PROVIDER BULLETIN
#03-2014

TO: Participating hospitals and ambulatory surgical centers

FROM: Contracting and Provider Networks

DATE: February 3, 2014

SUBJECT: Facility Claims Require a Valid Patient Discharge Status Code

This bulletin is being sent to reinforce that AmeriHealth requires a patient discharge status code for *all facility claims*, in accordance with the Centers for Medicare & Medicaid Services. It is important to select and report the correct patient discharge status code. Applying the correct code will help ensure that you will receive prompt and correct payment.

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 (e.g., a visit or an actual inpatient stay) or at the end of a billing cycle (i.e., the “through” date of a claim).

AmeriHealth requires a patient discharge status code for *all facility claims*, including the following bill types:

- hospital inpatient claims (bill types 11X and 12X);
- skilled nursing claims (bill types 18X, 21X, 22X, and 23X);
- outpatient hospital services (bill types 13X, 14X, 71X, 73X, 74X, 75X, 76X, and 85X);
- all hospice and home health claims (bill types 32X, 34X, 81X, and 82X).

The patient discharge status code should be included in Form Locator 17 on a UB-04 claim form or the electronic equivalent in the HIPAA-compliant 837 format. It must be entered in a two-digit format (e.g., “01”). In cases where two or more patient discharge status codes apply, code the highest level of care known. **Omitting a code or submitting a claim with an incorrect code is a claim billing error and will result in your claim being rejected.**

For more information about claims submission for AmeriHealth members, go to *www.amerihealth.com/edi*. Please contact your Network Coordinator if you have any questions about claim rejections.

We encourage you to share this information with appropriate members of your staff.