Line 8 – HIPPS Coding

Character 1: PT/OT Payment Group
Character 2: SLP Payment Group
Character 3: Nursing Payment Group
Character 4: NTA Payment Group
Character 5: Assessment Indicator

PT/OT, SLP, NTA Payment Groups to HIPPS Translation

PT/OT Payment Group	SLP Payment Group	NTA Payment Group	HIPPS Character
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

Nursing Payment Group to HIPPS Translation

Nursing Payment Group	HIPPS Character	Nursing Payment Group	HIPPS Character
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		

Assessment Indicator (AI) Crosswalk

HIPPS Character	Assessment Type
0	IPA
1	PPS 5-day
6	OBRA Assessment not coded as a PPS Assessment

Line 15 – Primary Diagnosis

FY2025 PDPM ICD-10 Mapping (ZIP) (effective 10-01-2024)

– Avoid Return to Provider codes

Line 19 – Extensive Services

Line 20 – Tracheostomy

- **O0110E1, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs *their* own tracheostomy care. *This item includes laryngectomy tube care.*

Line 21 – Ventilator/Respirator

- **O0110F1, Invasive Mechanical Ventilator (ventilator or respirator)**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) **unable to support *their* own respiration** in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

Example: *Resident* J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day *while a resident*, because of an irreversible neurological injury and inability to breathe on *their* own. O0110F*1b* should be checked, as *Resident* J is using an invasive mechanical ventilator because *they are* unable to initiate spontaneous breathing on *their* own and the ventilator is controlling *their* breathing.

- **O0110G1, Non-invasive Mechanical Ventilator**

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support *their* own spontaneous respiration** by providing enough pressure when the individual inhales to keep *their* airways open, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes *their* own BiPAP/CPAP mask/device.

  - ***O0110G2, BiPAP***

    Check if the non-invasive mechanical ventilator support was BiPAP.

  - ***O0110G3, CPAP***

    Check if the non-invasive mechanical ventilator support was CPAP.

Line 22 – Isolation

- **O01*1*0M*1*, Isolation *or quarantine* for active infectious disease (does not include standard *body/fluid* precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "single room isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in *their* room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O01*1*0M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, Section 2.6, 03. Significant Change in Status Assessment (SCSA) (A0310A = 04). Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's plan of care will likely need to be completed.

Line 25 – Function Score

		Section GG Item
Eating	GG0130A1	Self-care: Eating
Oral Hygiene	GG0130B1	Self-care: Oral Hygiene
Toileting Hygiene	GG0130C1	Self-care: Toileting Hygiene
Bed Mobility	GG0170B1	Mobility: Sit to lying
	GG0170C1	Mobility: Lying to sitting on side of bed
Transfer	GG0170D1	Mobility: Sit to stand
	GG0170E1	Mobility: Chair/bed-to-chair transfer
	GG0170F1	Mobility: Toilet transfer
Walking	GG0170J1	Mobility: Walk 50 feet with 2 turns
	GG0170K1	Mobility: Walk 150 feet

All items scored by PT/OT. Green items scored by nursing.

Performance options:

- Independent
- Set-up assistance
- Supervision or touching assistance
- Partial/moderate assistance
- Substantial/maximal assistance
- Dependent
- Refused
- N/A
- Not attempted

Line 38 - Cognition

BIMS Scoring

- C0500 – BIMS Summary Score
  - Add scores for questions C0200-C0400 and fill in total score (00-15)
    - 13-15: cognitively intact
    - 8-12: mildly impaired
    - 0-7: moderately impaired
    - 0: severe impairment

Line 45 – Swallowing Disorder

Line 52 – Nutritional Approaches

Line 55 – SLP Comorbidity

Line 70 – NTA Comorbidity Score

Line 73 and Line 76 – High and Low Level Parenteral IV Feeding

K0520: Nutritional Approaches

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***
   Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

		1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
		↓ Check all that apply ↓			
A.	**Parenteral/IV feeding**	☐	☐	☐	☐
B.	**Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C.	**Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	[redacted]	☐	☐
D.	**Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z.	**None of the above**	☐	☐	☐	☐

Percentage of Intake by Artificial Route (also qualifiers for Nursing RUGs and impact the NTA score)

- High intensity parenteral feeding (≥ 51% of total calories) (7 points)
- Low intensity parenteral feeding (26-50% of total calories and average fluid intake per day by IV or tube feeding was 501 cc/day) (5 points)

Line 74 – IV Medication Post-Admit

- **O0110H1, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Lactated Ringers given IV *is* not considered *a* medication and should not be coded here.
Resources and tools providing information on medications are available in Section N of this manual (see the end of item N0415 following the Example).

