Home Health Medicare Billing Codes Sheet

Type of Bill (TOB)* (FL 4)	
322	Request for Anticipated Payment (RAP)
327	Adjustment Claim
328	Void/Cancel Prior RAP/Claim
329	Final Claim for Episode
320	Nonpayment Claim
34X	Outpatient Services
3XQ	Reopening
3XG or 3XI	Contractor adjustment
CMS Pub. 100-04, Chapter 10 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf	

Priority (Type) of Admission or Visit Codes (FL 14)			
1	Emergency	4	Newborn
2	Urgent	5	Trauma
3	Elective	9	Information not available

Point of Origin (formerly Source of Admission Codes) (FL 15)	
1	Non-Health Care Facility Point of Origin
2	Clinic or Physician's Office
4	Transfer from Hospital (Different Facility)
5	Transfer from Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
8	Court/Law enforcement
9	Information not available

Patient Status Codes (FL 17)	
01	Discharge to home or self-care (routine discharge)
02	Discharge/transfer to short-term general hospital
03	Discharge/transfer to SNF
04	Discharge/transfer to ICF
05	Discharge/transfer to a designated cancer center or children's hospital
06	Discharge/transfer to home care of another HHA OR discharge and readmit to the same HHA within a 60-day episode
07	Left against medical advice or discontinued care
20	Expired – Occurrence code 55 also required.
21	Discharge/transfer to court/law enforcement
30	Still a patient. Services continue to be provided. (Required on RAPs.)
43	Discharge/transfer to federal hospital
50	Discharge/transfer for hospice services in the home
51	Discharge/transfer to hospice services in a medical facility
61	Discharge/transfer to hospital-based Medicare approved swing bed
62	Discharge/transfer to IRF (inpatient rehabilitation facility)
63	Discharge/transfer to long-term care hospital
65	Discharge/transfer to psychiatric hospital or psychiatric part unit of a hospital
66	Discharge/transfer to Critical Access Hospital (CAH)
70	Discharge/transfer to another type of health care institution not defined elsewhere in code list

Condition Codes (CC) (FL 18-28)	
07	Treatment of nonterminal condition for hospice patient
20	Beneficiary requested billing (demand denial)
21	Billing for denial notice (no-pay bill)
47	Transfer from another HHA when prev active period
54	No skilled HH visits in billing period.
C3	Expedited review – partial approval of Medicare-covered services
C4	Expedited review – services denied
C7	Expedited review – extended authorization of Medicare-covered services

Claim Change Reason Codes (CCRC) (FL 18-28) & Adjustment Reason Codes (ARC) (FISS only)			
Description	CCRC	ARC	TOB
Changes in Service Dates	D0	RF	327
Changes to Charges	D1	RG	327
Changes in revenue/HCPC/HIPPS codes	D2	RH	327
Cancel to correct provider/Medicare ID number	D5	RI	328
Cancel duplicate or OIG payment	D6	RJ	328
Change to make Medicare the secondary payer	D7	TB	327
Change to make Medicare the primary payer	D8	TB	327
Any other/multiple change (s) (must include REMARKS, FISS pg 4)	D9	RM	327
Change in patient status	E0	RN	327

NOTE: RAPs cannot be adjusted. If information must be changed on a processed RAP, it must be cancelled and resubmitted to Medicare.

Medicare Secondary Payer (MSP) Value Codes (VC) (FL 39-41)	
Description	VC
Working Aged	12
ESRD	13
No Fault (no attorney involved)	14
Worker's Compensation	15
Public Health Svc/Other Federal	16
Black Lung	41
Disabled	43
Obligated to Accept as Payment in Full (OTAF)	44
Liability	47
Conditional Payment	Any of the Above
Medicare	
NOTE: Medicare does not make secondary payer payments on RAPs. Submit RAPs with Medicare as primary.	
CMS Pub. 100-05, Chapter 3 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf	

Note: The codes listed on this billing codes sheet represent those most frequently submitted on home health RAPs/claims. A complete listing of all codes is accessible from the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual - http://www.nubc.org.

