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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"

Key Words

SE0622, CR3444, R299CP, Questions, Answers, Admission, Condition, Code, COP, Review, UR, 44, Status, Notification, Concurrence, Bill, Record, Requirements

Provider Types Affected

Hospitals, including those for which payment for Medicare Part B services is made under the hospital Outpatient Prospective Payment System (OPPS), as well as hospitals that are not subject to the OPPS for which payment for outpatient services is made under other payment methodologies

Key Points

The Use of Condition Code 44

- In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital's admission criteria.
- The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs.
- The definition of Condition Code 44 is as follows:
 - Condition Code 44 inpatient admission changed to outpatient.
 - It is for use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.
- CMS issued Transmittal 299 (Change Request 3444) on September 10, 2004, to implement new Section 50.3 in Chapter 1 of the *Medicare Claims Processing Manual*. Section 50.3 describes when and how a hospital may change a patient's status from inpatient to outpatient as well as the appropriate use of Condition Code 44.

- Following issuance of Transmittal 299 (Change Request 3444) on September 10, 2004, the Centers for Medicare & Medicaid Services (CMS) received numerous questions and requests for clarification.
- Special Edition article, SE0622, and the questions and answers that follow are intended to address those questions and provide clarification of Medicare policy related to inpatient admissions that are determined not to be medically necessary, as well as Medicare policy related to changing a beneficiary status from inpatient to outpatient, and how the two policies interface.

Questions and Answers

Q1. Isn't there a conflict between the Condition Code 44 policy and the standards included in the hospital Condition of Participation (CoP) related to review of admissions for medical necessity?

A1. No. The CoP standards in section 482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital. CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances.

For such cases, prior to implementation of Condition Code 44, a hospital could only receive payment for certain nonphysician medical and other health services payable under Part B that were furnished either directly or indirectly to an inpatient for which payment could not be made under Part A. Condition Code 44 allows hospitals to treat the entire episode of care as an outpatient encounter, to report as outpatient services whatever services are furnished, and to receive payment under the outpatient prospective payment system as though the patient had been registered as an outpatient.

Q2. If the hospital complies with the requirement for written notification within two days of the determination, can it still bill for the encounter as an outpatient episode of care and use Condition Code 44?

A2. Yes, as long as the patient has not yet been released from the hospital, and provided that the other prerequisites for use of Condition Code 44 are met.

Q3. Can a case manager or utilization management staff member change a patient's status from inpatient to outpatient after determining that the hospital's admission criteria were not met?

A3. CMS has received many questions regarding who may make the status change, and requests for clarification as to whether utilization management staff or a case manager may implement the change. The CoP in §482.30 of the regulations requires that the utilization review committee be comprised of at least two doctors of medicine or doctors of osteopathy, although it may include other specified practitioners.

The CoP provides that the determination concerning the medical necessity of an admission or continued stay must be made by members of the utilization review (UR) committee or quality improvement organization (QIO) in consultation with the practitioner(s) responsible for the care of the patient. The CoP in §482.12(c) provides that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.

If a Medicare patient is admitted by a practitioner not specified in Medicare regulations, the patient must be under the care of a doctor of medicine or osteopathy. Therefore, a case manager or other utilization

management staff person who is not a licensed practitioner permitted by the state to admit patients to a hospital or a doctor of medicine or osteopathy would not have the authority to change a patient's status from inpatient to outpatient.

However, we encourage and expect hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in the decision making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

Q4. Is the concurrence of any physician or practitioner acceptable when a hospital has determined that a patient's status should be changed from inpatient to outpatient?

A4. One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. The practitioner(s) responsible for the care of the patient must concur with the hospital's finding that inpatient admission criteria are not met. This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations.

This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

Q5. How does a hospital bill using Condition Code 44?

A5. When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred. When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Q6. How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?

A6. If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of Bill 12x for covered Part B Only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B Only services is located in the *Medicare Benefit Policy Manual* (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The *Medicare Benefit Policy Manual* includes a complete list of the payable Part B Only services.

Q7. How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?

A7. Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.

A8. The patient rights CoP in §482.13 of the regulations require a hospital to protect and promote each patient's rights. Medicare beneficiaries have the right to participate in treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible.

For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship. Additionally, the hospital is responsible for ensuring that when there is a question regarding the medical necessity of an inpatient admission that the required UR review of that patient's status is conducted as stated in 42 CFR 482.30.

The UR committee's responsibilities and functions may be conducted by the hospital's QIO that has assumed binding UR review. However, the hospital is responsible to have either a UR committee or have a QIO that carries out the UR activities as described in 42 CFR 482.30, including the review for medical necessity of an inpatient admission and continued stay.

Q9: HIPAA establishes the NUBC as the keeper of the UB-92 condition codes. How can CMS place extra requirements on the use of the code? Doesn't this violate HIPAA?

A9. No, this does not violate HIPAA. CMS has established conditions when this code may be used for payment purposes under Medicare. The CMS policy neither modifies nor contradicts the code descriptor published by NUBC. Instead, it sets additional payment conditions under Medicare. The HIPAA implementation guide is unaffected by payment policy decisions and the other insurers who use the UB-92 codes may continue to rely on the code as they otherwise would.

In another example, CMS and its contractors set payment policy related to CPT and HCPCS codes through national and local coverage determinations (NCDs and LCDs). These determinations include payment policy standards such as when, how, and by whom CPT and HCPCS codes may be used for a particular diagnosis or procedure. CMS pays only for services that meet the requirements of these coverage determinations.

Note: The instructions provided in CR3444 and the information in Special Edition article SE0622 should be followed within the framework of an individual hospital's existing policies and procedures and do not override or supersede other CMS policies or procedures on observation services, beneficiary financial liability protections, or other related policies.

Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf>

The instruction for Condition Code 44 that affects the *Medicare Claims Processing Manual* may be found at <http://www.cms.hhs.gov/transmittals/downloads/R299CP.pdf> on the CMS website.

For details concerning the "Part B Only" rule, see the *Medicare Benefit Policy Manual*, Chapter 6, Section 10, at <http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf> on the CMS website.

For a link to the Code of Federal Regulations, go to http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.