CAREBRIDGE

Electronic Visit Verification (EVV) Iowa Integration Guide and Technical Specifications

TABLE OF CONTENTS

Summary of Changes *3*

Introduction to CareBridge Integration 6

Overview *6*

What is CareBridge? *6*

Integration Overview *6*

SFTP Configuration Requirements *7*

SFTP Folder Structure *7*

SFTP Retention Policy *7*

File Format Specifications *7*

Naming Convention *7*

CareBridge Response File *7*

Testing Instructions *8*
- Testing Overview 8
- Initial Production Data Go-Live 8
- Claim Submitted via CareBridge 9
- Integration “Go-Live” 9

Data Field Specifications *10*

SUMMARY OF CHANGES

- SFTP Configuration Requirements
  - Login Credentials: SSH Key *(V2)*
- File Format Specifications
  - ApptID clarification *(V2)*
- Testing Instructions
  - Connection Testing *(V2)*
  - File Validation Testing *(V2), (V4)*
  - Data Validation Testing *(V2)*
  - Data Validation Testing -Staging *(V4)*
  - Data Validation Testing - Production *(V4)*
  - Claim Submitted via CareBridge *(V4)*
  - Integration "Go-Live" *(V4)*
  - Added links to CareBridge Integration Testing Guide required for new Third-Party Vendors (V5)
- CareBridge Response File Format
  - Additional details provided *(V2)*
- Appointments / Visits Data File Format
  - Added Max File Size Validation (V5)
  - Field Requirements updates
    - 24 - CheckInStreetAddress2 [N] *(V4)*
    - 33 - CheckOutStreetAddress2 [N] *(V4)*
    - 47 - DiagnosisCode: Appts [N] *(V4)*
  - Field Numbers updates *(V2)*
  - Field Name updates
    - 101 - Claim Invoice Number 1 *(V3)*
    - 102 - Claim Invoice Number 2 *(V3)*
    - 103 - Invoice Line Item ID 1 *(V3)*
    - 104 - Invoice Line Item ID 2 *(V3)*
  - New Field(s) added:
    - 8 - ProviderMedicaidID *(V2)*
    - 15 - MemberDateOfBirth *(V2)*
    - 43 - IsWaiver field added
    - 55 - CarePlanTasksCompleted *(V2)*
    - 56 - CarePlanTasksNotCompleted *(V2)*
    - 57 - CaregiverSurveyQuestions *(V2)*
    - 58 - CaregiverSurveyResponses *(V2)*
    - 101 - Claim Invoice Number 1 *(V2)*
    - 102 - Claim Invoice Number 2 *(V2)*
    - 103 - Line Item Invoice Number 1 *(V2)*
    - 104 - Line Item Invoice Number 2 *(V2)*
  - Field(s) removed
    - 55 - ICN *(V2)*
  - Field Description update

        - 7 - ProviderEIN: Max Length 9 *(V4)*
        - 8 - ProviderMedicaidID: 9 digits min/max *(V4)*
        - 16 - MemberMedicaidID: 7 digits followed by a letter, Max Length 8 *(V4)*
        - 48 - DiagnosisCode updated to be Tilde ~ delimited list *(V6)*
        - 49 - Rate: changed from Alphanumeric to Decimal *(V2)*
        - 55 - Changed CarePlanTasksCompleted from free text to specific codes (V5)
        - 56 - Changed CarePlanTasksNotCompleted from free text to specific codes (V5)
- Added Specific Service Codes and Unit Definitions for PCS and Home Health (V5)
    - Added Service Codes and Unit Definitions for Home Health Phase II Codes by Payer *(V6)*
    - Added Service Code S9124 Non-Waiver for Iowa Total Care *(V6.1)*
- Added Prior Authorization Requirements Section *(V6)*
- Manual Reason Codes
    - New Reason Code
        - MR1050 - Member Initiated *(V2)*
- Late Reason Code
    - New Reason Code
        - LR1020 - Scheduling Error *(V2)*
- Missed Reason Codes
    - New Reason Code
        - MVR1040 - Scheduling Error (V2)
- Added CarePlanTask Codes (V5)
- Added CarePlan Task Codes to Procedure Code Mapping (V5)
    - Added section mapping specific procedure codes to sets of care plan tasks (V5)
    - Updated CarePlan Task Codes *(V6)*
- Updated MCOIDs to include Molina *(V6)*
- Updated ClaimAction field to remove "C" to reduce confusion around what should be populated in that field. We will continue to accept "C" to ensure backwards compatibility, but recommend vendors always use "N" to generate claims and "V" to void claims.
- Pre-Billing Validation
    - This is a comprehensive list of CareBridge Pre-Billing validation responses – some may not be applicable to your specific integration. *(V2, V3, V4)*
    - Removed Pre-Billing Validation List and added link to Pre-Billing Validations page on website (V5)
- The Following Home Health Service Codes for Wellpoint have been updated from "Always" to "Sometimes" Prior Authorization
    - G0159
    - G0160
    - G0299
    - G0300
- Added the following fields for 837i Home Health Claim Elements **(V6.2)**:
    - FacilityType
    - InitialClaimFrequency
    - AdmissionDate

  - PatientStatus
  - AttendingProviderName
  - AttendingProviderNPI
  - AttendingProviderTaxonomyCode
  - ReferringProviderName
  - ReferringProviderNPI
  - ConditionCode
  - ValueCode
  - ValueCodeAmount
- Added the following tables **(V6.2)**:
  - Facility Type Codes
  - Initial Claim Frequency Codes
  - Patient Status Codes
  - Condition Codes
  - Value Codes

INTRODUCTION TO CAREBRIDGE INTEGRATION

OVERVIEW

Welcome! This Integration Guide is intended to help providers and EVV Vendors throughout the process of integrating with CareBridge to provide EVV data for the purposes of data aggregation. If at any point you have questions, our team is here to help: evvintegration@carebridgehealth.com.

WHAT IS CAREBRIDGE?

CareBridge is a company formed to support care for people who receive Long-Term Services and Supports (LTSS). We offer LTSS solutions including an Electronic Visit Verification Platform that can be utilized via a mobile phone, GPS-enabled tablet, landline, and web-based portal to record service delivery and facilitate day-to-day management of members' appointments. CareBridge also supports a wide array of EVV data aggregation solutions in which CareBridge builds an integration with a provider's EVV system, allowing provider agencies to keep their current EVV solution while still providing required data back to the health plan or state.

INTEGRATION OVERVIEW

CareBridge will engage providers that choose to integrate CareBridge's Platform with a 21st Century Cures Act compliant EVV solution. CareBridge's Platform supports data aggregation by way of accepting EVV Visit Data from third-party vendors and subsequently generating claims to be submitted to the clearinghouse and MCOs.

