Operationalizing the Onsite Physician Advisor Program

UTILIZATION MANAGEMENT UNIVERSITY

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Agenda

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- Understanding the Admission Process
- Condition Code 44
- Condition Code W2

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Understanding the Admission Process

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42 CFR 412.3 – Admissions

- This regulation states that the **decision to admit a patient as an inpatient must be made by a qualified physician (or other qualifying practitioner)** and that this decision must be based on professional judgment about the patient's medical needs. The physician's decision must be supported by clinical factors such as patient history, symptoms, medical needs, and risk of adverse events — all of which implies the physician has sufficient knowledge of the care needed before admitting the patient.

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42 CFR 412.3 – Admissions

- While 42 CFR 412.3 focuses primarily on **admissions criteria for Medicare payment purposes**, the interpretive guidance used by surveyors (and referenced in CMS manuals) further spells out that:
  - the ordering/admitting practitioner must be knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission, and
  - they must be authorized by state law and hospital privileges to admit patients.

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42 CFR 412.3 – Admissions

- This regulatory requirement isn't just procedural; it serves to ensure that admissions aren't rubber-stamped by someone unfamiliar with the patient's condition. In Medicare's view, the admitting physician's *knowledge of care needs and clinical judgment* are key to determining whether inpatient care is medically necessary.

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CMS Interpretive Guidance — *Hospital Inpatient Admission Decision*

- In **CMS guidance titled "Hospital Inpatient Admission Order and Certification,"** which surveyors use to interpret 42 CFR 412.3 and related CoPs:
- **Ordering/Admitting Practitioner Qualifications**
  - The inpatient admission order must be furnished by a physician or other practitioner who is:
  - *Licensed by the State to admit inpatients;*
  - *Granted privileges by the hospital to admit inpatients at that facility;* and
  - ***Knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission***.
- *The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision.*

CMS State Operations Manual (SOM), Appendix A – Hospital Interpretive Guidelines
(Conditions of Participation, 42 CFR Part 482)

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Condition Code 44

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Condition Code 44 - What is it?

- (CC 44) is a Medicare billing code used when a patient's status is changed from inpatient to outpatient (observation)after admission but before discharge.
- What It means
  - The patient **was admitted as an inpatient**
  - The hospital later determined the admission **did not meet inpatient criteria**
  - The status was **corrected to outpatient** while the patient was **still in the hospital – must not be invoked after discharge**

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Condition Code 44

- The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs.
- The UR process for a status change on patients with Medicare and non-contracted MA plans requires:
  - The change must be made before the discharge is effectuated
  - The hospital has not yet billed Medicare for the inpatient stay
  - The physician concurs with the decision by a physician on the UR committee
  - This concurrence is documented in the medical record

- (CMS Manual System Pub.100-04, Medicare Claims Processing Transmittal 299)

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Condition Code 44 - Billing Implications

- The stay is billed under **OPPS (outpatient rules)**, not IPPS
- Observation services, imaging, labs, and therapies are billed as outpatient
- **No inpatient DRG payment**
- The beneficiary may now be subject to **Part B cost-sharing**
- CMS expects hospitals to **correct mistakes promptly and properly**

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Condition Code 44 - Cautions

- **Do NOT change or delete the original inpatient admission order**
  The IP order remains part of the medical record. CC 44 corrects **billing status**, not history.
- **Do NOT backdate or rewrite orders**
  Backdating is a documentation integrity violation and a red flag in audits.
- **CC 44 changes the patient's status to outpatient — not to observation by default -** Outpatient status ≠ observation.
- **Observation must be ordered separately and explicitly**
  A **valid physician observation order** is required to bill observation services. No order = no observation billing.
- **Timing still applies**
  All of the above must occur **before discharge** and **before the claim is submitted**.

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The UR Committee

Its Role in the CC44 Process

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What is a UR Committee?

- (b) *Standard: Composition of utilization review committee.* A UR committee consisting of two or more practitioners must carry out the UR function. At least **two** of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).
- (1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:
- (i) A staff committee of the institution;
- *(ii) A group outside the institution -*
  - *(A) Established by the local medical society and some or all of the hospitals in the locality; or*
  - *(B) Established in a manner approved by CMS.*

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What Do the Regulations Say

The CC44 Process



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§ 482.30 - Condition of participation: Utilization review

- (d) *Standard: Determination* regarding admissions or continued stays. (1) The determination that an admission or continued stay is not medically necessary -
- May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity: and
- Must be made by at least ***two members*** of the UR committee in all other cases

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Why 2?

§ 482.30 - Condition of participation: Utilization review.
The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

…

(b) *Standard: Composition of utilization review committee.* A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).

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§ 482.30 - Condition of participation: Utilization review;

- (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
- (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);

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Utilization Review Committee - Who can do the review?

- (3) The committee's or group's reviews may not be conducted by any individual who -
  - Has a direct financial interest (for example, an ownership interest) in that hospital; or
  - Was professionally involved in the care of the patient whose case is being reviewed.

482.30 - Condition of participation: Utilization review

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Consider this scenario

- Patient admitted with an IP order
- Utilization review finds patient does not meet criteria
- Physician Advisor agrees
- Attending physician agrees
- Changes order to **Outpatient**

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Question

- With this scenario:
- Night-time covering hospitalist admits a patient from the ED as inpatient.
- Following morning attending hospitalist feels this patient should never have been admitted as an inpatient, changes patient to place in observation.