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Home Health Medicare Billing Codes Sheet

Value Code (FL 39-41)	
61	CBSA code for where HH services were provided. CBSA codes are required on **all** 32X TOB. Place "61" in the first value code field locator and the CBSA code in the dollar amount column followed by two zeros.
85	Federal Information Processing Standards (FIPS) State and County Code for what county the services were provided. FIPS codes are required on all 32X TOB. Place "85" in the first value code field locator and the FIPS code in the dollar amount column followed by two zeros. The FIPS State and County codes are available at https://www.census.gov/geographies/reference-files/2017/demo/popest/2017-fips.html.
Other value codes may be required when Medicare is the secondary payer. See the Medicare Secondary Payer (MSP) Web page for more information: https://www.cgsmedicare.com/hhh/education/materials/MSP.html	
CMS Pub. 100-04, Chapter 10 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf	

Common Revenue Codes (FL 42) and HCPCS/Rates/HIPPS Rate Codes (FL 44)			
Rev Code	Definition	HCPCS	Comments
0001	Total units/charges	N/A	No HCPCS required with revenue code.
0023	HIPPS code	As assigned by Grouper software	See CMS Coding and Billing information (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html) Web page for more information.
027X	Medical/Surgical Supplies	N/A unless 0274	HCPCS required when submitting revenue code 0274 (Prosthetic/Orthotic devices) – See CPT coding book for appropriate HCPCS code.
042X	Physical Therapy	Varied	Refer to the following link, section 40.2 for further information: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
043X	Occupational Therapy	Varied	
044X	Speech-Language Pathology	Varied	
055X	Skilled Nursing	Varied	
056X	Medical Social Services	G0155	For episodes beginning on/after 7/1/2013, see MLN article, MM8136 for additional information.
057X	Home Health Aide	G0156	
062X	Medical/Surgical Supplies	N/A	Optional Use: When HHAs choose to report additional breakdown for surgical/wound care dressings.
CMS Pub. 100-04, Chapter 10 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf			

* For revenue codes ending in an "X", sub-classifications exist. Use a "0" to indicate general classification when the subclassifications are not appropriate.

Website References:
Internet Only Manuals – Pub. 100-02, Chapter 7 & Pub. 100-04, Chapter 10: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
Home Health Agency (HHA) Center: http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

HCPC/Rates/HIPPS Rate Codes (FL44)		
HCPCS	Services performed in 15-minute increments	REV Code
G0151	Physical Therapy	042X
G0152	Occupational Therapy	043X
G0153	Speech-Language Pathology	044X
G0154 (see note)	Direct skilled services of a licensed nurse (LPN or RN) NOTE: Not valid for visits made on or after 1/1/2016	055X
G0155	Clinical Social Worker	056X
G0156	Home Health Aide	057X
G0157	PT assistant	042X
G0158	OT assistant	043X
G0159	PT establish or deliver safe and effective PT maintenance program	042X
G0160	OT establish or deliver safe and effective OT maintenance program	043X
G0161	SLP establish or deliver safe and effective SLP maintenance program	044X
G0162	RN (only) for management and evaluation of POC NOTE: Not valid for visits made on or after 1/1/2017	055X
G0163 (see note)	LPN or RN for the observation and assessment of the patient's condition NOTE: Not valid for visits made on or after 1/1/2017	
G0164 (see note)	LPN or RN training and/or education of patient or family member NOTE: Not valid for visits made on or after 1/1/2017	
G0299 (see note)	Direct skilled services of a licensed nurse (RN) NOTE: Valid for visits made on or after 1/1/2016	055X
G0300 (see note)	Direct skilled services of a licensed nurse (LPN) NOTE: Valid for visits made on or after 1/1/2016	055X
G0493 (see note)	RN for the observation and assessment of the patient's condition NOTE: Valid for visits made on or after 1/1/2017	055X
G0494 (see note)	LPN for the observation and assessment of the patient's condition NOTE: Valid for visits made on or after 1/1/2017	055X
G0495 (see note)	RN training and/or education of a patient or family member NOTE: Valid for visits made on or after 1/1/2017	055X
G0496 (see note)	LPN training and/or education of a patient or family member NOTE: Valid for visits made on or after 1/1/2017	055X
See Medicare Learning Network (MLN) Matters® article, MM7182 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7182.pdf) for additional information.		

HCPCS	Where home health services were provided	REV Code
Q5001	Care provided in patient's home/residence	042X, 043X, 044X, 055X, 056X, or 057X
Q5002	Care provided in assisted living facility	
Q5009	Care provide in place not otherwise specified (NO)	
See Medicare Learning Network (MLN) Matters® article, MM8136 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8136.pdf) for additional information.		

