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Home Health Medicare Billing Codes Sheet

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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

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	20 Beneficiary requested billing (demand denial)
21	21 Billing for denial notice (no-pay bill)
47	47 Transfer from another HHA
54	54 No skilled HH visits in billing period.
C3	C3 Expedited review – partial approval of Medicare-covered services
C4	C4 Expedited review – services denied
C7	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

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	

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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.

Common Revenue Codes (FL 42) and HCPCS/Rates/HIPPS Rate Codes (FL 44)

Rev Code	Definition	Comments	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 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	Click here for more 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.

HCPC/Rates/HIPPS Rate Codes (FL44)

HCPCS	Services performed in 15-minute increments	REV Code
G0151	Physical Therapy	042X
GO152	Occupational Therapy	043X
GO153	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
GO155	Clinical Social Worker	056X
GO156	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
GO161	SLP establish or deliver safe and effective SLP maintenance program	044X
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

HCPCS	Where home health services were provided	REV Code
G0151	Care provided in patient's home/residence	042X, 043X, 044X,
GO152	Care provided in assisted living facility	055X, 056X, or 057X
GO153	Care provide in place not otherwise specified (NO)	

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, 055x, 056x, and 057x
G0321	Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system.	
GO322	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	

*** 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.

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

FISS Pg	FISS Field Name	UB FL	FISS Field Name	Claims
1	MID	60	Medicare ID number	R
1	TOB	4	Type of Bill	R
1	NPI	56	NPI number	R
1	PAT. CNTL #	3a	Patient Control Number	O
1	STMT DATES FROM	6	From date of service	R
1	TO	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	Sex (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	C
1	OCC CDS/DATE	31-34	Occurrence code(s)/ date(s)	C
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	C
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	C
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	O
3	DIAG CODES	67	Diagnosis codes	R

R = Required C = Conditional
N = Not Required O = Optional

FISS Pg	FISS Field Name	UB FL	FISS Field Name	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	O
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	O[7]
4	REMARKS	80	Remarks (adjustments, cancels,demand/ no-pay bills, MSP)	C
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	C[5]
5	REL	59	Patient's relationship to insured	C[5]
5	CERT-SSN-MID	60	Insured's ID/Medicare ID number	C[5]
5	GROUP NAME	61	Insurance group name	C[5]
5	GROUP NUMBER	62	Insurance group number	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[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