



**News Flash – Each Office Visit is an Opportunity.** Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. **Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.** Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu\\_Products.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf) and <http://www.cms.gov/Medicare/Prevention/Immunizations/index.html> on the CMS website.

MLN Matters® Number: MM7156

Related Change Request (CR) #: 7156

Related CR Release Date: November 12, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R8090TN

Implementation Date: April 4, 2011

**Note:** This article was updated on December 11, 2012, to reflect current Web addresses. All other information remains unchanged.

## Additional Editing for Disaster Related Claims

### Provider Types Affected

This article is for providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries related to a disaster containing condition code "DR" and/or modifier "CR," in which payment for these services or items is conditioned on the presence of a "formal waiver."

### Provider Action Needed

CMS is implementing additional editing to ensure correct payment for claims related to a disaster containing "DR" condition code and/or "CR" modifiers, submitted for services and/or items for which Medicare payment is conditioned on the presence of a "formal waiver." Make sure your billing staffs are aware of these changes.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

## Background

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The Centers for Medicare & Medicaid Services (CMS) developed the “DR” condition code and “CR” modifier to facilitate the processing of claims affected by a disaster or other general emergency. The “DR” condition code and “CR” modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Use of the “DR” condition code and “CR” modifier is mandatory for any claim for which Medicare payment is conditioned on the presence of a “formal waiver” as defined below.

**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 Section 1135 of the Social Security Act (the Act). Although Medicare payment rules themselves are not waivable under this statutory provision, the waiver authority under Section 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 Section 1812(f) of the Act.

Several conditions must be met for a Section 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 Section 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 Section 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.

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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 Medicare contractor, alternative claims filing jurisdictions could be established. Informal waivers are made by the CMS Administrator or his/her delegates.

### **CR 7156 Claims Processing Instructions**

Of particular importance for hospitals in CR 7156 is that Medicare contractors will suspend claims received on types of bills 18X and 21X with condition code DR and modifier CR in order to ensure that the admission date/dates of service fall within or overlap a waiver period. If the claims meet the waiver period criteria, they will process. If they contain the DR condition code and CR modifier, but do not meet the waiver requirement, the claims will be returned to the provider.

## **Additional Information**

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The official instruction, CR 7156 issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R809OTN.pdf> on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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