

## Condition Code DR and Modifier CR Update

### UPDATED INFO

See yellow highlights for updated content from previous published version.

### Background

While CMS has provided technical direction in the use of Condition code DR and related Modifier CR for use during disasters and emergencies, the availability of clear clinical examples is lacking. nThrive has compiled the information currently available and will continue to provide updates as more information becomes available.

### Condition code DR and Modifier CR were also authorized for use on claims for items and services affected by subsequent emergencies.

Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission.

The definition of the Condition code DR, disaster related, requires it to be “used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.”

Condition code DR is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I.

In previous emergencies, use of the Condition code DR was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier’s discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned **directly or indirectly** on the presence of a “formal waiver.”

Modifier CR, *catastrophe/disaster related*, is used in relation to Part B items and services for **both institutional and non-institutional billing**. Non-institutional billing, i.e., claims submitted by “physicians and other suppliers”, are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format.

Modifier CR is historically considered no longer discretionary but is mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment

As part of its response to the 2005 *Katrina* hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed Condition code DR and Modifier CR to facilitate the processing of claims affected by that emergency.

is conditioned **directly or indirectly** on the presence of a “formal waiver.” However late Friday, April 3, 2020 CMS released a corrective bulletin indicating that Modifier CR is not to be used on 1500 professional claims for Telehealth services.<sup>1</sup> Rather CMS states, professional providers “should report the place of service equal to what it would have been had the service been furnished in-person; and Modifier 95, indicating that the service rendered was actually performed via telehealth.”

A “formal waiver” is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers.

1. Waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not “waivable” under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred.
2. Waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the “3-day qualifying hospital stay” requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

The use of Condition Code DR and Modifier CR indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.<sup>2</sup>

According to the Medicare Claims Manual the “DR condition code is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster.”<sup>3</sup>

The Manual also indicates that claims from institutional billers must be annotated with a **condition code when the entire claim** is so related or with a modifier for each relevant line item **when only certain line items** are so related.

Although a unique condition code and modifier were issued for Gulf Oil Spill the Claims Manual does use this example which provides some clarity to how these emergency or disaster related codes are to be used:

“In order to facilitate tracking of items and services provided for treatment of illnesses, injuries, or conditions that are related (directly or indirectly) to the Gulf oil spill, a new modifier and condition code have been established for providers and suppliers to use on claims specific to the aforementioned disaster. The modifier to be used for 2010 Gulf oil spill-related line items is CS. The condition code to be used for institutional claims is BP.

Effective for dates of service on or after April 20, 2010, all providers and suppliers must annotate their claims with the new modifier and/or condition code (where applicable) when submitting **claims for beneficiaries whose illness, injury, or condition is caused or exacerbated by** the Gulf oil spill or circumstances related to the Gulf oil spill, including but not limited to subsequent clean-up activities.”

Applying this to the COVID-19 Coronavirus Public Health Emergency (PHE) it would be apparent that patients admitted or treated for the disease itself have been affected by the PHE and the Condition code DR and Modifier CR would be applicable.

For patients hospitalized or receiving care unrelated to the COVID-19 Coronavirus it is less clear whether the provider needs to convey this information.

Due to the wide spread nature of the PHE and the volume of waivers that have been issued addressing topics that impact non-COVID-19 patients such as the waiver of Utilization Review and Case Management activities, assignment of attending practitioners, provider enrollment, medical record management, use of telehealth services; nThrive is recommending that all inpatient claims be assigned Condition code DR.

For Emergency Room, Mobile “Drive-Up” or COVID-19 Assessment Centers all claims would receive the Condition code DR. However, Modifier CR would only be applied to services related to COVID-19 Coronavirus.

Example: A patient arriving with an arm fracture may be triaged outside prior to a decision for treatment. This would substantiate application of Condition code DR. Once the patient is examined the decision is made to send to Radiology for an x-ray. Neither the E.R. exam nor the Radiology exam is related to the PHE therefore would not be assigned Modifier CR.

Example: A patient arrives with a fever, cough and shortness of breath. They are triaged outside prior to decisions for treatment. This substantiates application of Condition code DR. After exam the patient is placed in isolation and receives a portable chest x-ray. In this instance Modifier CR would be applied to the E.R. exam code and the Radiology exam as it relates to the PHE.

For the provision of scheduled, ordered services NOT modified by the fact that the hospital is under a Public Health Emergency (PHE) declaration neither Condition code DR nor Modifier CR would need to be applied. However, providers should be aware of all waivers being implemented at their facility including those affecting medical record completion, timely signatures, verbal orders, etc. If any of these are implemented scheduled outpatient claims should also report Condition code DR.

To help providers identify services provided under waiver that require the use of Condition code DR and/or Modifier CR, CMS has created a table which can be found at: <https://www.cms.gov/files/document/se20011.pdf>.

## Guidance

- ✓ Identify all PHE related waivers being implemented at the facility.
- ✓ Establish a process for HIM coders to review outpatient claims and assign Modifier CR as outlined above.
- ✓ Task Patient Registration or the Billing Department with assignment of Condition code DR as outlined above.



## Sources

1. CMS Special Edition Bulletin, April 3, 2020.
2. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6451.pdf>
3. CMS Claims Manual, Pub 100-04, Chapter 38, Section 10. ■