Through the use of condition codes 44 and W2, hospitals can now be paid under Medicare Part B for certain inpatient cases that they self-deny within a year of the date of service. This training handbook guides utilization review (UR) staff, compliance professionals, physician advisors, billers, case managers, and others through the choices and processes involved in using these codes, allowing them to make the best decisions for their organization's bottom line.

The Condition Codes 44 and W2 training handbook helps staff understand when and how to use condition codes 44 and W2, as well as the effects they have on reimbursement and the revenue cycle. This handbook leads readers through the complex decision-making processes regarding the options for rebilling self-denied claims. Providing clear, concise interpretation of complicated regulatory guidance, the handbook presents the information in practical, easy-to-understand terms for a wide range of hospital professionals.
Condition Codes 44 and W2

Kimberly Anderwood Hoy Baker, JD, CPC
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CHAPTER 1

Introduction to Condition Codes W2 and 44

Hospitals use condition code 44 and condition code W2 to bill for Medicare Part B payment in cases where the attending physician orders an inpatient stay that does not meet Medicare’s requirements for Part A payment. In such cases, Medicare will deny payment for inpatient admissions. Condition codes 44 and W2 both allow hospitals to recover some reimbursement for incorrect inpatient orders; however, they require different processes and, depending on the situation, may generate a slightly different payment.

Condition Code 44

Prior to October 1, 2013, using condition code 44 was the only option for hospitals to receive full payment under Part B for services provided during inpatient admissions not meeting Medicare’s requirements for Part A payment. Condition code 44 allowed the hospital to change a patient’s status from inpatient to outpatient and thereby receive payment under Medicare Part B.

The Centers for Medicare & Medicaid Services (CMS) introduced condition code 44 in 2004 (CMS, Medicare Claims Processing
Manual Transmittal 299). Due to significant provider confusion, CMS released a set of frequently asked questions and guidance on the proper use of the code in 2006 (CMS, MLN Matters SE0622). The code allows hospitals to change the status of an improperly admitted patient from inpatient to outpatient.

CMS stated that this process was intended to be used infrequently and not as a substitute for concurrent review to determine the correct admission status for patients needing hospitalization. Hospitals also should not use it for a patient who was properly admitted as an inpatient based on the 2-midnight rule but subsequently improved more quickly than expected, who was transferred to another hospital or to hospice, or who died. See Chapter 2 for more information on exceptions to the 2-midnight rule.

Once a patient is formally admitted as an inpatient via an admission order from a qualified practitioner, the condition code 44 process is the only way for an organization to change that patient’s status. Even the attending physician who wrote the original admission order cannot unilaterally revert the patient’s status to outpatient.

**Process**

In order to apply condition code 44, the process first begins with a determination by a physician representative of the utilization review committee. This determination must be compliant with the Conditions of Participation (CoP) for Utilization Review (UR). This may be facilitated by a utilization review nurse or case manager. This determination should be documented either in the UR committee’s records or in the medical record of the patient.
CMS has four requirements for a compliant condition code 44 process:

- The attending physician must agree with the UR committee’s determination
- The attending physician’s concurrence is documented in the medical record
- The patient must still be a patient in the hospital
- The hospital cannot have already billed for the stay

There must be an order to change the status to outpatient, which will generally include an order for observation if the physician plans to continue to treat the patient at the hospital. The order may be entered by the attending physician or may be a verbal order. For example, “I concur with Dr. Smith of the UR committee that the patient’s status should be changed to outpatient. [Place the patient in observation.] Read back from Dr. Jones (attending physician), by S. Seng, RN.”

A written notice must be provided to the patient prior to his or her discharge from the hospital. CMS does not specify the content of the notice other than the basic determination that his or her inpatient stay was not medically necessary. The provider may wish to advise the patient they will bill Part B on their behalf, the patient’s liability under Part B, and information about self-administered drugs.
Once the condition code 44 process is complete, the entirety of the patient’s stay becomes outpatient. If the condition code 44 process is done early in a medical stay and the order for observation is obtained, the hours of observation may contribute to payment for the stay. Eight or more hours of medically necessary observation following an emergency department or clinic visit triggers additional payment under the Comprehensive Observation APC.

