

Proper Use of Condition Code 44

In some instances, a physician may order a beneficiary to be admitted as an inpatient, but upon reviewing the case later, the hospital's utilization review (UR) committee determines that an inpatient level of care does not meet the hospital's admission criteria.

In these cases, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim, provided that all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- The practitioner(s) responsible for the patient's care concurs with the UR committee's decision; and
- That concurrence with the UR committee's decision is documented in the patient's medical record.

If all of the above conditions are met, the hospital should submit an outpatient claim (type of bill 13x or 85x) with condition code 44. Observation services require a physician's order for observation. It is not appropriate to bill observation from the inpatient hospital admit date using condition code 44. Observation services would be billed once a physician's order for observation was received. Outpatient services prior to that order are billable, however, observation is not. All services provided during the stay should be reported on one outpatient claim. Providers should not "split bill".

If not all of the requirements are met, the hospital may bill for Part B inpatient services only (type of bill 12x).

Before making the determination, the UR committee must consult with the practitioner(s) responsible for the care of the patient and afford the practitioner(s) the opportunity to present their views.

The determination that an admission is not medically necessary may be made by one member of the UR committee if the practitioner(s) responsible for the care of the patient concur with the determination or fail to present their views when afforded the opportunity. In all other cases, the determination must be made by at least two members of the UR committee. **Reviews may not be conducted by any individual who has a direct financial interest in the hospital or who was professionally involved in the care of the patient whose case is being reviewed.** CMS encourages and expects hospitals to employ case management staff. Requirements for UR committee composition and review standards can be found in 42 Code of Federal Regulations (CFR) 482.30.

Once the determination is made, the UR committee must give written notification, no later than two days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

Further information on condition code 44 can be found in CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 50.3 and the Medicare Learning Network (MLN) Special Edition article SE0622. For information on observation, see CMS IOM, Publication 100-04, Chapter 4, Section 290.2.2.