Home Health Billing Codes

Type of Bill (TOB) (FL 4)	
32A	Notice of Admission (NOA) • Start of Care (SOC) after 01.01.2022
32D	Cancellation of Admission • To cancel NOAs only
320	Nonpayment Claim
327	Adjustment Claim
328	Void/Cancel Claim
329	Final Claim for Period/Episode
34X	Outpatient Services
32Q	Reopening
32G, 32H, 32I	Contractor Adjustment

Type of Admission (FL 14)	
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma
9	Information Not Available

Point of Origin/Source of Admission (FL 15)	
1	Non-health Care Facility
2	Clinic or Physician/Allowed Practitioner'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

For specific NOA billing, refer to the following:

- Billing the Home Health Notice of Admission (NOA) Electronically
- Billing the Home Health Notice of Admission (NOA) via DDE

Home Health Billing Codes

Patient Status (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 designated cancer center or children's hospital
06	Reported in all cases where the home health agency (HHA) is aware that the period of care will be paid a partial-period payment adjustment. These are cases in which the HHA is aware that the beneficiary has transferred to another HHA within the 30-day period.
07	Left against medical advice or discontinued care
20	Expired (occurrence code 55 also required)
21	Discharge/transfer to court or law enforcement
30	Still a patient and 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 inpatient rehabilitation facility (IRF)
63	Discharge/transfer to long-term care hospital (LTCH)
65	Discharge/transfer to inpatient psychiatric hospital (IPH) or psychiatric 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

Home Health Billing Codes

Condition Code (FL 18-28)	
07	Treatment of non-terminal condition for hospice patient
20	Beneficiary requested billing (demand denial)
21	Billing for denial notice from Medicare (no-pay bill)
47	Transfer from another HHA
54	No skilled home health 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

Only CC 47 may be used on NOAs. No other CCs shall be reported on an NOA.

Claim Change Reason Code (CCRC) (FL 18-28) & Adjustment Reason Code (ARC)			
Description	CCRC	ARC	TOB
Change in Dates of Service (DOS)	D0	OT	327
Change in Charges	D1	OT	327
Change in Revenue/HCPCS/HIPPS Codes	D2	QC	327
Cancel to Correct Provider Number/Medicare ID Number	D5	PN	328
Cancel Duplicate or Office of Inspector General (OIG) Payment	D6	32	328
Change to make Medicare the secondary payer	D7	OT	327
Change to make Medicare the primary payer	D8	OT	327
Any Other/Multiple Change(s) (must include remarks)	D9	OT	327
Change in Patient Status	E0	DS	327

NOAs cannot be adjusted. If information must be changed on a processed NOA, it must be canceled (32D) and resubmitted to Medicare. Select this link for examples of NOA errors that would or would not require the NOA to be canceled and resubmitted.

Occurrence Code (FL 31-34)	
50	OASIS assessment completion date (OASIS item M0090) 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.
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.

If occurrence codes 61 and 62 are not present, Medicare systems will use inpatient claims history to assign institutional payment groups based on the most current information.

Home Health Billing Codes

MSP Value Code (FL 39-41)	
12	Working Aged
13	ESRD
14	No Fault (No Attorney Involved)
15	Workers' Compensation
16	Public Health Service/Other Federal
41	Black Lung
43	Disabled
44	Obligated to Accept as Payment in Full (OTAF)
47	Liability
Any of the above	Conditional Payment
	Medicare

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

Non-MSP Value Code (FL 39-41)	
61	Core-Based Statistical Area (CBSA) code for where home health services were provided. CBSA codes are required on all 329 TOBs, optional on 322 TOBs after 01.01.2021 and not required on 32A TOBs. 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 to designate where services were provided. FIPS codes are required on all 329 TOBs, optional on 322 TOBs after January 1, 2021 and not required on 32A TOBs. Place "85" in the first value code field locator and the FIPS code in the dollar amount column followed by two zeros. Select this link for more information on FIPS state and county codes.

