| CMS Manual System | Department of Health & Human Services (DHHS) |
| --- | --- |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1784** | **Date: July 31, 2009** |
| | **Change Request 6451** |

**Subject: The Use of the CR Modifier and DR Condition Code on Disaster/Emergency-Related Claims**

**I. SUMMARY OF CHANGES:** This instruction contains updated information for the modifier and condition code that were established for emergency related claims.

**New / Revised Material**
**Effective Date: August 31, 2009**
**Implementation Date: August 31, 2009**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | Chapter / Section / Subsection / Title |
| --- | --- |
| N | 38/Emergency Preparedness Fee-For-Service Guidance |
| N | 38/01/Foreword |
| N | 38/10/Use of the CR Modifier and DR Condition Code on Disaster/Emergency-Related Claims |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**
**Business Requirements**
**Manual Instruction**

**Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 1784 | Date: July 31, 2009 | Change Request: 6451 |
| --- | --- | --- | --- |

**SUBJECT:** The Use of the CR Modifier and the DR Condition Code on Disaster/Emergency-Related Claims

**Effective Date**: August 31, 2009

**Implementation Date:** August 31, 2009

## I. GENERAL INFORMATION

This Transmittal updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. This Transmittal also establishes a new chapter in the Medicare Claims Processing Manual, Pub. 100-04, dedicated to standing policies and procedures applicable to disasters and other public emergencies. Finally, this Transmittal rescinds and replaces Transmittal 181 (Change Request 4106, released on September 23, 2005).

**Background:** As part of its response to the 2005 *Katrina* hurricane emergency, the Centers for Medicare and Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier 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 use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued via one or more Joint Signature Memoranda (JSM)/Technical Direction Letters (TDL) regarding the emergency/disaster to which such JSM/TDL applies.

The DR Condition Code: The title of the DR condition code is "disaster related" and its definition 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." The DR condition code 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 DR condition code has been discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver, "as defined below. The DR condition code also may be required for any type of claim for which, at the Medicare claims processing contractor's discretion or as directed by CMS in a particular disaster or emergency, the use of the DR condition code is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.

The CR Modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier 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. In previous emergencies, use of the CR modifier has been discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned on the presence of a "formal waiver," as defined below. The CR modifier also may be

required for any HCPCS code for which, at the Medicare claims processing contractor's discretion or as directed by CMS in a particular disaster or emergency, the use of the CR modifier is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.

Formal Waivers: 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. One type is a temporary waiver or modification of a requirement under the authority described in § 1135 of the Social Security Act (the Act). Although Medicare payment rules themselves are not waivable under this statutory provision, the waiver authority under § 1135 may permit Medicare payment in a circumstance where such payment would otherwise be barred because of noncompliance with the requirement being waived or modified. The second type of formal waiver is a 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 § 1812(f) of the Act.

Several conditions must be met for a § 1135 waiver to be implemented. First, the President must declare an emergency or disaster under the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such a declaration will specify both an effective date and the geographic area(s) covered by the declaration. Second, the Secretary of the Department of Health and Human Services must declare – under § 319 of the Public Health Service Act – that a public health emergency exists within some or all of the areas covered by the Presidential declaration. Third, the Secretary must authorize the waiver of one or more requirements specified in § 1135 of the Act. Fourth, the Secretary or the Administrator of CMS must determine which Medicare program requirements, if any, may be waived or modified under the Secretary's authorization and whether specific conditions within the geographic area(s) specified by the Secretary's declaration warrant waiver or modification of one or more requirements of Title XVIII of the Act. If all of the foregoing conditions are met, the Secretary or CMS Administrator may specify the extent to which a waiver or modification of a specific Medicare requirement is to be applied within the geographic area(s) with respect to which the waiver authority has been invoked.