*Note:* Although inpatients have immediate appeal rights related to discharge, they have no ability to appeal the change from inpatient to outpatient via the condition code 44 process.

### Condition Code W2

In the 2014 inpatient prospective payment system (IPPS) final rule, CMS gave hospitals the ability to self-denial an inappropriate inpatient admission under the *CoP* for UR and then rebill all eligible services provided during the hospital stay under inpatient Part B (Type of Bill (TOB) 12X), with a companion outpatient bill for the outpatient services prior to the order (TOB 13X) (CMS, IPPS final rule, 2014).

**Process**

Similar to condition code 44, in order to apply condition code W2, the process first begins with a determination by a physician representative of the utilization review committee. This may be facilitated by a utilization review nurse or case manager. The determination should be documented either in the UR committee’s records or in the medical record of the patient.
The attending physician must be provided an opportunity to participate; however, if they elect not to participate in the determination, they can simply be notified of the outcome within two days. If they participate and disagree with the UR physician’s determination, a second UR physician must be consulted to finalize a determination.

A notice must be provided to the patient within two days of the determination. Because the determination is made after the patient’s discharge, the notice must be mailed to the patient.

The patient’s status remains inpatient, even though the care is billed for Part B payment. Inpatient Part B payment is available if the following occurs:

- The services would have been reasonable and necessary as outpatient services
- The services meet all applicable Part B coverage and payment conditions

To receive inpatient Part B payment, the hospital must first submit a non-covered inpatient Part A claim (TOB 110). Once this is processed, the hospital must report the document control number on the inpatient Part B claim (TOB 12X). The hospital must include condition code W2 on the 012X claim, attesting that the claim is a rebill and that no appeal is in process. The presence of condition code W2 causes the inpatient Part B claim to process for complete
outpatient prospective payment system (OPPS) payment. The provider must also submit an outpatient Part B claim (TOB 13X) for all services before the inpatient order was written.

Note that Medicare also makes inpatient Part B payment if the patient has no entitlement to Part A, the patient has exhausted his or her Part A benefits, or the services are only covered under Part B (i.e., preventive services). These claims are reported without condition code W2 and process for limited payment under the OPPS.

Prior to the 2014 IPPS final rule, if an inpatient admission was inappropriate and the hospital UR committee did not complete the condition code 44 process prior to the patient’s discharge, the hospital could only bill for a limited number of ancillary services similar to patients with no entitlement for Part A. The 2014 IPPS final rule expanded services that are payable under inpatient Part B to include all services that would be medically reasonable and necessary had the patient been an outpatient.

**Contractor denials**

Hospitals may also use condition code W2 to rebill a denied inpatient stay; however, hospitals that do so must pay close attention to the timely filing requirement.

Hospitals are allowed to submit a new claim for inpatient Part B payment after receiving a denial for inappropriate inpatient services provided for dates of service that occur after October 1, 2013 (CMS, IPPS, 2014). The window available to resubmit a claim
Introduction to Condition Codes W2 and 44

is one year after the original dates of service.

There is a different timely filing requirement for denials for services provided before October 1, 2013. A Medicare ruling states that hospitals have 180 days from when they received the final/binding appeal decision, or dismissal of appeal to bill for Part B inpatient. That means that if an organization were to receive an appeal decision for inpatient services that were delivered prior to October 1, 2013, it has 180 days to rebill using condition code W2. Given the backlog of Medicare contractor appeals, it is possible that a hospital could receive an appeal decision for services provided before October 1, 2013, many years later.

**Major Differences Between Condition Code 44 and Condition Code W2**

There are several significant differences between condition code 44 and W2. The timing requirements, payable services, and the weight of the attending physician’s concurrence in the UR process will help determine processes for applying condition codes 44 and W2.

**Timing**

The condition code 44 process for changing a patient from inpatient to outpatient must take place before the patient is discharged from the hospital. This is so the hospital can notify the patient of the determination before he or she leaves the hospital.