Home Health Medicare Billing Codes Sheet

FISS Fields and UB-04 Field Locators (FL) for Home Health Billing

R = required • C = conditional • N = not required • O = optional

FISS Pg	FISS Field Name	UB FL	Data Entered	RAP	Claims
1	MID	60	Medicare ID number	R	R
1	TOB	4	Type of Bill	R	R
1	NPI	56	NPI number	R	R
1	PAT. CNTL #	3a	Patient Control Number	O	O
1	STMT DATES FROM	6	From date of service	R	R
1	TO	6	To date of service	R	R
1	LAST	8	Patient's last name	R	R
1	FIRST	8	Patient's first name	R	R
1	DOB	10	Patient's date of birth	R	R
1	ADDR1	9	Patient's address	R	R
1	ADDR 2	9	City State	R	R
1	ZIP	9	Zip code	R	R
1	SEX	11	Gender (M or F)	R	R
1	ADMIT DATE	12	Date of admission	R	R
1	HR	13	Admission hour	R[1]	R[1]
1	TYPE	14	Admission type or visit	R	R
1	SRC	15	Point of Origin (formerly Source of Admission Codes)	R	R
1	STAT	17	Patient status	R	R
1	COND CODES	18-28	Condition codes	C	C
1	OCC CDS/DATE	31-34	Occurrence code(s)/date(s)	N	C
1	FAC.ZIP	1	Zip code for provider or subpart	R[1]	R[1]
1	DCN	64	Document control number	N	C[2]
1	VALUE CODES	39-41	Value codes	R[3]	R[3]
2	REV	42	Revenue codes	R[4]	R[4]
2	HCPC	44	HCPCS	R	R
2	MODIFS	44	Modifiers	N	C
2	TOT UNIT	46	Total Units	N	R
2	COV UNIT	46	Covered Units	N	R
2	TOT CHARGE	47	Total charges	N	R
2	NCOV CHARGE	48	Noncovered charges	N	C
2	SERV DATE	45	Service Date	R	R
3	CD	50	Payer code	R	R
3	PAYER	50	Payer name	R	R
3	RI	52	Release of information	R	R
3	MEDICAL RECORD NBR	3b	Medical Record Number	O	O
3	DIAG CODES	67	Diagnosis codes	R	R
3	ATT PHYS NPI	76	NPI of physician who signed POC	R	R
3	L	76	Last name of physician who signed POC	R	R
3	F	76	First name of physician who signed POC	R	R
3	M	76	Middle initial of physician who signed POC	O	O
3	REF PHYS	78	NPI of physician who cert/recert eligibility	R	R[7]
3	L	78	Last name of physician who cert/recert eligibility	R	R[7]
3	F	78	First name of physician who cert/recert eligibility	R	R[7]
3	M	78	Middle initial of physician who cert/recert eligibility	O	O[7]
4	REMARKS	80	Remarks (adjustments, cancels, demand/no-pay bills, MSP)	C	C
5	INSURED NAME	58	Insured's last name, first name	N	C[5]
5	SEX	N/A	Insured's sex code	N	C[5]
5	DOB	N/A	Insured's date of birth	N	C[5]
5	REL	59	Patient's relationship to insured	N	C[5]
5	CERT-SSN-MID	60	Insured's ID/Medicare ID number	N	C[5]
5	GROUP NAME	61	Insurance group name	N	C[5]
5	GROUP NUMBER	62	Insurance group number	N	C[5]
5	TREAT.AUTH.CODE	63	Claim-OASIS Matching Key code	R	R[6]

1 Required for DDE
2 Adjustments & cancels only
3 Value code 61 and CBSA code required. Effective 1.1.2019 value code 85 and FIPS code required.
4 Rev codes 0023 & 0001 required on RAPs& final claims
5 Required when Medicare is not the primary payer
6 Enter the Claims-OASIS Matching Key code on theTREAT AUTH CODE line that reflects Medicare'spayer status (primary, secondary, or tertiary)
7 For episodes beginning on/after 7/1/14, if different than the ATT PHYS

Common Home Health Billing Errors by Reason Code (RC)
(When RAP/claim is in FISS status/location (S/LOC) T B9997 or R B9997)

