THE INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) TRAINING MANUAL:

EFFECTIVE 10/01/2012

For patient assessments performed when a patient is discharged on or after October 1, 2012, the IRF-PAI Training Manual: Effective 10/01/2012 is the version of the manual that must be used when performing the patient assessment and recording that assessment data on the IRF-PAI.

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CMS Help Desk:

For all questions related to recording data on the IRF patient assessment instrument (IRF-PAI) or using the Inpatient Rehabilitation Validation Entry (IRVEN) Software:

Phone: 1-800-339-9313
Fax: 1-888-477-7871
Email: HELP@QTSO.COM
Coverage Hours: 8:00am (ET) to 8:00pm (ET) Monday through Friday

Please note: When sending an email, to receive priority, please include 'IRF Clinical' in the subject line.

Toll-Free Customer Service for IRF billing/payment questions:

See link below to the Medicare Learning Network. A document on that page provides toll-free customer service numbers for the fiscal intermediaries and Medicare Administrative Contractors (MACs).

http://www.cms.gov/MLNGenInfo/

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SECTION I
INTRODUCTION AND BACKGROUND INFORMATION

The purpose of this manual is to guide the user to complete the Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI), which is required by the Centers for Medicare & Medicaid Services (CMS) as part of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The IRF-PAI is used to gather data to determine the payment for each Medicare Part A fee-for-service patient admitted to an inpatient rehabilitation unit or hospital. This instrument will be completed for every Medicare patient discharged on or after the IRF PPS implementation date of January 1, 2002.

Background Information:

- Medicare statute was originally enacted in 1965 providing for payment for hospital inpatient services based on the reasonable costs incurred to Medicare beneficiaries.

- The statute was amended in 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA), which limited payment by placing a limit on deliverable costs per discharge.

- Social Security Amendments of 1983 established a Medicare prospective payment system for the operating costs of a hospital stay based on Diagnostic Related Groups (DRGs).
    - The following hospitals and hospital units are excluded from inpatient hospital DRG-based PPS:
        - Children's Hospitals
        - Psychiatric Hospitals
        - Long-term Hospitals
        - Rehabilitation Hospitals
        - Distinct part Psychiatric and Rehabilitation units of general acute care hospitals that are subject to PPS; and
        - Cancer Hospitals

- TEFRA remained the payment system for inpatient rehabilitation hospitals and distinct part rehabilitation units from 1982 - 2001. TEFRA payments are based upon costs during a base period, which resulted in inequities in payment between older and newer facilities.

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- The desire to control rapid growth of rehabilitation facilities and eliminate inequities in Medicare payments led to Congressional action:
    - Balanced Budget Act (BBA) of 1997
    - Balanced Budget Refinement Act (BBRA) of 1999
        - Provisions for implementation of a Prospective Payment System
        - Current implementation date of January 1, 2002

- Research began in an effort to develop a Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities:
    - 1984: the FIM™ instrument was developed to address the functional status measurement issue

    - 1987: RAND and the Medical College of Wisconsin investigated PPS
        - Diagnoses alone explained little of variance in cost
        - Functional status explained more of total costs for rehabilitation patients

    - 1993: Functional Related Groups (FRGs) concept developed by N. Harada and colleagues at VA Medical Center in Los Angeles as possible basis for rehabilitation prospective payment

    - 1994: FRGs concept refined and applied by M. Stineman and colleagues from the University of Pennsylvania to large rehabilitation database for use as a patient classification system

    - 1994: RAND commissioned to study the stability of the FRGs and their performance related to cost rather than length of stay.

    - 1997: RAND finds:
        - FRGs remained stable over time.
        - Explained 50% of patient costs and 65% of facility costs.
        - FRGs could be used as a case mix methodology to establish a PPS.

- 1997: Prospective Payment Assessment Commission (ProPAC) reports to Congress:
        - Implement IRF-PPS as soon as possible.
        - FIM-FRGs could be an appropriate basis for PPS.

- 1997: Health Care Financing Administration (HCFA) published the criteria for PPS.

