Priority Health	BILLING POLICY No. 005
FACILITY BILLING	
Date of origin: June 2024	**Review dates: 11/24, 2/2025, 5/2025, 6/2025, 9/2025, 3/2026,09/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for facility billing, ensuring claims are processed according to contractual agreements and industry standards. The data elements and design of the billing formats are determined by the National Uniform Billing Committee (NUBC) at the request of CMS, the State Uniform Billing Committees (SUBC) and provider and payer associations. Most of the UB04 Form Locators (FLs) are required data elements for Medicare billing. Unassigned codes and spaces on the claim form are available to meet the future reporting needs of CMS and state and local regulatory agencies and payer-specific requirements for hospital billing.

DEFINITION

The National Uniform Billing Committee (NUBC) is the governing body for forms and codes use in medical claims billing in the United States for institutional providers like hospitals, nursing homes, hospice, home health agencies, and other providers.

MEDICAL POLICY

- *Not Applicable*

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Condition Codes

- This policy addresses Form Locators (FLs) on the UB-04 and the required information for each field. If the information submitted is missing, incomplete, or invalid, the claim will be denied. Fields included in this policy include, but are not
- limited to:
- Condition Codes
- Claim Change Reason Codes
- Discharge Codes
- Occurrence Codes
- Type of Bill (TOB)
- Admission Source or Point of Origin Codes
- Accommodation Codes
- Value Codes
- ESRD-Related Conditions Codes
- SNF-Realted Condition Codes
- Beneficiary/Spouse Insurance Related Condition Codes
- Disaster Related Conditions Codes

Condition codes (a.k.a. reason codes) are designed to allow the collection of information related to the patient, particular services, service venue, and billing parameters which impact on the processing of a facility claim.
Priority Health follows the Centers for Medicare and Medicaid Services (CMS) standard billing guidelines. Review CMS guidelines to confirm whether an occurrence and/or value code must also be reported.

For accurate identification of facility claim corrections, facilities should report the appropriate adjustment indicator for a corrected or voided/canceled claim along with the claim change reason code.

See our Provider Manual's correcting a claim page for additional information regarding bill types to report in addition to the reason codes noted below. Claims reported without the bill type and change reason code will be denied.

Claim change reason codes

Condition Code	Description
D0	Changes to service dates
D1	Changes in charges
D2	Changes in revenue code/HCPC
D3	Second or subsequent interim PPS bill
D4	Change in Grouper input (DRG)
D5	Cancel only to correct a patient's Medicare ID number or provider number
D6	Cancel only - duplicate payment, outpatient to inpatient overlap, OIG overpayment
D7	Change to make Medicare secondary payer
D8	Change to make Medicare primary payer
D9*	Admitted as an inpatient to this hospital
E0	Change in Patient Status
G0	Distinct Medical Visit.

*Use of condition code D9 should also include a remark to mirror bold criteria below on the second line of remarks:

- **Patient control nbr**: Changing or adding a patient control number
- **Admission hour**: Changing or adding the admission hour
- **Admission type**: Changing or adding the admission type
- **Admission source**: Changing or adding the admission source
- **Medical record number**: Changing or adding the medical record number
- **Condition code**: Changing or adding a condition code
- **Occ codes**: Changing or adding an occurrence code
- **Occ span codes**: Changing or adding an occurrence span code
- **Value codes**: Changing or adding a value code
- **Modifier**: Changing or adding a modifier
- **Date of service**: Changing a date of service on a line or changing the statement from and to dates, use a D0
- **Units**: Changing units
- **Recalculation**: Claim recalculated for a different payment
- **Multiple changes**: Enter your changes
- **DX code**: Changing a diagnosis code on an outpatient claim, inpatient claims would use a D4
- **POA**: Changing, adding or removing a Present on Admission (POA) indicator, unless you're changing an N to a Y and/or if it affects reimbursement, in which case you would use D4
- **Removed non**: Removing non-covered charges
- **Other**: Place this information on the second line of the claim only. On the third line of claim, include a brief description of why the claim is being adjusted

- See additional information.

