more claims for a Group 1 support surface. For 27 sets of claims, Medicare paid for a Group 3 support surface and denied one or more claims for a Group 2 support surface. Two suppliers submitted these 27 sets of claims.

If these were for upgrades, Medicare should have only paid for the lower priced support surface, as opposed to the higher priced support surface, unless the higher priced surface was found to be

medically necessary. These sets of claims amounted to an additional $73,022 in potentially inappropriate payments in 2007.

Table 4: Sets of claims in which Medicare paid for a higher priced support surface, as opposed to a lower priced support surface

	Sets of claims	Potential inappropriate payments
Group 2 was paid, Group 1 was denied	64	$25,997
Group 3 was paid, Group 2 was denied	27	$47,025
Total	**91**	**$73,022**

Source: OIG analysis of pressure reducing support surface claims, 2009.

CONCLUSION

We found that in 2007, Medicare paid for 72 percent of all support surface claims with GA or GZ modifiers. Suppliers use these modifiers when they expect that Medicare will deny the claim as not reasonable and necessary. Medicare potentially inappropriately paid $4.4 million for these claims. In addition, suppliers submitted only four claims for upgrades in 2007, indicating that they may not be using the appropriate modifiers when providing upgrades.

Further, for a number of other claims, Medicare inappropriately paid for more than one support surface for the same beneficiary on the same service date. Some of these claims were for support surfaces within the same group, whereas others were for support surfaces in two different groups. In total, these claims amounted to $68,785 in inappropriate payments in 2007. In several other instances, Medicare paid for a higher priced support surface, as opposed to a lower priced support surface. These claims amounted to an additional $73,022 in potentially inappropriate payments.

Taken together, these results indicate that DME MACs may not have appropriate safeguards in place to pay for Part B claims with GA or GZ modifiers. They also show that the DME MACs do not have controls in place to flag claims for multiple support surfaces for the same beneficiary on the same service date. Further, the results demonstrate that suppliers may need further instructions on the appropriate use of these modifiers when they provide upgraded items to beneficiaries.

It is important to note that these modifiers can be used for other DME items, such as wheelchairs, hospitals beds, and prosthetics and for Part B services. In response, we plan to conduct additional work on these modifiers for other items and services. We will also refer the suppliers associated with the claims in the current analysis to CMS in a separate memorandum.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-07-00421 in all correspondence.