Appropriate Patient Discharge Status for Type of Bill Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

***Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the facility or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies**.*

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid product

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities, including, but not limited to, non-network authorized and percent of charge contract facilities

Policy

Overview

The uniform bill known as the UB-04, also called the CMS-1450, is used by Medicare and third-party payers for billing facility services.

The data elements and design of the billing formats are determined by the National Uniform Billing Committee (NUBC) at the request of CMS, the state uniform billing committees (SUBC) and provider and payer associations. Most of the UB-04 Form Locators (FLs) are required data elements for Medicare billing. Unassigned codes and spaces on the claim form are available to meet the future reporting needs of CMS and state and local regulatory agencies and payer-specific requirements for hospital billing.

The form and electronic format are flexible to accommodate most third-party payers and hospitals and to promote uniform use of the claim. The FL requirements, revenue codes and subcategory codes are revised on an ongoing basis by the NUBC. More information is available in the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual.

Reimbursement Guidelines

Based on national guidelines for completing and submitting a UB-04 (or the electronic comparative) a provider must assign a Patient Discharge Status code which aligns with the type of bill (TOB) submitted.

UnitedHealthcare Community Plan requires Patient Discharge Status codes for:
Hospital Inpatient Claims (TOBs 11X and 12X);
Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X)
Outpatient Hospital Services (TOBs 13X, 14X, 71X, 73X, 74X, 76X and 85X); and
All Hospice and Home Health Claims (TOBs 32X, 33X, 34X, 81X and 82X).

The appropriate type of bill is determined based on the following guidance from the NUBC:

- The first digit is a leading zero.
- The second digit is the type of facility.
- The third digit classifies the type of care being billed.
- The fourth digit indicates the sequence of the bill for a specific episode of care. The fourth digit is commonly referred to as the “frequency” code.

The fourth digit is indicative of the submission frequency, and should align with the Patient Discharge Status reported on the claim. A type of bill with a frequency reflective of an ongoing stay should align with a discharge status indicating that the patient is still receiving care. Additionally, a type of bill reflective of a discharge or final claim should be reported with a Patient Discharge Status that identifies where the patient is at the conclusion of a health care facility encounter, or at the end of a billing cycle (the ‘through' date of a claim).

It is important to select the correct Patient Discharge Status code. In cases in which two or more Patient Discharge Status codes apply, providers should code the highest level of care known.
UnitedHealthcare Community Plan will deny claims when the Patient Discharge Status is inconsistent with the type of bill reported.

For example, discharge status 30 (Still Patient) would not be appropriate with type of bill 211 (Inpatient Nursing Home: Admit through discharge claim).

Code	Description	Code	Description
01	Discharge to Home or Self Care (Routine Discharge)	40-42	Hospice Patient discharge status Codes - Hospice Claims Only (TOBs: 81X & 82X)
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care	43	Discharged/Transferred to a Federal Hospital
03	Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care	44-49	Reserved for National Assignment
04	Discharged/Transferred to an Intermediate Care Facility (ICF)	50 and 51	Discharged/Transferred to a Hospice
05	Discharged/Transferred to a Designated Cancer Center or Children’s Hospital	52-60	Reserved for National Assignment
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care	61	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
07	Left Against Medical Advice or Discontinued Care	62	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital

08	Reserved for National Assignment	63	Discharged/Transferred to Long Term Care Hospitals (LTCHs)
09	**Admitted as an Inpatient to this Hospital**- This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.	64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare
10-19	Reserved for National Assignment	65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
20	Expired	66	Discharged/Transferred to a CAH
21-29	Reserved for National Assignment	67-69	Reserved for National Assignment
30	Still Patient or Expected to Return for Outpatient Services	70	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
31-39	Reserved for National Assignment	71-99	Reserved for National Assignment

State Exceptions	
Florida	Inpatient admissions effective 02/01/2021 and after, per Florida State requirements, Providers will follow the directive below when submitting Interim Claims for Inpatient members when the length of stay exceeds 100 days: 1. Providers will bill the first 100 days using: • Type of Bill (TOB) 112 (first interim claim) • Discharge Status should reflect member is still Inpatient • Admission date to current date 2. Providers will bill for additional days after the initial billing using: • TOB 113 (continuing claim) • Discharge status that reflects member is still Inpatient • Admission date to current date • Claims should include billed amounts from previously billed claims through current billing dates • Previously billed claims will be voided and replaced with subsequent claims 3. Providers will bill the Final claim using • TOB 114 (discharge TOB) • Discharge status should reflect member has been discharged • Admission date to discharge date • Claims should include billed amounts from previously billed claims through discharge billing date • Previously billed claims will be voided and replaced with Final claim Per state requirements, effective 12/01/2018, providers may bill Outpatient types of bill 75X and 77X in addition to the Outpatient Hospital Services list above.

Definitions

Patient Discharge Status Code	A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim).

Questions and Answers

1	**Q:** Can Patient Discharge Status Code 30, Still a Patient, be used on both inpatient and outpatient claims? **A:** Yes, it can be used on both types of claims. Patient Discharge Status Code 30 should be used on inpatient claims when billing for leave of absence days, and for inpatient and outpatient interim bills. The primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 2: Interim - First Claim, or Frequency Code 3: Interim - Continuing Claim) Bill types ending in 2 or 3 should be reported with patient status of 30
2	**Q:** Does this Policy apply to Inpatient or Outpatient claims? **A:** This policy applies to both Inpatient and outpatient claims

Resources

CMS Outpatient Code Editor (OCE)
https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
MLN Matters® Number: SE1411
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1411.pdf

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services MLN Matters® Number: SE21001
https://www.cms.gov/files/document/se21001.pdf

Individual state Medicaid regulations, manuals & fee schedules

Medicare Claims Processing Manual Chapter 1 - General Billing Requirements
Medicare Claims Processing Manual (cms.gov)

Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing
CMS Publication 100-04, Chapter 3, Section 40.2.4 (PDF)

Medicare Claims Processing Manual Chapter 25 - Completing and Processing the Form CMS-1450 Data Set
Medicare Claims Processing Manual Crosswalk (cms.gov)

MS-DRG Classifications and Software
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National Uniform Billing Committee (NUBC)
http://www.nubc.org/

History

8/1/2023	Annual Anniversary Date and Version Change Header Logo Updated History Section: Archived dates prior to 08/01/2021
8/1/2022	Policy Version Change Resources Section: Added Resources
7/7/2022	Policy Version Change Resources Section: Updated Links
06/13/2022	Policy Version Change State Exceptions: Florida updated History Section: Archived dates prior to 06/13/2020
8/1/2021	Annual Anniversary Date and Version Change History Section: archived dates prior to 8/1/2019
12/1/2016	Policy implemented by UnitedHealthcare Community Plan

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