- Can an attending physician unilaterally change a level of care on a Medicare patient from inpatient to outpatient/observation?
- Yes
- No

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Answer - **NO**

- Note that the attending physician **may not unilaterally change** a Medicare patient from IP to OP without invoking the UR process
- WHY?
- UR process ignored or not invoked
- Increased financial burden for the beneficiary without a proper UR process

NOTE: A common misconception is that the change is to Observation. It is to outpatient as an order for Observation is required before this level of care can be instituted.

REMEMBER – Observation is a service provided to an outpatient in a hospital bed

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Condition Code 44 is not:

- A substitute for inadequate UR personnel staffing
- A substitute for continued education of physicians and hospital staff on admission protocols
- A representation of need to correct inappropriate admission practices
- Should become an increasingly rare occurrence

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But Why to Monitor it???

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- **High CC 44 volume signals admission decision failures upstream**, creating avoidable rework before discharge
- **There are currently no direct CMS penalties** tied solely to CC 44 volume
- **CC 44 use must be clearly defined in hospital policy** and applied consistently
- **CC 44 activity is routinely reviewed** by Joint Commission, DNV, and state surveyors
- **Elevated CC 44 utilization can attract audit attention**, even without a formal penalty
- **CC 44 volume may evolve into a monitored metric**, potentially appearing in PEPPER or similar tools

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Keep in Mind

- Medicare limits observation to fewer than two midnights, as it creates an increased financial burden for the patient. As observation charges are billed in eight-hour increments, the hospital can recover some costs for observation services after the order if more than eight hours of care are provided. Thus, getting to the correct level of care earlier in the process, rather than just before discharge, is advantageous.

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Understanding *the Parts of Medicare*

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Traditional Medicare

- Refers to **Part A + Part B**
- Governed directly by Centers for Medicare & Medicaid Services
- Rules are statutory and regulation-driven

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Understanding the Parts of Medicare (1 of 2)

- **Medicare Part A (Hospital Insurance)**
  - Covers inpatient hospital care, SNF (with qualifying stay), hospice, limited home health
  - Funded primarily through payroll taxes
  - Subject to the **3-day SNF rule**
- **Medicare Part B (Medical Insurance)**
  - Covers physician services, outpatient care, observation, ED visits, diagnostics
  - Premium-based
  - Inpatient denials often rebilled here under **Part B**

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Understanding the Parts of Medicare (2 of 2)

- **Medicare Part C (Medicare Advantage)**
  - Private plans replacing Parts A and B
  - Must cover Medicare benefits but **can waive certain rules** (e.g., SNF 3-day stay)
  - Coverage governed by **contract and prior authorization**
- **Medicare Part D (Prescription Drug Benefit)**
  - Covers outpatient prescription medications
  - Administered through private plans
  - Separate from hospital payment rules

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2026 CMS Deductibles and Copayments

- **Part A**
  $1,736 deductible for each benefit period
  Days 1–60: $0 coinsurance
  Days 61–90: $434 coinsurance per day
  Days 91 and beyond: $868 coinsurance per each *lifetime reserve day* after day 90 (up to 60 days over your lifetime)
  Beyond lifetime reserve days: **all costs**
- **Part B**
  $283 annual deductible
  20% copay for all covered services, Medicare will cover 80% of your Part B expenses
  100% for all non-covered services
- **Benefit Period Definition**
  The benefit period begins the day you enter the hospital or facility and ends after you have not needed inpatient care for **60 days in a row**.

CMS Fact Sheet — "2026 Medicare Parts A & B Premiums and Deductibles"

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UR Process Solutions – Best Practice

- 7-day/week UR coverage
- Initial review performed as close to admission as possible
- Physician Advisor involvement for questionable admissions
- UR-driven CC 44 determination prior to discharge *(status correction only — inpatient order is not changed)*
- Attending physician concurrence obtained and documented
- UR Committee involvement for second-level review when required

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Condition Code W2

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Condition code W2

- When hospitals determine **after discharge** that a patient did not meet inpatient criteria, they can file a provider liable claim using Condition Code W2 and be reimbursed for all services **as if the patient were an outpatient**
- The claims must be filed within 12 months after discharge.
- The medical record must be reviewed by the physician advisor and the utilization review committee before the claim is submitted.

*****Therefore, it is still advantageous to get the patient status right up front and prior to discharge**

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Beware – With Condition Code W2 (1 of 2)

- **The beneficiary's status remains inpatient for the entire stay**
  Once admitted, the inpatient status **does not change** after discharge—regardless of later review findings.
- **There is no mechanism to convert inpatient to outpatient after discharge**
  Post-discharge corrections are handled through **Part B rebilling**, not a status change.
- **Condition Code W2 reflects a post-discharge determination**
  It signals that the inpatient admission **did not meet medical necessity** and was identified **after the patient left the hospital**.

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Beware – With Condition Code W2 (2 of 2)

- **W2 has significant downstream impacts**
  Including effects on:
- Quality metrics
- Length of stay calculations
- Readmission statistics
- Benchmarking and utilization profiles
- **Frequent W2 use indicates upstream process failure**
  High W2 volume suggests **missed reviews, late escalation, or weak admission decision controls**.

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Condition Code 44 vs Condition Code W2 — At a Glance

Category	CC 44	CC W2
Timing	**Before discharge**	**After discharge**
Patient status	Changed to **outpatient**	**Remains inpatient**
Status change allowed?	✓ Yes (pre-discharge only)	❌ No (post-discharge prohibited)
UR / physician involvement	**UR review + attending concurrence required**	Not applicable
Billing outcome	**Outpatient (OPPS)**	**Part B rebill after Part A cancellation**
Operational meaning	**Prevention / real-time correction**	**Late correction / process failure**

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Thank you!

QUESTIONS

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