Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
The Centers for Medicare & Medicaid Services (CMS)

Transmittal A-01-124 **Date: SEPTEMBER 27, 2001**

This Program Memorandum re-issues Program Memorandum A-01-56, Change Request 1655 dated April 30, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1655

SUBJECT: Clarification to Health Insurance Prospective Payment System (HIPPS) Coding and Billing Instructions

This Program Memorandum (PM) provides further guidance on the use of the new two-digit assessment indicator codes presented in Transmittal A-00-47 dated August 7, 2000, which are part of the HIPPS rate codes that **were effective with services provided on or after October 1, 2000**. HIPPS rate codes are required for billing for Medicare Skilled Nursing Facility (SNF), Part A services, under the SNF PPS. In addition, this PM provides clarification of our payment policy with regard to billing based on "off-cycle" Minimum Data Set (MDS) assessments.

There have been no changes in the types of assessments used to bill for Part A services under SNF PPS. There are three types of assessments: Medicare required assessments, off-cycle assessments, and a Significant Correction of a Prior Assessment (SCPA). The Medicare required assessments are those scheduled for the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of the Medicare Part A covered stay. Off-cycle assessments include the Other Medicare Required Assessment (OMRA) and the Significant Change in Status Assessment (SCSA). In addition, the SCPA is now designated as an off-cycle assessment and thus, it must be used to "replace" a Medicare required assessment when the timing and type of assessment being corrected (e.g., comprehensive assessment), warrant the use of this assessment type and the assessment reference date of the SCPA falls at the time that a Medicare required assessment is due to be performed.

SCPAs are only performed to correct major errors in comprehensive assessments, that is, MDS assessments that include care planning and resident assessment protocols. An SCPA may never be performed to correct a regularly scheduled Medicare assessment (5-day, 14-day, 30-day, etc.) since none of those are comprehensive MDS assessments.

Example*:* A facility realized that the initial admission assessment performed regarding a Medicare beneficiary contained clinical information that was erroneous and did not accurately reflect that beneficiary's needs or his care plan. The facility realizes that it must do a new assessment, an SCPA, to have an accurate MDS for this beneficiary. The date chosen for the assessment reference date (ARD) for the SCPA was one of the days in the assessment window for the 30-day Medicare assessment. In this situation, the SCPA replaces the 30-day assessment. The rate of payment changes on the ARD of the SCPA.

Table 1 -Medicare required assessments and assessment windows

Medicare Required Assessment	Assessment Window (includes grace days)	Payment Period
5 – day	Days 1 – 8	Days 1 - 14
14 – day	Days 11 – 19	Days 15 - 30
30 – day	Days 21 – 34	Days 31 – 60
60 – day	Days 51 – 64	Days 61 - 90
90 – day	Days 81 – 94	Days 91 - 100

USE OF ASSESSMENT INDICATORS

As published in transmittal A-00-47, for use as of October 1, 2000, we added several assessment indicator codes to make it possible for providers to account for, and code, additional combinations of reasons for Medicare required assessments. As a result of the additional codes, one of the existing code's (38) definition has changed. To avoid confusion on the part of providers when billing for Part A SNF stays, we list below those assessment indicators for which the definitions have not changed, explain the one that did change, and provide complete definitions for those that have been added.

ASSESSMENT INDICATORS THAT HAVE NOT CHANGED

00 Default Code
01 5-day Medicare required assessment/not an initial admission assessment
02 30-day Medicare required assessment
03 60-day Medicare required assessment
04 90-day Medicare required assessment
07 14-day Medicare required assessment/not an initial admission assessment
08 Other Medicare Required Assessment
11 5-day (or readmission/return) Medicare required assessment and initial admission assessment
32 SCSA that replaces a Medicare required 30-day assessment
33 SCSA that replaces a Medicare required 60-day assessment
34 SCSA that replaces a Medicare required 90-day assessment
37 SCSA that replaces a Medicare required 14-day assessment
41 SCPA that replaces a Medicare required 5-day assessment
42 SCPA that replaces a Medicare required 30-day assessment
43 SCPA that replaces a Medicare required 60-day assessment
44 SCPA that replaces a Medicare required 90-day assessment
47 SCPA that replaces a Medicare required 14-day assessment
54 A Quarterly assessment that is used as a 90-day Medicare assessment

