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CMS Checklist: When to Use the DR Condition Code and CR Modifier

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Because of confusion around the use of the DR (disaster related) condition code and of the CR (catastrophe/disaster related) modifier in connection with waivers for the COVID-19 public health emergency, CMS on June 1 posted an *MLN Matters* article (SE20011 Revised)[1] explaining them in detail.

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency.		X
Housing Acute Care Patients in the Inpatient Rehabilitation Facility (IRF) or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units	Allows acute care hospitals to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatients.		X
Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this public health emergency.		X
Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)	CMS has determined it is appropriate to issue a blanket waiver to LTCHs to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs. In addition, during the applicable waiver time period, we would also apply this waiver to facilities not yet classified as LTCHs, but seeking classification as an LTCH.		X

Care for Patients in Extended Neoplastic Disease Care Hospital	Allows extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules.		X
Skilled Nursing Facilities (SNFs)	Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations or are otherwise affected by COVID-19. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).		X
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, allow the durable medical equipment (DME) Medicare administrative contractors (MACs) to have the flexibility to waive replacement requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description of the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.	X	
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and do not need to begin including the CR modifier until the 61st continuous day.	X	
Critical Access Hospitals	Waives the requirements that critical access hospitals limit the number of inpatient beds to 25, and that the length of stay, on an average annual basis, be limited to 96 hours.		X
Replacement Prescription Fills	Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the disaster or emergency.	X	

Hospitals Classified as Sole Community Hospitals (SCHs)	Waives certain eligibility requirements for hospitals classified as SCHs prior to the public health emergency, specifically the distance requirements and the "market share" and bed requirements (as applicable).		X
Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)	For hospitals classified as MDHs prior to the public health emergency, waives the eligibility requirements that the hospital has 100 or fewer beds during the cost reporting period and that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.		X
IRF 60 Percent Rule	Allows an IRF to exclude patients from its inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.		X
Waivers of Certain Hospital and Community Mental Health Center (CMHC) Conditions of Participation and Provider-Based Rules	Allows a hospital or CMHC to consider temporary expansion locations, including the patient's home, to be a provider-based department of the hospital or extension of the CMHC, which allows institutional billing for certain outpatient services furnished in such temporary expansion locations. If the entire claim falls under the waiver, the provider would only use the DR condition code. If some claim lines fall under this waiver and others do not, then the provider would only append the CR modifier to the particular line(s) that falls under the waiver.	X	X
Billing Procedures for ESRD Services When the Patient is in a SNF/NF	In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, end-stage renal disease (ESRD) facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the off-site ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition.	X	X

Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor National and Local Coverage Determinations	In the interim final rule with comment period (CMS-1744-IFC and CMS-5531-IFC), CMS states that clinical indications of certain national and local coverage determinations will not be enforced during the COVID-19 public health emergency. CMS will not enforce clinical indications for respiratory, oxygen, infusion pump and continuous glucose monitor national coverage determinations and local coverage determinations.	X	
Face-to-Face and In-Person Requirements for National and Local Coverage Determinations	In the interim final rule with comment period (CMS-1744-IFC), CMS states that to the extent a national or local coverage determination would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the COVID-19 public health emergency.	X	
Requirement for DMEPOS Prior Authorization	The requirement to submit a prior authorization request for certain DMEPOS items and services was paused. Suppliers were given the option to voluntarily continue submitting prior authorization requests or to skip prior authorization and have the claim reviewed through post-payment review at a later date. Claims that would normally require prior authorization, but were submitted without going through the process, should be submitted with a CR modifier.	X	
Signature Requirements for Proof of Delivery	The signature requirement for Part B drugs and certain DME that require a proof of delivery and/or a beneficiary signature was waived. Providers should use a CR modifier on the claim and document in the medical record the appropriate delivery date and that a signature could not be obtained because of COVID-19.	X	
Part B Prescription Drug Refills	MACs may exercise flexibilities regarding the payment of Medicare Part B claims for drug quantities that exceed usual supply limits, and to permit payment for larger quantities of drugs, if necessary. MACs may require the use of the CR modifier in these cases.	X	