

**Medicare
Home Health Prospective Payment System (HH-PPS)
Patient Classification Algorithm**

Overview

Effective October 1, 2014 (v3514)

**Questions about the Grouper software and classification logic may be directed via
email to grouperemail@mmm.com**

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Background and Versioning

Home Health Prospective Payment System Overview

Under Medicare's home health prospective payment system, a case mix adjusted payment for a 60-day episode is made using Home Health Prospective Payment System (HH-PPS). When used in Medicare claims, HH-PPSs are represented as Health Insurance Prospective Payment System (HIPPS) codes. HIPPS codes allow the HH-PPS code to be carried more efficiently and to include additional information on how the HH-PPS was derived. HIPPS codes represent specific characteristics (or case mix) on which Medicare payment determinations are made and vary by payment system. HIPPS payment codes have been established to represent case mix groups derived from research into provider utilization patterns. The payment system applicable to a particular HIPPS code is identified by the use of dedicated revenue codes submitted upon institutional claims to Medicare contractors for payment. The HIPPS code is placed in the HCPCS/ Accommodation Rates/HIPPS Rate Codes field of the claim while the associated revenue code is placed in the Revenue Codes field.

Changes for this Version

This version includes code changes as described on CMS's HH-PPS Regulations and Notices web site, located at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html>

Episodes

An episode is a 60-day unit of payment for the HH-PPS. The end date for a distinct episode is the 60th day after the **start** of care date reported in OASIS Field M0030. The HH-PPS utilizes the episode timing of adjacent episodes to distinguish between variations in resource needs.

Home Health Agencies (HHAs) are required to report if adjacent episodes are "early" or "later" using OASIS item M0110 "Episode Timing". When determining if two eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. When determining the interval between episodes the first

day after the last day of an episode is counted as day 1. Counting is continued and includes, the first day of the next episode.

Example:

A patient is admitted to Agency A on July 5th and is reported within a payment episode that ends on the date of Sept 2nd. The patient is then recertified on Sept 3rd, with an end of episode date of November 1st. Agency B admits on Jan 1, 2008. November 1st was the last day of the previous episode, (the second episode), and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1st would be reported by Agency B as “early”. December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. An episode starting December 31 would be reported by Agency B as “later.” Any episodes beginning between November 2 and December 31 in this example would also be reported as “later.”

Episode Timing

Episode timing is used within the HH-PPS to determine the HIPPS code for billing. The first position of the HIPPS code shows whether an episode is “early” or “later.” Since HHAs may not always have complete information about previous episodes, the HIPPS code is validated by Medicare systems. After submitting claims the Common Working File reads the episode history to determine whether an episode has been coded correctly based upon the most current information available to Medicare. If the HIPPS code disagrees with Medicare’s episode history, the claim will be recoded.

The receipt of any additional assessment (episode) may change the sequence of previously paid claims. For instance, a claim may be paid as “early” because the HHA was not aware of prior episodes and the previous HHA had not billed for the prior episodes. When the earlier dated episodes are received, Medicare systems will initiate an automatic adjustment to recode the previously paid claim and correct its payment.

When claims are recoded, values in the treatment authorization code submitted on the claim will be used to determine the new code. To avoid having to send the claim back to the provider (RTP), the HH-PPS generates four sets of scores based upon the OASIS (Outcome and Assessment Information Set) responses. The four sets of scores correspond to alternate outcomes obtained from scoring equations constructed within the HH-PPS model varying by episode timing and the number of therapy visits. The four HH-PPS severity scoring equations are outlined in Table 1 below.

Scores are outputted by the HH-PPS as a Claim-OASIS Matching String and submitted on claims in the “Treatment Authorization” field (FL63) in case they are needed during claims processing.

Table 1: Severity Scoring Table

Episode Timing (M0110)	01 or UK ("Early")		02 ("Later")	
Therapy visits (M2200)	0-13	14+	0-13	14+
SCORING EQUATION:	1	2	3	4

The Executable File and Versions

The executable file (.dll) is structured to accept an input string in the standard OASIS 1448-byte submission record format. The grouper accepts OASIS B1 and OASIS C formats, the use of which is determined by Assessment Completion Date M0090. Each valid assessment passed through the .dll in standard format will return:

5 character HIPPS code;
Data validity flag;
18 Character claim-OASIS matching key;
HH-PPS version identifier.

The HH-PPS version applicable for the episode is identified by the Assessment Completion Date M0090.

