

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

Condition Codes 44 and W2

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."

Condition Codes 44 and W2

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

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

The screenshot shows the Novitas Medicare JL website. The header includes the Novitas Solutions logo, the text 'Medicare JL Providers in DC, DE, MD, NJ & PA', and navigation links: 'Contact Us', 'Join E-Mail List', 'Policy Search', 'Novitasphere', and a search bar. A breadcrumb trail reads 'JL Home > Outreach and Education > Changing Inpatient to Outpatient'. The main content area is titled 'Inpatient to Outpatient Status Change' and contains the text: 'In some instances, patients are admitted as hospital inpatients, but upon review it is determined that the patient does not meet inpatient criteria. If the determination occurs prior to discharge, and other criteria are met, the status may be changed to outpatient. If the criteria are not met, the status must remain inpatient.'

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

The screenshot shows the Novitas Medicare JL website. The header is identical to the previous screenshot. The breadcrumb trail reads 'JL Home > Outreach and Education > Ancillary Services - Part A'. The main content area is titled 'Billing for Hospital Part B Inpatient Services – Ancillary Services' and contains the text: 'Payment may be made under Part B for some medical and health services when furnished by a hospital (including Critical Access Hospitals) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. Hospitals must bill Part B inpatient services on a Type of Bill (TOB) 012X. Inpatient Part B services include inpatient ancillary services that do not require an outpatient status and are not strictly provided in an outpatient setting. Services that require an outpatient status and are provided only in an outpatient setting are not payable inpatient Part B services, including Clinic Visits, Emergency Department Visits, and Observation Services (this is not a complete listing). These outpatient services are billed separately on a 013X TOB.'

CMS discusses Condition Code 44 in the MLN Matters :

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

The screenshot shows the Medicare Learning Network (MLN) Matters article SE0622. The header features the 'Medicare Learning Network' logo and the 'MLN Matters' title, with the CMS logo and tagline 'Improving Medicare Health Care' on the right. Below the title is the subtitle 'Information for Medicare Fee-For-Service Health Care Professionals'. The article details are as follows:

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"