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Q1: When should providers use the CS modifier?

A1: For the Medicare program, the Centers for Medicare and Medicaid Services (CMS) has issued guidance specifying that Part B providers and suppliers should use the CS modifier on ***applicable claim lines*** to identify ***COVID-19 testing-related services*** for which cost-sharing does not apply in accordance with the Families First Coronavirus Response Act. The use of the CS modifier identifies a service as a COVID-19 testing-related service subject to payment at 100 percent of the Medicare-approved amount.

- In the CMS guidance, CMS limits the applicable tests to COVID-19 lab test U0001, U0002, or CPT 87635.
- However, in public "Office Hours" calls as recently as April 23, 2020, CMS has deferred on answering questions as to whether serological antibody tests should also qualify. Additional guidance on this question is expected.

The CMS guidance defines ***COVID-19 testing-related services*** as ***medical visits*** that:

- are furnished between March 18, 2020 and the end of the public health emergency
- result in an order for or administration of a COVID-19 test
- are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test and
- are in any of the following categories of HCPCS[1] evaluation and management codes:
  - Office and other outpatient services
  - Hospital observation services
  - Emergency department services
  - Nursing facility services
  - Domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services

Furthermore, only payments for medical visit services made to the following individuals or entities should be billed using the CS modifier:

[1] Note that HCPCS codes may include Current Procedural Terminology (CPT) codes as well as other codes established by CMS (e.g. G-codes, APC codes, and more)

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System (OPPS)
- Physicians and other professionals under the Physician Fee Schedule (PFS)
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Since cost-sharing is waived and providers and suppliers will receive 100 percent of the Medicare-approved amount, providers and suppliers should not charge Medicare patients any co-insurance and/or deductible amounts for those services.

The above definition of COVID-19 testing related services is limited to those services specified under the *Families First Coronavirus Response Act* for the Medicare program and does not include services for the treatment of COVID-19. Likewise, the payment systems are also limited by statute, and do not – for example – include services paid under the Inpatient Prospective Payment System. Therefore, the CS modifier should NOT be used across-the-board for care related to COVID-19.

Note that the statutory provisions that govern waiver of cost-sharing for COVID-19 testing related services varies by payer, and the requirements that apply to the Medicare program are more circumscribed than those that apply to many other payers. CMS has issued separate guidance regarding the services for which cost-sharing must be waived under Medicaid and CHIP (see here), and for individual and group health plans (see here). For example, in the Medicaid guidance, CMS specifies that x-ray services could be considered a component of COVID-19 testing-related services, and both sets of guidance affirmatively state that serological antibody tests would be included.

Questions about waived cost-sharing for COVID-19 testing related services and the use of the CS modifier for non-Medicare payers should be directed to those payers.