The waiver of a Medicare requirement based on authority included in the provision of Title XVIII of the Act or its implementing regulations may be made at the discretion of the Administrator of CMS unless otherwise specified. Such a waiver does not require either a Presidential or a Secretarial declaration nor, if such declarations are made, would such a waiver be necessarily limited by the geographic boundaries specified in such declarations. Nevertheless, the Administrator may elect to limit the effect of "Title XVIII waivers" to such geographic areas and to such time frames as are specified by such declarations.

A Medicare requirement established in statute or regulation that is not subject to waiver under either of these types of "formal waiver" generally may not be waived as a matter of administrative discretion. Because most Medicare requirements are not "waivable," nearly all Medicare entitlement, coverage, and payment rules will remain in effect during a disaster or emergency.

Informal Waivers: An "informal waiver" is a discretionary waiver or relaxation of a procedural norm, when such norm is not required by statute or regulation, but rather is reflected in CMS guidance or policy. Such norm may be waived or relaxed administratively if circumstances warrant. One example of such a norm would be claims filing jurisdiction. In the event of a disaster/emergency that impaired or limited operations at a particular contractor, alternative claims filing jurisdictions could be established. Informal waivers are made by the CMS Administrator or his/her delegates.

Further Instructions in the Event of a Disaster or Emergency: In the event of a disaster or emergency, CMS will issue specific guidance to contractors via one or more JSM/TDL that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and

end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Reporting Utilization of the Condition Code and Modifier: Contractors must compile reports of utilization of the use of the condition code and/or modifier as specified in this Transmittal and/or via any JSM/TDL as may be issued in the event of a specific disaster or emergency.

**B. Policy:**

The DR Condition Code:

- The DR condition code is used for institutional billing only.
- Use of the DR condition code is required when a service is affected by an emergency or disaster and Medicare payment for such service is conditioned on the presence of a "formal waiver" (as that term is described in "Background", above)
- Use of the DR condition code also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.
- 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.

The CR Modifier:

- The CR modifier is used for Part B items and services only but may be used in either institutional or non-institutional billing.
- Use of the CR modifier is required when an item or service is impacted by an emergency or disaster and Medicare payment for such item or service is conditioned on the presence of a "formal waiver" (as that term is described in "Background", above)
- Use of the CR modifier also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6451.1 | Contractors shall continue to recognize the "DR" condition code established by Change Request 4106. | X | | X | | X | | | | | |
| 6451.2 | Contractors shall require the "DR" condition code on any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver" as described in this transmittal. | X | | X | | X | | | | | |
| 6451.2.1 | The use of the "DR" condition code is required in the following circumstances:<br><br>1. a §1135 waiver necessitates the use of the condition code; | X | | X | | X | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | 2. CMS mandates the use of the condition code (based on Title XVIII of the Act); or<br>3. A Contractor mandates the use of the condition code. | | | | | | | | | | |
| 6451.3 | Contractors shall continue to use their discretion in how the "DR" condition code can be utilized in their system to facilitate claims processing for emergency related claims for which Medicare payment is not conditioned directly or indirectly on the presence of a "formal waiver" as described in this transmittal. | X | | X | | X | | | | | |
| 6451.3.1 | Contractors shall advise providers concerning which HCPCS codes and dates of service are subject to the mandatory use of the condition code. | X | | X | | X | | | | | |
| 6451.4 | Contractors shall continue to recognize the "CR" modifier established by Change Request 4106. | X | X | X | X | X | | | | | |
| 6451.5 | Contractors shall require the "CR" modifier on any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver" as described in this transmittal. | X | X | X | X | X | | | | | |
| 6451.5.1 | The use of the "CR" modifier is required in the following circumstances:<br><br>1. a §1135 waiver necessitates the use of the modifier;<br>2. CMS mandates the use of the modifier (based on Title XVIII of the Act); or<br>3. a Contractor mandates the use of the modifier. | X | X | X | X | X | | | | | |
| 6451.6 | Contractors shall continue to use their discretion in how the "CR" modifier can be utilized in their system to facilitate claims processing for emergency related claims for which Medicare payment is not conditioned directly or indirectly on the presence of a "formal waiver" as described in this transmittal. | X | X | X | X | X | | | | | |
| 6451.6.1 | Contractors shall advise providers and suppliers concerning which HCPCS codes and dates of service are subject to the mandatory use of the modifier. | X | X | | X | X | | | | | |
| 6451.7 | Contractors shall continue to receive guidance from CMS in the form of JSMs/TDLs or instructions regarding any specific use of the modifier or condition code. | X | X | X | X | X | | | | | CMS CO |
| 6451.7.1 | Contractors shall be required to compile reports when the use of the modifier and condition code are required as specified in the form of a JSM/TDL specifically relating to the emergency. The JSM/TDL will specify to whom the reports shall be sent along with the requested form and content of the report. | X | X | X | X | X | | | | | CMS CO |
| 6451.8 | Contractors shall continue to work closely with the | X | X | X | X | X | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | appropriate regional office regarding any instructions associated with the emergency. | | | | | | | | | | |
| 6451.8.1 | CMS regional offices shall continue to facilitate contractor outreach regarding provider education on the use of the modifier and condition code. | | | | | | | | | | Regional Offices |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6451.9 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | X | X | X | X | | | | | |
| 6451.10 | In the event of an actual emergency, Contractors shall, when communicating with the provider community concerning such emergency preparedness guidance's, advise the provider community to monitor the contractor's Web site in order to determine how the DR condition code and the CR modifier shall be used in the emergency. | X | X | X | X | X | | | | | |

