Condition Codes 49, 50 and 53, Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This billing policy applies to all Molina Medicaid, Medicare, and Marketplace lines of business.

Condition codes can be found on the UB-04 billing form, which is used nationwide by institutional and facility healthcare providers. Condition codes are two-character numeric or alphanumeric indicators that reflect details about the patient, the services rendered, the setting in which care was delivered, or specific billing circumstances — all of which may influence how a payer reviews and processes an institutional or facility claim. Condition codes can be found in boxes 18-28 on the UB-04 institutional form.

The National Uniform Billing Committee (NUBC) maintains the UB-04 form and hence creates and maintains UB-04 Condition Codes.

The NUBC has assigned to Condition Code 49, the definition of "Product lifecycle replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly."

The NUBC has assigned to Condition Code 50, the definition of "Product replacement for known recall by a Product Manufacturer or FDA."

The NUBC has assigned to Condition Code 53, the definition of "The initial placement of a medical device provided as part of a clinical trial or a free sample."

However, it is the Centers for Medicare and Medicaid Services (CMS) that has developed policies as to how and when Condition Codes 49, 50 and 53 should be used.

CMS has developed policies and guidelines to indicate situations where a hospital or ambulatory surgical center receives a device at no cost or with significant credit from the manufacturer, necessitating specific reporting on the Medicare claim. That specific reporting involves using Condition Codes 49, 50, and 53. Molina Healthcare follows the same guidelines and policies that CMS created for Medicare claims, regarding Condition Codes 49, 50, and 53.

Condition Codes 49 and 50 are used for both inpatient and outpatient claims and ambulatory surgical center claims. Condition Code 53 is used only for outpatient and ambulatory surgical center claims.

Molina Healthcare shall provide coverage for the removal and replacement of recalled or defective medical devices when such procedures are determined to be medically necessary. In instances where an inpatient facility, an outpatient facility or an ambulatory surgical center receives a full or partial credit from the device

manufacturer – whether due to product recall or warranty coverage – Molina Healthcare shall not be liable for the full replacement cost of the device. Molina Healthcare reserves the right to conduct audits of any claims submitted in connection with such services.

Reimbursement Guidelines

When a provider submits a claim for a medically necessary removal and replacement of a recalled or defective medical devices, providers submitting claims to Molina Healthcare should ensure the following details are included on the inpatient, outpatient, and ambulatory surgery center claim forms, as appropriate:

Condition Code 49 - Product lifecycle replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly: This situation qualifies as a warranty-based replacement, prompted by signs that the item is malfunctioning and needs to be substituted before the expected end of its usable life. Value Code FD is usually used alongside Condition Code 49 on payer claims when a hospital or ambulatory surgical center receives a full or partial credit of 50% or more for a replaced medical device.

Condition Codes should be placed in Field Locator (FL) 39–41 on the UB-04 Form.

Condition Code 50 - Product replacement for known recall by a Product Manufacturer or FDA: In this case, the product must be replaced because it has been designated for recall by either the manufacturer or the U.S. Food and Drug Administration (FDA). Value Code FD is usually used alongside Condition Code 50 on payer claims when a hospital or ambulatory surgical center receives a full or partial credit of 50% or more for a replaced medical device.

Condition Codes should be placed in Field Locator (FL) 39–41 on the UB-04 Form.

Condition Code 53 - The initial placement of a medical device provided as part of a clinical trial or a free sample: Used to assist in the identification and tracking of medical devices supplied at no charge or with full reimbursement to the hospital or the ambulatory surgical center —such as those provided through a clinical trial or as free samples—Condition Code 53 must appear on the claim. When this code is reported, Value Code FD is usually reported as well.

Condition Code 53 is only for outpatient claims and ambulatory surgical center claims; ***it is not to be used for inpatient claims***.

Condition Codes should be placed in Field Locator (FL) 39–41 on the UB-04 Form.

More than one condition code (49, 50, or 53) can be reported on the same UB-04 claim—but only when the condition codes accurately reflect different, distinct services or different, distinct medical devices reported within that claim. Whether it is appropriate or valid to report multiple condition codes (example: 49 and 50, or 50 and 53) depends on the clinical and billing context.

Value Code FD - Credit Received from the Manufacturer for a Medical Device: Value Code FD is used when a hospital or ambulatory surgical center receives a full or partial credit of 50% or more for a replaced medical device due to warranty, recall, or field action. In such cases, the hospital or ambulatory surgical center must report the amount of the device credit in the amount portion for Value Code field on the claim.

