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GUIDELINES FOR UB-04 (CMS-1450) PATIENT STATUS CODES FOR DENIAL PREVENTION

COMPREHENSIVE EDUCATIONAL RESOURCE

UB -04 (CMS-1450) Patient Status Code
The UB-04 (CMS-1450) claim form is the standard billing form used by hospitals, skilled nursing facilities, rehabilitation centers and hospices to bill insurance payers. One critical element on this form is the Patient Status Code, also called the Discharge Disposition Code.

Definition of Patient Status Code
The Patient Status Code tells payers where the patient went at the conclusion of a healthcare facility encounter or at the end of a billing cycle (the 'through' date of a claim), and accurate coding is essential for proper reimbursement and compliance.

Examples include:
- 01 – Discharged to home/self-care
- 03 – Transferred to SNF
- 20 – Expired

Why Patient Status Codes Matter
Patient Status Codes are required on all final UB-04 (CMS-1450) claims in Form Locator 17 (FL17)
- CMS and NUBC standards mandate these codes to indicate the patient's status.
- They are essential for payment calculation, especially under Medicare's post-acute transfer policy.
- Missing or incorrect codes can lead to claim denials, payment delays or compliance issues.

Key Characteristics
- Two-digit numeric codes
- Required on all final UB-04 claims
- Must align with clinical documentation and payer rules
- Directly affects DRG payment and transfer policy

Compliance Best Practices
- Verify FL17 matches discharge summary and care plan.
- Use claim scrubbers to catch missing or invalid codes.
- Keep NUBC manual and CMS guidelines updated.
- Document planned readmissions clearly.

Common Denial Reasons
- Wrong code for Type of Bill (e.g., inpatient vs. outpatient)
- Code does not match discharge plan or medical record
- Missing or invalid code in FL17
- Using discontinued or reserved codes
- Failure to update codes for planned readmissions (81–84)

Summary
Accurate use of Patient Status Codes on the UB-04 claim form is essential for proper billing and compliance. These two-digit codes, entered in Form Locator 17 (FL17), indicate the patient's discharge status and directly impact payment accuracy, Medicare transfer policies and audit compliance. Missing or incorrect codes can lead to claim denials, payment delays and potential overpayment risks.

To prevent errors, providers should verify codes against clinical documentation, use claim scrubbers and follow best practices such as staff training and system edits. Understanding the correct application of these codes ensures compliance with CMS and payer rules, reduces denials and supports accurate reimbursement.

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