# Definition and Uses of Health Insurance Prospective Payment System Codes (HIPPS Codes)

## Definition

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. These HIPPS codes are reported on claims to insurers.

Institutional providers use HIPPS codes on claims in association with special revenue codes. One revenue code is defined for each prospective payment system that requires HIPPS codes. HIPPS codes are placed in data element SV202 on the electronic 837 institutional claims transaction or in Form Locator (FL) 44 ("HCPCS/rate") on a paper UB-04 claims form. The associated revenue code is placed in data element SV201 or in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim.

## Composition of HIPPS codes

HIPPS codes are alpha-numeric codes of five digits. Each code contains intelligence, with certain positions of the code indicating the case mix group itself, and other positions providing additional information. The additional information varies among HIPPS codes pertaining to different payment systems, but often provides information about the clinical assessment used to arrive at the code. Which positions of the code carry the case mix group information may also vary by payment systems. The specific composition of HIPPS codes for current payment systems is described in detail below.

## History and Uses of HIPPS codes

The Centers for Medicare and Medicaid Services (CMS) created HIPPS codes as part of the Medicare program's implementation of a prospective payment system for skilled nursing facilities in 1998. In recent years, additional HIPPS codes have been created for other prospective payment systems, including a system for home health agencies in October 2000 and one for inpatient rehabilitation facilities in January 2002. Use of the skilled nursing facility HIPPS codes was expanded to Medicare swing bed facilities in rural hospitals in July 2002.

TRICARE, the Department of Defense insurance program for active duty service members, their families, and retirees, expects to implement a prospective payment system for skilled nursing facilities using HIPPS code in 2003. Additionally, HIPPS codes may be used by the many State Medicaid programs that employ payment systems based on the Minimum Data Set patient assessment instrument.

Specific Uses of HIPPS Codes

*Skilled Nursing Facility Prospective Payment System*

Under the skilled nursing facility prospective payment system (SNF PPS), a case-mix adjusted payment for varying numbers of days of SNF care is made using one of 53 Resource Utilization Groups, Version III (RUG-III). On claims to Medicare and other payers these RUG-IIIs are represented as the first three positions of HIPPS codes. HIPPS codes are determined based on assessments made using the Minimum Data Set (MDS). Grouper software run at a skilled nursing facility or swing bed hospital uses specific data elements from the MDS to assign beneficiaries to a RUG III code. The Grouper outputs the RUG III code, which must be combined with the Assessment Indicator to create the HIPPS code. The HIPPS code is then entered on the claim.

The following scheme has been developed to create distinct 5-position, alphanumeric SNF HIPPS codes:

The first, second and third positions of the code represent the RUG-III case mix group. If the MDS assessment was not performed appropriately, these positions may instead carry a default value. These positions of the SNF PPS HIPPS code will only allow alphabetical characters. The valid values for these positions are as follows:

RUG-III GROUP CODES:

AAA (the default code)
BA1, BA2, BB1, BB2
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
RHA, RHB, RHC, RHL, RHX, RLA, RLB, RLX, RMA, RMB, RMC, RML, RMX,
RUA, RUB, RUC, RUL, RUX, RVA, RVB, RVC, RVL, RVX
SE1, SE2, SE3, SSA, SSB, SSC

**NOTE:** The following RUG Codes are only valid on or after January 1, 2006:
RHL, RHX, RLX, RML, RMX, RUL, RUX, RVL and RVX

The fourth and fifth positions of the code represent an assessment indicator, identifying the reason and timeframe for the completion of the MDS. These positions may be numeric or alphabetical. The valid values for these positions are as follows:

