CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 809	**Date: NOVEMBER 12, 2010**
	Change Request 7156

SUBJECT: Additional Editing for Disaster Related Claims

I. SUMMARY OF CHANGES: This Transmittal creates a process to edit claims submitted for disaster related services, 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" and determines if the claims should pay or deny.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 809	Date: November 12, 2010	Change Request: 7156

SUBJECT: Additional Editing for Disaster Related Claims

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

This Transmittal updates claims processing requirements for claims affected by 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".

A. Background: The Centers for Medicare and 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 § 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.

B. Policy: 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".

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	
7156.1	Contractors shall create an overrideable reason code to suspend all claims containing condition code "DR" and/or modifier "CR".						X				
7156.1.1	Contractors shall ensure this new reason code sets prior to the qualifying hospital stay reason codes applicable to 18x and 21x bill types.						X				
7156.2	Contractors shall create an Expert Claim Processing System (ECPS) event identifying waiver time periods, defined by CMS via Joint Signature Memorandums (JSM) and the following bypass criteria for the newly created reason code.	X		X							
7156.2.1	Contractors shall bypass claims with dates of service that fall within or overlap a waiver period when condition code "DR" and/or modifier "CR" are present.	X		X							
7156.2.2	Contractors shall bypass 18x and 21X bill types with a condition code "DR" when the admission date on the claim equals or falls within the period.	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	
7156.2.3	Contractors shall return to provider claims containing condition code "DR" and/or modifier "CR" if they do not meet the bypass above.	X		X							
7156.3	FISS shall bypass qualifying hospital stay reason codes for 18x and 21X bill types when a condition code "DR" is present.						X				

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	
7156.4	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							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Bill Ruiz, william.ruiz@cms.hhs.gov and Jason Kerr, Jason.kerr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office and Project Officer (PO)

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), 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)*:

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.