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- As a result, the Secretary of Health and Human Services:
  - Established Case Mix Groups (CMGs) and the method to classify patients within these groups.
  - Required inpatient rehabilitation facilities to submit data to establish and administer the PPS.
  - Provided a computerized data system to group patients for payment.
  - Provided software for data transmission.
  - Recommended that the Medicare claim form (discharge) contain appropriate CMG codes so that prospective payment system could begin.

- 2001: Centers for Medicare & Medicaid (CMS), formerly HCFA, established a patient assessment instrument following a comparison study of two proposed instruments.

- 2001: Final Rule for the inpatient rehabilitation PPS was published.

- In order to be paid under the IRF PPS, the DRG exclusion criteria for rehabilitation facilities state:
  - Medicare must have a provider agreement (as a unit or hospital)
  - The hospital must provide intensive multidisciplinary inpatient rehabilitation services to an inpatient population that includes patients being treated for:
    1. Stroke
    2. Congenital deformity
    3. Spinal cord injury
    4. Amputation
    5. Brain injury
    6. Major multiple trauma
    7. Hip fracture
    8. Burns
    9. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
    10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

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11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)
13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
    I. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
    II. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
    III. The patient is age 85 or older at the time of admission to the IRF.

- These diagnoses must make up 60% of the population and patient services will include: physician monitoring and some rehabilitation nursing, therapies, psychosocial and orthotic and prosthetic services.

The paper or electronic version of the patient assessment instrument illustrated in Appendix E (IRF-PAI) is the instrument that must be used to collect patient assessment data, which the software in the electronic version of the IRF-PAI will use to classify a patient into a CMG. The CMG determines the amount an IRF may be paid for the services it furnished to a Medicare patient.

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Note regarding revisions, refinements and updates:

This manual is a guide and is expected to change over time as the PPS is refined. These changes will include, but will not be limited to, changes that will result from research supporting this PPS, legislation, and refinements. Please refer to the following web site to obtain the most recent updates:
http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage.

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SECTION II

ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Item Completion

Admission and discharge IRF-PAI items must be completed before data records are transmitted to the Centers for Medicare & Medicaid Services (CMS). Completion of Items 1 to 24 and 29 to 47 is mandatory. Completion of the items in the Medical Needs section (Items 25 through 28) is not currently required, but may be voluntarily completed. Completion of the items in the Quality Indicators section (Items 48A through 50D) is not currently required; however, failure to complete such items may result in payment reductions of two percentage points starting in FY 2014. The CMS data system will accept a record if the Medical Needs and/or Quality Indicators items are not completed. For the remaining IRF-PAI items, missing or invalid data entered into the data collection software may cause a record to be rejected by CMS.

The federal regulations require that data must be collected and entered into the data collection software (i.e., encoded) by specified time periods. An inpatient rehabilitation facility may change the IRF-PAI data at any time before transmitting the data, but only if the data were entered incorrectly.

Item Completion When A Patient Has A Stay That Is Less Than 3 Calendar Days

If the patient's stay is less than 3 calendar days in length, the staff of the rehabilitation facility must complete the IRF-PAI admission items but do not have to complete all of the discharge IRF-PAI items. However, for the discharge assessment an IRF must complete all of the functional modifiers and FIM instrument items. The IRF is required to collect information and record it on the IRF-PAI as completely as possible. Although data collection for a patient whose stay is less than 3 calendar days in length may be more difficult, particularly the discharge assessment, codes of "0" may be used if necessary for certain function modifiers (See Overview For Use of Code "0" on page 8 of Section III of this manual). When coding the discharge assessment for a patient whose stay is less than 3 calendars days, it is possible that the discharge FIM scores may be same as the admission FIM scores. However, if a code of "0" was used on admission, then the corresponding FIM item should be scored with a "1" at discharge.

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The correct date for Item 13, Admission Assessment Reference Date, is typically the 3rd calendar day of the stay. If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).

