

Change Request Process for Health Insurance Prospective Payment System (HIPPS) Code Set

Code Set Maintainer:

The Division of Institutional Claims Processing within the Centers for Medicare and Medicaid Services (CMS) is named in the ASC X12 837 Institutional Claim Implementation Guide as the code source for HIPPS codes. As such, the Division not only creates and maintains HIPPS codes used by the Medicare program, but may create or modify codes to meet the needs of other payers that use case-mix adjusted methods of payment. (See the document “Definitions and Uses of HIPPS Codes” on the HIPPS code maintenance web page of cms.hhs.gov for information about case-mix adjustment and how it is represented in this code set.)

Frequency of Updates to HIPPS Codes:

The complete list of codes is available on the HIPPS code maintenance web page of cms.hhs.gov. This list reflects each HIPPS code currently approved for use, its definition, the payment settings to which it applies and its effective date. As codes are retired, the codes will be maintained on the list for reference, with an associated termination date. This list of codes will be updated on an as-needed basis, but no more frequently than quarterly.

Requesting Changes to the Code Set:

1. Requester Submission

1.1 All change requests must be submitted in writing to the CMS Division of Institutional Claims Processing. Change requests may be submitted via e-mail to HIPPS@cms.hhs.gov. Change requests may also be submitted in hard copy to the following address:

CMS Division of Institutional Claims Processing
Attn: HIPPS Code Maintenance
C4-10-07
7500 Security Blvd
Baltimore MD 21244

Change requests received within a given calendar quarter will be eligible for adoption with an effective date of the day after the close of the following calendar quarter. For example, if a request for a new code is received between July 1 and September 30, the new code could be effective no sooner than the following January 1. Receipt dates will be determined by the date stamp on the incoming e-mail or by postmark date.

1.2 Change requests are not required to be submitted on any specified form, but they must contain the following information:

- Requesting organization, return mailing address, and contact person or persons with their e-mail addresses, business phone numbers and fax numbers.
- A business case detailing the need for the change and its impact on any other entities (other payers, health care providers, standards organizations, etc.). Since this codeset is used in the national HIPAA standard claim format, requested codes must all be for use at the national level.
- If the request is to create new codes, submit a listing of the proposed code value(s), the proposed definition (s), the applicable payment setting, and the proposed effective date. Future effective dates may not be more than six quarters from the next available update. In support of the proposed definitions, submit sufficiently detailed information about the case-mix methodology reflected in the codes to allow CMS to determine that no duplication with existing codes is created by the proposal. This information may include, but not be limited to, the measuring instrument and the grouping logic/algorithm used to produce the case-mix groups.
- If the request is to modify an existing code, submit the proposed revision to the definition or payment setting and the proposed effective date of the change.
- If the request is to terminate an existing code, submit the proposed termination date, which can be no sooner than the next available update.

CMS may request supporting information as necessary to assess any change request. The need for additional information may alter the effective date of the requested code(s). If additional information is requested, the receipt date of the request for purposes of determining the earliest available update will become the date of the receipt of the requested information.

2. CMS Review of Request

2.1 Designated CMS HIPPS code maintenance staff will review all requests received in a given quarter for completeness and request additional information as necessary.

2.2. CMS HIPPS staff will review any proposals for new codes against the existing list of both HIPPS and HCPCS codes to ensure that no duplication of code values is created. If CMS staff discovers duplication, the request will be returned to the requester for modification.

2.3 CMS HIPPS staff will review all proposals for potential impacts –including but not limited to impacts on other payers, payment systems, and code sets.

2.3.1 If the impact analysis suggests more in-depth analysis is needed, CMS HIPPS staff will consult with other parties within CMS (e.g. consultation with payment policy staff, clinical staff, case-mix researchers or others) and without CMS (e.g. consultation with Designated Standards Maintenance Organizations, provider associations or others) as necessary to evaluate the business case and determine the response to the request.

2.3.2 If the impact analysis demonstrates the change is straightforward (e.g. a request for termination of a code from the only payer using the code), CMS HIPPS staff will approve the change independently and respond to the requester accordingly.

3. Response to the Request

3.1 CMS HIPPS staff will respond directly to the requester via e-mail or mail (depending on submission method) as soon as a determination is made on the request, always within the quarter following the quarter in which the request or complete additional information was received.

3.1.1. If a request is approved, the requester will be directed to watch for the next quarterly update of the HIPPS code list to provide official documentation of the request being approved.

3.1.2 If the request is denied, the requester will be provided with a full explanation of the rationale employed by CMS and any consulting parties.

3.2. CMS HIPPS staff will update the HIPPS code list on the HIPPS code maintenance web page at the start of the next calendar quarter, indicating the effective date of any new codes.

3.3 CMS HIPPS staff will update a tracking document on the HIPPS code maintenance web page to document all requests considered prior to the latest update and record of the disposition of each request.

3.4. CMS will provide notice of the update to the HIPPS code list to the Designated Standards Maintenance Organizations, requesting the information be distributed through their organizations as appropriate.

3.5 The requestor will be asked to provide CMS HIPPS staff with a reference copy of any provider billing instructions providing guidance on the use of HIPPS codes relating to the request. CMS HIPPS staff will maintain a library of these references, along with the initial request documents. This information will be available to the public upon request. Requests may be made to the same addresses used for code change requests.