Wisconsin Medicaid
Nursing Home PDPM Acuity Specific Billing Guidance
Effective 1/1/2022

Topic	Billing Policy
Admission / Discharge Dates	Continue to include admission day and exclude day of discharge
Aligning MDS assessments with billing	Bill the HIPPS code from the MDS assessment starting with the Admission Date or Assessment Reference Date (ARD), as applicable, through the day preceding the next assessment's ARD, unless the assessment is greater than 92 days old. Beginning for 1/1/2022 dates of service, bill using the HIPPS code from the current active assessment. There is no need to complete a new assessment solely due to the policy change or a payor source change.
Late / Missing Assessments	For assessments greater than 92 days old (as measured from the ARD (A2300)), the default HIPPS code ZZZZZ must be billed. Providers will bill the PDPM codes from the active MDS assessment until the resident discharges or the provider needs to bill default codes.
Late Admission Assessment	If the time between admission date (A1600 when A1700=1) and admission ARD (A2300) is greater than 14 days, the default HIPPS code ZZZZZ must be billed for the number of late days. The Admission assessment classifications can be used to determine rates for up to 14 service days prior to the assessment reference date, but no earlier than the admission date. If the admission assessment is 14 days or fewer from the admission entry date, the admission HIPPS code can be used from the entry date.
Medicare PPS assessments: 5-day, Interim Payment Assessments (IPAs)	HIPPS codes from Traditional Medicare PPS assessments (5-day, IPA) may be used in billing for the days that the assessment is active, if the PPS assessment is appropriate. (Chapter 5.1 of the RAI Manual requires that assessments completed for purposes other than OBRA and SNF PPS are not to be submitted.) If a resident receives a 5-day assessment during a Medicare stay and then changes to Medicaid, the 5-day may be used for billing until the next required assessment. Five day assessments shall not be submitted while a resident's primary payor is Medicaid.
Non-PDPM assessments	Medicare Part A Discharge Assessments and Optional State Assessments (OSAs) do not generate valid PDPM HIPPS codes and therefore cannot be used in billing. Assessments submitted only to Medicare Advantage plans may not be used for Medicaid billing.
Short stays	Residents discharged before an assessment is completed must be billed using the default HIPPS code ZZZZZ.
Combined Assessments	HIPPS codes obtained from combined OBRA/PPS assessments are applicable until another assessment is required by the RAI manual.

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Bed hold	Bed hold days under PDPM should continue to be billed using revenue codes 0183 or 0185 and without a HIPPS code. The CMIs applied under PDPM to obtain the fixed per diem rate are: NPG 0.32; NTA 0.23.
Medicaid Managed Care	Please contact the specific HMO or MCO for information.
Entry / Reentry Records	Bill Default HIPPS code ZZZZZ when applicable: **Scenario 1** - **Discharge Return Not Anticipated** (DCRNA) followed by Entry ** Bill the HIPPS code from the admission assessment following entry if A1700 = 1, beginning with entry date (if admission assessment completed within 14 days from admission date) Example: D/10 discharge date 1/15/2022 → Entry Date 1/25/2022 → Admission assessment ARD 2/5/2022 → Bill HIPPS code from admission assessment starting 1/25/2022 ** If No assessment within 14 days of entry followed by a **Discharge return not anticipated record** (D/10) or A1700 = 1 (admission) Example: D/10 discharge date 1/15/2022 → Entry Date 1/25/2022 → no subsequent assessment → HIPPS code ZZZZZ must be billed starting 1/25/2022 **Scenario 2 - Discharge Return Anticipated** (DCRA) followed by Entry within 30 days of discharge. (discharge date plus 30 days) ** Bill the HIPPS code from the assessment preceding discharge if D/11 followed by entry within 30 days and A1700 = 2 (reentry), until ARD of next assessment (or until the assessment is 92 days old). Example: 1/5/2022 OBRA assessment → D/11 discharge date 1/15/2022 → Reentry Date 1/25/2022 → Bill HIPPS code from 1/5/2022 OBRA assessment starting 1/25/2022 **Scenario 3 - Discharge Return Anticipated** (DCRA) followed by Entry greater than 30 days after discharge. (Discharge date plus 31 or more days) ** If No assessment within 14 days of entry followed by a Discharge return anticipated record (D/11), and there were more than 30 days between discharge and reentry Example: D/11 discharge date 1/15/2022 → Entry Date 2/25/2022 → no subsequent assessment → HIPPS code ZZZZZ must be billed starting 2/25/2022

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HIPPS Billing Guidance	HIPPS codes used in PDPM billing consist of 5 digits and are based on the PDPM components calculated from the MDS. All 5 characters of the assessment's HIPPS code need to be entered on the claim to be considered valid. *The 5-character HIPPS code requirement is specific to Medicaid billing submission; this does not affect HIPPS reporting on the MDS to CMS. For example, the MDS requires a four-character HIPPS code for OBRA assessments, but the HIPPS code on the claim submitted to Medicaid must be five characters.* The Nursing Payment Group and NTA Payment Group will receive case mix adjustments. The 5 character HIPPS code is also coded on item Z0100 (Medicare Part A HIPPS code) on the MDS. MDS items Z0200 (State Medicaid Billing) and Z0250 (Alternate State Medicaid Billing) are optional and are not required to be completed. Character 1 – Physical Therapy / Occupational Therapy Payment Group A through P Character 2 – Speech Language Pathology Payment Group A through L Character 3 – Nursing Payment Group A through Y Character 4 – Non Therapy Ancillary (NTA) Payment Group A through F Character 5 – Assessment Indicator 0: Interim Payment Assessment (IPA) 1: PPS 5-day Scheduled Assessment 6: OBRA Assessment Default Code - ZZZZZ