Examples Illustrating the Assessment and Discharge Assessment Schedules

(The following examples apply to patients whose stay is at least 3 calendar days)

Charts 1 and 2 below illustrate the assessment, coding, and data transmission dates for the IRF-PAI admission assessment. Charts 1 and 2 are similar to, but are updated versions of the charts that appear on pages 41330 and 41331 of the Final Rule entitled "Medicare Program; Prospective Payment System for Inpatient Rehabiliation Facilities; Final Rule." That Final Rule was published in the Federal Register, Volume 66, Number 152, on Tuesday August 7, 2001. **NOTE:** For more information regarding the admission and discharge assessments, please refer to the IRF PPS Final Rules and other CMS publications, such as program memoranda, for authoritative guidance. The CMS publications related ot the IRF PPS can be located at the CMS IRF PPS website: https://www.cms.gov/InpatientRehabFacPPS/

Chart 1. - Patient Assessment Instrument Admission Assessment Schedule of Dates

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By	Payment Time Covered By This Assessment	Patient Assessment Data Must Be Encoded By	Patient Assessment Instrument Data Must Be Transmitted By
Admission Assessment	First 3 Calendar Days	Day 3*	Day 4	Entire Medicare Stay Time Period	Day 10	See ** Below For How To Calculate This Date

*In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

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Chart 2. - Example Applying the Patient Assessment Instrument Admission Assessment Schedule of Dates

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By	Payment Time Covered By This Assessment	Patient Assessment Data Must Be Encoded By	Patient Assessment Instrument Data Must Be Transmitted By
Admission Assessment	10/4/11 to 10/6/11	10/6/11*	10/7/11	Entire Medicare stay time period	10/13/11	See ** Below For How To Calculate This Date

*In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

Chart 3 below illustrates how to determine the assessment, coding, and data transmission dates for the IRF-PAI discharge assessment. Chart 3 is similar to, but is an updated version of a chart that appears on page 41332 of the August 7, 2001 Final Rule and on page 45683 of the August 1, 2003, Final Rule entitled "Medicare Program; Changes to the Inpatient Rehabilitation Facility Prospective Payment System and Fiscal Year 2004 Rates; Final Rule." The August 1, 2003, Final Rule was published in the Federal Register, Volume 68, Number 148. Chart 3 illustrates that CMS will determine that the IRF-PAI data was not transmitted late if it is transmitted no later than 27 calendar days from the day the patient is discharged. **NOTE:** The discharge day is counted as one of the 27 calendar days, and the 27 calendar day time span also includes the 10 calendar days specified in §412.614(d)(2). Also, the meaning of the term "discharge day," which is one of the days counted in the 27 calendar day time span, is the day defined according to the revised definition of "discharge" specified in §412.602 as stipulated in the August 1, 2003 Final Rule. In some cases, that may be different from the dicharge assessment reference day specificed in §412.610(c)(2)(ii).

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Chart 3. - Example Applying the Patient Assessment Instrument Discharge Assessment Schedule of Dates

Assessment Type	Discharge Date*	Assessment Reference Date	Patient Assessment Instrument Must Be Completed On**	Patient Assessment Instrument Data Must Be Encoded By	Date When Patient Assessment Instrument Data Transmission Is Late
Discharge Assessment	10/16/11	10/16/11*	10/20/11	10/26/11	11/12/11***

* In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**This is the last day by when the discharge patient assessment must be completed. However, this does not prohibit discharge patient assessment data from being recorded on the patient assessment instrument prior to this date.
***Or any day after 11/12/11.

Identification Information

1. **Facility Information (A, B):**
   A. **Facility Name:** Enter the full name of the facility.
   B. **Facility Medicare Provider Number:** Enter the Facility Medicare Provider Number assigned by the Centers for Medicare & Medicaid Services (CMS), using the same digit/letter sequence as assigned.

2. **Patient Medicare Number:** Enter the patient's Medicare Number (Part A). Verify the number through the business office.

3. **Patient Medicaid Number:** Enter the patient's Medicaid Number. Verify the number through the business office.

4. **Patient First Name:** Enter the patient's first name.

5A. **Patient Last Name:** Enter the patient's last name.

5B. **Patient Identification Number:** Enter the patient's medical record number or other unique identifier.

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6. Birth Date: Enter the patient's birthdate. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)* , and *YYYY* is the full year (e.g., 1938).

7. Social Security Number: Enter the patient's Social Security Number. Verify the number with the patient and/or business office.

