

## **New Billing Requirement for Medicare Advantage Organizations**

---

Beginning July 1, 2014, CMS is requiring Medicare Advantage Organizations (MAOs) to submit Health Insurance Prospective Payment System (HIPPS) codes with all of their claims for care delivered to skilled nursing facility (SNF) and home health agency (HHA) patients. It may have an impact on the data SNFs will be required to submit to their plan partners.

### **Overview of New Requirement**

The following is a brief description of the new requirement as outlined in a May 23, 2014, guidance memo from CMS to MAOs:

#### ***HIPPS Codes for SNF Encounters Starting with July 1, 2014 Dates of Service***

CMS is clarifying that for 2014 DOS beginning on or after July 1<sup>st</sup>, MAOs must submit a HIPPS code on a SNF encounter that comes from the initial OBRA-required comprehensive assessment (Admission Assessment). Specifically, SNF encounters with “from” dates July 1, 2014 or after that are submitted without a HIPPS code will be rejected. The OBRA-required tracking records and assessments are federally mandated for all residents of Medicare and/or Medicaid certified SNFs and nursing facilities.

For 2014 encounter data submissions, CMS will not require MAOs to submit HIPPS codes from any other OBRA-required comprehensive or non-comprehensive assessments; we also will not require submission of HIPPS codes for any scheduled or unscheduled SNF Prospective Payment System (PPS) assessments. Nevertheless, we do encourage you to submit the HIPPS codes both from other OBRA assessments and from PPS assessments when available from the providers. We especially encourage submission of the HIPPS code based on the Discharge Assessment, which is based on a OBRA-required assessment.

### **Implications for Providers**

This new requirement may have implications for SNFs. Below are some FAQs we have compiled to help explain what this might mean for providers.

➤ ***Will this require any changes to the way providers submit claims for MA patients?***

It depends. Plan-provider operations are governed primarily by their established contracts. If your contract with a plan already requires submissions of HIPPS codes, then you will likely not need to change your process. However, many plans do not require SNFs to submit this information and this would represent a change. Providers should contact their plans to determine what will be required of them under this new rule.

➤ ***What types of contracts will this primarily impact?***

The implications of this requirement are largely dependent on the type of payment arrangement outlined in plan-provider contracts. For example, if contracted rates are based on RUGs, it means plans already require HIPPS data and nothing will change. However, there are several other types of payment arrangements common between plans and providers (e.g., levels of care, tiers, negotiated per diem, etc.) Under these arrangements, submission of HIPPS codes may or may not be required (they typically are not), but specific requirements should be outlined in plan-provider contracts. Providers should examine their plan contracts closely to understand what is required in when submitting claims.

➤ ***Does this requirement mean increased costs for providers?***

Again, it depends. If HIPPS codes are not already required per the plan-provider contract, then providers may need to perform additional assessments on MA patients. This would mean additional time spent by nursing staff performing assessments. It is recommended that providers try to determine, through internal analysis, what impact the requirement will have on additional nursing hours, and factor this information into contract negotiations.

➤ ***What if my plan hasn't contacted me about this new requirement?***

At AHCA, we have heard from many providers that their plan partners may not necessarily be communicating with them as actively as CMS expects. In these cases, it is recommended that providers proactively engage their plan partners and request further guidance on how to implement this requirement. If plans continue not to communicate with you, CMS encourages you to email them at [encounterdata@cms.hhs.gov](mailto:encounterdata@cms.hhs.gov) and provide them with a summary of the situation and the specific plan in question. CMS is collecting information on plans who are not proactively engaging their provider partners.

➤ ***Which assessments specifically will be required under this new requirement?***

CMS has answered this question directly:

MAOs and other entities must submit HIPPS codes for SNF encounters with DOS on or after July 1, 2014 based on ***the initial OBRA required comprehensive Admission Assessment***. CMS will not require MAOs and other entities to submit HIPPS codes from any other assessments.

Some AHCA members have raised the fact that for short-stay patients residing fewer than 14 days, an OBRA Admission Assessment is not required. CMS has not offered any additional guidance on this issue, but AHCA continues to press them for answers. Please stay tuned for additional information from AHCA as it becomes available.

➤ ***Who should I contact if I run into any issues with plans as a result of this requirement?***

CMS has provided an email inbox for providers to send questions, concerns, and issues to: [encounterdata@chs.hhs.gov](mailto:encounterdata@chs.hhs.gov). Please also feel free to email James Michel at AHCA ([jmichel@ahca.org](mailto:jmichel@ahca.org)) with any questions or to raise any concerns. ***Please email James immediately if you are running into any issues related to payment timeliness and/or increased denials. We will address these issues with CMS directly.***