

Condition Code 44: Changing an Inpatient to Outpatient for Traditional Medicare Beneficiaries

When a Traditional Medicare inpatient admission does not meet medical necessity, CC44 lets the hospital change the patient to outpatient and bill Part B, but only before discharge.

THE BOTTOM LINE: CC44 is the **only** way to change a Traditional Medicare inpatient to outpatient. It **must** be completed **before the patient leaves the hospital**, and the attending **must** agree.

1 BEFORE DISCHARGE

- A **UR committee physician** determines the inpatient admission is **not** medically necessary.
- The **attending concurs** and writes the order for outpatient with observation services.
- UR staff and Physician Advisors **cannot** enter the order.
- No inpatient (Part A) claim has been submitted.

2 DOCUMENT IN THE BUSINESS RECORD

- The status change **order** and the attending's **concurrence**.
- **Why** the status was changed and the care furnished.
- Who participated in the decision.
- Do **not** delete or alter the original inpatient order.

3 BILL

- An outpatient claim with **CC44**.
- Observation hours start at the **observation order**. Inpatient hours are **never** converted to observation time.
- Medicare does **not** allow retrospective orders.
- At least **8 hours** of observation are needed to bill C-APC 8011.

CC44 CAN BE USED WHEN

- ✓ The patient is still in the hospital
- ✓ The attending agrees with the status change and documents concurrence in the health record (e.g., why patient status is changing).
- ✓ A UR committee physician member made the determination
- ✓ The hospital has **not** billed Part A for the stay

CC44 CANNOT BE USED WHEN

- ✗ The patient was already discharged (use self-denial)
- ✗ The attending disagrees or does not respond (patient stays inpatient; self-deny and bill Part B inpatient)
- ✗ The patient has Medicare Advantage (follow the plan contract or bill as directed by the plan)

Notices after CC44: Each has its own trigger, and one does not satisfy another.

Written UR notice: to the patient, attending, and hospital within **2 days** of the determination.

Medicare Outpatient Observation Notice (MOON CMS-10611)

- Required if observation exceeds **24 hours**.
- Deliver no later than **36 hours** after observation begins (the clock starts at the observation order). Explain the status change in the notice, give an oral explanation, and obtain a signature or document refusal.
- MOON is delivered to **all qualifying Medicare beneficiaries**.

Medicare Change of Status Notice (MCSN CMS-10868)

- Required when Traditional Medicare is primary, the patient is reclassified to outpatient **receiving observation** and has no Part B or reaches the **3rd hospital day**.
- Deliver no later than **4 hours before discharge**. The patient may appeal to the BFCC-QIO before leaving.

TIPS:

- Observation is a Part B service. The patient may owe coinsurance and costs for self-administered drugs.
- Observation days do **not** count toward the 3 inpatient days needed for SNF coverage.
- Medicare Advantage (MA) plans may or may not use this process depending on their contract.

References: Medicare Claims Processing Manual (Pub. 100-04), Ch. 1, §50.3.2 and Ch. 30, §§400 and 450; 42 CFR 482.30(d); 42 CFR 489.20(y); 42 CFR 405.1210 to 405.1212.