All EVV Visit and Claims data must ultimately be reflected in the CareBridge Platform for MCO receipt, payment, and monitoring.

The following is a description of the steps in the data aggregation process:

1. Appointments / Visits data file is placed in SFTP folder by provider and/or third-party vendor
2. CareBridge imports and processes Appointments / Visits file
3. CareBridge places response file in SFTP for review by provider and/or third-party vendor
    a. Provider takes action on response errors and resubmits
4. CareBridge utilizes visit data to generate claims and submits to clearinghouse / MCOs
5. Providers can continue to receive claim remittances through previously established mechanisms (Availity)

Appointments / Visits data should be submitted to CareBridge at least once daily for all appointments / visits that have had incremental changes since last submission.

SFTP CONFIGURATION REQUIREMENTS

- CareBridge test environment: sftp.dev.carebridgehealth.com
- CareBridge production environment: sftp.prd.carebridgehealth.com
- Port: 22
- Login Credential: Vendor's public SSH key
- When transferring files via SFTP, select BINARY mode

SFTP FOLDER STRUCTURE

/input – Used to send files to CareBridge for import into the CareBridge system
/output – Used to retrieve Response Files from CareBridge

SFTP RETENTION POLICY

- Once files have been downloaded from /output, they should be deleted. If they are not deleted, they will be retained for 30 days.
- Files will be deleted from /input upon load and processing by CareBridge.

FILE FORMAT SPECIFICATIONS

- File type: CSV (pipe-delimited)
- Values can be enclosed with double quotes (and should be when a pipe could exist in the data)
- Double quotes within the data itself should be escaped using double quotes ("""").
- Headers should be included
- One row per appointment / visit
- All DateTime fields should be UTC with zero offset
- Visit data will be placed in an ***on hold*** claim status if there is already an existing *ApptID* that is part of the same claim, but has not yet reached a terminal status (Rejected, Paid, Denied)

NAMING CONVENTION

The general naming convention is as follows:

VISITS_IA_ProviderTaxID_YYYYMMDDHHMMSS.CSV

For Test Files, "TEST" will prepend the file name as follows:
TEST_VISITS_IA_ProviderTaxID_YYYYMMDDHHMMSS.CSV
Note: The state initials are required for files to be processed.

CAREBRIDGE RESPONSE FILE

VISITS_IA_ProviderTaxID_ERROR_YYYYMMDDHHMMSS.txt

For Test Files, "TEST" will prepend the file name as follows:
TEST_VISITS_IA_ProviderTaxID_ERROR_YYYYMMDDHHMMSS.txt

TESTING INSTRUCTIONS

Testing Overview

Vendors are required to complete testing scenarios in order to begin sending production data to CareBridge. If a vendor has already completed the integration process in IA and is sending production data, additional testing is not required for Home Health.

The goal of the testing process is to ensure that data is able to be successfully transmitted from Third-party vendors to CareBridge. CareBridge has created several test cases designed to ensure specific scenarios are understood and passed by vendors prior to production go-live.

The test cases are outlined in a separate document: ***Iowa - Third-Party EVV Vendor Integration Testing Process Guide***, available on the CareBridge EVV Data Integration web page: http://evvintegration.carebridgehealth.com, under ***Additional Documents for Third-Party Vendors*** > ***Iowa - Third-Party EVV Vendor Integration Testing Process Guide***.

Additionally, there are 3 different testing milestones summarized below:

- Connection Testing – Vendors credentials are working properly and they are able to successfully connect to the SFTP site.
- File Validation Testing – Vendors are able to successfully send files in accordance with our file specifications.
- Data Validation Testing– Vendors are able to send records in accordance with our data specifications. A full list of CareBridge Pre-Billing Validations can be found under **Technical Specifications for Third-Party Vendors** > **Pre-Billing Validation Errors.**

Initial Production Data Go-Live

Once a vendor has successfully completed the required test cases and is approved to send data to production, they can begin sending production appointment/visit data to the production environment. Prior to sending any data, Provider Agencies should complete the following form *here* to have their Tax ID Associated with the appropriate vendor within the CareBridge System. If this is not completed, **data from your Third-Party Vendor system will not be loaded.** This must be done for each Tax ID.

CareBridge highly recommends that EVV Vendors follow the process outlined below:

(1) Send a file in the production environment with actual visit/appointment data.
    a. Only sending 1-5 rows of data initially.
    b. Sending visit data with the *ClaimAction* field as null.
    c. At least one row of data be visit data rather than appointment data.
(2) Download the response file in the /output folder and review the pre-billing errors.
(3) Update data to remedy those errors; email evvintegration@carebridgehealth.com with questions about specific errors.
(4) Repeat steps 1-3 until you receive a response file with headers only. This means that there were no row level errors and the data was processed successfully.

(5) Repeat steps 1-4 for each unique provider agency TIN for whom you provide EVV services.

Claim Submitted via CareBridge

Once a vendor is able to successfully send a file of appointment/visit data without errors on behalf of a provider, they can coordinate with the provider to submit their first claim.

- Re-send the visit data previously sent in Initial Production Data Go-Live with the *ClaimAction* field as 'N'. This will generate a claim for those visits.

Note: If visits sent in *Data Validation Testing – Production* included the *ClaimAction* field as 'N' rather than null, *Data Validation in Production* and *Claim Submitted* via CareBridge would be completed simultaneously.

Integration "Go-Live"

Once a vendor is able to successfully submit a claim via CareBridge, they can begin implementation of *Integration Go-Live* – submitting all claims via CareBridge.

<u>This will require coordination between the vendor, the agency(ies) they support, and CareBridge.</u>

The process is as follows:

(1) Direct providers using your system to the CareBridge Integration Document for Providers site. It contains instructions for their expectations and next steps.
(2) Identify a go-live date with each agency to begin sending all data and communicate that date to CareBridge.
(3) Develop a process with your agency for resolving response file errors on an ongoing basis.
   - It is up to vendors and their agencies whether response files will be passed to their agencies directly or incorporated into the Third-party EVV system's UI.
   - It is required that vendors leverage both the:
     1. The ***Pre-Billing Validation Report*** in addition to response files to ensure providers have the most up-to-date information regarding outstanding visit errors.
     2. The ***Appointment Status Report*** to ensure providers have accurate information regarding visit or claim status over time.

     > *The supplemental report specifications can be found on the CareBridge EVV Data Integration web page: http://evvintegration.carebridgehealth.com, under **Additional Documents for Third-Party Vendors**.*

   - Integrating agencies will not be able to make updates to their data in the CareBridge EVV portal. Updated data should be sent via integration process.

