Anthem Blue Cross and Blue Shield

HIPPS Codes Required for All Skilled Nursing and Home Health Providers

Starting July 1, 2014 all claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received by Anthem Blue Cross and Blue Shield (Anthem) Medicare Advantage, must contain a valid HIPPS code. **This pertains to both Contracted and Non-Contracted Providers.** Anthem understands that in the past we did not require these codes from all of our Contracted Providers, however CMS now requires that we must include this information on all processed claims data we submit to CMS. As a result, all SNF and HHA claims for services rendered on or after July 1st that are sent to Anthem without the valid HIPPS code may be denied and sent back to the provider.

What and How to Bill

- SNFs should bill the HIPPS code derived from the “Admission Assessment”
- HHAs should bill the HIPPS code derived from the “Start of Care Assessment”
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable PPS Revenue Code (022 or 023), the HIPPS code, 1 unit, and billed charges of 0.00.

Additional Information

- This billing instruction applies to all Medicare Advantage Plans including Dual Eligible Special Needs Plans. But does not, however, apply to Medicare Supplemental Plans.
- HHAs are not required to bill Treatment Authorization Codes.
- If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your payment.