Priority Health	BILLING POLICY No. 005
CONDITION CODES	
Date of origin: June 2024	**Review dates: 11/24, 2/2025, 5/2025, 6/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Condition codes (a.k.a. reason codes) are designed to allow the collection of information related to the patient, particular services, service venue and billing parameters which impact the processing of a facility claim.

Priority Health follows the Centers for Medicare and Medicaid Services (CMS) standard billing guidelines. Review CMS guidelines to confirm whether an occurrence and/or value code must also be reported.

For accurate identification of facility claim corrections, facilities should report the appropriate adjustment indicator for a corrected or voided/canceled claim along with the claim change reason code.

See our Provider Manual's correcting a claim page for additional information regarding bill types to report in addition to the reason codes noted below. Claims reported without the bill type and change reason code will be denied.

POLICY SPECIFIC INFORMATION

Claim change reason codes

- **D0**: Changes to service dates
- **D1**: Changes in charges
- **D2**: Changes in revenue code/HCPC
- **D3**: Second or subsequent interim PPS bill
- **D4**: Change in Grouper input (DRG)
- **D5**: Cancel only to correct a patient's Medicare ID number or provider number
- **D6**: Cancel only - duplicate payment, outpatient to inpatient overlap, OIG overpayment
- **D7**: Change to make Medicare secondary payer
- **D8**: Change to make Medicare primary payer
- **D9***: Any other changes (should be used only when no other change reason is applicable)
- **E0**: Change in Patient Status
- **G0**: Distinct Medical Visit. See additional information on use in our Provider Manual.

*Use of condition code D9 should also include a remark to mirror bold criteria below on the second line of remarks:

- **Patient control nbr**: Changing or adding a patient control number
- **Admission hour**: Changing or adding the admission hour
- **Admission type**: Changing or adding the admission type
- **Admission source**: Changing or adding the admission source
- **Medical record number**: Changing or adding the medical record number
- **Condition code**: Changing or adding a condition code
- **Occ codes**: Changing or adding an occurrence code
- **Occ span codes**: Changing or adding an occurrence span code
- **Value codes**: Changing or adding a value code
- **Modifier**: Changing or adding a modifier
- **Date of service**: Changing a date of service on a line or changing the statement from and to dates, use a D0
- **Units**: Changing units
- **Recalculation**: Claim recalculated for a different payment
- **Multiple changes**: Enter your changes
- **DX code**: Changing a diagnosis code on an outpatient claim, inpatient claims would use a D4
- **POA**: Changing, adding or removing a Present on Admission (POA) indicator, unless you're changing an N to a Y and/or if it affects reimbursement, in which case you would use D4
- **Removed non**: Removing non-covered charges
- **Other**: Place this information on the second line of the claim only. On the third line of claim, include a brief description of why the claim is being adjusted

Accommodation condition codes

- **40**: Same day transfer
- **41**: Partial hospitalization
- **42**: Continuing care not related to inpatient admission
- **43**: Continuing care not provided within prescribed post discharge window
- **44**: Inpatient admission changed to outpatient. See additional information in our Provider Manual.

Beneficiary/Spouse insurance related condition codes

- **45**: Ambiguous gender category. See additional information in our Provider Manual.

Disaster related condition codes

- **DR**: Disaster related, used to identify claims that are or may be impacted by specific payer/health plan policies related to national or regional disasters.

ESRD related condition codes

- **59**: Non-primary ESRD facility
- **70**: Self-administered Epoetin (EPO)
- **71**: Full care in unit
- **72**: Self-care in unit
- **73**: Self-care training
- **74**: Home

- **76**: Back-up in-facility dialysis
- **80**: Patient receives dialysis services at home – patients' home is nursing facility
- **84**: Dialysis for acute kidney injury on monthly basis
- **87**: ESRD self-care retraining
- **H3**: Reoccurrence of GI bleed comorbid category
- **H4**: Reoccurrence of pneumonia comorbid category
- **H5**: Reoccurrence of pericarditis comorbid category

Hospitalization, product and service-related condition codes

- **27**: Patient referred to a sole community hospital for a diagnostic laboratory test.
    - Don't report this code when the specimen only is referred/sent for testing.
- **30**: Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
- **40**: Same day transfer. Transfer of a patient to another facility before midnight on the day of admission.
    - The dates in the statement covers field must be the same as the same-day transfer date
- **41**: Claim is for partial outpatient hospitalization services which include a variety of psychiatric programs.
- **42**: Continued care plan is not related to the inpatient admission condition or diagnosis.
- **43**: Continued care was not provided within the post discharge window.
- **44**: Inpatient admission changed to outpatient. This code is used on outpatient claims, when the physician ordered inpatient services, but utilization review determined that the services did not meet inpatient criteria, before the claim was originally submitted. Click here for additional information.
- **49**: Product lifecycle replacement of product earlier than the anticipated lifecycle due to an indication that the product isn't functioning properly
- **50**: Product replacement for known recall by a product manufacturer of FDA
- **51**: Provider attestation that services billed are unrelated to outpatient non-diagnostic services which should not be bundled into the inpatient hospital claim.
- **53**: The initial placement of the medical device was provided as part of a clinical trial or as a free sample.
- **79**: Comprehensive Outpatient Rehab Facilities (CORF) services provided off site. (Physical therapy, Occupational therapy or Speech Pathology)
- **B4**: Admission unrelated to discharge on the same day
- **G0**: Distinct medical visit. Multiple, distinct, independent evaluation and management visits on the same day in the same revenue center. Not reported by CAHs.

See our Surgical Implants and Devices policy for additional information on these condition codes (49, 50, 53).

SNF related condition codes

- **55**: SNF bed not available
- **56**: Medical appropriateness
- **57**: SNF readmission

See additional information on above condition codes in our Provider Manual.

Related denial language

Prism explanation code: **y04 – Invalid condition code**

REFERECES

- Condition codes – JE Part A (Noridian Medicare)
- Medicare claims processing manual (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 11, 2024	• Added Hospitalization condition codes 27, 30, 40, 41, 42, 43, 44, 51, 79, B4 and G0. • Added "References" section
Feb. 4, 2025	Added "Disclaimer" section

May 13, 2025	• Added “Related denial language” section with prism explanation code y04 – Invalid condition code • Updated “Applies to” section
June 4, 2025	No changes made