# Condition Codes 44 and W2

When an inpatient stay doesn't meet medical criteria, hospitals often have confusion about billing. This paper addresses how to bill for services with the use of Condition Code 44, which may be appropriate if the beneficiary is still a patient in the hospital and Condition Code W2 when the hospital has discharged the patient.

**Condition Code 44** - A hospital may report Condition Code 44 when a practitioner ordered inpatient services, but upon review, the UR Committee determined the admission was not medically necessary. The committee must include a physician, osteopath or other practitioner (42 CFR $482.12(c)) per the Conditions of Participation (CoP 482.13). Once a patient is admitted, even the practitioner who wrote the admitting order cannot retroactively change the patient's status to an outpatient without meeting all requirements of Condition Code 44.

The **Medicare Claims Processing Manual Chapter 1, 50.3,** provides clarification on Condition Code 44.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

- The hospital has not submitted the claim to Medicare for an inpatient admission
- The change from inpatient to outpatient is made while the beneficiary is still a patient.
- The UR committee physician/practitioner and the treating practitioner must agree with the decision to change the patient status.
- The concurrence of treating practitioner and the UR committee must be documented in the patient's medical record. In addition to orders, the record must also contain the notes that explain what lead to the decision to change the patient status, the care provided to the patient, and who was involved in the decision.
- The patient must be notified of the change from inpatient to outpatient, in writing, before discharge.

On an outpatient (13x or 85x) claim, reporting Condition Code 44 allows a hospital to receive payment for medically necessary Medicare Part B services. The claim must report all services ordered and provided to the patient. Condition code 44 does not change the payment that would have been made for covered services if the claim did not require a Condition Code 44. However, when using the Condition Code 44 process, the hospital informs the patient that the stay is outpatient before he or she leaves the hospital. Medicare will reimburse under OPPS all outpatient services billed on a 13x with Condition Code 44.

While the patient is still in the hospital, if the treating practitioner does not agree with the UR Committee physician, the patient's status must remain an inpatient.

After discharge and when the hospital did not meet the requirements for Condition Code 44, the UR committee may still review a record and determine the patient's condition didn't meet admission criteria. The UR committee must provide an opportunity for the admitting physician to participate in making that

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determination. However, if the physician disagrees with the UR committee, a second UR committee physician must be consulted before making a final decision. If the admitting physician chooses not to review the record with the UR committee, within two days of the resolution, the committee must notify the admitting physician of the outcome. If the committee determines the admission was not medically necessary, the hospital must inform the patient.

**Condition Code W2** - If the UR committee determines a patient's condition did not meet admission criteria, but the hospital did not meet the requirements for Condition Code 44, the hospital may still submit claims to receive Part B service payments. The 2014 Inpatient Prospective Payment System (IPPS) final rule expanded services payable under inpatient Part B to cover all services that were medically reasonable and necessary had the patient been an outpatient, except those services that require an outpatient status.

- After filing a non-covered Part A type of bill (TOB) 110, the hospital must then report the non-covered 110 claim document control number (DCN) on a 12x TOB (Part B inpatient) with Condition Code W2 indicating a "self-denial." Condition Code W2 attests that the 12x is a rebill and the hospital is not appealing, which allows the inpatient Part B 12x claim to process for payment.
- The hospital can also submit a 13x TOB for outpatient services provided in the three-day payment window (i.e., observation, ER) before the admission order. After a patient's discharge, Medicare allows hospitals one year to review the admission and file for a Part B payment.

When the hospital submits an inpatient Part B claim, the patient is liable for both the Part B deductible, coinsurance, and any self-administered drugs not covered under Part B.

Hospitals are required to maintain documentation to support all services billed. Some hospitals may not capture documentation the same way for inpatients as it does for outpatient. Documentation must include services provided by nurses such as start and stop times of drugs and nebulizer treatments. Medicare reminds us that hospitals may include all charges for costs incurred for services provided to the patient during the visit. For example, a hospital may charge monitoring and nursing care on the claim with a revenue code of 0762 (observation) without a HCPCS code. If the treating practitioner wrote an order for observation after meeting the requirements of condition code 44, the hospital might also report, on a second claim line, any observation hours (if eight or more hours) that followed the order with the G0378.

Medicare Advantage Plans may or may not require Condition Code 44. Per the **Medicare Managed Care Manual, Chapter 4, 10.2**:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

"MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail."


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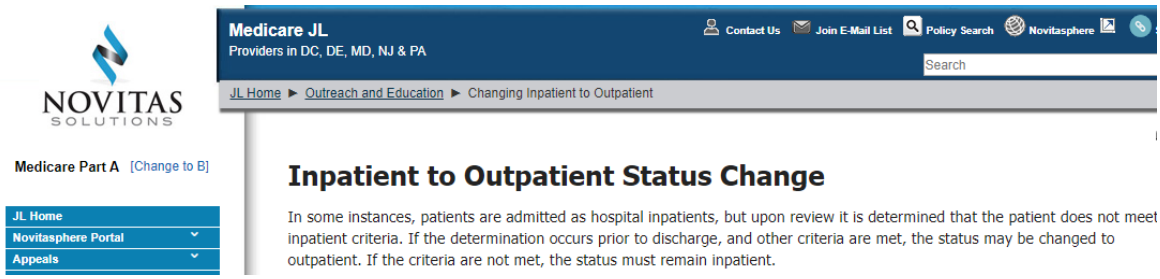
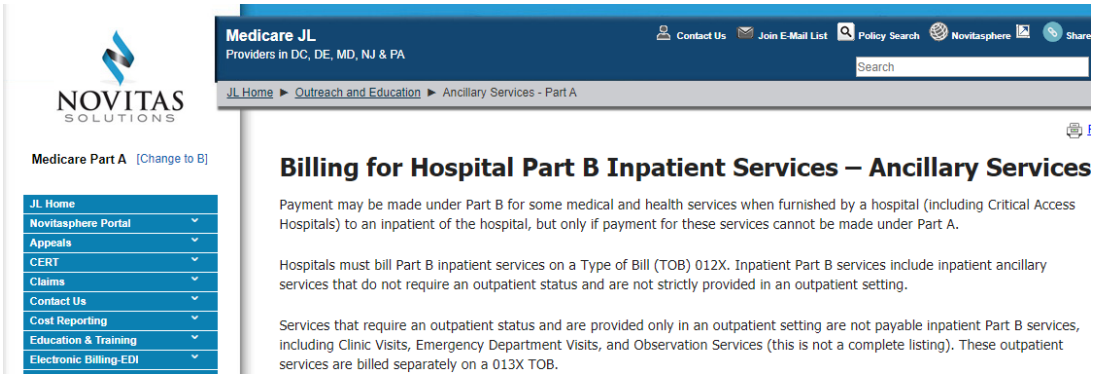
One of the Medicare contractors, Novitas, provides useful information through the following links:

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00151916




https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00151915




CMS discusses Condition Code 44 in the MLN Matters :

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0622.pdf


**MLN Matters Number: SE0622** **Related Change Request (CR) #: 3444**

**Related CR Release Date: September 10, 2004** **Effective Date: N/A**

**Related CR Transmittal #: R299CP** **Implementation Date: N/A**

**Note:** This article was updated on October 1, 2012, to reflect current Web addresses. All other information remains unchanged.

**Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient"**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