  - ***O0110H2, Vasoactive medications***

    Check when at least one of the IV medications was an IV vasoactive medication.

  - ***O0110H3, Antibiotics***

    Check when at least one of the IV medications was an IV antibiotic.

  - ***O0110H4, Anticoagulation***

    Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

  - ***O0110H10, Other***

    Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

Line 78 – Transfusion

- **O0110I1, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

Line 80 – Active Diagnoses
Active Diagnoses = Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Line 98 – Radiation

- **O0110B1, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

Line 103 – Other Foot Skin Problems

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓	Check all that apply
	Foot Problems
☐	A. **Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	B. **Diabetic foot ulcer(s)**
☐	C. **Other open lesion(s) on the foot**
	Other Problems
☐	D. **Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	E. **Surgical wound(s)**
☐	F. **Burn(s)** (second or third degree)
☐	G. **Skin tear(s)**
☐	H. **Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	Z. **None of the above** were present

Line 108 – Suctioning

- **O0110D1, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs *their* own tracheal and/or nasopharyngeal suctioning.

- ***O0110D2, Scheduled***

  Check if suctioning was scheduled. Scheduled suctioning is performed when the resident is assessed as clinically benefiting from regular interventions, such as every hour or once per shift. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, and guidelines.

- ***O0110D3, As needed***

  Check if suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted or a sudden desaturation occurs from a mucus plug.

Line 124 – Resident Mood Interview

Line 125 – PHQ-2 to D9 Scoring

D0160: Total Severity Score

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

Item Rationale

Health-related Quality of Life

- *The **Total Severity Score** is a summary of the frequency scores on the PHQ-2 to 9© that indicates the extent of potential depression symptoms.*
- The ***Total Severity Score*** does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up.

Planning for Care

- The PHQ-*2 to* 9© **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.
- *Responses to PHQ-2 to 9© can indicate possible depression if the full PHQ-2 to 9© is completed (i.e., interview is not stopped after D0150B due to responses). Responses can be interpreted as follows:*
  - *Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the assessment period.*

D0160: Total Severity Score (cont.)

- *Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the assessment period.*
- *In addition, PHQ-2 to 9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:*

  1-4: minimal depression
  5-9: mild depression
  10-14: moderate depression
  15-19: moderately severe depression
  20-27: severe depression

Line 126 – PHQ-9-OV Scoring (Staff Assessment of Resident Mood)

D0600: Total Severity Score changes

- **Can be interpreted as follows:**
  - 1-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-30: severe depression

Line 128 – Conditions/Services that can Impact Nursing Category

Line 131 to 133 – Behavioral Symptoms

E0200: Behavioral Symptom—Presence & Frequency

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Enter Code ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)

Enter Code ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)

Enter Code ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Line 134 – Rejection of Care

E0800: Rejection of Care—Presence & Frequency

E0800. Rejection of Care - Presence & Frequency

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Line 135 – Wandering

E0900: Wandering—Presence & Frequency

E0900. Wandering - Presence & Frequency

Has the resident wandered?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Line 148 – Weight Loss

K0300: Weight Loss

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

Line 158 and 159 – Skin and Ulcer/Injury Treatments

M1200: Skin and Ulcer/Injury Treatments

M1200. Skin and Ulcer/Injury Treatments	
↓	Check all that apply
☐	A. **Pressure reducing device for chair**
☐	B. **Pressure reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention** to manage skin problems
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	H. **Applications of ointments/medications** other than to feet
☐	I. **Application of dressings to feet** (with or without topical medications)
☐	Z. **None of the above** were provided

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment. If it is determined that nutritional supplementation, that is, adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.
- It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M1200E, Pressure ulcer/injury care.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include, but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

Line 160 – Application of Dressings to the Feet

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer/injury**.
- Do **not** code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Line 174 – Restorative Nursing

Line 186 – Facility Location