The version identifier occupies a 5 character space with the following format:

v & [OASIS indicator] & [logic release indicator] & [effective starting year indicator]

v3514 uses OASIS C flat file record format, logic change 5 (based on previous releases), and effective starting year of 2014

Data Validation

Valid Assessments

Assessments must have the following range of OASIS responses to be assigned a HIPPS code:

OASIS Field: M0100 (Reason for Assessment) is 01,03,04,05

OASIS Field: M0090 (Assessment Completion Date) is within the valid date range for the HH-PPS (after January 1 2008 and the current effective end date).

Assessments not meeting criteria for M0100 or M0090 will not return grouping results, i.e. the HIPPS code is blank.

More details on specific validation can be found in the HH-PPS source code.

Data Validity Flag

The HH-PPS outputs a data validity flag separate from the HIPPS assignment as part of the standard grouper output. The validity flag can be observed at the end of the output record after grouping. This single data validity flag combines validation returns from four separate flags that are switched through internal grouper logic: Manifestation Flag; Clinical Domain Flag; Functional Domain Flag and Service Domain Flag. Table 2 describes how the single data validity flag reports the combination of data validation errors encountered during assignment.

Table 2: Data Validity Flag Output

Manifestation Flag	Clinical Domain Flag	Functional Domain Flag	Service Domain Flag	Data Validity Flag
0	0	0	0	1
0	1	0	0	2
0	0	1	0	3
0	0	0	1	4
0	1	1	0	5
0	0	1	1	6
0	1	0	1	7
0	1	1	1	8
1	0	0	0	A
1	1	0	0	B
1	0	1	0	C
1	0	0	1	D
1	1	1	0	E
1	0	1	1	F
1	1	0	1	G
1	1	1	1	H

For all assessments utilizing grouper versions beginning October 1, 2009 onwards, regardless of original M0090 date, is the requirement for all ICD-9-CM Codes used in assignment to conform to ICD-9-CM coding guidelines. Manifestation flags are encountered where diagnosis codes that have been included in the payment model are entered on an assessment but the necessarily preceding etiology codes for validation have not been recorded.

A full inventory of edit checks that may result in the assignment of validation flags can be obtained by referring to the HH-PPS source code. Similarly a complete list of valid ICD-9-CM codes complete with acceptable etiologies may be found by consulting the tables accompanying the HH-PPS source code.

OASIS fields flagged as having a validation error during assignment by the HH-PPS neither contribute points to the case mix score nor influence the assignment of HIPPS codes. For example, the presence of the service domain data issue flag leads to a recognized therapy service level of 0 in HIPPS code assignment.

Grouping and Scoring

Diagnostic Groups (DG)

Diagnosis Codes, reported in OASIS C Fields M1020 (Primary Diagnosis), M1022 (Other Diagnosis) and M1024 (Payment Diagnosis) of OASIS C, are used to classify patients within distinct Diagnostic Groups (DGs). A complete listing of diagnosis codes and DG assignments can be found by reviewing the HH-PPS source code and accompanying tables. Starting with V3413 (effective Jan 1 2013) consideration of codes submitted within the payment diagnosis field for scoring will be significantly reduced however no HH-PPS restriction is placed upon their submission.

DG Scoring

The OASIS instrument permits the entry of a single Primary Diagnosis [M1020] and up to 5 Other Diagnoses [M1022]. Each of the diagnosis fields has a companion Payment Diagnosis [M1024] field in which two ICD-9-CM codes can be placed to act, under defined rules, as substitutes for the codes entered in M1020 or M1022 by the HH-PPS. Substitution is described in the following section entitled “V-Codes and Payment Diagnoses”.

Diagnosis codes recognized by the HH-PPS for scoring are assigned to one of the Diagnostic Groups shown in Table 3 below.

Table 3: Diagnostic Groups

Diagnostic Group Description	ID
Blindness and low vision	1
Blood disorders	2
Cancer and selected benign neoplasms	3
Diabetes	4
Dysphagia	5
Gait Abnormality	6
Gastrointestinal disorders	7
Heart Disease	8
Hypertension	9
Neuro 1 - Brain disorders and paralysis	10
Neuro 2 - Peripheral neurological disorders	11
Neuro 3 - Stroke	12
Neuro 4 - Multiple Sclerosis	13
Ortho 1 - Leg Disorders	14
Ortho 2 - Other Orthopedic disorders	15
Psych 1 - Affective and other psychoses, depression	16
Psych 2 - Degenerative and other organic psychiatric disorders	17
Pulmonary disorders	18
Skin 1 -Traumatic wounds, burns and post-operative complications	19
Skin 2 - Ulcers and other skin conditions	20
Tracheostomy Care	21
Urostomy/Cystostomy Care	22

During scoring it is possible to accrue points from more than one Diagnosis Group (DG) per episode but each DG may contribute points only once.