DATA FIELD SPECIFICATIONS

CareBridge Response File Format

Field	Value	Description
ERROR_CODE	See sections below	The error code indicating the type of issue
ERROR_DESCRIPTION	See sections below	The description of the error code, this is dynamic based on the error
IS_FILE_ERROR	True or False	Indicates if the error is a file level error or row / field level error
ERROR_SEVERITY	ERROR or WARNING	Indicates the severity of the error
FILE_NAME	Name of the inbound file	Name of the file that was received by CareBridge

In addition to these 5 fields, the CareBridge response file will also contain each field included in the inbound data file for Third-Party EVV Vendor reference.

File Level Validation

Error Number	Description
F1001	File is not an expected file type.
F1002	File contains invalid delimiters.
F1003	File cannot be parsed, it may be incomplete or invalid.
F1004	File is a duplicate.
F1005	File exceeds max allowed file size. (5 GB)

Appointments / Visits Data File Format

Field No	Field Name	Description	Data Type	Required for		Example	Max Length
				Scheduled Appointment	Completed Visit		
1	VendorName	Name of EVV vendor sending data	Alphanumeric	Y	Y	EVV Vendor	
2	TransactionID	Unique identifier for the transaction and should be unique in every file. It is only used for tracking and troubleshooting purposes	Alphanumeric	Y	Y	71256731	
3	TransactionDateTime	Time stamp associated with the visit data being sent to CareBridge	Datetime	Y	Y	YYYY-MM-DD HH:MM "2020-01-01 14:00"	
4	ProviderID	Unique identifier for the provider	Alphanumeric	Y	Y	43134	100
5	ProviderName	Name of provider	Alphanumeric	Y	Y	Home Health, LLC	255
6	ProviderNPI	NPI of provider	Numeric	Y *(required unless the provider is atypical)*	Y *(required unless the provider is atypical)*	1609927608	10
7	ProviderEIN	Tax ID or EIN of provider	Alphanumeric	Y	Y	208076837	9
8	ProviderMedicaidID	MedicaidID number for Provider – 9 digit min/max	Numeric	Y	Y	000456789	9
9	ApptID	Unique identifier for the visit, used to identify an appointment and should be consistent for every appointment update	Alphanumeric	Y	Y	1231248391	100

10	CaregiverFName	First name of caregiver who completed the visit	Alphanumeric	Y	Y	John	
11	CaregiverLName	Last name of caregiver who completed the visit	Alphanumeric	Y	Y	Smith	
12	CaregiverID	Unique ID assigned to caregiver (Employee ID)	Alphanumeric	Y	Y	982123	
13	MemberFName	First name of member	Alphanumeric	Y	Y	Jane	
14	MemberLName	Last name of member	Alphanumeric	Y	Y	Johnson	
15	MemberDateOfBirth	Date of birth of member	Alphanumeric	N	N	YYYY-MM-DD	
16	MemberMedicaidID	Medicaid ID for member - 7 digits followed by a letter	Alphanumeric	Y	Y	1234567A	8
17	MemberID	If not using Medicaid ID	Alphanumeric	N	N	47138493	
18	ApptStartDateTime	Date / Time that the appointment was scheduled to begin	DateTime	Y	Y	YYYY-MM-DD HH:MM “2020-01-01 14:00”	
19	ApptEndDateTime	Date / Time that the appointment was scheduled to end	DateTime	Y	Y	YYYY-MM-DD HH:MM “2020-01-01 14:00”	
20	ApptCancelled	(C) if appointment was cancelled	Alphanumeric	N	N	C	
21	CheckInDateTime	Date / Time that the visit was checked into	Datetime	N	Y	YYYY-MM-DD HH:MM “2020-01-01 14:00”	
22	CheckInMethod	EVV (E), Manual (M), IVR (I)	Alphanumeric	N	Y	E	

23	CheckInStreetAddress	Street address where check in occurred	Alphanumeric	N	Y	926 Main St	
24	CheckInStreetAddress2	Additional street address info where check in occurred	Alphanumeric	N	N	Suite B	
25	CheckInCity	City where check in occurred	Alphanumeric	N	Y	Nashville	
26	CheckInState	State where check in occurred	Alphanumeric	N	Y	TN	
27	CheckInZip	Zip code where check in occurred	Alphanumeric	N	Y	37206	
28	CheckInLat	Latitude of coordinates where check in occurred	Alphanumeric	N	Y if CheckInMethod = E	##.######	
29	CheckInLong	Longitude of coordinates where check in occurred	Alphanumeric	N	Y if CheckInMethod = E	###.######	
30	CheckOutDateTime	Date / Time that the visit was checked out of	Datetime	N	Y	YYYY-MM-DD HH:MM “2020-01-01 14:00”	
31	CheckOutMethod	EVV (E), Manual (M), IVR (I)	Alphanumeric	N	Y	E	
32	CheckOutStreetAddress	Address where check out occurred	Alphanumeric	N	Y	926 Main St	
33	CheckOutStreetAddress2	Additional address info where check out occurred	Alphanumeric	N	N	Suite B	
34	CheckOutCity	City where check out occurred	Alphanumeric	N	Y	Nashville	
35	CheckOutState	State where check out occurred	Alphanumeric	N	Y	TN	
36	CheckOutZip	Zip code where check out occurred	Alphanumeric	N	Y	37206	

37	CheckOutLat	Latitude of coordinates where check out occurred	Alphanumeric	N	Y if CheckOutMethod = E	##.######	
38	CheckOutLong	Longitude of coordinates where check out occurred	Alphanumeric	N	Y if CheckOutMethod = E	###.######	
39	AuthRefNumber	Authorization Number as indicated by health plan	Alphanumeric	Y	Y (with exceptions outlined in the Prior Authorization Requirements Section)	1080421390	
40	ServiceCode	Service code for services rendered during visit (HCPCS Procedure Code)	Alphanumeric	Y	Y	S5125	
41	Modifier 1	Modifier code for services rendered during visit	Alphanumeric	N	N	U5	
42	Modifier 2	Second modifier code for services rendered during visit	Alphanumeric	N	N	UA	
43	IsWaiver[1]	Indication of whether the visit was performed under Waiver or Non-Waiver Program	Alphanumeric	Y	Y if required for Service Code/Payer (See Service Code and Unit Definition tables below)	Yes	
44	TimeZone	Time zone that the visit took place in	Alphanumeric	Y	Y	US/Central	
45	CheckInIVRPhoneNumber	Phone Number used to check in	Alphanumeric	N	Y if CheckInMethod = I	+14156665555	
46	CheckOutIVRPhoneNumber	Phone Number used to check out	Alphanumeric	N	Y if CheckOutMethod = I	+14156665555	
47	ApptNote	Free text note related to the visit	Alphanumeric	N	N	Scheduling related note	