The timing requirements for a self-denial using condition code W2 are less restrictive than those in the condition code 44 process. For
dates of service on or after October 1, 2013, Medicare allows hospitals approximately one year after the patient’s discharge to review the appropriateness of the admission and file for Part B payment.

Despite the fact that CMS allows up to one year, it is in the hospital’s best interest to complete the UR review process as close to the discharge date as possible and do a self-denial if necessary. Doing so encourages a more efficient review and limits the impact on the revenue cycle. Note that it is also not uncommon for hospitals to receive denials from contractors for services that were provided more than one year prior. In cases where hospitals receive a denial for services that were provided more than a year ago, they have no ability to resubmit a claim.

The difference in timing requirements makes the condition code W2 process less resource-intensive than the condition code 44 process. To consistently meet the requirements for using condition code 44, hospitals need to coordinate with the UR physician and the attending physician, then provide notice to the patient in a short period of time before the patient is discharged—which can be quite resource intensive. With condition code W2, hospitals continue to do concurrent review, but can coordinate between the physicians and provide notice to the patient in an efficient and planned manner after the patient’s discharge. Multiple determinations can be completed at weekly, biweekly, or monthly meetings in a short period of time. See Figure 1.1 for more information.
**Figure 1.1**

<table>
<thead>
<tr>
<th></th>
<th>Condition code 44</th>
<th>Condition code W2</th>
</tr>
</thead>
<tbody>
<tr>
<td>UR determination</td>
<td><strong>Before</strong> discharge</td>
<td><strong>After</strong> discharge</td>
</tr>
<tr>
<td>Notice</td>
<td><strong>Before</strong> discharge</td>
<td>Within <strong>two days</strong> of determination</td>
</tr>
<tr>
<td>Patient status</td>
<td><strong>Outpatient</strong> (Type of Bill (TOB) 13X)</td>
<td><strong>Inpatient</strong> (TOB 12X)</td>
</tr>
<tr>
<td>Attending physician</td>
<td><strong>Concurrence</strong> required</td>
<td><strong>Offer opportunity,</strong> if no concurrence, two UR reps override</td>
</tr>
<tr>
<td>consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payable</td>
<td><strong>All</strong> covered services</td>
<td>All covered services (except infusions, injections, transfusions, nebulizer treatments for some hospitals – more later)</td>
</tr>
</tbody>
</table>


**Concurrence from the attending physician**

To use condition code 44, the attending physician’s concurrence with the UR committee is required and must be documented in the patient record. In contrast, the attending physician does not have to concur with the UR committee’s decision to rebill a self-denial using condition code W2. CMS only requires that the UR committee offer the attending physician an opportunity to provide his or her views to the committee at a review meeting. If the attending physician disagrees with the committee’s determination, two physician members of the UR committee can override the attending physician’s opinion.
Payable services

When hospitals bill for outpatient services using condition code 44 on a TOB 13X or for inpatient services using condition code W2 on a TOB 12X, Medicare will reimburse hospitals under the OPPS for all covered outpatient services.

When an inpatient Part B claim is submitted, the patient is liable for the normal Part B deductible and coinsurance. The patient is also liable for any self-administered drugs not covered under Part B received during the stay. This is the same liability the patient would have if he or she had originally been placed in outpatient status rather than mistakenly placed in inpatient status.

Note: Services that are outpatient by nature are payable on the outpatient 13X claim.

<table>
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<tr>
<th>Special Note on Ancillary Services</th>
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<tbody>
<tr>
<td>Inpatient Part B claims may include ancillary nursing services. Ancillary services are services for which hospitals customarily charge separately in addition to the room and board rate. These may include infusions, injections, transfusions, and nebulizer treatments at some hospitals. Hospitals must follow all instructions in the Provider Reimbursement Manual and the principles of cost apportionment for Medicare to recognize its treatment of the services as ancillary. All Part B documentation requirements (e.g., documentation of the length of the infusion) must be met to bill ancillary nursing services on an inpatient Part B claim.</td>
</tr>
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References


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