If a Primary and Other Diagnosis code fall within the same DG, points are calculated for the primary diagnosis only. If multiple “Other” diagnosis codes fall into a single DG the single code generating the highest points score is calculated as the allowed.

If a manifestation ("M") code and its etiology earn points in distinct DGs only the greater of the two scores is allowed. Scoring considers the interaction of Dx codes and allowable DG points. For example where another Dx Code generates points within a DG the impact upon those points of an "M" or etiology code within the DG is incorporated into the scoring algorithm. The presence of other "losing" manifestation or etiology codes within a DG does not prevent the attribution of points to other codes within the DG. For scoring purposes an etiology/manifestation pair may both be considered for primary diagnosis points where the etiology occupies the primary diagnosis position. Where a similar score is obtained for the "M" and etiology code the etiology code is passed to the grouper for score with no impact on final HIPPS assignment.

V-Codes and Payment Diagnoses

Beginning with V3413 (effective Jan 1 2013) the HH-PPS will recognize a dedicated list of Payment Diagnoses entered in OASIS field M1024 for select paired V-Codes entered as primary diagnoses (M1020) or other diagnoses (M1022). A list of V-Codes recognized for substitution by the HH-PPS may be found by consulting the tables accompanying the HH-PPS source code.

Payment diagnosis codes that act as substitutes for designated V-codes within the HH-PPS are subject to the same manifestation and etiology requirements outlined in the preceding section. A manifestation code requires submission in column 4 of OASIS field M1024 with a valid etiology code to be entered into column 3 of OASIS field M1024.

When a valid etiology and manifestation pair are entered in the payment diagnosis field and substituted for a designated V-code in the primary/other diagnosis field, both payment diagnosis codes are considered for DG and NRS assignment purposes. As with other manifestation and etiology code contentions, described in the preceding section, only one of the etiology and manifestation code pair is recognized for points scoring by the HH-PPS.

Primary Point Promotion

Beginning with V3413 (effective Jan 1 2013) the HH-PPS will review V-codes submitted in the primary diagnosis field (M1020) and for a select range of V-codes will treat the first secondary diagnosis, or diagnosis pair if in etiology manifestation contention, as if it were primary for scoring purposes. Details of V-codes recognized with this change are available within the tables accompanying the HH-PPS source code.

Clinical and Functional Scores

The HH-PPS calculates assessment scores by combining the “Severity Score” (see Table 1) with clinical and functional attributes. Points are awarded for diagnosis groups and some specified responses in OASIS fields stratified by the severity scoring equation.

Points scores associated with Diagnosis Groups, OASIS values and the severity scoring equation are shown in Table 4 below.