Assessment indicator codes have been required since the implementation of SNF PPS. The codes are only used for billing Medicare for covered SNF Part A stays. To the extent possible, every combination of reasons for MDS assessment relevant for Medicare payment has been captured by the HIPPS assessment indicator codes. However, to avoid undue complexity and because the information is not relevant for payment, there are some combinations that are not specifically identifiable using the codes. This means that although there are instances in which all of the information contained on the MDS is not captured by the HIPPS assessment indicator code, it is still an accurate code for billing purposes. For example, "08" indicates that the bill is based on an MDS assessment performed to fulfill the Medicare requirement for an OMRA 8 - 10 days after the discontinuation of all rehabilitation therapy. From the standpoint of Medicare payment, it does not matter if the MDS (the required OMRA) was also used to fulfill the clinical requirement for an SCSA or a Quarterly. For this reason, the assessment indicator code "08" is used for billing several different combinations of reasons for assessment, as can be seen in Table 2. The important information for the payor is that the facility performed the required MDS in a timely manner and that the payment rate changes as of the ARD of the assessment. Note that several assessment indicator

codes (i.e., “05”, “01”, “11”, and “07”), like “08”, are used in multiple situations, but always to convey the most important information from a billing standpoint. (See Tables 2 and 3 for a display of combinations of reasons for assessment and the appropriate assessment indicator code to use for billing.)

ASSESSMENT INDICATORS THAT HAVE CHANGED

38 The code now signifies an OMRA that replaces the 60-day Medicare required assessment. Prior to October 1, 2000, “38” signified that the bill was based on either a SCSA only or on a SCSA that was also used to satisfy the requirement for an OMRA.

An SCSA that is performed for a Medicare Part A covered beneficiary (and, as such is to be billed to Medicare) when no Medicare required assessment is due, is now coded as a “30”. Indicator code “30” signifies that the only reason for assessment was a SCSA. Similarly, the new HIPPS assessment indicator code for a bill based on an MDS that was performed for the combination of a SCSA and an OMRA, is “08”.

ASSESSMENT INDICATORS THAT HAVE BEEN ADDED

05 This code is used to signify that the bill is based on a readmission/return assessment. There may, or may not, be a clinical reason for the assessment.

17 This code is used to signify that the bill is based on an MDS that is satisfying two requirements: the clinical requirement for an initial admission assessment and the Medicare payment requirement for a 14-day assessment.

18 This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 5-day assessment and “replaces” the Medicare required 5-day assessment. This combination of assessment types is extremely rare and, accordingly, this code will not likely be used often.

28 This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 30-day assessment and “replaces” the Medicare required 30-day assessment.

30 This code is used to signify that the bill is based on a SCSA performed for clinical reasons as required by OBRA 1987. As defined in the Long Term Care Resident Assessment Instrument User’s Manual, MDS 2.0, a SCSA is appropriate if there is a consistent pattern of change, with either two or more areas of decline or two or more areas of improvement in the beneficiary’s clinical status.

31 This code is used to signify that the bill is based on a SCSA that was performed for clinical reasons within the window of a Medicare required 5-day assessment and “replaces” the Medicare required 5-day assessment.

35 This code is used to signify that the bill is based on a SCSA that was performed within the assessment window for a readmission/return assessment and will “replace” the readmission/return assessment.

40 This code is used to signify that the bill is based on a SCPA that was performed for clinical reasons.

45 This code is used to signify that the bill is based on a SCPA that was performed within the assessment window of a readmission/return assessment and “replaces” the readmission/return assessment.

48 This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 90-day Medicare required assessment and “replaces” the Medicare required 90-day assessment.

78 This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 14-day Medicare required assessment and "replaces" the Medicare required 14-day assessment.

BILLING BASED ON OFF-CYCLE MDS ASSESSMENTS

If an off-cycle assessment is performed within the assessment window of a Medicare required assessment, it must replace the Medicare required assessment. Payment will change effective with the ARD of the off-cycle assessment that "replaces" the Medicare required assessment and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first. This policy is applied when there is a single off-cycle assessment that is performed within the Medicare required assessment window. However, when the ARD of the "replacement" (or off-cycle) assessment is on one of the grace days, the payment rate changes on the day it would have changed based on the regularly schedule assessment.

Example 1: If the ARD of an OMRA is set on day 22 of the Part A covered stay, which is within the assessment window for setting the ARD for the 30-day Medicare required assessment, it must replace the 30 day Medicare required assessment. Payment will change on day 22, the ARD of the OMRA, and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

Example 2: If the ARD of an OMRA is set for day 32 of the stay and the OMRA is replacing the Medicare 30-day assessment, then the payment will change as of day 31, as if it were a regularly scheduled 30-day assessment. The payment rate changes retrospectively in this case because otherwise, there is no appropriate rate to bill for day 31. Payment based on the 14-day assessment may only go through day 30.

