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	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		3	Elective	5	Trauma		
2	Urgent	4	Newborn	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
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						
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	ТОВ			
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	ТВ	327			
Change to make Medicare the primary payer	D8	ТВ	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.

	Occurrence Codes (OC) (FL 31-34)						
50	OASIS assessment completion date (OASIS item MO090) for start of care, resumption of care, recertification or other follow-up OASIS occurring most recently before the claim "From" date. Required on final claims with "From" dates of January 1, 2020.						

- 61 The "Through" date of an acute care hospital discharge within 14 days prior to the "From" date of any home health claim. Optional on admission claims and continuing claims with "From" dates of January 1, 2020. (See Note below.)
- The "Through" date of a SNF, IRF, LTCH, or IPF discharge within 14 days prior to the admission date of the first home health claim. Optional on admission claims with "From" dates of January 1, 2020. (See Note below.)

NOTE: If OC 61 and 62 are not present, Medicare systems will use inpatient claims history to assign Institutional payment groups based on the most current information.

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 M. II.				

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.





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 Co what county the services were provided. FIPS codes are required on a 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 .						
Oth	Constitution and a constitution of the constit						

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			
043X	Occupational Therapy	Varied	for further information: http://www. cms.gov/Regulations-and-Guidance/ Guidance/Manuals/Downloads/			
044X	Speech-Language Pathology	Varied	clm104c10.pdf			
055X	Skilled Nursing	Varied				
056X	Medical Social Services	G0155				
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 F	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.

HCPC/Rates/HIPPS Rate Codes (FL44)						
HCPCS	Services performed in 15-minute increments	Code				
G0151	Physical Therapy	042X				
G0152	Occupational Therapy	043X				
G0153	Speech-Language Pathology	044X				
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	055X				
G0299	Direct skilled services of a licensed nurse (RN)	055X				
G0300	Direct skilled services of a licensed nurse (LPN)	055X				
G0493	RN for the observation and assessment of the patient's condition	055X				
G0494	LPN for the observation and assessment of the patient's condition	055X				
G0495	RN training and/or education of a patient or family member	055X				
G0496	LPN training and/or education of a patient or family member	055X				
G2168	Services performed by a PT assistant, each 15 minutes NOTE: Valid for claims submitted after October 5, 2020, for services on or after January 1, 2020. Type of bill 032x other than 0322. See MM11721 (https://www.cms.gov/files/document/mm11721.pdf)	042X				
G2169	Services performed by an OT assistant, each 15 minutes NOTE: Valid for claims submitted after October 5, 2020, for services on or after January 1, 2020. Type of bill 032x other than 0322. See MM11721 (https://www.cms.gov/files/document/mm11721.pdf)	043X				
		REV				
HCPCS	Where home health services were provided	Code				
Q5001	Care provided in patient's home/residence	042X, 043X,				
Q5002	Care provided in assisted living facility	043X, 044X,				
Q5009	Care provide in place not otherwise	055X,				
	specified (NO)	056X,				
		or 057X				

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

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	R	R
			number		_
1	TOB	4	Type of Bill	R	R
1	NPI	56	NPI number	R	R
1	PAT. CNTL #	3a	Patient Control Number	0	0
1	STMT DATES FROM	6	From date of service	R	R
1	ТО	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	R1	R1
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	С	С
1	OCC CDS/ DATE	31-34	Occurrence code(s)/date(s)	N	С
1	FAC.ZIP	1	Zip code for provider or subpart	R1	R1
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	С
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	С
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	0	0
3	DIAG CODES	67	Diagnosis codes	R	R

FISS		UB			
Pg	FISS Field Name	FL	Data Entered	RAP	Claims
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	0	0
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	0	07
4	REMARKS	80	Remarks (adjustments, cancels, demand/no-pay bills, MSP)	С	С
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 ₂
5	CERT-SSN-MID	60	Insured's ID/Medicare ID number	N	C ₅
5	GROUP NAME	61	Insurance group name	N	С2
5	GROUP NUMBER	62	Insurance group number	N	С5
5	TREAT.AUTH. CODE	63	Claim-OASIS Matching Key code NOTE: Not required on claims with "From" dates of service on or after January 1, 2020.	R	R ⁶

¹ Required for DDE

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/medicare_dynamic/j15/j15hhh_reasoncodes/j15hhh_reasoncodes.aspx?31018				
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//medicare_dynamic/j15/j15hhh_reasoncodes/j15hhh_reasoncodes.aspx?38107				
38157, 38200	Duplicate billing transaction; adjust or cancel claim or RAP instead of resubmitting				
	https://www.cgsmedicare.com/medicare_dynamic/j15/j15hhh_reasoncodes/j15hhh_reasoncodes.aspx?38157				
	https://www.cgsmedicare.com/medicare_dynamic/j15/j15hhh reasoncodes/j15hhh_reasoncodes.aspx?38200				
U538I	Enter condition code 47 to indicate transfer between HHAs https://www.cgsmedicare.com/medicare_dynamic/j15/j15hhh_ reasoncodes/j15hhh_reasoncodes.aspx?U538i				

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 the TREAT AUTH CODE line that reflects Medicare's payer status (primary, secondary, or tertiary)