48	DiagnosisCode	Tilda delimited list of ICD-10 Diagnosis code attributed to the visit. (Enter in the order that they are billed and primary dx should be the first listed.)	Alphanumeric	N	Y	I50.9~R68.89	
49	ApptAttestation	Member attestation associated with the visit	Alphanumeric	N	N	See Member Attestation Codes table below	
50	Rate	Billed unit rate associated with the visit	Decimal	Y	Y	3.85	
51	ManualReason	Reason for manual entry associated with the visit	Alphanumeric	N	Y if CheckInMethod or CheckOutMethod = M	See Manual Reasons Codes table below	
52	LateReason	Reason the visit was late	Alphanumeric	N	Y if check in occurred between one and three hours after the scheduled start time	See Late Reasons Codes table below	
53	LateAction	Action taken due to visit being late	Alphanumeric	N	Y if check in occurred between one and three hours after the scheduled start time	See Late Actions Codes table below	
54	MissedReason	Reason the visit was missed	Alphanumeric	N	Y if check in occurred greater than three hours after the scheduled start time	See Missed Reasons Codes table below	
55	MissedAction	Action taken due to the visit being missed	Alphanumeric	N	Y if check in occurred greater than three hours after the scheduled start time	See Missed Actions Codes table below	
56	CarePlanTasksCompleted	Tilda delimited list of tasks completed during the visit	Alphanumeric	N	N	CP1000~CP1015~CP1030 See Care Plan Tasks Codes	
57	CarePlanTasksNotCompleted	Tilda delimited list of tasks not completed during the visit	Alphanumeric	N	N	CP1005~CP1020~CP1025 See Care Plan Tasks Codes	

58	CaregiverSurveyQuestions	Tilda delimited list of survey questions presented to the caregiver	Alphanumeric	N	N	Has the member fallen since the last visit? ~ Is the member looking or acting different than they usually do?	
59	CaregiverSurveyResponses	Tilda delimited list of survey responses to questions presented to the caregiver in the same order as the questions listed in field 57	Alphanumeric	N	N	Yes~No	
60	ClaimAction	New Claim (N), Corrected Claim (C), Void (V)	Alphanumeric	N	Y	N	
61	MCOID	Identifies health plan the member is associated with	Alphanumeric	Y	Y	See MCOID table below	
62	FacilityType*	The Facility Type Code to be used on the claim	Numeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	See Facility Type Codes table below	2
63	InitialClaimFrequency*	The Claim Frequency Code to be used on an initial claim	Alphanumeric	N	Y, if submitting initial claim for visit and provider is configured to manage this value for 837i claims	See Initial Claim Frequency Codes table below	
64	AdmissionDate*	The Admission Date to be used on the claim	Date	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	YYYY-MM-DD	
65	PatientStatus*	The Patient Status Code to be used on the claim	Alphanumeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims.	See Patient Status Codes table below	2
66	AttendingProviderName*	The Attending Provider Name or Organization Name to be used on the claim	Alphanumeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	Richards	

67	AttendingProviderNPI*	The Attending Provider NPI to be used on the claim	Numeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	1234567893	
68	AttendingProviderTaxonomy Code*	The Attending Provider Taxonomy Code to be used on the claim	Alphanumeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	251E00000X	
69	ReferringProviderName*	The Referring Provider Name or Organization Name to be used on the claim	Alphanumeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	Jack Stevens	
70	ReferringProviderNPI*	The Referring Provider NPI to be used on the claim	Alphanumeric	N	Y, if claiming visit and provider is configured to manage this value for 837i claims	1234567893	
71	ConditionCode*	Tilde delimited list of condition codes to be used on the claim	Alphanumeric	N	N	See Condition Codes table below	2
72	ValueCode*	Value Code to be used on the claim	Alphanumeric	N	N	See Value Codes table below	
73	ValueCodeAmount*	Value Code Amount to be used on the claim	Alphanumeric	N	N	11280	
101	Claim Invoice Number 1	Claim level invoice number in third-party system	These fields can be used for reconciliation of the data sent to CareBridge. If you would like to use these fields, please contact the CareBridge Integration team at evvintegration@carebridgehealth.com				
102	Claim Invoice Number 2	Claim level invoice number in third-party system					
103	Line Item Invoice Number 1	Unique identifier of the invoice line item in the third-party					

104	Line Item Invoice Number 2	Unique identifier of the invoice line item in the third-party system	

*See Home Health Claim Element Technical Details for additional information.

PCS Service Codes Unit Definitions

Code	Modifier1	Procedure Description	Unit of Measure	Unit Quantity
S5125		ATTENDANT CARE SERVICES, PER 15 MINUTES	Minutes	15
S5125	U3	CDAC (AGENCY); 15 MINUTE UNIT -SKILLED	Minutes	15
T1019		PERSONAL CARE SERVICES, PER 15 MINUTES	Minutes	15
T1019	U3	CDAC (INDIVIDUAL); 15 MINUTE UNIT SKILLED	Minutes	15
S5130		HOMEMAKER NOS, PER 15 MINUTES	Minutes	15
S5150[1]		UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN	Minutes	15
S5150[1]	U3	UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN	Minutes	15
S5150[1]	UC	UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN	Minutes	15

1 S5150 is an optional service code that is only applicable for Wellpoint Iowa.

Home Health Service Codes and Unit Definitions (Phase 1)[1]

Code	Modifier1	Procedure Name	Program Type	Unit of Measure	Unit Quantity
S9122[2]	None	Home Health Aide	Waiver	Hours	1
S9123[2]	None	Nursing Care, RN, home	Waiver	Hours	1
S9124[2]	None	Nursing Care, LPN, home	Waiver	Hours	1
T1002	None	Nursing Care, RN, IMMT, home		Minutes	15
T1003	None	Nursing Care, LPN, IMMT, home		Minutes	15
T1004	None	Home Health Aide, IMMT		Minutes	15
T1004	U3	Home Health Aide		Minutes	15
T1021	None	Home Health Aide		Hours	2
T1030	None	Nursing Care, RN, home		Hours	2
T1031	None	Nursing Care, LPN, home		Hours	2

1 Phase 1 Services will always have prior authorizations and therefore, will always require the AuthRefNumber field to be populated.