Revenue Code (FL 42), HCPCS/Rates/HIPPS Rate Codes (FL 44)			
REV	Description	HCPCS	Comments
0001	Total Units or Charges	N/A	No HCPCS required with revenue code
0023	HIPPS Code	As assigned by Grouper software	Select this link for more information on coding and billing
027X	Medical/Surgical Supplies	N/A unless 0274	HCPCS required when submitting 0274
042X	Physical Therapy	Varied	Visit the Medicare Claims Processing Manual (Chapter 10) for more information
043X	Occupational Therapy	Varied	
044X	Speech-language Pathology	Varied	
055X	Skilled Nursing	Varied	
056X	Medical Social Services	G0155	N/A
057X	Home Health Aide	G0156	N/A
062X	Medical/Surgical Supplies	N/A	Optional when an HHA chooses to report additional breakdown for surgical or wound care dressings

Sub-classifications exist for revenue codes ending in an "X." Use a "0" to indicate general classification when sub-classifications are not appropriate.

Home Health Billing Codes

HCPCS/Rates/HIPPS Rate Codes (FL 44)		
HCPCS	Services Performed in 15-minute Increments	REV
G0151	Physical Therapy	042X
G0152	Occupational Therapy	043X
G0153	Speech-language Pathology	044X
G0155	Clinical Social Worker	056X
G0156	Home Health Aide	057X
G0157	Physical Therapist Assistant	042X
G0158	Occupational Therapist Assistant	043X
G0159	Physical therapy establish or deliver safe and effective physical therapy maintenance program	042X
G0160	Occupational therapy establish or deliver safe and effective occupational therapy maintenance program	043X
G0161	Speech-language pathology establish or deliver safe and effective speech-language pathology maintenance program	044X
G0162	Registered nurse (only) for management and evaluation of plan of care (POC)	055X
G0299	Direct skilled services of a registered nurse	055X
G0300	Direct skilled services of a licensed practical nurse	055X
G0493	Registered nurse for the observation and assessment of patient's condition	055X
G0494	Licensed practical nurse for the observation and assessment of patient's condition	055X
G0495	Registered nurse training and/or education of a patient or family member	055X
G0496	Licensed practical nurse training and/or education of a patient or family member	055X
G2168	Services performed by a physical therapy assistant, each 15 minutes (Valid for claims submitted after October 5, 2020, for services on or after January 1, 2020. TOB 032X other than 0322. Select this link for more information.)	042X
G2169	Services performed by an occupational therapy assistant, each 15 minutes (Valid for claims submitted after October 5, 2020, for services on or after January 1, 2020. TOB 032X other than 0322. Select this link for more information.)	043X

Home Health Billing Codes

HCPCS/Rates/HIPPS Rate Codes (FL 44)		
HCPCS	Where Home Health Services Were Provided	REV
Q5001	Care provided in patient's home or residence	042X 043X 044X 055X 056X 057X
Q5002	Care provided in assisted living facility	
Q5009	Care provided in place not otherwise specified (NO)	
HCPCS	Telehealth Coding	REV
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 057X
G0321	Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system	
*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.	

*Voluntary on or after January 1, 2023. Required on or after July 1, 2023.

For HCPCS G0322, you must submit services provided via telecommunications technology in line-item detail. Report each service as separate dated line under the appropriate revenue code for each discipline providing the service.

You can only report the above G codes on 032X TOBs. You should only report these codes with revenue codes 042X, 043X, 044X, 055X, 056X and 057X. Select this link for more information.

