Program Memorandum Intermediaries

**Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

Transmittal A-00-47 **Date: AUGUST 7, 2000**

CHANGE REQUEST 1223

SUBJECT: Skilled Nursing Facility (SNF) Annual Update: Prospective Payment System (PPS) Pricer and Health Insurance Prospective Payment System (HIPPS) Coding Changes

This Program Memorandum (PM) informs you of changes that will be required as part of the annual Skilled Nursing Facility (SNF) Update. Systems staff must incorporate the changes to the Health Insurance Prospective Payment System (HIPPS) modifiers presented in this document into their claims processing systems. These instructions should be implemented within your current operating budget. Additional instructions related to the use of these codes for billing will be issued separately.

Annual Pricer Update

Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by Medicare, Medicaid, and the Balanced Budget Refinement Act of 1999 (BBRA), related to Medicare payments and consolidated billing for SNFs. A final rule will be published on or before July 31, 2000 containing the PPS rates for fiscal year 2001. A revised pricer program will be created and distributed after the release of the final rule. The revised pricer program must be installed timely to ensure accurate payments for SNF services on and after October 1, 2000.

HIPPS Coding Changes

These changes will be reflected in an updated SNF PPS pricer. The Arkansas Part A Standard System (APASS), Fiscal Intermediary Standard System (FISS), and local intermediary systems must assure that the new HIPPS codes can be accepted into the data entry and claims processing systems, and can be processed appropriately throughout the system.

The 5-digit HIPPS code includes two components: the 3-digit classification code assigned to each Resource Utilization Group (RUG), version 3 (RUG-III) group, and a 2-digit assessment indicator that specifies the type of Medicare-required assessment used to support billing. Front-end edits are currently in place to ensure that payment will only be made for SNF claims that are billed with valid HIPPS codes.

RUG-III Codes: For fiscal year 2001, there will be no changes to the 44-group RUG-III coding system.

Assessment Indicator Codes: Effective October 1, 2000, the number of allowable 2-digit assessment indicator codes will be expanded. The allowable codes are shown below. New codes are in bold type. The new codes are being added to facilitate the planned electronic generation of all assessment indicator codes discussed below.

Please remember that the purpose of this PM is to allow systems personnel to prepare for the annual update by providing advance notice of the coding changes planned for October 1, 2000. We realize that your staff will need more information and training prior to implementation. Training materials are now being developed to explain how and when the codes should be used. Training sessions on these changes are also being scheduled.

01 5-day Medicare-required assessment/not an initial admission assessment

02 30-day Medicare-required assessment

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03 60-day Medicare-required assessment
04 90-day Medicare-required assessment
05 Readmission/Return Medicare-required assessment
07 14-day Medicare-required assessment/not an initial admission assessment
08 Off-cycle Other Medicare-required assessment (OMRA)
11 5-day (or readmission/return) Medicare-required assessment AND initial admission assessment

17 14-day Medicare-required assessment AND initial admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes Currently, code 07 is used for all 14-day Medicare assessments, regardless of whether it is also a clinical initial admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18 OMRA replacing 5-day Medicare-required assessment
28 OMRA replacing 30-day Medicare-required assessment

30 Off-cycle significant change assessment (outside assessment window)
31 Significant change assessment REPLACES 5-day Medicare-required assessment
32 Significant change assessment **REPLACES** 30-day Medicare-required assessment
33 Significant change assessment **REPLACES** 60-day Medicare-required assessment
34 Significant change assessment **REPLACES** 90-day Medicare-required assessment
35 Significant change assessment REPLACES a readmission/return Medicare-required assessment
37 Significant change assessment **REPLACES** 14-day Medicare-required assessment
38 OMRA replacing 60-day Medicare-required assessment

40 Off-cycle significant correction assessment of a prior assessment (outside assessment window)
41 Significant correction of a prior assessment **REPLACES** a 5-day Medicare-required assessment
42 Significant correction of a prior assessment **REPLACES** 30-day Medicare-required assessment
43 Significant correction of a prior assessment **REPLACES** 60-day Medicare-required assessment
44 Significant correction of a prior assessment **REPLACES** 90-day Medicare-required assessment
45 Significant correction of a prior assessment REPLACES a readmission/return assessment
47 Significant correction of a prior assessment **REPLACES** 14-day Medicare-required assessment
48 OMRA replacing 90-day Medicare-required assessment

54 90-day Medicare assessment that is also a quarterly assessment
78 OMRA replacing 14-day Medicare-required assessment

00 Default code

Automating the HIPPS Codes: Currently, determining the correct assessment modifier code needed for billing is a manual process. It is clear that providers have experienced problems generating the proper codes. To eliminate this source of error, we plan to modify our Minimum Data Set validation reports to list the assessment indicator code as well as the RUG-III code. As a first step effective October 1, 2000, we will expand the number of assessment indicator codes to cover all the coding possibilities. Providers will assign the codes manually until the automation effort is completed. We are anticipating that the coding changes will be completed in Spring 2001. Specifications will also be released to allow providers to add this capability to their in-house software.

Provider Billing Instructions

The pricer program determines the proper payment amount using the "Service Through" date on the bill. In order to ensure accurate payment, we cannot accept bills for services both before and after the October 1 annual rate update effective date, regardless of the provider's regular monthly billing cycle. Providers

must be instructed to submit separate bills for services that span September 30, 2000 and October 1, 2000.

This policy is the same one used for previous rate changes including the October 1999 annual update, and the April 1, 2000 update required under the BBRA. However, unlike previous transition procedures, the HIPPS code required for billing may change for services provided on and after October 1, 2000.

The effective date for this Program Memorandum (PM) is October 1, 2000.

The implementation date for this PM is October 1, 2000.

This PM may be discarded after October 1, 2001.

If you have any questions, contact Dana Burley (410) 786-4547 or Sheila Lambowitz (410) 786-7605.