2 These Service Codes require the IsWaiver field to be populated with “Yes” if performed under the Waiver program and “No” if performed as Non-Waiver services

Home Health Service Codes and Unit Definitions (Phase 2) – Wellpoint Iowa

Code	Modifier1	Procedure Name	Program Type	Prior Authorized	Unit of Measure	Unit Quantity
S9122[1]	None	Home Health Aide	Non-Waiver	Always	Hours	1
S9123[1]	None	Nursing Care, RN, home	Non-Waiver	Always	Visit	1
S9124[1]	None	Nursing Care, LPN, home	Non-Waiver	Always	Visit	1
G0151	None	Physical Therapist (PT), home health setting or hospice		Sometimes	Visit	1
G0152	None	Occupational Therapist (OT), home health setting or hospice		Sometimes	Visit	1
G0153	None	Speech Language Pathologist (SLP or ST), home health setting or hospice		Sometimes	Visit	1
G0156	None	Home Health Aide, home health or hospice setting		Sometimes	Visit	1

Code	Modifier1	Procedure Name	Program Type	Prior Authorized	Unit of Measure	Unit Quantity
G0158	None	OT Assistant, home health setting or hospice		Sometimes	Visit	1
G0159	None	PT, home health setting		Sometimes	Visit	1
G0160	None	OT, home health setting		Sometimes	Visit	1
G0161	None	SLP, home health setting		Sometimes	Visit	1
G0299	None	RN Direct Care, home health or hospice setting		Sometimes	Visit	1
G0300	None	LPN Direct Care, home health setting or hospice		Sometimes	Visit	1

1 These Service Codes require the IsWaiver field to be populated with "Yes" if performed under the Waiver program and "No" if performed as Non-Waiver services

Home Health Service Codes and Unit Definitions (Phase 2) – Iowa Total Care

Code	Modifier1	Procedure Name	Program Type	Prior Authorized	Unit of Measure	Unit Quantity
S9122[1]	None	Home Health Aide	Non-Waiver	Never	Hours	1
S9123[1]	None	Nursing Care, RN, home	Non-Waiver	Never	Visit	1
S9124[1]	None	Nursing Care, LPN, home	Non-Waiver	Never	Visit	1
G0151	None	Physical Therapist (PT), home health setting or hospice		Never	Visit	1
G0152	None	Occupational Therapist (OT), home health setting or hospice		Never	Visit	1
G0153	None	Speech Language Pathologist (SLP or ST), home health setting or hospice		Never	Visit	1
G0156	None	Home Health Aide, home health or hospice setting		Never	Visit	1
G0158	None	OT Assistant, home health setting or hospice		Never	Visit	1
G0159	None	PT, home health setting		Never	Visit	1
G0160	None	OT, home health setting		Never	Visit	1
G0161	None	SLP, home health setting		Never	Visit	1
G0299	None	RN Direct Care, home health or hospice setting		Never	Visit	1
G0300	None	LPN Direct Care, home health setting or hospice		Never	Visit	1

1 These Service Codes require the IsWaiver field to be populated with "Yes" if performed under the Waiver program and "No" if performed as Non-Waiver services

Home Health Service Codes and Unit Definitions (Phase 2) – Molina Healthcare of Iowa

Code	Modifier1	Procedure Name	Program Type	Prior Authorized	Unit of Measure	Unit Quantity
S9122[1]	None	Home Health Aide	Non-Waiver	Sometimes	Hours	1
S9123[1]	None	Nursing Care, RN, home	Non-Waiver	Sometimes	Visit	1
S9124[1]	None	Nursing Care, LPN, home	Non-Waiver	Sometimes	Visit	1
G0151	None	Physical Therapist (PT), home health setting or hospice		Sometimes	Visit	1
G0152	None	Occupational Therapist (OT), home health setting or hospice		Sometimes	Visit	1

G0153	None	Speech Language Pathologist (SLP or ST), home health setting or hospice		Sometimes	Visit	1
G0156	None	Home Health Aide, home health or hospice setting		Sometimes	Visit	1
G0158	None	OT Assistant, home health setting or hospice		Sometimes	Visit	1
G0159	None	PT, home health setting		Sometimes	Visit	1
G0160	None	OT, home health setting		Sometimes	Visit	1
G0161	None	SLP, home health setting		Sometimes	Visit	1
G0299	None	RN Direct Care, home health or hospice setting		Sometimes	Visit	1
G0300	None	LPN Direct Care, home health setting or hospice		Sometimes	Visit	1

1 These Service Codes require the IsWaiver field to be populated with “Yes” if performed under the Waiver program and “No” if performed as Non-Waiver services

Prior Authorization Requirements:

- “**Always**” authorized procedure codes in the tables above require the AuthRefNumber field to be populated for all visits.
- “**Sometimes**” authorized procedure codes will require the AuthRefNumber field to be populated if an authorization has been issued. If an authorization has not been issued, but a valid EVV Visit occurs for a member, this field should be left null.
- “**Never**” authorized procedure codes require that the AuthRefNumber field be left null for all EVV Visits.

Member Attestation Codes

Code	Description
MA1000	Complete
MA1005	Member Refused
MA1010	Member Unable
MA1015	No Signature (Other)

Manual Reasons Codes

Code	Description
MR1000	Caregiver error
MR1005	No access to application or IVR
MR1010	Technical error
MR1015	Duplicates/overlapping
MR1020	Forgot to clock in
MR1025	Missing/waiting for authorization
MR1030	Employee removed from current budget

MR1035	Possible EIN issues
MR1040	Overtime with two service codes and no OT Agreement
MR1045	Over budget without a form on file
MR1050	Member Initiated
MR1055	New Agency Using EVV

Late Reasons Codes

Code	Description
LR1000	Caregiver forgot to check in
LR1005	Technical issue
LR1010	Member would not allow staff to use device
LR1015	Member rescheduled
LR1020	Scheduling Error

Late Reason Actions Taken Codes

Code	Description
LA1000	Rescheduled
LA1005	Back-up plan initiated
LA1010	Contacted service coordinator
LA1015	Contacted MCO member services
LA1020	Caregiver checked in late

Missed Reasons Codes

Code	Description
MVR1000	Caregiver did not show up
MVR1005	Caregiver forgot to check in / out
MVR1010	Technical issue
MVR1015	Unplanned hospitalization
MVR1020	Authorization not in place at time of visit
MVR1025	Member or family refused service
MVR1030	Provider agency unable to staff
MVR1035	Member rescheduled
MVR1040	Scheduling Error

Missed Visit Actions Taken Codes

Code	Description

MVA1000	Rescheduled
MVA1005	Back-up plan initiated
MVA1010	Contacted service coordinator
MVA1015	Contacted MCO member services
MVA1020	Service provided as scheduled

MCOID Codes

Code	Description
IA_AGP	Wellpoint Iowa
IA_ITC	Iowa Total Care
IA_MHC	Molina Healthcare of Iowa

Facility Type Codes

Code	Description
32	Hospice (hospital based)
33	Outpatient hospital, or outpatient SNF
34	Hospital referenced laboratory services, home health agency, rehabilitation agency

Initial Claim Frequency Codes

Code	Description
1	Admit through discharge claim
2	Interim – first claim
3	Interim – continuing claim
4	Interim – last claim

Patient Status Codes

Code	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to other short- term general hospital for inpatient care
03	Discharged/transferred to a skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care or outpatient services
06	Discharged/transferred to home with care of organized home health services
07	Left care against medical advice or otherwise discontinued own care
08	Discharged/transferred to home with care of home IV provider

