Home Health Medicare Billing Codes Sheet

Type of Bill (TOB)* (FL 4)			
32A	Notice of Admission (NOA)		
32D	Cancellation of Admission		
327	Adjustment Claim		
328	Void/Cancel 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.				
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		

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

Occurrence Codes (OC) (FL 31-34)

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: Submit NOA with Medicare as primary, even in MSP situations. MSP data should be added to claims

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 NOAs/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 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.				
Oth	Other value codes may be required when Medicare is the				

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,	
043X	Occupational Therapy	Varied	section 40.2 for further information: http://www.	
044X	Speech- Language Pathology	Varied	cms.gov/Regulations- and-Guidance/Guidance/ Manuals/Downloads/ clm104c10.pdf	
055X	Skilled Nursing	Varied	<u>ciii1104010.pai</u>	
056X	Medical Social Services	G0155	For episodes beginning on/after 7/1/2013, see	
057X	Home Health Aide	G0156	MLN article, MM8136 for additional information.	
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

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)			
		REV	
HCPCS	Services performed in 15-minute increments	Code	
G0151	Physical Therapy	042X	
G0152	Occupational Therapy	043X	
G0153	Speech-Language Pathology	044X	
*G0154	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		
G0162	RN (only) for management and evaluation of POC	055X	
*G0163 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	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	Direct skilled services of a licensed nurse (RN) NOTE: Valid for visits made on or after 1/1/2016	055X	
*G0300	Direct skilled services of a licensed nurse (LPN) NOTE: Valid for visits made on or after 1/1/2016	055X	
*G0493	RN for the observation and assessment of the patient's condition NOTE: Valid for visits made on or after 1/1/2017	055X	
*G0494	LPN for the observation and assessment of the patient's condition NOTE: Valid for visits made on or after 1/1/2017	055X	
*G0495	RN training and/or education of a patient or family member NOTE: Valid for visits made on or after 1/1/2017	055X	
*G0496	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.			

* 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,		
Q5002	Care provided in assisted living facility	055X, 056X, or 057X		
Q5009	Care provide in place not otherwise specified (NO)			
O - Madis and Lagranian Naturals (MIN) Matter & atial - MM0400 (later than 1)				

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.

HCPCS	Description	REV Code			
G0320	Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system.	042x, 043x, 044x,			
G0321	Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system.	055x, 056x, and			
*G0322	The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring) Report the use of remote patient monitoring that spans a number of days as a single line item showing the start date of monitoring and the number of days of monitoring in the units field.	057x			

* Voluntarily on/after 1/1/2023; Required on/after 7/1/2023

**G0322: You'll submit services provided via telecommunications technology in line-item detail. Report each service as a separate dated line under the appropriate revenue code for each discipline providing the service.

You can only report the above 3 G-codes on Type of Bill 032x. You should only report these codes with revenue codes 042x, 043x, 044x, 055x, 056x, and 057x.

MM12805 - Telehealth Home Health Services: New G-Codes (https://www.cms.gov/files/document/mm12805-telehealth-home-health-services-new-q-codes.pdf)

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

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	Claims
1	MID	60	Medicare ID number	R
1	ТОВ	4	Type of Bill	R
1	NPI	56	NPI number	R
1	PAT. CNTL #	3a	Patient Control Number	0
1	STMT DATES FROM	6	From date of service	R
1	ТО	6	To date of service	R
1	LAST	8	Patient's last name	R
1	FIRST	8	Patient's first name	R
1	DOB	10	Patient's date of birth	R
1	ADDR1	9	Patient's address	R
1	ADDR 2	9	City State	R
1	ZIP	9	Zip code	R
1	SEX	11	Gender (M or F)	R
1	ADMIT DATE	12	Date of admission	R
1	HR	13	Admission hour	R ¹
1	TYPE	14	Admission type or visit	R
1	SRC	15	Point of Origin (formerly Source of Admission Codes)	R
1	STAT	17	Patient status	R
1	COND CODES	18-28	Condition codes	С
1	OCC CDS/DATE	31-34	Occurrence code(s)/ date(s)	С
1	FAC.ZIP	1	Zip code for provider or subpart	R ¹
1	DCN	64	Document control number	C ²
1	VALUE CODES	39-41	Value codes	R ³
2	REV	42	Revenue codes	R ⁴
2	HCPC	44	HCPCS	R
2	MODIFS	44	Modifiers	С
2	TOT UNIT	46	Total Units	R
2	COV UNIT	46	Covered Units	R
2	TOT CHARGE	47	Total charges	R
2	NCOV CHARGE	48	Noncovered charges	С
2	SERV DATE	45	Service Date	R
3	CD	50	Payer code	R
3	PAYER	50	Payer name	R
3	RI	52	Release of information	R
3	MEDICAL RECORD NBR	3b	Medical Record Number	0
3	DIAG CODES	67	Diagnosis codes	R

FISS		UB		
Pg	FISS Field Name	FL	Data Entered	Claims
3	ATT PHYS NPI	76	NPI of physician who signed POC	R
3	L	76	Last name of physician who signed POC	R
3	F	76	First name of physician who signed POC	R
3	M	76	Middle initial of physician who signed POC	0
3	REF PHYS	78	NPI of physician who cert/recert eligibility	R ⁷
3	L	78	Last name of physician who cert/ recert eligibility	R ⁷
3	F	78	First name of physician who cert/ recert eligibility	R ⁷
3	M	78	Middle initial of physician who cert/ recert eligibility	07
4	REMARKS	80	Remarks (adjustments, cancels, demand/no-pay bills, MSP)	С
5	INSURED NAME	58	Insured's last name, first name	C ⁵
5	SEX	N/A	Insured's sex code	C ₅
5	DOB	N/A	Insured's date of birth	C5
5	REL	59	Patient's relationship to insured	C ₅
5	CERT-SSN-MID	60	Insured's ID/Medicare ID number	C ₂
5	GROUP NAME	61	Insurance group name	C5
5	GROUP NUMBER	62	Insurance group number	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 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 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

Billing the Home Health Notice of Admission (NOA) Electronically: https://www.cgsmedicare.com/hhh/claims/pdf/billing_noa_837elec_version_2022

Billing the Home Health Notice of Admission (NOA) via DDE: https://www.cgsmedicare.com/hhh/claims/pdf/billing_noa_dde_version_2022_v1.pdf