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
330	Non-payment Claim
340	Outpatient Services
338 or 339	Continuous 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 18)			
1	Emergency	5	Newborn
2	Urgent	6	Trauma
3	Elective	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 EP; discharge and readmit to the same HHA within a 60 day episode
07	Left against medical advice or discontinued care
20	Expired – Occurrence code 69 also required
21	Discharge/transfer to court/law enforcement
30	Still inpatient. 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
61	Discharge/transfer to hospital-based Medicare approved swing bed
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 accidental 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
63	Expedited review – partial approval of Medicare-covered services
64	Expedited review – services denied
67	Expedited review – extended authorization of Medicare-covered services

Claim/Change Reason Codes (ESRC) (FL 19-20) & Adjustment Reason Codes (ARC) (FTSS only)			
Description	ESRC	ARC	FTSS
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/HIC #	D3	RI	328
Cancel duplicate or OIG payment	D4	RJ	328
Any other multiple change(s)	D5	RM	327
Change in patient status	D6	RN	327

NOTE: RAPs cannot be adjusted if information must be changed on a processed RAP. It must be cancelled and resubmitted to Medicare.

Medicare Secondary Payer (MSP) Value Codes (VC) (FL 26-41)	
Description	VC
Working Aged	12
ESRD	13
No Fault/Insurance/Mandatory	14
Workers Compensation	15
Public Health Svc/Other Federal	16
Black Lung	41
Disabled	42
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/clm104c10.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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