UnitedHealthcare Community Plan

Summary of New Facility Reimbursement Policy for UnitedHealthcare Community Plan

New Facility Reimbursement Policy: Effective Dec. 1, 2016

The following facility reimbursement policy will be effective for dates of service on or after Dec. 1, 2016 and applicable to facility services reported using the UB-04 form or its electronic equivalent:

- **Appropriate Patient Status for Type of Bill Policy**

The new Appropriate Patient Status for Type of Bill Policy will address patient discharge status reporting for specific types of bills.

Overview of New Facility Reimbursement Policy for UnitedHealthcare Community Plan

Appropriate Patient Status for Type of Bill Policy

Frequency codes are a component of the UB-04 type of bill structure. Type of bill values are assigned based on the following National Uniform Billing Committee (NUBC) guidelines:

- The first digit is a 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.

Patient discharge status codes identify the status of the patient as of the last day the member is in the hospital. The new policy will apply the following requirements:

- If the frequency code in the type of bill is a “1” (Admit through Discharge Claim) or a “4” (Interim-Last Claim), the final Patient Discharge Status code should be reported. Patient Discharge Status code “30” submitted on an Admit through Discharge Claim or an Interim – Last Claim is considered inappropriate.
- If the “the frequency code in the type of bill is a “2” (Interim – First Claim) or a “3” (Interim-Continuing Claim), the only appropriate Patient Discharge Status code is a “30.”

Guidance from CMS regarding selection of the appropriate Patient Discharge Status code can be found at cms.gov > Outreach-and-Education > Medicare-Learning-NetworkMLN/MLNMattersArticles > downloads > SE0801.pdf.

As with all UnitedHealthcare Community Plan policies, other factors affecting reimbursement may supplement, modify or supersede them, including, but are not limited to: federal and/or state regulatory requirements, physician or other care provider contracts, and/or the member’s benefit coverage documents.

Unless otherwise noted as follows, these reimbursement policies apply to services reported using the CMS-1500 or its electronic equivalent, or its successor form. UnitedHealthcare Community Plan reimbursement policies do not address all issues related to reimbursement for services rendered to our members, such as the member’s benefit plan documents; our medical policies; and the UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment. Other applicable reimbursement and medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed at UHCCommunityPlan.com > For Health Care Professionals (click on the appropriate state) > Reimbursement Policies. In the event of an inconsistency or conflict between the information in this Provider Notification and the posted policy, the provisions of the posted reimbursement policy prevail. If you have any questions, please contact your Health Plan Representative or call the number on your Provider Remittance Advice/Explanation of Benefits.