

Home Health Medicare Billing Codes Sheet

Type of Bill (OSR) (PL 4)	
000	Request for Anticipated Payment (RAP)
001	Adjustment Claim
002	Visit/Consult Prior RAP/Claim
003	Final Claim for Expense
004	Repayment Claim
005	Outpatient Services
006 or 007	Contractor adjustment

CMS Pub. 100-04, Chapter 10 <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/c10004.pdf>

Priority (Type) of Admission or Visit Codes (PL 14)			
1	Emergency	4	Neurology
2	Urgent	5	Trauma
3	Elective	9	Information not available

Point of Origin (Primary Source of Admission Code) (PL 16)	
1	Non-Health Care Facility Point of Origin
2	Clinic or Physicians 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 (PL 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
08	Expired - Occurrence code 95 also required
21	Discharge/transfer to court/law enforcement
22	Still a patient. Services continue to be provided. (Required on RAPs.)
43	Discharge/transfer to federal hospital
60	Discharge/transfer for hospice services in the home
61	Discharge/transfer to hospice services in a medical facility
62	Discharge/transfer to hospital-based Medicare approved wing/bed
63	Discharge/transfer to ICF (inpatient rehabilitation facility)
64	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) (PL 18-20)	
01	Treatment of nonterminal condition for hospice patient
20	Beneficiary requested billing (demand denial)
21	Billing for denial review (no-pay bill)
47	Transfer from another HHA
C3	Expedited review - partial approval of Medicare-covered services
C4	Expedited review - services denied
C5	Expedited review - extended authorization of Medicare-covered services

Claim Change Reason Codes (CCRC) (PL 19-28) & Adjustment Reason Codes (ARC) (PL55 only)			
Description	CCRC	ARC	TSR
Changes in Service Dates	00	RP	307
Changes in Charges	01	RC	307
Changes in revenue/HCPC/HTPS codes	02	RP	307
Cancel for correct procedure #	05	RP	308
Cancel duplicate or OIG payment	06	RJ	308
Any other multiple change (s)	09	RR	307
Change in patient status	10	RP	307

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

Medicare Secondary Payer (MSP) Value Codes (VC) (PL 39-41) & Payer Codes (PC) (PL55 only)		
Description	VC	PC
Working Agent	12	N/A
ESRD	13	N/A
No Feature (agency involved)	14	N/A
Worker's Compensation	15	N/A
Public Health Serv/Other Federal	16	N/A
Black Lung	41	N/A
Diabetic	43	N/A
Obligated to Accept as Payment in Full (OTMF)	44	A, M or L
Liability	47	N/A
Conditional Payment	Any of the Above	C
Medicare		Z

NOTE: Medicare does not make secondary payer payments on RAPs. Submit RAPs with Medicare as primary.

CMS Pub. 100-05, Chapter 2 <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/c10005.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 available from the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual - <http://www.nubc.org>

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