10	Discharged/transferred to mental health care
11	Discharged/transferred to Medicaid certified rehabilitation unit
12	Discharged/transferred to Medicaid certified substance abuse unit
13	Discharged/transferred to Medicaid certified psychiatric unit
20	Expired
30	Remains a patient or is expected to return for outpatient services (valid only for non-DRG claims)
40	Hospice patient died at home
41	Hospice Patient died at hosp
42	Hospice patient died unknown
43	Discharge/transferred to Fed Health
50	Hospice Home
51	Hospice Medical Facility
61	Transferred to Swing bed
62	Transferred to Rehab Facility
64	Transferred to Nursing Facility
65	Disc Tran Psychiatric Hosp
71	Trans for another Outpat Fac
72	Trans for Outpatient Service

Condition Codes

Code	Description
01	Military service related.
02	Condition is employment related.
03	Patient is covered by an insurance not reflected here.
04	Bill is submitted for informational purposes only.
05	Lien has been filed.
06	ESRD patient in the first 30 months of entitlement covered by employer group health insurance.
07	Treatment of a non-terminal condition for a hospice patient.
08	Beneficiary would not provide information concerning other insurance coverage.
09	Neither the patient nor the spouse is employed.
10	Patient and/or spouse is employed but no EGHP coverage exists.
11	Disabled beneficiary but no LGHP.
17	Patient is homeless.
18	Maiden name retained.

19	Child retains mother's maiden name.
20	Beneficiary requested billing.
21	Billing for denial notice.
22	Patient on Multiple Drug Regimen
23	Home Care Giver Available
24	Home IV Patient Also Receiving HHA Services
25	Patient Is a Non-U.S. Resident
26	VA eligible patient chooses to receive services in a Medicare Certified Facility.
27	Patient referred to a sole community hospital for a diagnostic laboratory test.
28	Patient's and/or spouse's EGHP is secondary to Medicare.
29	Disabled beneficiary and/or family member's LGHP is secondary to Medicare.
30	Qualifying Clinical Trial.
31	Patient is a student (full time - day).
32	Patient is a student (cooperative/work study program).
33	Patient is a student (full-time - night).
34	Patient is student (part-time).
36	General care patient in a special unit.
37	Ward accommodation at patient's request.
38	Semi-private room is not available.
39	Private room medically necessary.
40	Same day transfer.
41	Partial hospitalization.
42	Continuing care is not related to the patient's inpatient hospitalization.
43	Continuing care not provided within prescribed post discharge window.
44	Inpatient admission changed to outpatient.
45	Gender Incongruence.
46	Non-availability statement on file.
48	"Psychiatric Residential Treatment Centers for children and adolescents (RTCs). "
49	Product replacement within product lifecycle.
50	Product replacement for known recall by a product.
51	Attestation of unrelated outpatient nondiagnostic services.
52	Out of hospice service area.
53	Initial placement of a medical device provided as part of a clinical trial or a free sample.
54	No skilled home health visits in billing period. Policy exception documented at the home health agency.

55	SNF bed not available.
56	Medical appropriateness.
57	SNF readmission.
58	Terminated Medicare+Choice organization enrollee.
59	Non-primary ESRD facility.
60	Day outlier.
61	Cost outlier.
66	Provider does not wish cost outlier payment
67	Beneficiary elects not to use Lifetime Reserve (LTR) days.
68	Beneficiary elects to use Lifetime Reserve (LTR) days.
69	IME/DGME)/N&AH payment only.
70	Self-administered Anemia management drug.
71	Full care in unit.
72	Self-Care in unit.
73	Self-Care training.
74	Home
75	Home - 100 percent reimbursement.
76	Back-up in-facility dialysis.
77	Provider accepts/obligated/required due to contractual arrangement / law to accept payment by a primary payer as payment in full.
78	New covered not implemented by HMO.
79	CORF services provided offsite.
80	Home dialysis - Nursing Facility.
81	C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
82	C-sections or inductions performed at less than 39 weeks gestation electively.
83	C-sections or inductions performed at 39 weeks gestation or greater.
84	Dialysis for Acute Kidney Injury (AKI).
85	Delayed Recertification of Hospice Terminal Illness.
87	ESRD self care retraining.
88	Allogeneic Stem Cell transplant related donor charges.
89	Opioid Treatment Program.
90	Expanded Access approval.
91	Emergency Use Authorization.
92	Intensive Outpatient Program (IOP).
A0	TRICARE external partnership program.

A1	EPSDT/CHAP
A2	Physically handicapped children's program.
A3	Special federal funding.
A4	Family planning.
A5	Disability
A6	Vaccines/Medicaid 100% payment.
A9	Second opinion for surgery.
AA	Abortion performed due to rape.
AB	Abortion performed due to incest.
AC	Abortion performed due to serious fetal genetic defect, deformity, or abnormality.
AD	Abortion performed due to life endangering physical condition.
AE	Abortion performed due to physical health of mother that is not life endangering.
AF	Abortion performed due to emotional/psychological health of mother.
AG	Abortion performed due to social economic reasons.
AH	Elective abortion.
AI	Sterilization.
AJ	Payer responsible for copayment.
AK	Air ambulance required.
AL	Specialized treatment/bed unavailable.
AM	Non-emergency medically necessary stretcher transport required.
AN	Preadmission screening not required.
B0	Medicare Coordinated Care Demonstration Program.
B1	Beneficiary is ineligible for Full Demonstration Program.
B2	Critical Access Hospital ambulance attestation.
B3	Pregnancy indicator.
B4	Admission unrelated to discharge on same day.
BP	Gulf oil spill of 2010.
C1	Approved as billed.
C2	Automatic approval as billed based on focused review.
C3	Partial approval.
C4	Admission/service denied.
C5	Post payment review applicable.
C6	Admission preauthorization.
C7	Extended authorization.
D0	Changes to service dates

D1	Changes to charges
D2	Changes in revenue codes/HCPCS/HIPPS Rate codes
D3	Second or subsequent interim PPS bill.
D4	Change in ICD-9/ICD-10 Diagnosis codes and ICD-9/ICD-10 Procedure codes.
D5	Cancel to correct HICN or Provider ID.
D6	Cancel Only to repay a duplicate or OIG overpayment.
D7	Changes to make Medicare the Secondary payer.
D8	Changes to make Medicare the Primary payer.
D9	Any other changes.
DR	Disaster related.
E0	Change in Patient Status.
G0	Distinct medical visit.
H0	Delayed filing, statement of intent submitted.
H2	Discharge by a Hospice Provider for a Cause.
H3	Reoccurrence of GI bleed comorbid category.
H4	Reoccurrence of Pneumonia comorbid category.
H5	Reoccurrence of pericarditis comorbid category.
P1	Do not resuscitate order (DNR).
P7	Direct inpatient admission from Emergency Room.
R1	Request for reopening reason code - Mathematical or computational mistakes.
R2	Request for reopening reason code - Inaccurate data entry.
R3	Request for reopening reason code - Misapplication of a fee schedule.
R4	Request for reopening reason code - Computer errors.
R5	Request for reopening reason code - Incorrectly identified duplicate claim.
R6	Request for reopening reason code - Other clerical errors or minor errors and omissions not specified in R1-R5.
R7	Request for reopening reason code - Corrections other than clerical errors.
R8	Request for reopening reason code - New and material evidence.
R9	Request for reopening reason code - Faulty evidence.
UU	Payer Code.
W0	United Mine Workers of America demonstration indicator.
W2	Duplicate of Original Bill.
W3	Level I Appeal.
W4	Level II Appeal.
W5	Level III Appeal.

