

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2999	Date: July 25, 2014
	Change Request 8772

SUBJECT: Update to Pub. 100-04, Chapter 38 to Provide Language-Only Changes for Updating ASC X12

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 38. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: January 1, 2012

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

IMPLEMENTATION DATE: August 25, 2014

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
R	38/10/ Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims
R	38/20.1/ Modifier CS
R	38/20.2/ Condition Code BP

III. FUNDING:

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 obliged 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**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2999	Date: July 25, 2014	Change Request: 8772
--------------------	--------------------------	----------------------------	-----------------------------

SUBJECT: Update to Pub. 100-04, Chapter 38 to Provide Language-Only Changes for Updating ASC X12

EFFECTIVE DATE: January 1, 2012

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

IMPLEMENTATION DATE: August 25, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 38.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			DME MAC	Shared-System Maintainers				Other	
		A	B	HHH		FIS	MCS	VMS	CWF		
8772.1	A/B MACs (A, B, and HHH) and DME MACs shall be aware of the updated language for ASC X12 in Pub. 100 - 04, Chapter 38.	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable, 123-456-7890.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

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

(Rev. 2999, Issued; 07-25-14, Effective: 01-01-12, Implementation: 08-25-14)

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 *using the ASC X12 837 institutional claim format or* on an institutional paper claim Form CMS-1450. 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 *using the ASC X12 837 professional claim format or* on a professional paper claim Form CMS-1500 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 Technical Direction Letter (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 via any 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.

20.1 – Modifier CS

(Rev. 2999, Issued; 07-25-14, Effective: 01-01-12, Implementation: 08-25-14)

The long description of the CS modifier is as follows: “Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities.”

The short description of the CS modifier is as follows: “Gulf Oil Spill 2010 Related”.

The CS modifier is used in relation to Part B items and services for both institutional and non-institutional billing, but may be submitted on either institutional or non-institutional (i.e., claims submitted by physicians or other suppliers) claims. Non-institutional claims are submitted *using the ASC X12 837 professional claim format or* on paper via the *Form* CMS-1500, or, for pharmacies, in the NCPDP format. Use of the CS modifier is mandatory for applicable HCPCS codes on any claim for which the provider or supplier seeks Medicare Part B payment for treatment of illnesses, injuries, or conditions arising from the Gulf oil spill or related circumstances.

20.2 – Condition Code BP

(Rev. 2999, Issued; 07-25-14, Effective: 01-01-12, Implementation: 08-25-14)

The title of the BP condition code is “Gulf oil spill of 2010” and its definition is as follows: “This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities.”

The BP condition code is used only for institutional billing, i.e., claims submitted by providers *using the ASC X12 837 institutional claim format or* on an institutional paper claim *Form* CMS-1450. Use of the BP condition code is mandatory for any claim for which a provider seeks Medicare payment for treatment of illnesses, injuries, or conditions arising from the Gulf oil spill or related circumstances. The BP condition code is used at the claim level when all of the services/items billed on the claim are related to the Gulf oil spill or related circumstances.

Contractors must compile utilization reports to track the use of the condition code and/or modifier as well as track Medicare spending on claims containing the same as specified via any TDL as may be subsequently issued.

CMS will issue, as necessary, specific guidance to contractors via one or more TDLs that will contain a summary of the Secretary’s declaration (if any); specify the end dates that apply to the use of the CS modifier and/or the BP condition code; specify what other uses of the modifier and/or condition code, if any, will be required for this particular disaster; and communicate any other pertinent information as it relates to this disaster and/or the use of the modifier and/or condition code.