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	**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**	**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.

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.)
62	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: 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	
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.

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
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

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)	

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 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 **NOTE:** Not required on claims with "From" dates of service on or after January 1, 2020.	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 the TREAT AUTH CODE line that reflects Medicare's payer 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/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