Value Codes

Code	Description
01	Most Common Semiprivate Rate
02	Hospital Has No Semiprivate Rooms
04	Inpatient Professional Component Charges Which are Combined Billed
05	Professional Component included in Charges and also Billed Separate to Carrier
06	Blood Deductible
08	Life Time Reserve Amount in the First Calendar Year
09	Coinsurance Amount in the First Calendar Year
10	Lifetime Reserve Amount in the Second Calendar Year
11	Coinsurance Amount in the Second Calendar Year
12	Working Aged Beneficiary/Spouse With Employer Group Health Plan
13	ESRD Beneficiary in a Medicare Coordination Period With an Employer Group Health Plan
14	No-Fault, Including Auto/Other
15	Worker's Compensation
16	PHS, or Other Federal Agency
21	Catastrophic
22	Surplus
23	Recurring Monthly Income
24	Medicaid Rate Code
25	Offset to the Patient-Payment Amount - Prescription Drugs
26	Offset to the Patient-Payment Amount - Hearing and Ear Services
27	Offset to the Patient-Payment Amount - Vision and Eye Services
28	Offset to the Patient-Payment Amount - Dental Services
29	Offset to the Patient-Payment Amount - Chiropractic Services
30	Preadmission Testing
31	Patient Liability Amount
32	Multiple Patient Ambulance Transport
33	Offset to the Patient-Payment Amount - Podiatric Services
34	Offset to the Patient-Payment Amount - Other Medical Services
35	Offset to the Patient-Payment Amount - Health Insurance Premiums
37	Units of Blood Furnished
38	Blood Deductible Units
39	Units of Blood Replaced
40	New Coverage Not Implemented by HMO (for inpatient service only)

41	Black Lung
42	VA or PACE
43	Disabled Beneficiary Under Age 65 with LGHP
44	Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received.
45	Accident Hour
46	Number of Grace Days
47	Any Liability Insurance
48	Hemoglobin Reading
49	Hematocrit Reading
50	Physical Therapy Visit
51	Occupational Therapy Visits
52	Speech Therapy Visits
53	Cardiac Rehab Visits
54	Newborn birth weight in grams
55	Eligibility Threshold for Charity Care
56	Skilled Nurse - Home Visit Hours (HHA only)
57	Home Health Aide - Home Visit Hours (HHA only)
58	Arterial Blood Gas (PO2/PA2)
59	Oxygen Saturation (O2 Sat/Oximetry)
60	HHA Branch MSA
61	Place of Residence where Service is Furnished (HHA and Hospice)
66	Medicaid Spenddown Amount
67	Peritoneal Dialysis
68	EPO-Drug
69	State Charity Care Percent
80	Covered Days
81	Non-Covered Days
82	Co-insurance Days
83	Lifetime Reserve Days
85	County where Service is Rendered
87	Gene Therapy Invoice Cost
88	Allogeneic Stem Cell Transplant - Number of Related Donors Evaluated
89	Allogeneic Stem Cell Transplant - Total All-inclusive Donor Charges
90	Cell Therapy Invoice Cost

91	Charges for Kidney Acquisition
A0	Special ZIP Code Reporting
A1	Deductible Payer A
A2	Coinsurance Payer A
A3	Estimated Responsibility Payer A
A4	Covered Self-Administrable Drugs - Emergency
A5	Covered Self-Administrable Drugs - Not Self-Administrable in Form and Situation Furnished to Patient
A6	Covered Self-Administrable Drugs - Diagnostic Study and Other
A7	Co-payment Payer A
A8	Patient Weight
A9	Patient Height
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A
B1	Deductible Payer B
B2	Coinsurance Payer B
B3	Estimated Responsibility Payer B
B7	Co-payment Payer B
BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B
C1	Deductible Payer C
C2	Coinsurance Payer C
C3	Estimated Responsibility Payer C
C7	Co-payment Payer C
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C
D3	Patient Estimated Responsibility
D4	Clinical Trial Number Assigned by NLM/NIH
D5	Last Kt/V Reading
D6	Total Number of Minutes of Dialysis Provided During the Billing Perion
FC	Patient Paid Amount
FD	Credit received from the Manufacturer for a replaced Medical Device
G8	Facility where Inpatient Hospice Service is Delivered
P1	Heart Rate
P2	Blood Pressure - Systolic

P3	Blood Pressure - Diastolic
Y1	Part A Demonstration Payment
Y2	Part B Demonstration Payment
Y3	Part B Coinsurance
Y4	Conventional Provider Payment Amount for Non- Demonstration Claims
Y5	Part B Deductible

Care Plan Task Codes

Code	Description
CP1000	N-1 Dressing
CP1005	N-2 Bathing, grooming, personal hygiene
CP1010	N-3 Meal prep and feeding
CP1015	N-4 Toileting
CP1020	N-5 Transferring, ambulation, mobility
CP1025	N-6 Essential Housekeeping: Changing bed linens
CP1030	N-6 Essential Housekeeping: Scrubbing floors
CP1035	N-6 Essential Housekeeping: Trash removal
CP1040	N-6 Essential Housekeeping: Vacuuming
CP1045	N-6 Essential Housekeeping: Washing Dishes
CP1050	N-6 Essential Housekeeping: Cleaning bathroom
CP1055	N-6 Essential Housekeeping: Cleaning kitchen
CP1060	N-6 Essential Housekeeping: Cleaning medical equipment
CP1065	N-6 Essential Housekeeping: Cleaning stove/refrigerator
CP1070	N-6 Essential Housekeeping: Cleaning up after personal care tasks
CP1075	N-6 Essential Housekeeping: Dusting
CP1080	N-6 Essential Housekeeping: Essential Shopping
CP1085	N-6 Essential Housekeeping: Laundry
CP1090	N-7 Minor wound care
CP1095	N-8 Financial and scheduling assistance
CP1100	N-9 Assistance in the workplace
CP1105	N-10 Communication

