

## 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.

\*CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

### 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 Nevada.

### 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).

Code	Description	Code	Description
01	Discharged to home or self-care (routine discharge)	64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
02	Discharged/transferred to a short-term general hospital for inpatient care	65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification	66	Discharged/transferred to a critical access hospital (CAH)
04	Discharged/transferred to a facility that provides custodial or supportive care	67	Reserved for national assignment
05	Discharged/transferred to a designated cancer center or children's hospital	68	Reserved for national assignment
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care	69	Discharged/transferred to a designated disaster alternate care site (effective 10/1/13)

07	Left against medical advice or discontinued care	70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
08	Reserved for national assignment	71	Discontinued 4/1/03
09	Admitted as an inpatient to this hospital	72	Discontinued 4/1/03
10-19	Reserved for national assignment	73-80	Reserved for national assignment
20	Expired	81	Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
21	Discharged/transferred to court/law enforcement	82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
22-29	Reserved for national assignment	83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
30	Still patient	84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
31-39	Reserved for national assignment	85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
40	Expired at home	86	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission (effective 10/1/13)
41	Expired in a medical facility (e.g., hospital, SNF, ICF, or free-standing hospice)	87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
42	Expired - place unknown	88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
43	Discharged/transferred to a federal health care facility	89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
44-49	Reserved for national assignment	90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)

50	Hospice - home	91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
51	Hospice - medical facility (certified) providing hospice level of care	92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
52-60	Reserved for national assignment	93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
61	Discharged/transferred to a hospital-based Medicare approved swing bed	94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital	95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/1/13)
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)	96-99	Reserved for national assignment

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	<p><b>Q:</b> Can Patient Discharge Status Code 30, Still a Patient, be used on both inpatient and outpatient claims?</p> <p><b>A:</b> 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.</p>
2	<p><b>Q:</b> Does this Policy apply to Inpatient or Outpatient claims?</p> <p><b>A:</b> This policy applies to both Inpatient and outpatient claims.</p>

Resources
<p>CMS Outpatient Code Editor (OCE)  <a href="https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html">https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html</a></p> <p>Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services            MLN Matters® Number: SE1411  <a href="https://www.cms.gov/sites/default/files/repo-new/67/se1411_0.pdf">https://www.cms.gov/sites/default/files/repo-new/67/se1411_0.pdf</a></p>

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>

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

[MS-DRG Classifications and Software | CMS](#)

National Uniform Billing Committee (NUBC)

<http://www.nubc.org/>

## History

<b>12/30/2025</b>	Policy Version Change Updated Application Language
<b>9/1/2025</b>	Policy Version Change Updated Application Language Resources section updated
<b>4/14/2024</b>	Policy Version Change Updated Application Language Resources section updated
<b>6/23/2022</b>	Policy Version Change: Template update removing references to CMS 1500 form
<b>1/1/2022</b>	Policy Version Change: Template update Attachments Section: Removed from policy
<b>1/1/2021</b>	Policy implemented by UnitedHealthcare Value & Balance Exchange