Value Codes and corresponding credit amounts should be placed in Field Locator (FL) 39–41 on the UB-04 Form.

Value Code FD — Report the credit amount received.

Enter FD in one of the value code fields (FL 39a, 40a, or 41a, etc.) and place the dollar amount of the manufacturer's credit next to it.

What it does: Tells the payer how much money the hospital got back from the manufacturer (typically ≥50% of the device's cost).

Purpose: To allow the payer to adjust the payment downward, avoiding double reimbursement.

Reported as a dollar amount (e.g., FD = $2,000), which reflects the manufacturer's credit, not the charge for the medical device.

Value Code FD is not always reported with Condition Codes 49, 50, or 53. This is because a device may have been replaced due to a warranty or recall without the hospital or ambulatory surgical center receiving credit that impacted reimbursement.

Regarding modifiers FB and FC for Outpatient Prospective Payment System (OPPS) claims: CMS Transmittal 11937, dated March 31, 2023 states that effective January 1, 2014, hospitals paid under the Outpatient Prospective Payment System (OPPS) are no longer required to use modifiers FB or FC on the UB-04 claim form, to reflect the dollar amount of the credit received from the manufacturer.

According to the Medicare Claims Processing Manual, Chapter 4, modifiers FB and FC were created and used specifically for outpatient claims; thus, modifiers FB and FC were never intended to be used inpatient claims. Instead, for inpatient claims, the hospital must report Condition Code 49 or 50 and Value Code FD (if appropriate) to reflect the dollar amount of the credit received from the manufacturer when a replaced medical device is credited at 50% or more of its cost.

Ambulatory Surgical Centers do not use Value Code FD to reflect the dollar amount of the credit received from the manufacturer when a replaced medical device is credited at 50% or more of its cost. Instead, Ambulatory Surgical Centers use Condition Codes 49, 50 or 53, with either modifier FB or FC.

Modifier FB - Item Provided Without Cost to Provider, Supplier, or Practitioner, or Full Credit Received for Replaced Device: Item provided without cost to provider, supplier, or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples).

Modifiers should be entered in Field Locator (FL) 44 on the UB-04 form; the field is called the HCPCS/Rate/HIPPS Code.

Enter the applicable procedure or device code (CPT or HCPCS) and modifier(s). Up to four modifiers may be entered on outpatient UB-04

claims in Field Locator 44. All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate/HIPPS field with no spaces.

Modifier FB is attached to the CPT/HCPCS code ***for the procedure*** that involves the use or implantation of the no-cost or fully credited device.

Modifier FB ***does not*** attach to the medical device HCPCS line item.

The medical device HCPCS line item has a charge of $0 or $1 in Field Locator 47 of the UB-04 form, which is labeled Total Charges.

Modifier FB is used when a device is furnished at no cost or when full credit is received for a replacement device.

Modifier FC – Partial Credit Received for Replaced Device.

Modifiers should be entered in Field Locator (FL) 44 on the UB-04 form; the field is called the HCPCS/Rate/HIPPS Code.

Enter the applicable procedure or device code (CPT or HCPCS) and modifier(s). Up to four modifiers may be entered on outpatient UB-04 claims in Field Locator 44. All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate/HIPPS field with no spaces.

Modifier FC is attached to the CPT/HCPCS code ***for the procedure*** that involves the use or implantation of the partially credited medical device.

Modifier FC ***does not*** attach to the medical device HCPCS line item.

The medical device HCPCS line-item charge in Field Locator 47 of the UB-04 form, which is called Total Charges: The Ambulatory Surgical Center should report the actual charge that reflects the reduced cost of the device after the partial credit is applied.

Modifier FC is used when a provider receives a partial credit equal to or greater than 50% of the cost of a new replacement medical device due to warranty, recall or field action.

Do not use Modifier FC when the credit is less than 50% of the medical device's cost. In that case, no modifier (or standard claim billing) is used.

