Discharge Status Codes

Code	Description
01	**Discharge to home or self-care (routine discharge).** Includes: discharged on home oxygen or home durable medical equipment services (without home health), court/law enforcement, residential care, foster care, assisted living facilities other than "state designated," personal care home.
02*	**Discharged/Transferred to a short-term general hospital for inpatient care.** Use this code to bill a same day transfer claim for an inpatient claim.
03†	**Discharge/Transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.** Indicates that the patient is discharged/transferred to a Medicare certified skilled nursing bed and qualifies for skilled care (regardless of whether the patient has skilled benefit days). Includes rehab unit of a SNF. For hospitals with an approved swing bed arrangement, use code 61; for reporting transfer to nursing facilities see 04 and 64.
04	**Discharge/Transferred to an intermediate care facility (ICF).** Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients who are discharged/ transferred to nursing facility with neither Medicare nor Medicaid certification and for discharges/transfer to state designated assisted living faculties. For transfers to dual-certified, confirm level of care with physician; i.e. skilled (03), hospice (50/51), or intermediate care (04).
05†	**Discharged/Transferred to a designated cancer center on children's hospital** *(effective 4/1/08)* Transfers to non-designated cancer hospitals use 02. See www3.cancer.gov/cancercenters/centerslist.html for list of National Cancer Institute-designated cancer centers.
06†	**Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care.** Report this code when the patient is discharged/transferred to home with a written plan of care for home care services and those services are to begin within 3 days following discharge. (40.2.4(c) Medicare Claims Processing Manual).
07	**Left against medical advice or discontinued care.** These claims are treated as transfers if the patient is subsequently admitted to another inpatient PPS hospital on the same day. Medicare PM A-03-073, August 22, 2003.
20	**Expired** (or did not recover; e.g., Christian Science patient).
43	**Discharged/Transferred to a federal health care facility.** Includes VA hospital, VA nursing facility. Dept. of Defense hospital, psych unit of VA hospital. Use whenever the destination at discharge is a federal hospital, whether or not the patient lives there.
50	**Discharged to hospice-home.** If discharged with hospice *referral*, code to site (01, 03, etc) rather than 50/51, as patient has not yet been accepted to hospice with determination of hospice level of care.
51	**Discharged to hospice-medicare facility (certified) providing hospice level of care.** Includes hospice provided at a SNF. For hospice *referral*, see note above in code 50.
61	**Discharged/Transferred to a hospital-based Medicare-approved swing bed**
62†	**Discharged/Transferred to rehab facility, including rehabilitation-distinct units of a hospital**
63†	**Discharged/Transferred to a long-term-care hospital**
64	**Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare.** Acute care hospitals, SNFs, outpatient hospital providers are required to report this code, if appropriate, although the use of this code does not impact payment.
65†	**Discharged/Transferred to a psych hospital or psych-distinct unit of a hospital**
66	**Discharged/Transferred to critical access hospital.** *(See www.ahd.com to clarify if CAH).*
70	**Discharged/Transferred to another type of health care institution not defined elsewhere in this code list** *(effective 4/1/08).* Includes chemical dependency treatment facility if the facility is not a psychiatric hospital or unit and the patient is undergoing inpatient/residential treatment.

* Each transferring hospital is paid a per diem rate, not to exceed the full MS-DRG payment that would have been made if the patient had been discharged without being transferred.

† Affects reimbursement if assigned to one of 273 select MS-DRGs.

Source: Deborah K. Hale, CCS.