| Assessment Type Indicator | Definition |
|---|---|
| 00 | No assessment completed/default code |
| 11 | Medicare 5 day assessment (comprehensive) AND initial admission assessment |
| 01 | Medicare 5 day assessment (Full) |
| 07 | Medicare 14 day assessment (Full or comprehensive) |
| 02 | Medicare 30 day assessment (Full) |
| 03 | Medicare 60 day assessment (Full) |
| 04 | Medicare 90 day assessment (Full) |
| 54 | Quarterly review assessment-Medicare 90 day assessment (Full) |
| 38 | [7/98 def.] Significant Change in Status Assessment (SCSA), [10/98 def.] OMRA replacing 60-day Medicare required assessment |
| 08 | Other Medicare Required Assessment (OMRA) |
| 41 | Significant Correction of Prior Full Assessment/Medicare 5 Day Assessment |
| 47 | Significant Correction of Prior Full Assessment/Medicare 14 Day Assessment |
| 42 | Significant Correction of Prior Full Assessment/Medicare 30 Day Assessment |
| 43 | Significant Correction of Prior Full Assessment/Medicare 60 Day Assessment |
| 44 | Significant Correction of Prior Full Assessment/Medicare 90 Day Assessment |
| 31 | [7/98 def.] SCSA or OMRA/ Medicare 5 Day Assessment (Replacement), [10/00 def.] Significant change assessment REPLACES 5-day Medicare required assessment |
| 37 | [7/98 def.] SCSA or OMRA/ Medicare 14 Day Assessment (Replacement), [10/00 def.] Significant change assessment REPLACES 14-day Medicare required assessment |
| 32 | [7/98 def.] SCSA or OMRA/ Medicare 30 Day Assessment (Replacement), [10/00 def.] Significant change assessment REPLACES 30-day Medicare required assessment |
| 33 | [7/98 def.] SCSA or OMRA/ Medicare 60 Day Assessment (Replacement), [10/00 def.] Significant change assessment REPLACES 60-day Medicare required assessment |
| 34 | [7/98 def.] SCSA or OMRA/ Medicare 90 Day Assessment (Replacement), [10/00 def.] Significant change assessment REPLACES 90-day Medicare required assessment |

| | |
|---|---|
| 05 | Readmission/Return Medicare assessment |
| 17 | 14-day Medicare assessment AND initial admission assessment |
| 18 | OMRA replacing 5-day Medicare assessment |
| 28 | OMRA replacing 30-day Medicare assessment |
| 30 | Off-cycle significant change assessment (outside assessment window) |
| 35 | Significant change assessment REPLACES a readmission/return Medicare-required assessment |
| 40 | Off-cycle significant change correction assessment of a prior assessment (outside assessment window) |
| 45 | Significant correction of a prior assessment REPLACES a readmission/return assessment |
| 48 | OMRA replacing 90-day Medicare-required assessment |
| 78 | OMRA replacing 14-day Medicare-required assessment |
| 19 | Special payment situation 5-day assessment |
| 29 | Special payment situation 30-day assessment |
| 39 | Special payment situation 60-day assessment |
| 49 | Special payment situation 90-day assessment |
| 79 | Special payment situation 14-day assessment |
| 8A | TRICARE 120-day assessment |
| 8B | TRICARE 150-day assessment |
| 8C | TRICARE 180-day assessment |
| 8D | TRICARE 210-day assessment |
| 8E | TRICARE 240-day assessment |
| 8F | TRICARE 270-day assessment |
| 8G | TRICARE 300-day assessment |
| 8H | TRICARE 330-day assessment |
| 8I | TRICARE 360-day assessment |
| 8X | TRICARE Post 360-day assessments with 30-day interval |

The default group and default assessment type indicator, when used, are only valid in association with each other, to form the default HIPPS code of AAA00. Otherwise, any RUG-III group may be used in combination with any assessment type indicator. The combinations of these 53 groups and 44 indicators, plus the one default code, results in 2333 valid SNF HIPPS codes.

HIPPS codes created using the SNF structure are only valid on claim lines reporting revenue code 0022.

*Home Health Prospective Payment System*

Under the home health prospective payment system (HH PPS), a case-mix adjusted payment for up to 60 days of care is made using one of 80 Home Health Resource Groups (HHRG). On Medicare claims these HHRGs are represented as HIPPS codes. HIPPS codes are determined based on assessments made using the Outcome and Assessment Information Set (OASIS). Grouper software run at a home health agency site uses specific data elements from the OASIS data set to assign beneficiaries to a HIPPS code. The Grouper outputs the HIPPS code, which must be entered on the claim.

**For HH PPS episodes beginning on and after October 1, 2000,** the following scheme has been developed to create distinct 5-position, alphanumeric home health HIPPS codes:

The first position is a fixed letter "H" to designate home health, and does not correspond to any part of the HHRG case mix grouping.