Supplemental Information

Definitions

Term	Definition
Ambulatory Surgical Center (ASC)	A health care facility that specializes in providing same-day surgical care, including diagnostic and preventive procedures, to patients who do not require hospitalization.
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
Condition Codes	Condition codes can be found on the UB-04 billing form, which is used nationwide by institutional and facility healthcare providers. Condition codes are two-character numeric or alphanumeric indicators that reflect details about the patient, the services rendered, the setting in which care was delivered, or specific billing circumstances — all of which may influence how a payer reviews and processes an institutional or facility claim. Condition codes can be found in boxes 18-28 on the UB-04 institutional form. Condition Codes can be numeric, alphanumeric, or alphabetic.
CPT Code	Current Procedural Terminology. Used by physician offices and physicians and clinicians in all settings, outpatient hospital facilities, outpatient dialysis centers, and ambulatory surgery centers. CPT codes are used to report most claims submitted.
FDA	The Food and Drug Administration (FDA) is a federal agency within the U.S. Department of Health and Human Services. It is responsible for protecting public health by ensuring the safety, effectiveness, and security of a wide range of products, including drugs (both prescription and over the counter); medical devices; biologics; food products; cosmetics; tobacco products and radiation-emitting electronic products.

HCPCS Code	Healthcare Common Procedure Coding System. Used by physician offices, outpatient hospital facilities, inpatient, outpatient dialysis centers, and ambulatory surgery centers. Medicare mandates that providers (regardless of the type of provider) use alphanumeric HCPCS codes to report various biologicals, drugs, devices, supplies, and certain services.
Medicare	Medicare is a federal health insurance program in the United States. It helps pay for healthcare for people who are 65 or older, some younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure). Traditional fee-for-service Medicare (also called "Original Medicare") covers 80% of medical services, regardless of what they are, and the patient is expected to pay the remaining 20% of the Medicare allowable.
Modifiers	Two-digit modifiers are two-character codes used to provide additional information about a service or procedure. They are added to the CPT or HCPCS codes to indicate specific details about how a procedure was performed, any unusual circumstances, or any adjustments that might apply to the standard billing.
National Uniform Billing Committee (NUBC)	NUBC stands for The National Uniform Billing Committee (NUBC). It is an organization responsible for designing and maintaining the UB-04 health insurance claim form. NUBC works directly with CMS (Centers for Medicare and Medicaid Services) as a key partner in standardizing medical billing data across the healthcare industry.
Outpatient Prospective Payment System (OPPS)	The Outpatient Prospective Payment System (OPPS) is a Medicare reimbursement system used by the Centers for Medicare & Medicaid Services (CMS) to pay hospitals for outpatient services. It sets out predetermined, fixed payments based on the type of service, rather than actual costs incurred.
UB-04 Form	Used for billing institutional claims for inpatient and outpatient services at hospitals, ambulatory surgery centers, cancer treatment centers, dialysis centers and skilled nursing facilities; it can also be used for billing drugs and durable medical equipment associated with the institutional visit.

Term	Definition
Value Codes	A field in the UB-04 form. Value codes communicate key details and unusual circumstances associated with a claim, enabling payers to accurately calculate the correct reimbursement amount. Value Codes are at Field Locator (FL) 39–41 on the UB–04 Form. Value Codes can be numeric, alphanumeric, or alphabetic.

Documentation History

Type	Date	Action
Effective Date	04/28/2025	New Policy

References

This policy was developed using this.

- individual state Medicaid regulations, manuals & fee schedules.
- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services.
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

Reference	Reference Link

CMS	Medicare Claims Processing Manual - Medicare Claims Processing Manual, Chapter 4, Rev. 12979, Issued November 22, 2024. Sections 20.6.9, 20.6.10, 61.3.5, and 61.3.6.
CMS	R11937CP – CMS Manual System, Pub 100-04, Transmittal 11937, March 31, 2023.
CMS	Medicare Billing for Cardiac Device Credits - The Medicare Learning Network Fact Sheet, Medicare Billing for Cardiac Device Credits, March 2018.
CMS	r3181cp.pdf – CMS Manual System, Pub 100-04, Transmittal 3181, Date: January 30, 2015.
Department of Health and Human Services, Office of the Inspector General	Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits, A-05-16-00059 - Department of Health and Human Services, Office of the Inspector General, Hospitals Did Not Comply with Medicare Requirements for Reporting Certain Cardiac Device Credits, report by Gloria L. Jarmon, March 2018, Report Number A-05-16-00059.
The Federal Register	Federal Register :: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction – Category IV. IV. OPPS Payment for Devices, Subcategory B: Use of the Three Criteria to Designate Device-Intensive Procedures, Section 4, Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices, Subsection A: Background and Subsection B: Policy for No Cost/Full Credit and Partial Credit Devices.

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes not effective when the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only.*

Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.