Discharge Codes

CMS facility discharge codes are critical for accurate billing, compliance, and proper payment processing. Using the correct code ensures that both the discharging and receiving facilities are reimbursed appropriately and helps maintain accurate Medicare error rates. Facilities should maintain careful documentation, verify patient destinations, and follow up on any changes to prevent claim errors and unnecessary adjustments. Partial list of discharge codes:

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Discharge Code	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04	Discharged/transferred to a facility that provides custodial or supportive care
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
08	Reserved for national assignment
09	Admitted as an inpatient to this hospital

Occurrence Codes

Occurrence codes are two-digit alphanumeric codes used on CMS claim forms such as the CMS-1450 (UB-04) and 837I to indicate specific events that occurred during a patient's care or relate to the billing period. Each code is paired with a date that specifies when the event occurred, providing payers with context for claim processing, determining liability, coordinating benefits, and administering subrogation. These codes are maintained by the National Uniform Billing Committee (NUBC) and are recognized by Medicare, Medicaid, and private insurers.

Occurrence Code	Description
01	Accident/Medical Coverage
02	No Fault Insurance Involved - Including Auto Accident/Other
03	Accident/Tort Liability
04	Accident/ Employment Related
05	Accident/No Medical or Liability Coverage
06	Crime Victim
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness

Type of Bill

The Type of Bill (TOB) code is essential for Medicare and other payers to understand the nature of a claim and route it correctly for processing. It is reported in box 4 on the UB-04 claim form and is primarily used for institutional claims, not professional claims submitted on CMS-1500 forms.
This four-digit alphanumeric code provides three specific pieces of information after a leading zero. CMS ignores the leading zero. This three-digit alphanumeric code gives three specific pieces of information.

First Digit = Leading zero. Ignored by CMS
Second Digit = Type of facility
Third Digit = Type of care

Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code

Short list of Type of Bill by Facility Type:

Type Of Bill	Description
011X	Hospital Inpatient (Including Medicare Part A)
012X	Hospital Inpatient (Medicare Part B only)
013X	Hospital Outpatient
014X	Hospital -Laboratory
021X	Skilled Nursing Facility-Inpatient (Medicare Part A)
022X	Skilled Nursing Facility (Medicare Part B only)
023X	Skilled Nursing Facility Outpatient
028X	Skilled Nursing Facility-Swing Beds
032X	Home Health Services

- Type of bill 014X is used for the billing of non-patient laboratory specimens only. All other services billed on type of bill 014X will be denied.

Admission Source or Point of Origin Codes

CMS admission source codes (also called **Point of Origin codes**) are standardized values used in institutional inpatient claims (especially UB-04/CMS-1450) to indicate how a patient was admitted to a healthcare facility. They are maintained by the **National Uniform Billing Committee (NUBC)** and are required for Medicare inpatient claims.
The provider must enter the code indicating the source of the referral for admission or visit. Required except for Bill Type 014X, (the bill type is used for non-patient laboratory specimens and the point of origin would not be known).

Code structure for Admission Source or Point of Origin Codes:

Discharge Code	Description
1	Non-Health Care Facility Point of Origin (Physician Referral)
2	Clinic or Physician's Office
3	Hospital Outpatient
4	Transfer from a Hospital (different facility).
5	Transfer from a SNF, ICF, ALF, or NR
6	Transfer from another Health Care Facility
7	Reserved
8	Court/Law Enforcement
9	Information not available

Accommodation condition codes

“Accommodation” condition codes are used to indicate changes to patient status, service dates, or room/bed configurations that affect billing, such as private room or special program accommodations.

Accommodation Condition Code	Description
D0	Change to the claim’s from- and to- dates.
D1	Change to covered charges (e.g., adding a modifier that makes a non-covered charge covered).
D2	Change to revenue codes, HCPCS codes, RUG code, or HIPPS code.
D3	Second or subsequent interim claim for inpatient PPS hospitals.
D4	Change in grouper input (ICD□9/10 diagnosis or procedure codes).
D5	Cancel claim to correct Medicare ID or provider number.
D6	Cancel claim for other reasons (e.g., repayment of overpayment).

D7	Change Medicare from primary to secondary payer.
D8	Change Medicare from secondary to primary payer.
D9	Information not available
E0	Only change is correction to patient status code.
Private Room/Special Accommodation Codes	**Description**
Condition Code 38	Semi-private room not available.
Condition Code 39	Private room is medically necessary.
Value Code 02	Hospital has no semi-private rooms ($0.00 amount).

Value Codes

Value codes are two-character alphanumeric codes used on CMS billing forms to report specific numeric or non-dollar data elements for institutional claims.

What Are Value Codes?

Value codes are used on CMS-1450 (UB-04) and 837I forms to report important claim information that does not always involve dollar amounts. They identify data elements such as Medicare lifetime reserve days, no-fault payments, blood deductible amounts, or patient height for dialysis claims.