Table 4: Clinical and Functional Scores

ROW	VARIABLE DESCRIPTION	POINTS by SCORING EQUATION:			
		1	2	3	4
	CLINICAL DIMENSION				
1	Primary or Other Diagnosis = Blindness/Low Vision	3	3	3	3
2	Primary or Other Diagnosis = Blood disorders	2	5	0	0
3	Primary or Other Diagnosis = Cancer, selected benign neoplasms	3	8	3	10
4	Primary Diagnosis = Diabetes	5	13	1	8
5	Other Diagnosis = Diabetes	3	5	1	5
6	Primary or Other Diagnosis = Dysphagia AND Primary or Other Diagnosis = Neuro 3 – Stroke	2	6	0	6
7	Primary or Other Diagnosis = Dysphagia AND M1030 (Therapy at home) = 3 (Enteral)	0	6	0	0
8	Primary or Other Diagnosis = Gastrointestinal disorders	2	6	1	5
9	Primary or Other Diagnosis = Gastrointestinal disorders AND M1630 (ostomy)= 1 or 2	2	0	0	0
10	Primary or Other Diagnosis = Gastrointestinal disorders AND Primary or Other Diagnosis = Neuro 1 – Brain disorders and paralysis, OR Neuro 2 – Peripheral neurological disorders, OR Neuro 3 – Stroke, OR Neuro 4 – Multiple Sclerosis	0	0	2	0
11	Primary or Other Diagnosis = Heart Disease OR Hypertension	3	6	1	7
12	Primary Diagnosis = Neuro 1 – Brain disorders and paralysis	3	8	5	8
13	Primary or Other Diagnosis = Neuro 1 – Brain disorders and paralysis AND M1840 (Toileting) = 2 or more	3	10	3	10
14	Primary or Other Diagnosis = Neuro 1 – Brain disorders and paralysis OR Neuro 2 – Peripheral neurological disorders AND M1810 or M1820 (Dressing upper or lower body)= 1, 2, or 3	1	4	1	2
15	Primary or Other Diagnosis = Neuro 3 – Stroke	0	2	0	0
16	Primary or Other Diagnosis = Neuro 3 – Stroke AND M1810 or M1820 (Dressing upper or lower body)= 1, 2, or 3	1	3	2	8
17	Primary or Other Diagnosis = Neuro 3 – Stroke AND M1860 (Ambulation) = 4 or more	1	5	0	0
18	Primary or Other Diagnosis = Neuro 4 – Multiple Sclerosis AND AT LEAST ONE OF THE FOLLOWING: M1830 (bathing) = 2 or more OR M1840 (Toileting) = 2 or more OR M1850 (Transferring) = 2 or more OR M1860 (Ambulation) = 4 or more	3	3	12	18
19	Primary or Other Diagnosis = Ortho 1 – Leg Disorders or Gait Disorders AND M1324 (most problematic pressure ulcer stage)= 1, 2, 3 or 4	2	0	0	0
20	Primary or Other Diagnosis = Ortho 1 – Leg OR Ortho 2 – Other orthopedic disorders AND M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	5	5	0	0
21	Primary or Other Diagnosis = Psych 1 – Affective and other psychoses, depression	4	6	2	6
22	Primary or Other Diagnosis = Psych 2 – Degenerative and other organic psychiatric disorders	1	3	0	3
23	Primary or Other Diagnosis = Pulmonary disorders	1	5	1	5
24	Primary or Other Diagnosis = Pulmonary disorders AND M1860 (Ambulation) = 1 or more	1	0	0	0
25	Primary Diagnosis = Skin 1 –Traumatic wounds, burns, and post-operative complications	10	20	8	20
26	Other Diagnosis = Skin 1 – Traumatic wounds, burns, post-operative complications	6	6	4	4
27	Primary or Other Diagnosis = Skin 1 –Traumatic wounds, burns, and post-operative complications OR Skin 2 – Ulcers and other skin conditions AND M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	2	0	2	0
28	Primary or Other Diagnosis = Skin 2 – Ulcers and other skin conditions	6	12	5	12
29	Primary or Other Diagnosis = Tracheostomy	4	4	4	0
30	Primary or Other Diagnosis = Urostomy/Cystostomy	6	22	4	22
31	M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	8	15	5	11
32	M1030 (Therapy at home) = 3 (Enteral)	4	11	0	11
33	M1200 (Vision) = 1 or more	1	0	0	2
34	M1242 (Pain)= 3 or 4	1	0	0	0

35	M1308 (Number Pressure Ulcers) = Two or more pressure ulcers at stage 3 or 4	3	3	5	5
36	M1324 (Most problematic pressure ulcer stage)= 1 or 2	5	11	5	11
37	M1324 (Most problematic pressure ulcer stage)= 3 or 4	16	26	12	22
38	M1334 (Stasis ulcer status)= 2	7	7	7	7
39	M1334 (Stasis ulcer status)= 3	11	11	11	11
40	M1342 (Surgical wound status)= 2	0	2	3	0
41	M1342 (Surgical wound status)= 3	4	4	4	4
42	M1400 (Dyspnea) = 2, 3, or 4	2	2	0	0
43	M1620 (Bowel Incontinence) = 2 to 5	1	2	1	0
44	M1630 (Ostomy)= 1 or 2	5	9	3	9
45	M2030 (Injectable Drug Use) = 0, 1, 2 or 3	0	1	2	3
FUNCTIONAL DIMENSION					
46	M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	2	4	2	2
47	M1830 (Bathing) = 2 or more	3	3	6	6
48	M1840 (Toilet transfer) = 2 or more	2	3	2	0
49	M1850 (Transferring) = 2 or more	0	1	0	0
50	M1860 (Ambulation) = 1, 2, or 3	1	0	1	0
51	M1860 (Ambulation) = 4 or more	3	3	4	5

Non-Routine Medical Supplies (NRS)

The HH-PPS incorporates a separate scoring algorithm for non routine medical supplies (NRS). The NRS model uses the same diagnoses and clinical information from the OASIS assessment to calculate points before assigning the assessment to one of 6 NRS severity levels.