## IV. SUPPORTING INFORMATION

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| None. | |

**Section B: For all other recommendations and supporting information, use this space:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Cynthia Thomas for Practitioner Claims Processing, Cynthia.Thomas2@cms.hhs.gov; Bill Ruiz for Institutional Claims Processing, William.Ruiz@cms.hhs.gov; and Angela Costello for DME MACs Claims Processing, Angela.Costello@cms.hhs.gov.

**Post-Implementation Contact(s):** Your appropriate Regional Office (RO) or Project Officer (PO).

## VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

# Medicare Claims Processing Manual

## *Chapter 38 - Emergency Preparedness Fee-For-Service Guidance*

***(Rev. 1784, 07-31-09)***

*01 – Foreward*
*10 – Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims*

## *01 – Foreward*

***(Rev. 1784, Issued: 07-31-09, Effective: 08-31-09, Implementation: 08-31-09)***

*Generally, this chapter describes the guidance that may be implemented for the Medicare fee-for-service program in the event of a disaster/emergency. As part of its preparedness efforts for a disaster/emergency, the Centers for Medicare and Medicaid Services (CMS) has developed certain disaster/emergency guidance that may be implemented for the Medicare fee-for-service program in the event of a disaster/emergency. CMS has also developed certain additional disaster/emergency guidance that may be implemented if: 1. the President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and 2. the Secretary of the Department of Health and Human Services declares – under § 319 of the Public Health Service Act – that a public health emergency exists, and 3. the Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to § 1135 of such Act. Until CMS declares these guidances to be in effect, the guidances are considered to be pending.*

## *10 – Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims*

***(Rev. 1784, Issued: 07-31-09, Effective: 08-31-09, Implementation: 08-31-09)***

*In order to facilitate claims processing and track services and items provided to beneficiaries during disaster/emergency situations, a modifier and condition code have been established for providers to use on disaster/emergency related claims. The modifier and condition code have been in effect since August 21, 2005. The codes are effective for dates of service on and after August 21, 2005. The modifier and/or condition code can be used by providers submitting claims for beneficiaries who are emergency patients in any part of the country.*

*The DR Condition Code: The title of the DR condition code is "disaster related" and its definition 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." The DR condition code 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 DR condition code has been discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver,"as defined below. The DR condition code also may be required for any type of claim for which, at the Medicare claims processing contractor's discretion or as directed by CMS in a particular disaster or emergency, the use of the DR condition code is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.*