Home Health Billing Codes

FISS Field & UB-04 FL				
FISS Pg	FISS Field Name	UB FL	Data Entered	Claim
1	MID	60	Medicare ID Number	Required
1	TOB	4	Type of Bill	Required
1	NPI	56	NPI Number	Required
1	Pat.Cntl#	3a	Patient Control Number	Optional
1	Stmt Date From	6	From DOS	Required
1	To	6	To DOS	Required
1	Last	8	Patient's Last Name	Required
1	First	8	Patient's First Name	Required
1	DOB	10	Patient's Date of Birth	Required
1	Addr 1	9	Patient's Address	Required
1	Addr 2	9	City, State	Required
1	ZIP	9	ZIP Code	Required
1	Sex	11	Sex Code (M or F)	Required
1	Admit Date	12	Date of Admission	Required
1	Hr	13	Admission Hour	Required[1]
1	Type	14	Type of Admission	Required
1	Src	15	Point of Origin	Required
1	Stat	17	Patient Status	Required
1	Cond Codes	18-28	Condition Code	Conditional
1	Occ Cds/Date	31-34	Occurrence Code/Date	Conditional
1	Fac.ZIP	1	ZIP Code for Provider or Subpart	Required[1]
1	DCN	64	Document Control Number	Conditional[2]
1	Value Codes	39-41	Value Codes	Required[3]

[1] Required for Direct Data Entry (DDE)
[2] Adjustments and cancels only
[3] Value code 61 and CBSA code required on 329 TOBs. Not required on NOAs.

Home Health Billing Codes

FISS Field & UB-04 FL				
FISS Pg	FISS Field Name	UB FL	Data Entered	Claim
2	Rev	42	Revenue Codes	Required[4]
2	HCPC	44	HCPCS	Required
2	Modifs	44	Modifiers	Conditional
2	Tot Unit	46	Total Units	Required
2	Cov Unit	46	Covered Units	Required
2	Tot Charge	47	Total Charges	Required
2	Ncov Charge	48	Non-covered Charges	Conditional
2	Serv Date	45	Service Date	Required
3	CD	50	Payer Code	Required
3	Payer	50	Payer Name	Required
3	RI	52	Release of Information	Required
3	Medical Record Nbr	3b	Medical Record Number	Optional
3	Diag Codes	67	Diagnosis Codes	Required
3	Att Phys NPI	76	Physician/Allowed Practitioner NPI Who Signed POC	Required
3	L	76	Last Name of Physician/Allowed Practitioner Who Signed POC	Required
3	F	76	First Name of Physician/Allowed Practitioner Who Signed POC	Required
3	M	76	Middle Initial of Physician/Allowed Practitioner Who Signed POC	Optional
3	Ref Phys	78	Physician/Allowed Practitioner NPI Who Certified/Recertified Eligibility	Required[7]
3	L	78	Last Name of Physician/Allowed Practitioner Who Certified/Recertified Eligibility	Required[7]
3	F	78	First Name of Physician/Allowed Practitioner Who Certified/Recertified Eligibility	Required[7]
3	M	78	Middle Initial of Physician Who Certified/Recertified Eligibility	Optional[7]

[4] Revenue codes 0001 and 0023 required on final claims
[7] For periods/episodes if different than the ATT PHYS

Home Health Billing Codes

FISS Field & UB-04 FL				
FISS Pg	FISS Field Name	UB FL	Data Entered	Claim
4	Remarks	80	Remarks (adjustments, cancels, MSP, etc.)	Conditional
5	Insured Name	58	Insured's Last Name, First Name	Conditional[5]
5	Sex	N/A	Insured's Sex Code	Conditional[5]
5	DOB	N/A	Insured's Date of Birth	Conditional[5]
5	REL	59	Patient's Relationship to Insured	Conditional[5]
5	CERT-SSN-MID	60	Insured's ID/Medicare ID Number	Conditional[5]
5	Group Name	61	Insurance Group Name	Conditional[5]
5	Group Number	62	Insurance Group Number	Conditional[5]
5	Treat Auth Code	63	Treatment authorization codes are not required on all claims. The HHA submits a code in this field only if the period is subject to pre-claim review for the HH Review Choice Demonstration. In that case, the required tracking number is submitted in the first position of the field in all submission formats.	Required[6]

[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)

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- Billing the Home Health Notice of Admission (NOA) via DDE