# 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) health insurers use to make payment determinations 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. 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, using an HP qualifier, 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 past and current payment systems is described in detail below.

HIPPS Code Effective Dates

Under the Health Insurance Portability and Accountability Act (HIPAA) rules for transactions and code sets, HIPPS codes are defined as a non-medical code set. Therefore, these codes are effective by transaction date. The HIPPS Code Master List on this website shows code effective "From" and "Through" dates.

Effective From Dates: HIPPS codes are valid under HIPAA on transactions on or after this date. Since all HIPPS codes to date have been initially created for Original Medicare payment systems, this is also date of service the codes begin to be payable by Medicare. While it is valid under HIPAA rules that a claim for dates of service before this date could be submitted on a transaction after this date, CMS is not aware of a business need

for a provider to do so. The code would not be payable by any insurer and no Grouper software would be available to produce a code for those dates.

Effective Through Dates: HIPPS codes are no longer valid under HIPAA on transactions on or after this date. This date may vary from the date a code ceases to be payable by Medicare, since other payers may continue to use older HIPPS codes after Medicare transitions to a new payment system. Since CMS, as the HIPPS code set maintainer, may not have complete information about other payers' uses of these codes, codes may remain effective under HIPAA long after they cease to be payable on Medicare claims. To reflect this, a separate column on the HIPPS Code Master List indicates the Medicare Payment Though Date.

HIPPS Codes and Modifiers

HIPPS codes do not have a dedicated set of modifiers to accompany them. In the great majority of cases, HIPPS codes do not require modifiers. In special circumstances, when a modifier is needed to clarify a payment policy that applies to the claim, it is valid to report a HIPPS code with a HCPCS modifier (e.g., the KX modifier).

History and Uses of HIPPS codes

The Centers for Medicare and Medicaid Services (CMS) created HIPPS codes as part of the Original Medicare program's implementation of a prospective payment system for skilled nursing facilities in 1998. Additional HIPPS codes were created for other prospective payment systems, including for home health agencies in October 2000 and 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, also uses HIPPS codes on their claims. Additionally, HIPPS codes have been used by certain State Medicaid programs.

Specific Uses of HIPPS Codes

*Skilled Nursing Facility Prospective Payment System*

*Past Uses*

Under the skilled nursing facility prospective payment system (SNF PPS), from October 1, 2010 to September 30, 2019, a case-mix adjusted payment for varying numbers of days of SNF care was made using one of 66 Resource Utilization Groups, Version IV (RUG-IV). These groups replaced the RUG-III system, which was in effect from 1998 to 2010.

SNF HIPPS codes are based on assessments made using the Minimum Data Set (MDS). Grouper software run at a skilled nursing facility or swing bed hospital used specific data

elements from the MDS to assign beneficiaries to a RUG-IV code. The Grouper output the RUG-IV code, which is combined with an assessment indicator to create the HIPPS code to be entered on the claim.

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

The first, second and third positions of the code represent the RUG-IV case mix group. If the MDS assessment was not performed appropriately, these positions may instead carry a default value. The valid values for these positions were as follows:

RUG-IV GROUP CODES:

> **Rehabilitation Plus Extensive Services:**
> RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
> **Rehabilitation:**
> RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
> **Extensive Services:**
> ES3, ES2, ES1 **Special Care High:**
> HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1
> **Special Care Low:**
> LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1
> **Clinically Complex:**
> CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1
> **Behavioral Symptoms and Cognitive Performance:**
> BB2, BB1, BA2, BA1
> **Reduced Physical Function:**
> PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1
> **Default:**
> AAA

The fourth and fifth positions of the code represented an assessment indicator (AI), identifying the reason and timeframe for the completion of the MDS. These positions may be numeric or alphabetical. Valid values for RUG-IV billing are available for download from Chapter 6 of the Resident Assessment Instrument (RAI) Version 3.0 Manual at:
http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

NOTE: Providers may view the valid RUG-III codes and AIs used under the previous version RUG-III system, termed 9/30/2010, in Chapter 6 of the RAI Version 2.0 Manual, archived on the same webpage.

*Patient-Driven Payment Model*

Beginning October 1, 2019, the case-mix system of the SNF PPS was replaced with the Patient-Driven Payment Model (PDPM). Under PDPM, the HIPPS code is structured differently. Instead of a three position RUG group, there are five case-mix adjusted rate

components. In order to represent five components plus an AI in a five position code, the first position of the code represents both the Physical and Occupational Therapy case-mix group. The second position represents the Speech-Language Pathology case-mix group. The third position represents the nursing case-mix group. The fourth position represents the Non-Therapy Ancillary case-mix group. This leaves the fifth position to represent the AI code. Under the PDPM, there is a much greater number of valid HIPPS codes compared to RUG-IV.