*The CR Modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier 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. In previous emergencies, use of the CR modifier has been discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned on the presence of a "formal waiver," as defined below. The CR modifier also may be required for any HCPCS code for which, at the Medicare claims processing contractor's discretion or as directed by CMS in a particular disaster or emergency, the use of the CR modifier is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.*

*Formal Waivers: 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. One type is a temporary waiver or modification of a requirement under the authority described in § 1135 of the Social Security Act (the Act). Although Medicare payment rules themselves are not waivable under this statutory provision, the waiver authority under § 1135 may permit Medicare payment in a circumstance where such payment would otherwise be barred because of noncompliance with the requirement being waived or modified. The second type of formal waiver is a 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 § 1812(f) of the Act.*

*Several conditions must be met for a § 1135 waiver to be implemented. First, the President must declare an emergency or disaster under the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such a declaration will specify both an effective date and the geographic area(s) covered by the declaration. Second, the Secretary of the Department of Health and Human Services must declare – under § 319 of the Public Health Service Act – that a public health emergency exists within some or all of the areas covered by the Presidential declaration. Third, the Secretary must authorize the waiver of one or more requirements specified in § 1135 of the Act. Fourth, the Secretary or the Administrator of CMS must determine which Medicare program requirements, if any, may be waived or modified under the Secretary's authorization and whether specific conditions within the geographic area(s) specified by the Secretary's declaration warrant waiver or modification of one or more requirements of Title XVIII of the Act. If all of the foregoing conditions are met, the Secretary or CMS Administrator may specify the extent to which a waiver or modification of a specific Medicare requirement is to be applied within the geographic area(s) with respect to which the waiver authority has been invoked.*

*The waiver of a Medicare requirement based on authority included in the provision of Title XVIII of the Act or its implementing regulations may be made at the discretion of the Administrator of CMS unless otherwise specified. Such a waiver does not require either a Presidential or a Secretarial declaration nor, if such declarations are made, would such a waiver be necessarily limited by the geographic boundaries specified in such declarations. Nevertheless, the Administrator may elect to limit the effect of "Title XVIII waivers" to such geographic areas and to such time frames as are specified by such declarations.*

*A Medicare requirement established in statute or regulation that is not subject to waiver under either of these types of "formal waiver" generally may not be waived as a matter of administrative discretion.*

*Because most Medicare requirements are not "waivable," nearly all Medicare entitlement, coverage, and payment rules will remain in effect during a disaster or emergency.*

*Informal Waivers: An "informal waiver" is a discretionary waiver or relaxation of a procedural norm, when such norm is not required by statute or regulation, but rather is reflected in CMS guidance or policy. Such norm may be waived or relaxed administratively if circumstances warrant. One example of such a norm would be claims filing jurisdiction. In the event of a disaster/emergency that impaired or limited operations at a particular contractor, alternative claims filing jurisdictions could be established. Informal waivers are made by the CMS Administrator or his/her delegates.*

*Further Instructions in the Event of a Disaster or Emergency: In the event of a disaster or emergency, CMS will issue specific guidance to contractors via one or more Joint Signature Memorandum/Technical Direction Letter (JSM/TDL) that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.*

*Reporting Utilization of the Condition Code and Modifier: Contractors must compile reports of utilization of the use of the condition code and/or modifier as specified in this Transmittal and/or via any JSM/TDL as may be issued in the event of a specific disaster or emergency.*

***B. Policy:***

*The DR Condition Code:*

- *The DR condition code is used for institutional billing only.*
- *Use of the DR condition code is required when a service is affected by an emergency or disaster and Medicare payment for such service is conditioned on the presence of a "formal waiver" (as that term is described in "Background", above)*
- *Use of the DR condition code also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.*
- *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.*

*The CR Modifier:*

- *The CR modifier is used for Part B items and services only but may be used in either institutional or non-institutional billing.*
- *Use of the CR modifier is required when an item or service is impacted by an emergency or disaster and Medicare payment for such item or service is conditioned on the presence of a "formal waiver" (as that term is described in "Background", above)*
- *Use of the CR modifier also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.*