

Reimbursement Instructions for DRG Claims with New Patient Status Codes January 19, 2016

Effective retroactively for dates of service on or after July 1, 2014, providers may use new patient status codes (70 and 81 – 95) when completing diagnosis-related group (DRG) claims. The patient status codes describe discharge and transfer situations. Refer to the *UB-04 Completion: Inpatient Services* section of the Part 2 provider manual for a list of patient status codes.

DRG claims denied with admission dates of service from July 1, 2014, through September 21, 2015, that were denied with Remittance Advice Details (RAD) code **076: The submitted documentation was not adequate**, may be resubmitted.

To receive reimbursement, resubmitted claims must contain the statement “New patient status code” in the *Remarks* field (Box 80) or on an attachment to the claim. Claims also must contain either:

- Delay reason code “11” in the *Delay Reason* field (Box 37A), if the claim is being submitted more than 6 months, but fewer than 12 months after the date of admission; or
- Delay reason code “10” in *Delay Reason* field (Box 37A), if the claim is being submitted more than 12 months after the date of admission.

Timeliness will be waived through June 1, 2016, for resubmitted claims that meet the above criteria. Failure to follow these instructions may result in denied or incorrectly processed claims.