8. Gender: Enter the patient's gender as:

1 Male
2 Female

9. Race/Ethnicity: Check all that apply.

A. American Indian or Alaska Native
B. Asian
C. Black or African American
D. Hispanic or Latino
E. Native Hawaiian or Other Pacific Islander
F. White

10. Marital Status: Enter the patient's marital status at the time of admission.

1 Never Married
2 Married
3 Widowed
4 Separated
5 Divorced

11. Zip Code of Patient's Pre-Hospital Residence: Enter the 5-digit zip code of the patient's pre-hospital residence.

Admission Information

12. Admission Date: Enter the date that the patient begins receiving covered Medicare services in an inpatient rehabilitation facility. Typically, this will coincide with the date that the patient was first admitted to the rehabilitation facility. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31*), and *YYYY* is the full year (e.g., *2011*).

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13. Assessment Reference Date: This is the 3rd calendar day of the rehabilitation stay, which represents the last day of the 3-day admission assessment time period. These 3 calendar days are the days during which the patient's clinical condition should be assessed. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31),* and *YYYY* is the full year (e.g., *2011*).

Example: If Admission Date is 07/04/11, then the Assessment Reference Date is 07/06/11.

14. Admission Class: Enter the admission classification of the patient, as defined below:

1. **Initial Rehabilitation** – This is the patient's first admission to any inpatient rehabilitation facility for this impairment.

2. **Evaluation** – This is a pre-planned stay of fewer than 10 days on the rehabilitation service for evaluation. (Do not use this code for a rehabilitation stay that is **completed** in fewer than 10 days.)

3. **Readmission -** This is a stay in which the patient was previously admitted to an inpatient rehabilitation facility for this impairment, but is **NOT** admitted to the current rehabilitation program DIRECTLY from another rehabilitation program.

4. **Unplanned Discharge** - This is a stay that lasts less than 3 calendar days because of an unplanned discharge (e.g., due to a medical complication). If the patient stays less than 3 calendar days, see the first page of Section II for item completion instructions.

5. **Continuing Rehabilitation -** This is part of a rehabilitation stay that began in another rehabilitation program. The patient was admitted directly from another inpatient rehabilitation facility.

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15. Admit From: Enter the setting from which the patient was admitted to rehabilitation.*

01 **Home** - A private, community-based dwelling (a house, apartment, mobile home, etc.) that houses the patient, family, or friends.

02 **Board & Care** - A community-based setting where individuals have private space (either a room or apartment), or a structured retirement facility. The facility may provide transportation, laundry, and meals, but no nursing care.

03 **Transitional Living** - A community-based, supervised setting where individuals are taught skills so they can live independently in the community.

04 **Intermediate Care (nursing home)** - A long-term care setting that provides health-related services, but a registered nurse is not present 24 hours a day. Patients live by institutional rules; care is ordered by a physician, and a medical record is maintained. Patients in intermediate care are generally less disabled than those in skilled care facilities.

05 **Skilled Nursing Facility (nursing home)** - A long-term care setting that provides skilled nursing services. A registered nurse is present 24 hours a day. Patients live by institutional rules; care is ordered by a physician, and a medical record is maintained.

06 **Acute Unit of Own Facility** - An acute medical/surgical care unit in the same facility as the rehabilitation unit.

07 **Acute Unit of Another Facility** - An acute medical/surgical care facility separate from the rehabilitation unit.

08 **Chronic Hospital** - A long-term care setting classified as a hospital.

09 **Rehabilitation Facility** - An inpatient setting that admits patients with specific disabilities and provides a team approach to comprehensive rehabilitation services, with a physiatrist (or physician of equivalent training/experience) as the physician of record.

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10 **Other** - Used only if no other code is appropriate (e.g., prison/correctional facility, homeless shelter, residential substance abuse treatment facility).

12 **Alternate Level of Care (ALC) Unit** - A physically and fiscally distinct unit that provides care to individuals who no longer meet acute care criteria.

13 **Subacute Setting**† - Subacute care is goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalization to treat one or more specific active, complex medical conditions and overall situation. Generally, the condition of an individual receiving subacute care is such that the care does not depend heavily on high-technology monitoring or complex diagnostic procedures. Subacute care requires the coordinated services of an interdisciplinary team, including physicians, nurses, and other relevant professional disciplines who are knowledgeable and trained to assess and to manage these specific conditions and perform the necessary procedures. Subacute care is given as part of a specifically defined program, regardless of site. Subacute care is generally more intensive than traditional nursing home care but less than acute inpatient care. It requires frequent (daily to weekly) patient assessment and review of the clinical course and treatment plan for a limited time period (several days to several months), until a condition is stabilized or a predetermined course is completed.