While not a common occurrence, there may be situations in which multiple assessments are performed within one Medicare required assessment window. In these instances, the off-cycle assessment with an ARD closest to, and before, the date on which the Medicare required assessment is due (i.e., day 5, day 14, day 30, day 60 or day 90) is the assessment that must replace the Medicare required assessment. Any other assessment performed in the assessment window must be billed as a stand-alone assessment and cannot replace the Medicare required assessment.

If there is one off-cycle assessment within the assessment window and another off-cycle assessment performed with an ARD on a grace day, the assessment with the grace day ARD must be billed separately as an off-cycle assessment and cannot replace the Medicare required assessment. The assessment with the ARD closest to, and before, the date on which the assessment was due must replace the assessment. In this case, there was an off-cycle assessment with an ARD before the assessment due date, therefore, that assessment is the replacement assessment. The assessment with an ARD in the grace period must be billed separately. There is no longer a Medicare assessment to be replaced. The required Medicare assessment was already replaced by the assessment that was performed within the assessment window and before the due date.

Example 3: A SNF sets the ARD for a SCSA on day 22 of the covered stay. The beneficiary "grouped" into a rehabilitation RUG. Therapy ends on day 24 and the SNF performs an OMRA with an ARD of day 33. The SNF must use the SCSA with the ARD of day 22 of the covered stay to replace the Medicare required assessment. This assessment must be used as the replacement assessment because its ARD is within the assessment window for the Medicare required assessment and is before the date on which the Medicare required assessment is due. The OMRA with an ARD that fell on day 33 of the stay cannot replace the Medicare required assessment since it already has been replaced by the SCSA. Payment to the SNF will change on day 22 (the ARD of the SCSA), since the SCSA must be used to replace the Medicare required assessment, and then again on day 33 of the covered stay, based on the OMRA. The payment associated with the RUG code derived from the OMRA will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

Table 2—HIPPS ASSESSMENT INDICATOR CODES

Reason for Assessment*	Medicare 5-day			Medicare 30-day			Medicare 60-day			Medicare 90-day			Readmission/ Return			Medicare 14-day			Other Medicare Required OMRA		
	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**	A8a	A8b	**HIPPS**
Initial Admission	01	1	**11**	--	--	--	--	--	--	--	--	--	01	5	**11**	01	7	**17**	01	8	**08**
Annual	02	1	**01**	02	2	**02**	02	3	**03**	02	4	**04**	02	5	**05**	02	7	**07**	02	8	**08**
Significant Change in Status-SCSA	03	1	**31**	03	2	**32**	03	3	**33**	03	4	**34**	03	5	**35**	03	7	**37**	03	8	**08**
Significant Correction of Prior Full	04	1	**41**	04	2	**42**	04	3	**43**	04	4	**44**	04	5	**45**	04	7	**47**	04	8	**08**
Quarterly	05	1	**01**	05	2	**02**	05	3	**03**	05	4	**54**	05	5	**05**	05	7	**07**	05	8	**08**
Significant Correction of Prior Quarterly	10	1	**41**	10	2	**42**	10	3	**43**	10	4	**44**	10	5	**45**	10	7	**47**	10	8	**08**
None of the Above	00	1	**01**	00	2	**02**	00	3	**03**	00	4	**04**	00	5	**05**	00	7	**07**	00	8	**08**

***A8a and A8b are used in the table headings rather than AA8a and AA8b due to space constraints. The two are interchangeable for coding reason for assessment. The values listed for A8a are identical to what will be coded in AA8a, similarly, the values listed for A8b are identical to the coding in AA8b.**

Table 3--HIPPS Assessment Indicator Codes for billing when there are two Medicare reasons for assessment; two codes in MDS item AA8b or no reason for assessment to be coded in AA8b.

Reason for Assessment	Medicare 5-day	Medicare 14-day	Medicare 30-day	Medicare 60-day	Medicare 90-day	Readmission/ Return Assessment	SCSA	SCPA
Other State-required assessment*	01	07	02	03	04	05	30	40
OMRA	18	78	28	38	48	18	08	08
No reason for assessment in AA8b	N/A	N/A	N/A	N/A	N/A	N/A	30	40

*This item in Section AA8b of the MDS is not used in every State and has no implications for Medicare billing. It is shown here only in the interest of providing clear and complete information.

The *effective date* for this PM is October 1, 2000.

The *implementation date* for this PM is April 30, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after September 30, 2002.

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