Modifiers Used during the COVID-19 Public Health Emergency (PHE)

Modifier	Part A *Billed on UB04?*	Part B *Billed on 1500?*	Details	References	Exceptions/Special usage
CS	Exception	Yes	• Waives cost-sharing during the PHE • Should only be used for a medical visit that results in an order for or administration of a COVID-19 lab test • Should be applied to each applicable line on the claim that would result in patient responsibility	• https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf	• Part A providers can use on claims for HCPCS C9803 "Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [COVID-19]), any specimen source" • Cost-sharing does not apply to an inpatient visit • Part B: in addition to the visit, apply for all COVID-19 testing-related services to get 100% of the Medicare-approved amount, does not need to be applied to Lab Codes
CR	Exception	Yes	• Defined as "Catastrophe/disaster-related" • Should be used for Part B billing, both institutional and non-institutional (i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format) • This requirement does not apply for purposes of compliance with waivers (blanket or individual) of sanctions under the physician self-referral law	• https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf • *https://www.cms.gov/files/document/se20011.pdf*	• The in-center dialysis center should also apply condition code DR to claims if all of the treatments billed on the claim meet this condition, or modifier CR, on the line level to identify individual treatments meeting this condition REMINDER: Not applicable to line items for telehealth services.
DR*	Yes	No	• Defined as "Disaster-related claim covered by the blanket waivers" • Condition Code DR should be used for institutional billing (i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450), at the claim level, when all of the services/items billed on the claim are related to a COVID-19 waiver	• https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf • https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf • https://www.cms.gov/files/document/se20011.pdf	
95	Exception	Yes	• Defined as "Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System"	• https://www.cms.gov/files/document/se20016.pdf	• Rural Health Clinics (RHCs): optional; not required • Federally Qualified Health Centers (FQHCs):required with 99214 (or other FQHC PPS Qualifying Payment Code) and

			• Should only be appended to approved telehealth codes appearing on the current listing located at: https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes.		G2025 from January 27, 2020 through June 30, 2020; optional starting July 1, 2020 • Hospitals do not use the 95 modifier when billing for the originating site fee only REMINDER: Also used on audio-only E/M services.
CG	Yes	No	• Identifies that policy criteria were applied to claim • Required on RHC claims from January 27, 2020, through June 30, 2020	• https://www.cms.gov/files/document/se20016.pdf • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf	

Note: Blanket Waiver — when a determination has been made that all similarly situated providers in the emergency area need such a waiver or modification. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. Once approved these waivers apply automatically to all applicable providers and suppliers. Providers and suppliers do not need to apply for an individual waiver if a blanket waiver is issued by CMS.

***Condition Codes**, not a modifier