The following crosswalk describes how PDPM HIPPS codes are derived:

The first, second and fourth positions of the code use this table to translate PT/OT, SLP, NTA Payment Groups into code values:

| PT/OT Payment Group (Position 1) | SLP Payment Group (Position 2) | NTA Payment Group (Position 4) | HIPPS Code Value |
|---|---|---|---|
| TA | SA | NA | A |
| TB | SB | NB | B |
| TC | SC | NC | C |
| TD | SD | ND | D |
| TE | SE | NE | E |
| TF | SF | NF | F |
| TG | SG | | G |
| TH | SH | | H |
| TI | SI | | I |
| TJ | SJ | | J |
| TK | SK | | K |
| TL | SL | | L |
| TM | | | M |
| TN | | | N |
| TO | | | O |
| TP | | | P |

The third position of the code uses this table to translate the Nursing Payment Group into code values:

| Nursing Payment Group | HIPPS Code Value | Nursing Payment Group | HIPPS Code Value |
|---|---|---|---|
| ES3 | A | CBC2 | N |
| ES2 | B | CA2 | O |
| ES1 | C | CBC1 | P |
| HDE2 | D | CA1 | Q |
| HDE1 | E | BAB2 | R |
| HBC2 | F | BAB1 | S |

| HBC1 | G | PDE2 | T |
|------|---|------|---|
| LDE2 | H | PDE1 | U |
| LDE1 | I | PBC2 | V |
| LBC2 | J | PA2 | W |
| LBC1 | K | PBC1 | X |
| CDE2 | L | PA1 | Y |
| CDE1 | M |  |  |

The fifth position of the code uses this table to translate the assessment indicator:

| Assessment Type | HIPPS Code Value |
|-----------------|------------------|
| Initial Patient Assessment | 0 |
| PPS 5-day Assessment | 1 |

Note that there are many fewer assessment indicators under the PDPM.

Example:
• PT/OT Payment Group: TN
• SLP Payment Group: SH
• Nursing Payment Group: CBC2
• NTA Payment Group: NC
• Assessment Type: 5-day PPS Assessment

HIPPS Code: NHNC1

PDPM Case Mix Group Combinations

PDPM has 16 PT/OT case mix groups, 12 SLP case mix groups, 25 Nursing case mix groups and 6 NTA case mix groups, which multiplies to 28800 combinations. Among these combinations, some are not valid:

1. PT/OT and SLP case mix groups both depend on clinical category. When PT/OT clinical category is not Acute Neurologic (TA-TL), the SLP case mix group cannot be SJ-SL. For this reason, 5400 combinations are excluded.

2. PT/OT function score should be higher or equal to nursing function score by design. This means that PT/OT score bin 6-9 (TB TF TJ TN) cannot coexist with nursing score bins 11-16 and 15-16 (CA2 CA1 BAB2 BAB1 PA2 PA1) and that PT/OT score bin 0-5 (TA TE TI TM) cannot coexist with nursing score bins 6-14, 11-16, and 15-16 (HBC2 HBC1 LBC2 LBC1 CBC2 CBC1 CA2 CA1 BAB2 BAB1 PBC2 PBC1 PA2 PA1). For this reason, 5760 combinations are excluded.

3.    The PT/OT function score can be up to 8 points higher than the nursing score, so PT/OT score 24 (TD TH TL TP) cannot coexist with nursing score bins 0-5, 0-14, and 6-14 (all nursing groups except CA2 CA1 BAB2 BAB1 PA2 PA1). For this reason, 5472 combinations are excluded.

The three scenarios above are not mutually exclusive. Specifically, there are 2106 combinations that are double counted in scenario 1 and scenario 2-3. The ending number of case mix group combinations is 14274. With the addition of the default ZZZZZ code, there are 14275 possible combinations in the first four HIPPS characters under the SNF PDPM.

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

*Home Health Prospective Payment System*

*Past Uses*

Under the home health prospective payment system (HH PPS), from October 1, 2000 to December 31, 2019, Original Medicare made a case-mix adjusted payment for up to 60 days of care using Home Health Resource Groups (HHRG). The HHRGs were represented on claims as HIPPS codes. Home health HIPPS codes were determined based on assessments made using the Outcome and Assessment Information Set (OASIS). Grouper software run at a home health agency site used specific data elements from the OASIS data set to assign beneficiaries to a HIPPS code. The Grouper output the HIPPS code to be entered on the claim.

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

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

The second, third and fourth positions of the code were a one-to-one crosswalk to the three domains of the initial HHRG coding system. Note the second through fourth positions of the HH PPS HIPPS code only allowed alphabetical characters.

The fifth position indicated 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 was incomplete. This position did not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position only allowed numeric characters.

| 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 could be combined with any of the 8 data validity flags, resulting in 640 valid HH HIPPS codes.

Note: Medicare only accepted the October 2000 HH HIPPS code set through on claims with a "From" date before 12/31/2007.

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

- The first position was 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 contained a numeric value representing the grouping step that applies to the three domain scores that follow.

- The second, third, and fourth positions of the code remained 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 assigned each episode into one of 6 NRS severity levels and created the fifth position of the HIPPS code with the values S through X. If the HHA was aware that supplies were not provided during an episode, they changed 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 level 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.