RC	Resolution
31018	If billing > 60 days, status code must be other than 30 https://www.cgsmedicare.com/hhh/education/materials/31018.html
31790	Must report HCPCS Q5001, Q5002, or Q5009 to indicate location of where services were provided. https://www.cgsmedicare.com/hhh/education/materials/31790.html
38107	Re-bill RAP if auto-cancel AND ensure RAP is in P B9997 AND ensure "FROM" date, "ADMIT" date, first 4 position of HIPPS code, and 0023 date matches between RAP and claim for same episode https://www.cgsmedicare.com/hhh/education/materials/38107.html
38157, 38200	Duplicate billing transaction; adjust or cancel claim or RAP instead of resubmitting https://www.cgsmedicare.com/hhh/education/materials/38031_38157_38200.html
U538I	Enter condition code 47 to indicate transfer between HHAs https://www.cgsmedicare.com/hhh/education/materials/U538I.html

CHAPTER 5 - FSS CLAIM & ATTACH. CORRECTIONS

CLAIM ADJUSTMENTS/CANCELS

ADJUSTMENT CODE MATRIX

UB92 COND CODE	DESCRIPTION	FSS ADJUSTMENT REASON CODE	DESCRIPTION
D0	Service Dates	DT	Change in dates of service
D1	Charges	CC	Change charge
D2	Revenue Codes HCPCS	CE OE	Revenue code correction HCPC changes
D3	PPS Interim	IB	PPS interim bill
D4	Diagnosis Procedure	AG SP	Diagnosis coding change Surgical procedure coding change
D5	HICN Provider Number	IH IP	Incorrect HICN Incorrect provider number
D6	Overpayment	BE	Charges billed in error
D7	Medicare as Secondary	WA ES AU LI WC FA DB BL VA	Make working aged prime Make ESRD prime Make automobile prime Make liability prime Make worker's compensation prime Make federal agency prime Make disability prime Make black lung prime Make VA prime
D8	Medicare as Primary	WB ER AT LJ WD FC DE BM VB	Working aged was prime ESRD was prime Automobile was prime Liability was prime Worker's compensation was prime Federal agency was prime Disability was prime Black lung was prime VA was prime
D9	Other Changes	OT	Other change
E0	Patient Status	DS	Discharge status change

Occurrence 05 - 10/24/05 not. 24

CHAPTER 5 - FSS CLAIM & ATTACH. CORRECTIONS

CLAIM ADJUSTMENTS/CANCELS

In order to process any UB92 adjustment claim (TOB XX7) in the Remote FSS you must report an applicable 2 digit alpha-numeric condition code. The condition code fields are located on page 1 of the Remote FSS claim screen (form locators 24-30 on the UB92 claim form). An adjustment condition code is also reported when cancelling a claim (TOB XX8). FSS also requires a matching Adjustment Reason Code on page 3 of the claim screen.

Listed on the following pages are the valid adjustment condition codes which can be used when adjusting or cancelling a processed claim in Remote FSS. Following the list is a MATRIX showing allowed combinations of adjustment codes.

CLAIM ADJUSTMENT - CONDITION CODES

DO*	Service Dates (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect changes in the service dates reported on the processed bill.
D1*	Adjusted Charges (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect changes in the charges reported on the processed bill.
D2*	Revenue Codes/HCPCS (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect changes to revenue codes/HCPCS reported on the processed bill.
D3*	PPS Interim Adjustment (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims when submitting the second or subsequent interim prospective payment system bill (e.g., every 60 days).
D4*	Diagnosis/Procedure Code (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect changes in diagnosis or procedure coding reported on the processed bill.

D5*	HIC/Provider Number (Cancel Bills Only - TOB XX8)	Report this claim change reason code on cancel claims to correct a Medicare Health Insurance Claim (HIC) number or Medicare provider number reported on the processed bill.
D6*	Overpayment/Bundling (Cancel Bills Only - TOB XX8)	Report this claim change reason code on cancel claims when canceling a claim to repay a duplicate payment or an OIG overpayment, and/or cancellation of an outpatient bill containing services required to be included on the inpatient bill.
D7*	Medicare as Secondary (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to change Medicare to secondary payer.
D8*	Medicare as Primary (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to change Medicare to the primary payer.
D9*	Other Changes (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect any other changes from the processed bill.
E0*	Patient Status (Adjustment Bills Only - TOB XX7)	Report this claim change reason code on adjustment claims to reflect a change in patient status coding reported on the processed bill.

* Only one claim change reason code may be reported on the adjustment/cancel request. If more than one reason could apply, choose the single reason that best describes the adjustment being requested. Use claim change reason code "D1" when the charges are the only change on the claim. Other claim change reasons will frequently change the charges on the claim; however, reason code "D1" is not reported in addition to the single reason best describing the adjustment/cancel request.