Diagnosis codes recognized by the HH-PPS for NRS scoring are assigned to one of twelve Diagnosis Groups shown in Table 5 below. A complete listing of diagnosis codes and diagnosis group assignments for NRS can be found by reviewing the HH-PPS source code and accompanying tables.

Table 5: NRS Diagnostic Groups

NRS Diagnostic Group Description	ID
Anal fissure, fistula and abscess	1
Cellulitis and abscess	2
Diabetic Ulcers	3
Gangrene	4
Malignant neoplasms of skin	5
Non-pressure and non-stasis ulcers (other than diabetic)	6
Other infections of skin and subcutaneous tissue	7
Post-operative Complications	8
Traumatic wounds, burns and post-operative complications	9
V-code, Cystostomy Care	10
V-code, Tracheostomy Care	11
V-code, Urostomy Care	12

Scoring of NRS

The HH-PPS calculates assessment scores for NRS by combining Diagnostic Categories with additional clinical attributes obtained from specified OASIS fields.

Point scores associated with NRS Diagnostic Categories and OASIS values are shown in Table 6 below.

Table 6: NRS Scores

ROW	SELECTED SKIN CONDITIONS	Points
1	Primary diagnosis = Anal fissure, fistula and abscess	15
2	Other diagnosis = Anal fissure, fistula and abscess	13
3	Primary diagnosis = Cellulitis and abscess	14
4	Other diagnosis = Cellulitis and abscess	8
5	Primary diagnosis = Diabetic Ulcers ¹	20
6	Primary diagnosis = Gangrene	11
7	Other diagnosis = Gangrene	8
8	Primary diagnosis = Malignant neoplasms of skin	15
9	Other diagnosis = Malignant neoplasms of skin	4
10	Primary or Other diagnosis = Non-pressure and non-stasis ulcers ¹	13
11	Primary diagnosis = Other infections of skin and subcutaneous tissue	16
12	Other diagnosis = Other infections of skin and subcutaneous tissue	7
13	Primary diagnosis = Post-operative Complications	23
14	Other diagnosis = Post-operative Complications	15
15	Primary diagnosis = Traumatic Wounds and Burns	19
16	Other diagnosis = Traumatic Wounds and Burns	8
17	Primary or other diagnosis = V code, Cystostomy care	16
18	Primary or other diagnosis = V code, Tracheostomy care	23
19	Primary or other diagnosis = V code, Urostomy care	24
20	OASIS M1322 = 1 or 2 pressure ulcers, stage 1	4
21	OASIS M1322 = 3+ pressure ulcers, stage 1	6
22	OASIS M1308 = 1 pressure ulcer, stage 2	14
23	OASIS M1308 = 2 pressure ulcers, stage 2	22
24	OASIS M1308 = 3 pressure ulcers, stage 2	29
25	OASIS M1308 = 4+ pressure ulcers, stage 2	35
26	OASIS M1308 = 1 pressure ulcer, stage 3	29
27	OASIS M1308 = 2 pressure ulcers, stage 3	41
28	OASIS M1308 = 3 pressure ulcers, stage 3	46
29	OASIS M1308 = 4+ pressure ulcers, stage 3	58
30	OASIS M1308 = 1 pressure ulcer, stage 4	48
31	OASIS M1308 = 2 pressure ulcers, stage 4	67
32	OASIS M1308 = 3+ pressure ulcers, stage 4	75
33	OASIS M1308 Unstageable Dressing/Device or Unstageable Slough/Eschar = 1+	17
34	OASIS M1332 = 2 (2 stasis ulcers)	6
35	OASIS M1332 = 3 (3 stasis ulcers)	12
36	OASIS M1332 = 4 (4+ stasis ulcers)	21
37	OASIS M1330 = 1 or 3 (unobservable stasis ulcers)	9
38	OASIS M1334 = 1 (status of most problematic stasis ulcer: fully granulating)	6

¹ If episode receives points for diabetic ulcers, it cannot also receive points for “Non-pressure and non-stasis ulcers.”