Note: Medicare only accepts the October 2008 HH HIPPS code set on claims with "From" dates on or before 12/31/2019.

*Patient-Driven Groupings Model*

Beginning January 1, 2020, the case-mix system of the HH PPS is replaced with the Patient-Driven Groupings Model (PDGM). Under the PDGM, payments for 60-day episodes are replaced by a case-mix adjusted payment for a period of care of up to 30 days. These 30 day periods of care are paid using one of 432 Home Health Resource Groups (HHRG). The HHRGs combine claims and OASIS assessment data to group patients according to their admission source and timing, a clinical group assignment, the patient's functional level and the presence of co-morbidities.

The HHRG system will continue to be recorded on claims as HIPPS codes, using the following code structure:

| Position #1 | Position #2 | Position #3 | Position #4 | Position #5 |
|---|---|---|---|---|
| Source & Timing | Clinical Group | Functional Level | Co-Morbidity | Placeholder |
| 1 - Community Early | A - MMTA Other | A - Low | 1 - None | 1 |
| 2 - Institutional Early | B - Neuro Rehab | B - Medium | 2 - Low | |
| 3 - Community Late | C - Wounds | C - High | 3 - High | |
| 4 - Institutional Late | D - Complex Nursing Interv. | | | |
| | E - MS Rehab | | | |
| | F – Behavioral Health | | | |
| | G – MMTA Surgical Aftercare | | | |
| | H – MMTA Cardiac & Circulatory | | | |
| | I – MMTA Endocrine | | | |
| | J – MMTA GI/GU | | | |
| | K – MMTA Infectious Disease | | | |
| | L – MMTA Respiratory | | | |

Using this structure, a second period for a patient with a hospital inpatient stay before the period, in the Wounds group, with high functional severity and no co-morbidity would be coded 4CC11. Under this coding structure there is a 1:1 relationship between HHRGs and HIPPS codes, resulting in 432 valid codes.

HIPPS codes created using any of the HH coding structures are only valid on claim lines reporting revenue code 0023.

*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 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 not all values in that range are used.

Rehabilitation Impairment Categories (RICs) are used to group cases that are similar in clinical characteristics and resource use. The RICs are codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. The second and third positions of the HIPPS code indicate the RIC. The fourth and fifth positions represent functional measures of motor and cognitive scores.

The majority of 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.

When CMS initially implemented the IRF PPS, there were 95 CMGs using 4 comorbidity tiers, plus the five "atypical" codes and the default code. Codes were added and deleted effective October 1, 2005 and October 1, 2019, resulting in 447 valid 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 Medicare regulations and instructions:

SNF PPS Final Rules -- **Federal Register:**
-   Vol. 83, No. 153, Wednesday, August 8, 2018, beginning at p. 39183
-   Vol. 74, No. 153, Tuesday, August 11, 2009, beginning at p. 40288
-   Vol. 70, No. 149, Thursday, August 4, 2005, beginning at p. 45026
-   Vol. 66, No. 147, Tuesday, July 31, 2001, beginning at p. 39562 (Swing beds)
-   Vol. 63, No. 91 / Tuesday, May 12, 1998, beginning at p. 26251

Transmittal 2278, Change Request 11152, April 11, 2019, Replaces RUG-IV-based SNF
    HIPPS code system with coding to support the Patient-Driven Payment Model
Transmittal 1958, CR 6916, April 28, 2010, Implements new HIPPS codes resulting from
    the conversion to the RUG-IV (66 groups) coding system.
Transmittal 630, CR 3962, July 29, 2005 –Implements 9 new RUG-III categories resulting
    in a 53-group RUG-III coding system (formerly 44-group RUG-III coding system)
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 Final Rules -- **Federal Register:**
-   Vol. 83, No. 219/ Tuesday, November 13, 2018, beginning at p. 56446
-   Vol. 72, No. 167/ Wednesday, August 29, 2007, beginning at p. 49764
-   Vol. 65, No. 128 / Monday, July 3, 2000, beginning at p. 41128

Transmittal 4244, Change Request 11081, February 15, 2019, Replaces 2008 HH HIPPS
    code system with coding to support the Patient-Driven Groupings Model

Transmittal 1348, CR 5746, October 5, 2007, Replaces original HH HIPPS codes with codes supporting 2008 cased mix reform.

PM A-00-41, July 27, 2000—Outlines transition to HH PPS and provides complete list of original HH HIPPS codes

IRF PPS Final Rules -- **Federal Register:**
- Vol. 84, No. 153 / Thursday, August 8, 2019, beginning at p.39054
- Vol. 70, No. 156/Monday August 15, 2005, beginning at p. 47880
- Vol. 66, No. 152 / Tuesday, August 7, 2001, beginning at p. 41316

Transmittal 4368, CR 11345, August 15, 2019, Modifies IRF CMG list to reflect FY 2020 final rule

Transmittal 680, CR 4037, September 16, 2005, Modifies IRF CMG list to 87 CMGs plus 5 special CMGs (formerly 95 CMGs plus 5 special CMGs)

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