14 **Assisted Living Residence**‡- A community-based setting that combines housing, private quarters, freedom of entry and exit, supportive services, personalized assistance, and healthcare designed to respond to individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours a day to meet scheduled and unscheduled needs in a way that promotes maximum dignity and independence for each resident. These services involve the resident's family, neighbors, and friends.

† **Source: Joint Commission on Accreditation of Health Care Organizations**
‡ **Source: Assisted Living Facilities of America**

*Note: Some of the labels and definitions listed in Item 15, such as Subacute Setting, do not correspond to labels and definitions recognized by CMS. Nevertheless, since these labels and definitions have been used historically by the field of rehabilitation, it is important that the IRF-PAI item, Admit From (Item 15), be coded using the codes listed above.

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16. Pre-Hospital Living Setting: Enter the setting where the patient was living prior to being hospitalized. See **Item 15** (Admit From) for definitions of codes.

01 Home
02 Board & Care
03 Transitional Living
04 Intermediate Care (nursing home)
05 Skilled Nursing Facility (nursing home)
06 Acute unit of your own facility
07 Acute unit of another facility
08 Chronic Hospital
09 Rehabilitation Facility
10 Other
12 Alternate Level of Care (ALC) unit
13 Subacute Setting
14 Assisted Living Residence

17. Pre-Hospital Living With: Complete this item *only* if you selected code 01 (Home) in Item 16 (Prehospital Living Setting). Enter the relationship of any individuals who resided with the patient prior to the patient's hospitalization. If more than one person qualifies, enter the first appropriate category on the list.

1 Alone
2 Family/Relatives
3 Friends
4 Attendant
5 Other

18. Pre-Hospital Vocational Category: Indicate whether the patient was employed, a student, a homemaker, or retired prior to hospitalization for the current condition. If more than one category applies, enter the first appropriate code on the list. EXCEPTION: If the patient is retired (usually 60 years of age or older) and receiving retirement benefits, enter code 6 - Retired for Age.

1 **Employed** - The patient works for pay in a competitive environment or is self-employed.

2 **Sheltered** - The patient works for pay in a non-competitive environment.

3 **Student** - The patient is enrolled in an accredited school (including trade school), college, or university.

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4 **Homemaker** - The patient works at home, does not work outside the home, is not paid by an employer, and is not self-employed.

5 **Not Working** - The patient is unemployed, but is not retired or receiving disability benefits.

6 **Retired for Age** - The patient is retired (usually 60 years of age or older) and is receiving retirement benefits.

7 **Retired for Disability** - The patient is receiving disability benefits and is less than 60 years of age.

19. Pre-Hospital Vocational Effort: Complete this item *only* if Item 18 (Pre-Hospital Vocational Category) is coded 1 through 4. Enter the patient's vocational effort prior to hospitalization for the current condition.

1 **Full-time** - The patient worked a full schedule (e.g., 37.5 or 40 hours per week - whichever is normal where (s)he works).

2 **Part-time** - The patient worked less than full time (e.g., less than 37.5 or 40 hours per week, depending on the norm where (s)he works).

3 **Adjusted Workload** - The patient's workload was adjusted due to disability. The patient was not able or expected to perform all the work duties of the position.

Payer Information

20. Payment Source: Enter the source of payment for inpatient rehabilitation services. Enter the appropriate category for both primary and secondary source of payment. **Note:** Medicare regulations require completion of the IRF-PAI for patients admitted to an inpatient rehabilitation facility who are covered under the Medicare Part A fee-for-service program or enrolled in a Medicare Advantage plan (Medicare MCO) as the primary payor source. If you think there is any possibility that the patient may become eligible for Medicare Part A fee-for-service payment during the stay, complete the IRF-PAI.

Code "02" indicates original Medicare Part A fee-for-service as a payer source for IRF-PAI Item 20. The IRF-PAI data transmission system will reject the transmission of an IRF-PAI record if either Medicare Part A fee-for-service or Medicare MCO (code "51") is not recorded in either Item 20A or Item 20B.