39	OASIS M1334 = 2 (status of most problematic stasis ulcer: early/partial granulation)	25
40	OASIS M1334 = 3 (status of most problematic stasis ulcer: not healing)	36
41	OASIS M1342 = 2 (status of most problematic surgical wound: early/partial granulation)	4
42	OASIS M1342 = 3 (status of most problematic surgical wound: not healing)	14

ROW	OTHER CLINICAL FACTORS:	Points
43	OASIS M1630=1(ostomy not related to inpt stay/no regimen change)	27
44	OASIS M1630=2 (ostomy related to inpt stay/regimen change)	45
45	Any `Selected Skin Conditions` (rows 1-42 above) AND M1630=1(ostomy not related to inpt stay/no regimen change)	14
46	Any `Selected Skin Conditions` (rows 1-42 above) AND M1630=2(ostomy related to inpt stay/ regimen change)	11
47	OASIS M1030 (Therapy at home) =1 (IV/Infusion)	5
48	OASIS M1610 = 2 (patient requires urinary catheter)	9
49	OASIS M1620 = 4 or 5 (bowel incontinence, daily or >daily)	10

Generating HIPPS Codes

The HH-PPS outputs HIPPS codes for assessments beginning on and after January 1, 2008, using a distinct 5-position, alphanumeric code.

HIPPS Positions

The first position of the HIPPS code is a numeric value that represents the interaction of episode timing and number of therapy visits (grouping step). The second, third, and fourth positions of the code reflect clinical severity, functional severity and service utilization respectively.

Table 7: HIPPS Positions 1 to 4

Position 1: Grouping Step

Episode Sequence	Episode 1 or 2 (Early)		After 2nd Episode (Late)		All Episodes
Total Therapy Visits	0 to 13	14 to 19	0 to 13	14 to 19	20+
HIPPS Value	1	2	3	4	5

Position 2: Clinical Severity Level (By points)

Grouping Step:	1	2	3	4	5	HIPPS Value
C1 (Low)	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7	A
C2 (Moderate)	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14	B
C3 (High)	9+	15+	6+	17+	15+	C

Position 3: Functional Severity Level (By points)

Grouping Step:	1	2	3	4	5	HIPPS Value
F1 (Low)	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6	F
F2 (Moderate)	6	7	9	8	7	G
F3 (High)	7+	8+	10+	9+	8+	H

Position 4: Services Utilization Level (Therapy Visits)

Grouping Step:	1	2	3	4	5	HIPPS Value
S1	0 to 5	14 to 15	0 to 5	14 to 15	20	K
S2	6	16 to 17	6	16 to 17	N/A	L
S3	7 to 9	18 to 19	7 to 9	18 to 19	N/A	M
S4	10	N/A	10	N/A	N/A	N
S5	11 to 13	N/A	11 to 13	N/A	N/A	P

The fifth HIPPS code position indicates a severity group for non-routine supplies (NRS) based upon the scoring of NRS described previously.

Table 8: HIPPS Position 5

Non Routine Supplies	Points	With NRS	No NRS
NRS1	0	S	1
NRS2	1 to 14	T	2
NRS3	15 to 27	U	3
NRS4	28 to 48	V	4
NRS5	49 to 98	W	5
NRS6	99+	X	6

Note: In order to promote more accurate billing of supplies, CMS established a separate set of codes (numbers 1 to 6) for the fifth position of the HIPPS code that is to be submitted on claims for episodes where no supplies were provided. For episodes where supplies were not provided, the HHA must edit the HIPPS code outputted by the HH-PPS and enter the correct final digit before submitting the claim for payment. (See MLN Matters 5746 on <http://cms.hhs.gov> for further details.)

Claim-OASIS Matching String Format

The 18-character claim-OASIS matching string, applicable for claim submissions for episodes beginning on or after January 1, 2008, is required for Medicare claim submissions to identify the OASIS assessment used to generate the HIPPS code and to store OASIS information if a HIPPS code correction is required. The output string from the HH-PPS is entered on a standard UB04 as the Treatment Authorization Code (Field 63). Information contained in this string may be required for calculating payment.

An explanation of the string format is shown in Table 9 with an example shown in Table 10.

Table 9: Claim-OASIS Matching String

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values;
The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic value with 0 or 1 = A, 2 = B, 3 = C, etc and 26+ = Z.

Table 10: Example String

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

The treatment authorization code that should appear on the claim is:
07JK08AA41GBMDCDLG.