Home Health Medicare Billing Codes Sheet

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

* FISS will automatically change the 2nd digit of HH PPS TOBs from 2 to 3, if required. Example: 329 to 339.

Claim Change Reason Codes (CCRC) (FL 18-28) & Adjustment Reason Codes (ARC) (FISS only)			
Description	**CCRC**	**ARC**	**TOB**
Changes in Service Dates	D0	RF	3X7
Changes to Charges	D1	RG	3X7
Changes in revenue/HCPC/HIPPS codes	D2	RH	3X7
Cancel to correct provider/HIC #	D5	RI	3X8
Cancel duplicate or OIG payment	D6	RJ	3X8
Any other/multiple change (s)	D9	RM	3X7
Change in patient status	E0	RN	3X7

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

Core Based Statistical Area (CBSA) Value Code (FL 39-41)	
61	CBSA code for where HH services were provided. CBSA codes are required on **all** 32X and 33X TOB. Place "61" in the first value code field locator and the CBSA code in the dollar amount column followed by two zeros.
Other value codes may be required when Medicare is the secondary payer. See the Medicare Secondary Payer (MSP) webpage 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	

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	**5**	Transfer from Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
2	Clinic or Physician's Office	**6**	Transfer from Another Health Care Facility
4	Transfer from Hospital (Different Facility)	**9**	Information not available

Medicare Secondary Payer (MSP) Value Codes (VC) (FL 39-41) & Payer Codes (PC) (FISS only)					
Description	**VC**	**PC**	**Description**	**VC**	**PC**
Working Aged	12	N/A	Black Lung	41	N/A
ESRD	13	N/A	Disabled	43	N/A
No Fault (no attorney involved)	14	N/A	Liability	47	N/A
Worker's Compensation	15	N/A	Conditional Payment	Any of the Above	C
Public Health Svc/Other Federal	16	N/A	Medicare		Z
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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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Home Health Medicare Billing Codes Sheet

Patient Status Codes (FL 17)			
01	Discharge to home or self-care (routine discharge)	**43**	Discharge/transfer to federal hospital
02	Discharge/transfer to short-term general hospital	**50**	Discharge/transfer for hospice services in the home
03	Discharge/transfer to SNF	**51**	Discharge/transfer to hospice services in a medical facility
04	Discharge/transfer to ICF	**61**	Discharge/transfer to hospital-based Medicare approved swing bed
05	Discharge to designated cancer center or children's hospital	**62**	Discharge/transfer to IRF (inpatient rehabilitation facility)
06	Discharge/transfer to home care of another HHA OR discharge and readmit to the same HHA within a 60-day episode	**63**	Discharge/transfer to long-term care hospital
07	Left against medical advice or discontinued care	**64**	Discharge/transfer to Medicaid certified, but non-Medicare certified nursing facility
20	Expired. For claims submitted on/after 10/01/12, also submit occurrence code 55 and the beneficiary's date of death in FL 31-34	**65**	Discharge/transfer to psychiatric hospital or psychiatric part unit of a hospital
21	Discharge/transfer to court/law enforcement	**66**	Discharge/transfer to Critical Access Hospital (CAH)
30*	Still a patient. Services continue to be provided	**70**	Discharge/transfer to another type of health care institution not defined elsewhere in code list

* Required on RAPs.

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	See Medicare Learning Network (MLN) article, MM7182 – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7182.pdf – for more information. For episodes beginning on/after 7/1/2013, see MLN article, MM8136 – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8136.pdf – for additional information.
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.

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**	**RC**	**Resolution**
31018	If billing > 60 days, status code must be other than 30 https://www.cgsmedicare.com/hhh/education/materials/31018.html	31147	If 5th position of HIPPS code is a letter, non-routine supplies must be submitted on the claim https://www.cgsmedicare.com/hhh/education/materials/31147.html
31755	The service date of a visit must match the service date billed with revenue code 0023 https://www.cgsmedicare.com/hhh/education/materials/31755.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
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	U538I	Enter condition code 47 to indicate transfer between HHAs https://www.cgsmedicare.com/hhh/education/materials/U538I.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	HIC	60	Medicare (HIC) 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	Primary care physician's NPI	R	R
3	L	76	Primary physician's last name	R	R
3	F	76	Primary physician's first name	R	R
3	M	76	Primary physician's middle initial	O	O
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-HIC	60	Insured's ID/HIC#	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 & CBSA 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)

Website References:

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