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Centers for Medicare & Medicaid Services  
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**CENTER FOR MEDICARE  
MEDICARE PLAN PAYMENT GROUP**

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**TO:** All Medicare Advantage Organizations (MAOs), PACE Organizations, Cost Plans, and certain Demonstrations

**FROM:** Cheri Rice, Director  
Medicare Plan Payment Group

**SUBJECT:** Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System

**DATE:** May 23, 2014

As noted in the November 4, 2013 HPMS memo, “Encounter Data Submission of HIPPS Codes,” the disposition for the HIPPS codes edits will be changed from ‘Informational’ to ‘Reject’ effective with July 1, 2014 dates of service (DOS) for any Skilled Nursing Facility (SNF) and Home Health Agency (HHA) encounters submitted without HIPPS codes. The purpose of this memo is to provide additional details about this requirement, and encourage MAOs and other entities to continue to work with SNF and HHA providers to meet this requirement.

**I. HIPPS Codes for SNF Encounters Starting with July 1, 2014 Dates of Service**

CMS is clarifying that for 2014 DOS beginning on or after July 1<sup>st</sup>, MAOs must submit a HIPPS code on a SNF encounter that comes from the initial OBRA-required comprehensive assessment (Admission Assessment). Specifically, SNF encounters with “from” dates July 1, 2014 or after that are submitted without a HIPPS code will be rejected. The OBRA-required tracking records and assessments are federally mandated for all residents of Medicare and/or Medicaid certified SNFs and nursing facilities.

For 2014 encounter data submissions, CMS will not require MAOs to submit HIPPS codes from any other OBRA-required comprehensive or non-comprehensive assessments; we also will not require submission of HIPPS codes for any scheduled or unscheduled SNF Prospective Payment System (PPS) assessments. Nevertheless, we do encourage you to submit the HIPPS codes both from other OBRA assessments and from PPS assessments when available from the providers. We especially encourage submission of the HIPPS code based on the Discharge Assessment, which is based on a OBRA-required assessment.

## **II. HIPPS Codes for HHA Encounters Starting with July 1, 2014 Dates of Service**

CMS is clarifying that for 2014 DOS beginning on or after July 1<sup>st</sup>, MAOs must submit a HIPPS code on an HHA encounter that comes from the initial Outcome and Assessment Information Set (Start of Care assessment), or OASIS. The OASIS assessments are federally mandated for all Medicare and/or Medicaid patients receiving skilled care from HHAs.

For 2014 encounter data submissions, CMS will not require MAOs to submit HIPPS codes from any other assessments. Nevertheless, we do encourage you to submit the HIPPS codes from any completed assessments when available from the providers.

## **III. Additional Information**

HIPPS codes from SNF or HHA encounters with “from” dates prior to July 1, 2014 may be submitted.

We remind MAOs that SNF and home health encounters must be submitted in the 837-Institutional format.

For your reference, attached is an appendix with an overview of SNF and HHA assessments, and resources on HIPPS codes.

We encourage MAOs and other entities to share the information in this memo with their providers. Please send any questions related to this guidance to [encounterdata@cms.hhs.gov](mailto:encounterdata@cms.hhs.gov) and specify ‘HPMS memo-HIPPS Codes’ in the subject line.

## **Appendix. Overview of HIPPS Codes from SNF and HHA Assessments**

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types.

For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group.

SNF HIPPS codes are determined based on assessments made using the Minimum Data Set (MDS) data collection tools.

Home Health HIPPS codes are determined based on assessments made using the Outcome and Assessment Information Set (OASIS) data collection tools.

See the following document for more information regarding HIPPS codes:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspectivePayment/Downloads/hippsusesv4.pdf>.

### **I. Clinical Assessment Data from Skilled Nursing Facilities**

The Minimum Data Set (MDS) 3.0 consists of standardized data items that must be collected during assessments of all residents of facilities certified to participate in Medicare or Medicaid. The MDS 3.0 represents a core set of screening, clinical, and functional status elements that provide extensive information on the resident's nursing and therapy needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses.

The MDS 3.0 comprises several different assessments, under two different sets of requirements: OBRA assessments and Medicare PPS assessments.

#### **A. OBRA Assessments**

The OBRA-required assessments apply to Medicare and/or Medicaid certified (as well as dually certified under both programs) facilities and include the initial and periodic assessments of all their residents. For residents on a Medicare Part A stay, SNFs use information from the MDS 3.0 assessment to classify their residents into a series of groups representing the residents' relative direct care resource requirements, or Resource Utilization Groups (RUGs), which are necessary for payment. The RUG-IV classification system is the current SNF PPS case-mix classification system.

HIPPS codes are determined based on the information recorded on the MDS assessments. Grouper software run at a SNF or swing bed hospital uses specific data elements from the MDS to assign beneficiaries to a RUG-IV code. The Grouper outputs the RUG-IV code,

which must be combined with the Assessment Indicator (AI) to create the HIPPS code. The HIPPS code is then entered on the claim.

Each Medicare claim contains a five-position HIPPS code for the purpose of billing Part A covered days. The first three positions of the HIPPS code contain the RUG-IV group code to be billed for Medicare payment. The RUG-IV group is calculated from the MDS assessment clinical data. The last two positions of the HIPPS code represent the Assessment Indicator (AI), identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods.

For more information on the HIPPS Code, see Publication 100-04, Medicare Claims Processing Manual, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing, 30.1 - HIPPS Rate Code.

