6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of PPS assessments. The 5-Day assessment is the only required PPS assessment that is used to support PPS reimbursement. However, as described in Chapter 2, Section 2.9, an optional assessment, the Interim Payment Assessment (IPA), may be used to reclassify the resident into a new PDPM classification, and would also affect the associated payment rate. See Chapter 2 of this manual for greater detail on assessment types and requirements.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements.

For example, if a resident's status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a PDPM classification is not an indication that the requirements for a SNF Part A stay have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all-inclusive and definitive. Refer to the **Medicare Claims Processing Manual**, Chapter 6

(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf), for detailed claims processing requirements and policies.

The SNF claim must include two data items derived from the MDS assessment:

Assessment Reference Date (ARD)

The ARD must be reported on the SNF claim. CMS has developed internal mechanisms to link the MDS assessment and the claims processing system.

Health Insurance Prospective Payment System (HIPPS) Code

Each SNF claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC). The HIPPS code consists of a series of codes representing the resident's PDPM classification and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

PDPM Classification

The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement. The PDPM classification is calculated from the MDS assessment clinical data. See Section 6.6 for calculation details on each PDPM group. CMS provides standard software, development tools, and logic for PDPM calculation. CMS software, or private software developed with the CMS data specifications, is used to encode and transmit the MDS assessment data and automatically calculates the resident's PDPM classification. CMS edits and validates the PDPM classification code of transmitted MDS assessments. Skilled nursing facilities are not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the PDPM classification code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (ZZZZZ). See Section 6.8 for details.

Table 1. First Character: PT/OT Component

Clinical Category	Section GG Function Score	PT/OT Case-Mix Group	HIPPS Character
Major Joint Replacement or Spinal Surgery	0-5	TA	A
Major Joint Replacement or Spinal Surgery	6-9	TB	B
Major Joint Replacement or Spinal Surgery	10-23	TC	C
Major Joint Replacement or Spinal Surgery	24	TD	D
Other Orthopedic	0-5	TE	E
Other Orthopedic	6-9	TF	F
Other Orthopedic	10-23	TG	G
Other Orthopedic	24	TH	H
Medical Management	0-5	TI	I
Medical Management	6-9	TJ	J
Medical Management	10-23	TK	K
Medical Management	24	TL	L
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	M
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	N
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	O
Non-Orthopedic Surgery and Acute Neurologic	24	TP	P

Table 2. Second Character: SLP Component

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	HIPPS Character
None	Neither	SA	A
None	Either	SB	B
None	Both	SC	C
Any one	Neither	SD	D
Any one	Either	SE	E
Any one	Both	SF	F
Any two	Neither	SG	G
Any two	Either	SH	H
Any two	Both	SI	I
All three	Neither	SJ	J
All three	Either	SK	K
All three	Both	SL	L

Table 3. Third Character: Nursing Component

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	A
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	B
ES1	Infection	-	-	-	0-14	ES1	C
HE2/HD2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	0-5	HDE2	D
HE1/HD1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	E
HC2/HB2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	F
HC1/HB1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	G
LE2/LD2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	0-5	LDE2	H
LE1/LD1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	0-5	LDE1	I
LC2/LB2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	6-14	LBC2	J

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
LC1/LB1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	6-14	LBC1	K
CE2/CD2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	L
CE1/CD1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	0-5	CDE1	M
CC2/CB2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	N
CA2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	O
CC1/CB1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	6-14	CBC1	P
CA1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	15-16	CA1	Q
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	R
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	S
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	T

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	U
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	V
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	W
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	X
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	Y

Table 4. Fourth Character: NTA Component

NTA Score Range	NTA Case-Mix Group	HIPPS Character
12+	NA	A
9-11	NB	B
6-8	NC	C
3-5	ND	D
1-2	NE	E
0	NF	F

The PDPM HIPPS code is recorded on the MDS 3.0 in item Z0100A (Medicare Part A HIPPS code). The HIPPS code included on the SNF claim depends on the specific type of assessment involved (as described below).

The HIPPS code in item Z0100A is validated by CMS when the assessment is submitted. If the submitted code is incorrect, the validation report will include a warning giving the correct code; the facility must enter this correct code in the HIPPS code item on the bill.

The provider must ensure that all PPS assessment requirements are met. When the provider fails to meet the PPS assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the PDPM classification-based HIPPS code validated by CMS in item Z0100A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

AI Code

The last position of the HIPPS code represents the AI, identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of item A0310B. CMS provides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility must enter this correct AI code in the HIPPS code item on the bill. The code consists of one digit, which is defined below. In situations when the provider is to bill the default code, the AI provided on the validation report is to be used along with the default code, ZZZZZ, on the SNF claim.

Refer to the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

The AI code identifies the assessment used to establish the per diem payment rate for the standard PPS payment periods. These assessments are the 5-Day assessment and Interim Payment Assessment. Table 5 displays the AI code for each of the PPS assessment types and the standard payment period for each assessment type.

Table 5. Assessment Indicator Table

AI Code	Assessment Type (abbreviation)	Standard Payment Period
0	Interim Payment Assessment	See Chapter 2, Section 2.9
1	5-Day	Entire Part A Stay