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Therefore, if Medicare Part A fee-for-service becomes responsible for paying all or part of a claim, the IRF-PAI must be completed and transmitted with code "02" or "51" appropriately recorded in Item 20A or Item 20B. **Note:** Item 20A can't be coded "02" or "51" **if** Item 20B is also coded "02" or "51." Similarly, Item 20B can't be coded "02" or "51" **if** Item 20A is also coded "02" or "51."

Payment Source (Item 20) Continued:

A. **Primary Source**
B. **Secondary Source**

Code each source according to the following list:

01 **Blue Cross** (Fee for service)
02 **Medicare non-MCO** (non-Managed Care Organization/fee-for-service)
03 **Medicaid non-MCO** (non-Managed Care Organization/fee-for-service)
04 **Commercial Insurance**
05 **MCO HMO** (Managed Care Organizations, including Health Maintenance Organizations and Preferred Provider Organizations)
06 **Workers' Compensation**
07 **Crippled Children's Services**
08 **Developmental Disabilities Services**
09 **State Vocational Rehabilitation**
10 **Private Pay**
11 **Employee Courtesy**
12 **Unreimbursed** (Use only for 20.A. - Primary Source)
13 **CHAMPUS**
14 **Other**
15 **None** (Use only for 20.B. - Secondary Source)
16 **No-Fault Auto Insurance**
51 **Medicare MCO (**Managed Care Organization, including Medicare+Choice)
52 **Medicaid MCO (**Managed Care Organization)

Medical Information

21. Impairment Group: For the admission assessment, enter the code that best describes the primary reason for admission to the rehabilitation program (Codes for this item are listed following this explanation, and also in Appendix A: Impairment Group Codes). Each Impairment Group Code (IGC) consists of a two-digit number (indicating the major Impairment Group) followed by a

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decimal point and 1 to 4 additional digits identifying the subgroup. Exceptions to this general format are Impairment Group Codes 09, 11, 13, 15, and 16, which have no subgroups, and therefore no decimal places. **Please be sure to code as specifically as possible to ensure appropriate Case Mix Group assignment.** Whenever possible, avoid use of Impairment Code 13 – Other Disabling Impairments.

For most patients, the IGC at discharge will be the same code as the admission IGC. If, during the inpatient rehabilitation Medicare-covered stay, the patient develops another impairment that uses more resources than the admission impairment, record the second IGC at discharge.

The Case Mix Group (CMG) assigned for payment depends upon the IGC at admission, and is NOT affected by the discharge IGC. The second impairment should be coded as a Comorbid Condition, and may affect payment for the stay as described in the comorbidity policies published in the Final Rule.

Listing of Impairment Group Codes (IGCs) for Item 21:

Stroke

01.1	Left Body Involvement (Right Brain)
01.2	Right Body Involvement (Left Brain)
01.3	Bilateral Involvement
01.4	No Paresis
01.9	Other Stroke

Brain Dysfunction

02.1	Non-traumatic
02.21	Traumatic, Open Injury
02.22	Traumatic, Closed Injury
02.9	Other Brain

Neurologic Conditions

03.1	Multiple Sclerosis
03.2	Parkinsonism
03.3	Polyneuropathy
03.4	Guillain-Barré Syndrome
03.5	Cerebral Palsy
03.8	Neuromuscular Disorders
03.9	Other Neurologic

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Spinal Cord Dysfunction, Non-traumatic

04.110	Paraplegia, Unspecified
04.111	Paraplegia, Incomplete
04.112	Paraplegia, Complete
04.120	Quadriplegia, Unspecified
04.1211	Quadriplegia, Incomplete C1-4
04.1212	Quadriplegia, Incomplete C5-8
04.1221	Quadriplegia, Complete C1-4
04.1222	Quadriplegia, Complete C5-8
04.130	Other Non-Traumatic Spinal Cord

Spinal Cord Dysfunction, Traumatic

04.210	Paraplegia, Unspecified
04.211	Paraplegia, Incomplete
04.212	Paraplegia, Complete
04.220	Quadriplegia, Unspecified
04.2211	Quadriplegia, Incomplete C1-4
04.2212	Quadriplegia, Incomplete C5-8
04.2221	Quadriplegia, Complete C1-4
04.2222	Quadriplegia, Complete C5-8
04.230	Other Traumatic Spinal Cord Dysfunction