Code	Description
CP1240	ADLs: care for hair and teeth
CP1245	ADLs: exercise
CP1250	ADLs: get in and out of bed
CP1255	ADLs: helping the member bathe
CP1260	ADLs: helping with toileting
CP1265	ADLs: retraining the member in necessary self-help skills
CP1270	ADLs: taking medications
CP1275	Household Services: changing the member's bed linens
CP1280	Household Services: laundering
CP1285	Household Services: light cleaning
CP1290	Household Services: light meal preparation
CP1295	Household Services: rearrangement of member's necessary supplies or medications
CP1300	Observation and reporting of physical or emotional needs
CP1305	Personal Care Services
CP1310	Administration of medications
CP1315	Bowel & bladder care
CP1320	Coordination of services
CP1325	Informing physician and other personnel of changes in the member's condition and needs
CP1330	Injections
CP1335	Intravenous & Enteral feedings
CP1340	Maintenance Services
CP1345	Observation and evaluation

CP1110	N-11 Essential Transportation
CP1115	N-12 Medication assistance
CP1120	S-1 Tube feedings
CP1125	S-2 Intravenous therapy assistance
CP1130	S-3 Parenteral injections
CP1135	S-4 Catheterizations
CP1140	S-5 Respiratory Care
CP1145	S-6 Care of decubiti and other areas
CP1150	S-7 Rehabilitation services
CP1155	S-8 Colostomy care
CP1160	S-9 Care of medical conditions
CP1165	S-10 Post-surgical nurse delegated activities
CP1170	S-11 Monitoring reactions to medication
CP1175	S-12 Prepare/monitor therapeutic diets
CP1180	S-13 Recording and reporting of changes in vital signs to the nurse or therapist
CP1185	Meal preparation and planning balanced meals
CP1190	Essential Housekeeping: vacuuming
CP1195	Essential Housekeeping: dusting
CP1200	Essential Housekeeping: scrubbing floors
CP1205	Essential Housekeeping: defrosting refrigerators
CP1210	Essential Housekeeping: cleaning medical equipment
CP1215	Essential Housekeeping: cleaning stove/refrigerator
CP1220	Essential Housekeeping: washing and mending clothes
CP1225	Essential Housekeeping: washing personal items used by the member
CP1230	Essential Housekeeping: washing dishes
CP1235	Essential Shopping for basic needs

CP1350	Preparation of clinical and progress notes
CP1355	Restorative Services
CP1360	Skin care
CP1365	Supervisory visit for Home Health Aide
CP1370	Teaching and training
CP1375	Therapeutic exercise
CP1380	Wound care
CP1385	Hypodermoclysis
CP1390	Supervision; 1:1; not provided while usual caregiver is working or is a CDAC provider
CP1395	Toileting
CP1400	Venipunctures
CP1405	Meal Prep and Feeding
CP1410	Minor wound care
CP1415	The member's functional limitations
CP1420	Dressing
CP1425	Documentation of progress toward the goals
CP1430	Goals
CP1435	Essential Shopping for basic needs
CP1440	Date of onset of conditions being treated
CP1445	Transferring and ambulation
CP1450	Supervision; 1:1; not provided while usual caregiver is working or is a CDAC provider provided by a home care agency with a Medicare and/or Medicaid certification
CP1455	Supervision; 1:1; not provided while usual caregiver is working or is a CDAC provider- Specialized medical needs requiring the care, monitoring or supervision of an LPN or RN
CP1460	Modalities of treatment
CP1465	Restorative potential
CP1470	Progress notes

Procedure Code to Care Plan Task Codes

PCA Service Codes

Procedure Code	Care Plan Task Codes
S5125 T1019	CP1000
	CP1005
	CP1010
	CP1015
	CP1020
	CP1025
	CP1030
	CP1035
	CP1040
	CP1045
	CP1050
	CP1055
	CP1060
	CP1065
	CP1070
	CP1075
	CP1080
	CP1085
	CP1090
	CP1095
	CP1100
	CP1105
	CP1110
	CP1115
S5125U3 T1019U3	CP1120
	CP1125
	CP1130
	CP1135
	CP1140
	CP1145
	CP1150
	CP1155
	CP1160
	CP1165
	CP1170
	CP1175
	CP1180
S5130	CP1185
	CP1190
	CP1195
	CP1200
	CP1205
	CP1210
	CP1215

Home Health Service Codes

Procedure Code	Care Plan Task Codes
S9122 T1004 T1004 U3 T1021	CP1240
	CP1245
	CP1250
	CP1255
	CP1260
	CP1265
	CP1270
	CP1275
	CP1280
	CP1285
	CP1290
	CP1295
	CP1300
	CP1305
S9123 S9134 G0300	CP1310
	CP1315
	CP1320
	CP1325
	CP1330
	CP1335
	CP1340
	CP1345
	CP1350
	CP1355
	CP1360
	CP1365
	CP1370
	CP1375
	CP1380
T1002 T1003 T1030 T1031	CP1310
	CP1315
	CP1320
	CP1325
	CP1330
	CP1335
	CP1340
	CP1345
	CP1350
	CP1355
	CP1360
	CP1365
	CP1370
	CP1375
	CP1380

	CP1220
	CP1225
	CP1230
	CP1235
S5150	CP1240
	CP1245
	CP1250
	CP1255
	CP1270
	CP1305
	CP1390
	CP1395
	CP1405
	CP1410
	CP1420
	CP1445
S5150U3	CP1240
	CP1245
	CP1250
	CP1255
	CP1270
	CP1305
	CP1310
	CP1315
	CP1320
	CP1325
	CP1330
	CP1335
	CP1340
	CP1345
	CP1350
	CP1355
	CP1360
	CP1365
	CP1370
	CP1375
	CP1380
	CP1395
	CP1405
	CP1410
	CP1420
	CP1445
	CP1455
S5150U3	CP1240
	CP1245
	CP1250
	CP1255

	CP1385
G0299	CP1310
	CP1315
	CP1320
	CP1325
	CP1330
	CP1335
	CP1340
	CP1345
	CP1350
	CP1355
	CP1360
	CP1365
	CP1370
	CP1375
	CP1380
	CP1400
G0151 **G0152** **G0153** **G0158** **G0159** **G0160** **G0161**	CP1415
	CP1425
	CP1430
	CP1440
	CP1460
	CP1465
	CP1470

	CP1270
	CP1305
	CP1395
	CP1405
	CP1410
	CP1420
	CP1445
	CP1450

Pre-Billing Validation

Pre-billing checks are performed in the CareBridge system to ensure that clean claims are generated. If validation errors are present in response files or appointment error files, they must be resolved by the agency or vendor prior to claim generation.

A full list of CareBridge Pre-Billing Validations can be found under **Technical Specifications for Third-Party Vendors** > **Pre-Billing Validation Errors**