

# Home Health Medicare Billing Codes Sheet

Type of Bill (OSR) (PL 4)	
000	Request for Anticipated Payment (RAP)
001	Adjustment Claim
008	Visit/Consult Prior RAP/Claim
009	Final Claim for Expense
020	Nonpayment Claim
040	Outpatient Services
080 or 081	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
30	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 (outpatient 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 dental services (to-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) (P155 only)			
Description	CCRC	ARC	TCR
Changes in Service Dates	00	RP	307
Changes in Charges	01	RC	307
Changes in revenue/HCPCS/PTSD 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) (P155 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 3 <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>

# Medicare Rev Codes Quick Reference Guide

**J Dewey**



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*Effective Management of Coding Services* Lou Ann Schraffenberger,2002 This is a resource for coding managers across the continuum of health care settings with a special emphasis on acute care and hospital based ambulatory settings Addresses the scope and organization of clinical coding data including standards for electronic record systems coding practice issues recruitment and retention of coding staff chargemaster management quality control issues compliance reporting issues and financial issues Contains numerous examples and case studies to illustrate issues and demonstrate how coding decisions affect other areas in the health care organization    **Medicare Home Health Agency Manual** ,1900

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