CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 299 **Date: September 10, 2004**

CHANGE REQUEST 3444

SUBJECT: Use of Condition Code 44, "Inpatient Admission Changed to Outpatient"

I. SUMMARY OF CHANGES: This transmittal implements Chapter 1, Section 50.3, which describes when and how a hospital may change a patient's status from inpatient to outpatient, and further describes the appropriate use of Condition Code 44 in Form Locator (FL) 24-30, or its electronic equivalent, on outpatient claims (Bill Type 13X, 85X).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2004
IMPLEMENTATION DATE: October 12, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
N	1/50.3/When an Inpatient Admission May Be Changed to Outpatient Status

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 299	Date: September 10, 2004	Change Request 3444

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I. GENERAL INFORMATION

A. Background:

Payment is made under the Hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under current payment methodologies for hospitals not subject to OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

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

CMS has obtained a new condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004:

> **Condition Code 44--Inpatient admission changed to outpatient –** For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

B. Policy:

1. In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

    a. 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;
    b. The hospital has not submitted a claim to Medicare for the inpatient admission;
    c. A physician concurs with the utilization review committee's decision; and
    d. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

2. When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the <u>entire</u> episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

3. Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed; for information regarding financial liability protections.

4. When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to 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.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "Medlearn Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3444.1	FIs shall instruct hospitals that, in cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the conditions identified in section B.1. are met.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3444.1.1	FIs shall instruct hospitals that when the hospital has determined that it may submit an outpatient claim, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.	X								
3444.1.2	FIs shall instruct hospitals that when the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to 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.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2004 **Implementation Date:** October 12, 2004 **Pre-Implementation Contact(s):** Melissa Dehn mdehn@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 299, 09-10-04)

50.3 - When an Inpatient Admission May Be Changed to Outpatient Status

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(Rev. 299, 09-10-04, Effective: 04-01-04, Implementation: 10-12-04)

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

CMS has obtained a new condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004:

Condition Code 44--Inpatient admission changed to outpatient – *For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.*

Policy and Billing Instructions:

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. *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;*

2. *The hospital has not submitted a claim to Medicare for the inpatient admission;*

3. *A physician concurs with the utilization review committee's decision; and*

4. *The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.*

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed; for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to 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 not affect payment. It will be used for monitoring purposes only to allow CMS and Quality Improvement Organizations (QIOs), to track and monitor these occurrences.