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 Individual Exchange reimbursement policies may use 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 the UB-04 form or its electronic equivalent or its successor form. 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 Individual Exchange's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Individual Exchange 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 Individual Exchange enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to legislative mandates, the physician 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 Individual Exchange due to programming or other constraints; however, UnitedHealthcare Individual Exchange strives to minimize these variations.

UnitedHealthcare Individual Exchange 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 Individual Exchange products.

This reimbursement policy applies to services reported using the UB04 claim form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network outpatient facility claims, Ambulatory Surgical Centers (ASC), Outpatient Surgical Centers (OSC), including, but not limited to, non-network authorized, and percent of charge contract facilities.

Applicable States:

This reimbursement policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York.

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 Individual Exchange 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 Individual Exchange 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).

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

National Uniform Billing Committee (NUBC)
http://www.nubc.org/

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
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/se1411.pdf

History	
4/14/2024	Policy Version Change Updated Application Language Resources section updated
6/23/2022	Policy Version Change: Template update removing references to CMS 1500 form
1/1/2022	Policy Version Change: Template update Attachments Section: Removed from policy
1/1/2021	Policy implemented by UnitedHealthcare Value & Balance Exchange

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