The second, third and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the HH PPS final rule. Note the second through fourth positions of the HH PPS HIPPS code will only allow alphabetical characters.

The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters.

**The first position of every home health HIPPS code will be: 'H'**. The remaining four positions discussed above can be summarized as follows:

| **Position 2 Clinical Domain** | **Position 3 Functional Domain** | **Position 4 Service Domain** | **Domain Level** | **Position 5 "Data Validity Flag"** |
|---|---|---|---|---|
| **A** | **E** | **J** | = min | **1** = 2nd, 3rd & 4th positions computed |
| **B** | **F** | **K** | = low | **2** = 2nd position derived |
| **C** | **G** | **L** | = mod | **3** = 3rd position derived |

| | | | | |
|---|---|---|---|---|
| **D** | **H** | **M** | = high | **4** = 4th position derived |
| | **I** | | = max | **5** = 2nd & 3rd positions derived |
| | | | | **6** = 3rd & 4th positions derived |
| | | | | **7** = 2nd & 4th positions derived |
| | | | | **8** = 2nd, 3rd & 4th positions derived |
| | | **N** thru **Z** | Expansion values for future use | **9**, **0** |

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

Based on this coding structure, any of the 80 HHRGs may be combined with any of the 8 data validity flags, resulting in 640 valid HH HIPPS codes.

HIPPS codes created using the HH structure are only valid on claim lines reporting revenue code 0023.

**Note**: **Medicare only accepts the above October 2000 HH HIPPS code set through 12/31/2007.**

**For HH PPS episodes beginning on and after January 1, 2008**, the distinct 5-position, alphanumeric home health HIPPS code is created as follows:

- The first position is no longer a fixed value. The refined HH PPS uses a four-equation case-mix model which assigns differing scores in the clinical, functional and service domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores that follow.

- The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system.

- The fifth position indicates a severity group for non-routine supplies (NRS). The HH PPS grouper software will assign each episode into one of 6 NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number 1 through 6 before submitting the claim. .

Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

| | **Position #1** | **Position #2** | **Position #3** | **Position #4** | **Position #5** | | |
|---|---|---|---|---|---|---|---|
| | **Grouping Step** | **Clinical Domain** | **Functional Domain** | **Service Domain** | **Supply Group – supplies provided** | **Supply Group – supplies not provided** | **Domain Levels** |
| **Early Episodes (1st & 2nd )** | **1** (0-13 Visits) | **A** (HHRG: C1) | **F** (HHRG: F1) | **K** (HHRG: S1) | **S** (Severity Level: 1) | **1** (Severity Level: 1) | = min |
| | **2** (14-19 Visits) | **B** (HHRG: C2) | **G** (HHRG: F2) | **L** (HHRG: S2) | **T** (Severity Level: 2) | **2** (Severity Level: 2) | = low |
| **Late Episodes (3rd & later)** | **3** (0-13 visits) | **C** (HHRG: C3) | **H** (HHRG: F3) | **M** (HHRG: S3) | **U** (Severity Level: 3) | **3** (Severity Level: 3) | = mod |
| | **4** (14-19 Visits) | | | **N** (HHRG: S4) | **V** (Severity Level: 4) | **4** (Severity Level: 4) | = high |
| **Early or Late Episodes** | **5** (20 + Visits) | | | **P** (HHRG: S5) | **W** (Severity Level: 5) | **5** (Severity Level: 5) | = max |
| | | | | | **X** (Severity Level: 6) | **6** (Severity Level: 6) | |
| | 6 thru 0 | D thru E | I thru J | Q thru R | Y thru Z | 7 thru 0 | Expansion values for future use |

Examples:

- First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level and non-routine supplies were not provided = HIPPS code 1AFK1

- Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity leve1 4 = HIPPS code 4CHMV
- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score is high and supply severity level 6 = HIPPS code 5BHNX

Based on this coding structure:

- 153 case-mix groups defined in the 2007 HH PPS final rule are represented by the first four positions of the code.
- Each of these case-mix groups can be combined with any NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix groups times 6 NRS severity levels).
- Each HIPPS code will represent a distinct payment amount, without any duplication of payment weights across codes.