There are both Federally-mandated comprehensive and non-comprehensive OBRA assessments:

OBRA comprehensive assessments include:

1. Admission Assessment,
2. Annual Assessment,
3. Significant Change in Status Assessment, and
4. Significant Correction to Prior Comprehensive Assessment.

OBRA non-comprehensive assessments include:

1. Quarterly Assessment,
2. Significant Correction to Prior Quarterly Assessment, and
3. Discharge Assessments (return anticipated and return not anticipated).

Non-comprehensive assessments do not contain all MDS data elements. Note that discharge assessments are unique in that they not only include clinical items for quality monitoring, but also capture discharge tracking information when the resident leaves the SNFs.

## **B. Required Medicare PPS Assessments**

Medicare PPS assessments are required for FFS payment purposes under Medicare Part A.

Medicare PPS assessments are either scheduled or unscheduled, and similarly provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be paid under the SNF PPS for both SNFs and Swing Bed providers. Scheduled assessments occur at specific points during a Medicare Part A stay and include the 5-day, 14-day, 30-day, 60-day and 90-day assessments. Under Medicare FFS, scheduled assessments set the reimbursement rate for a given period of time, which normally consists of a 2 to 4 week period.

Unscheduled assessments, as opposed to scheduled assessments, are not completed at regular intervals during the Part A stay, but are instead triggered by particular events which may

occur during the stay. Events that may trigger the completion of an unscheduled assessment may include when there are significant changes in the status of the resident (Significant Change in Status Assessment or SCSA), therapy starts and/or ends (Start of Therapy or SOT, End of Therapy or EOT), the level of therapy changes (Change of Therapy or COT), or when there is a significant error identified in an assessment that must be corrected (Significant Correction). When an unscheduled assessment is completed, there may be implications regarding payment, and the facility needs to be aware that an increase or decrease of payment may occur based on potential changes in the RUG-IV as a result of the completion of an unscheduled assessment.

Since all residents of the facility must have OBRA assessments completed, whether in FFS Medicare or enrolled in an MA plan, the residents who are on Medicare Part A must have both types of assessments completed during their stay. In order to reduce assessment burden, a SNF may combine certain assessments to satisfy both OBRA and Medicare requirements for payment under Medicare FFS. Additionally, Medicare Scheduled and Unscheduled assessments, or two Medicare Unscheduled assessments, may be combined. Two Medicare-required Scheduled assessments may never be combined since these assessments have specific assessment windows that do not occur at the same time. The timeframes and instructions regarding the completion and/or combination of assessments vary, so it is imperative that staff fully understand the requirements for all types of assessments in order to ensure appropriate reimbursement, avoid unnecessary duplication of effort and to remain in compliance with Medicare PPS and OBRA requirements.

### **C. Other SNF Resources**

See CMS' Long-Term Care Facility Resident Assessment Instrument User's Manual, specifically Chapter 2: Assessments for the Resident Assessment Instrument (RAI) and Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). The manual can be accessed at:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>.

The CMS SNF Medicare Claims Processing Manual can be accessed at:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

## **II. Clinical Assessment Data from Home Health Agencies**

### **A. OASIS Assessments**

Medicare-certified HHAs are required to collect a standard set of data items, known as OASIS (Outcome and Assessment Information Set), as part of a comprehensive assessment of all patients who are receiving skilled care that is reimbursed by Medicare or Medicaid. OASIS data elements must be collected for both traditional fee-for-service (HH PPS) and Managed Care (Medicare Advantage) patients (with the exception of certain groups of patients such as those receiving only non-skilled services).

The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient, and that form the basis for measuring patient outcomes for purposes of Outcome-Based Quality Improvement (OBQI). This assessment is used both to measure changes in a patient's clinical and functional status between the start and end of care and for risk-adjustment purposes. Completion of the OASIS, among other assessments, is one of the requirements an HHA must meet to participate in the Medicare program as set forth in the Medicare payment regulations and conditions of participation.

HIPPS codes are determined based on assessments made using OASIS. Under the HH PPS, a case-mix adjusted payment for an episode of care (60 days) is made by CMS using one of 153 Home Health Resource Groups (HHRGs). Accordingly, on Medicare claims these HHRGs are reflected as HIPPS codes, which are determined using data from the OASIS assessments. OASIS is required for Medicare and Medicaid patients only.

For OASIS-C1/ICD-9 (most recent updated data set), these are the data collection and submission requirements required at these specific time points:

1. Start of Care
2. Resumption of Care (after an inpatient stay)
3. Follow-Up (Recertification assessment/other follow-up assessment)
4. Transfer to an Inpatient Facility  
(Transferred to an inpatient facility—patient not discharged from an agency and  
Transferred to an inpatient facility—patient discharged from agency)
5. Discharge from Agency – Not to an Inpatient Facility (Death at home and discharge from agency)

The grouper software run at a HHA uses specific data elements from the OASIS data set to assign beneficiaries a HIPPS code. The Grouper outputs the HIPPS code, which must be entered on the claim.

For more information on the HIPPS Codes, see Publication 100-04, Medicare Claims Processing Manual, 10.1.9 - Composition of HIPPS Codes for HH PPS.

## **B. Other HH Resources**

You can access manuals on the CMS Home Health Quality Initiative homepage such related to the OASIS OBQI/Outcome-Based Quality Improvement Reports and OASIS OBQM/Outcome-Based Quality Monitoring Reports at:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html>. The OASIS-C1 Data Set can be accessed through this link.

In addition, the CMS HH Medicare Claims Processing Manual can be accessed at:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.