Each value code allows up to 9 numeric digits and can represent either dollar amounts or units depending on the code.

Value Code	Description
01	Most common Semi-Private Rate - to provide for recording hospital's most common semi- private rate.
02	Hospital has no semi-private rooms - using this code requires $0.00 amount.
04	Inpatient Professional Component Charges Which Are Combined Billed - (Used only by some all- inclusive rate hospitals)
05	Professional component included in charges and billed separately to carrier - (Applies to Part B bills only)
06	Medicare Part A and Part B Blood Deductible for un-replaced deductible pints of blood supplied times the charge per pint. If all deductible pints have been replaced this code is not used
07	Reserved for National Assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period
12	Working Aged Beneficiary Spouse with an EGHP (Payer Code A)
13	ESRD Beneficiary in Medicare Coordination Period

ESRD-Related Condition Codes

In Medicare ESRD billing, “condition codes” are used on Type of Bill (TOB) 72X claims to indicate the nature of the claim, and certain codes are required for every ESRD facility bill. Centers for Medicare & Medicaid Services. The most common ESRD-related condition codes are:

ESRD-Related Condition Code	Description
59	Non-primary ESRD facility
70	Self-administered Epoetin (EPO)

71	Full care in unit
72	Self-care in unit
73	Self-care training
74	Home
76	Back-up in-facility dialysis
80	Patient receives dialysis services at home – patients' home is nursing facility
84	Dialysis for acute kidney injury on monthly basis
87	ESRD self-care retraining
H3	Reoccurrence of GI bleed comorbid category
H4	Reoccurrence of pneumonia comorbid category
H5	Reoccurrence of pericarditis comorbid category

SNF-Related Condition Codes

SNF condition codes are two-character codes used on claims to communicate specific circumstances that affect payment or claim processing. They are primarily used for adjustments, cancellations, or special billing situations under Medicare Part A.

ESRD-Related Condition Code	Description
20	Beneficiary requested billing. Provider determined services are part of a non-covered level of care or excluded, but beneficiary requests determination by payer. (Limited to home health and inpatient SNF claims.)
55	SNF bed is not available. Patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical appropriateness condition code. Patient's SNF admission was delayed more than the 30 days after hospital discharge as patient's condition made it inappropriate to begin active care within that period.
57	SNF readmission when patient previously received Medicare covered SNF care within 30 days of current SNF admission.
58	NF patient terminated MA Plan enrollment. Providers report this code to waive 3-day qualifying stay requirement.

Beneficiary/Spouse insurance related condition codes

- **45**: Ambiguous gender category. See additional information in our Provider Manual.

Disaster related condition codes

- **DR**: Disaster related, used to identify claims that are or may be impacted by specific payer/health plan policies related to national or regional disasters.

REFERECES

- Condition codes – JE Part A (Noridian Medicare)
- Medicare claims processing manual (CMS)
- Patient Discharge Status Codes - JF Part A - Noridian
- Type of Bill By Facility - JE Part A - Noridian
- Point of Origin Codes - JE Part A - Noridian
- https://med.noridianmedicare.com/web/jea/topics/claim-submission/value-codes
- esrd related condition codes – Noridian
- Skilled Nursing Facility Billing Reference - MLN006846
- https://medicalbillingrcm.com/ub-04-condition-codes/#google_vignette
- National Uniform Billing Committee (NUBC) CMS
- Medical Code Edits (MCE) OptumInsight, Inc. UB Editor

- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated
- publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

FAQ

N/A

Resources

- https://www.priorityhealth.com/provider/manual

Related policies

- N/A

Related denial language

Prism explanation code: y04 – Invalid condition code

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 11, 2024	• Added Hospitalization condition codes 27, 30, 40, 41, 42, 43, 44, 51, 79, B4 and G0. • Added “References” section
Feb. 4, 2025	Added “Disclaimer” section
May 13, 2025	• Added “Related denial language” section with prism explanation code y04 – Invalid condition code • Updated “Applies to” section
June 4, 2025	No changes made
Sept 22, 2025	Name change, added content regarding type of bill 014x
March 25, 2026	No changes made
September 14, 2026	• Added Policy Overview, Definitions and updated policy specific information tables. • Accommodation condition codes table has been updated. • Hospitalization, product, and service-related condition codes were deleted. • Facility Discharge Codes / Occurrence & Value Codes / TOB, Admission Source has been added. • References and Disclaimer have been updated.