*Inpatient Rehabilitation Facility Prospective Payment System*

Under the inpatient rehabilitation facility prospective payment system (IRF PPS), a case-mix adjusted payment for varying numbers of days of IRF care is made using one of 93 Case Mix Groups (CMG). On Medicare claims these CMGs are represented as HIPPS codes. HIPPS codes are determined based on assessments made using the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). Grouper software run at a rehabilitation facility site uses specific data elements from the IRF-PAI data set to assign beneficiaries to a HIPPS code. The Grouper outputs the HIPPS code, which must be entered on the claim.

The following scheme has been developed to create distinct 5-position, alphanumeric IRF HIPPS codes:

The first position of the code represents a comorbidity tier. Comorbidities that may appear in the case of an IRF patient are arrayed in three tiers based on whether the costs associated with that comorbidity are considered high, medium or low. The first position of the IRF PPS HIPPS codes will only allow alphabetical characters. The valid values for this position are as follows:

A = without comorbidities

B = comorbidity in tier 1 (high)

C = comorbidity in tier 2 (medium)

D = comorbidity in tier 3 (low)

The second, third, fourth and fifth positions of the code represent the CMG itself. The fifth position will only allow numeric characters. Valid values fall within the range of 0101 through 5104 and 9999 (default code), though only 93 values in that range are used. A full listing of CMGs can be found in the IRF PPS final rule.

The first 87 CMGs can be used in association with any of the four comorbidity tier indicators. The last (highest numbered) five CMGs are defined as "atypical" CMGs and are assigned by Medicare claims processing systems in special situations, such as a particularly short stay in the facility or the death of the patient. These "atypical" CMGs are only combined with the 'A' comorbidity value. IRF providers never submit these codes (A5001, A5101, A5102, A5103 and A5104). In addition, the default code is combined with the "A" comorbidity (A9999) only. The default code is used for informational-only Managed Care claims The combinations of the 87 groups and 4 comorbidity tiers, plus the five "atypical" codes and the default code result in 354 valid IRF HIPPS codes.

HIPPS codes created using the IRF structure are only valid on claim lines reporting revenue code 0024.

Regulation and Instruction References

For additional information about the payment systems described above and details about HIPPS code use for billing Medicare, consult the following sources.

*Medicare Regulations:*

These documents are accessible via the Government Printing Office website at: www.access.gpo.gov/su_docs/aces/aces140.html.

SNF PPS Final Rule -- **Federal Register** / Vol. 63, No. 91 / Tuesday, May 12, 1998, beginning at p. 26251
HH PPS Final Rule -- **Federal Register** / Vol. 65, No. 128 / Monday, July 3, 2000, beginning at p. 41128
IRF PPS Final Rule -- **Federal Register** / Vol. 66, No. 152 / Tuesday, August 7, 2001, beginning at p. 41316
Swing Bed PPS Final Rule-- **Federal Register** / Vol. 66, No. 147 / Tuesday, July 31, 2001, beginning at p. 39562

*Medicare Instructions*

Medicare Program Memoranda (PMs) and Manual Instructions are available via the CMS website at: cms.hhs.gov/manuals/

*SNF PPS*
PM A-02-016, February 15, 2002—Details conversion of Swing Bed Facilities to SNF PPS and outlines use of HIPPS codes in billing for swing bed services

PM A-01-56, April 30, 2001– Provides clarifications about the use of HIPPS codes in SNF billing, particularly the uses of assessment type indicators
PM A-00-47, August 7, 2000—Outlines SNF PPS payment rate update for Federal fiscal year 2001, in which several new assessment type indicators were created
PM A-00-46, August 3, 2000—Provides instructions for billing SNF adjustment claims to correct HIPPS codes (Also re-issued September 27, 2001 as PM A-01-121)

*HH PPS*
Medicare Intermediary Manual, sections 3638.12 through 3640.11
Medicare Home Health Agency Manual, sections 467 through 468.11 and section 475
PM A-00-41, July 27, 2000—Outlines transition to HH PPS and provides complete list of HH HIPPS codes

*IRF PPS*
PM A-01-92, July 31, 2001—Details implementation of IRF PPS and outlines use of HIPPS codes for these services
PM A-01-110, September 14, 2001—Provides revisions and modifications to PM A-01-92