Amputation

05.1	Unilateral Upper Limb Above the Elbow (AE)
05.2	Unilateral Upper Limb Below the Elbow (BE)
05.3	Unilateral Lower Limb Above the Knee (AK)
05.4	Unilateral Lower Limb Below the Knee (BK)
05.5	Bilateral Lower Limb Above the Knee (AK/AK)
05.6	Bilateral Lower Limb Above/Below the Knee (AK/BK)
05.7	Bilateral Lower Limb Below the Knee (BK/BK)
05.9	Other Amputation

Arthritis

06.1	Rheumatoid Arthritis
06.2	Osteoarthritis
06.9	Other Arthritis

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Pain Syndromes

07.1	Neck Pain
07.2	Back Pain
07.3	Limb Pain
07.9	Other Pain

Orthopaedic Disorders

08.11	Status Post Unilateral Hip Fracture
08.12	Status Post Bilateral Hip Fractures
08.2	Status Post Femur (Shaft) Fracture
08.3	Status Post Pelvic Fracture
08.4	Status Post Major Multiple Fractures
08.51	Status Post Unilateral Hip Replacement
08.52	Status Post Bilateral Hip Replacements
08.61	Status Post Unilateral Knee Replacement
08.62	Status Post Bilateral Knee Replacements
08.71	Status Post Knee and Hip Replacements (Same Side)
08.72	Status Post Knee and Hip Replacements (Different Sides)
08.9	Other Orthopaedic

Cardiac Disorders

09	Cardiac

Pulmonary Disorders

10.1	Chronic Obstructive Pulmonary Disease
10.9	Other Pulmonary

Burns

11	Burns

Congenital Deformities

12.1	Spina Bifida
12.9	Other Congenital

Other Disabling Impairments

13	Other Disabling Impairments

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Major Multiple Trauma

14.1	Brain + Spinal Cord Injury
14.2	Brain + Multiple Fracture/Amputation
14.3	Spinal Cord + Multiple Fracture/Amputation
14.9	Other Multiple Trauma

Developmental Disability

15	Developmental Disability

Debility

16	Debility (non-Cardiac, non-Pulmonary)

Medically Complex Conditions

17.1	Infections
17.2	Neoplasms
17.31	Nutrition with Intubation/Parenteral Nutrition
17.32	Nutrition without Intubation/Parenteral Nutrition
17.4	Circulatory Disorders
17.51	Respiratory Disorders - Ventilator Dependent
17.52	Respiratory Disorders - Non-ventilator Dependent
17.6	Terminal Care
17.7	Skin Disorders
17.8	Medical/Surgical Complications
17.9	Other Medically Complex Conditions

Note: The IGCs listed above are the same IGCs listed in the column on the right side of Chart 5 of pages 41342-41344 of the August 7, 2001 Final Rule (66 FR 152). In Item 21, record the appropriate IGC as listed above. The grouper software embedded in the data collection software provided by CMS will reassign the admission IGC into a RIC, and then into a Case Mix Group (CMG) for payment.

22. Etiologic Diagnosis: Enter the ICD-9-CM code to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Appendix B for ICD-9-CM codes associated with specific Impairment Groups. Commonly used ICD-9-CM codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD-9-CM coding books for exact codes.

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23. Date of Onset of Impairment: Enter the onset date of the impairment that was coded in Item 21 (Impairment Group). The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2002*).

If a condition has an insidious onset, or if the exact onset date is unknown for any reason, follow these general guidelines:

a. If the year and month are known, but the exact day is not, use the first day of the month (e.g., *MM/01/YYYY*).

b. If the year is known, but the exact month is not, use the first of January of that year (e.g., *01/01/YYYY*).

c. If the year is an approximation, use the first of January of the approximate year (e.g., *01/01/YYYY*).

The following represents more specific instructions for determining date of onset for major impairment groups:

Instructions for Coding Date of Onset for Each Impairment Group

Stroke*

Date of admission to acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke.

Brain Dysfunction

Traumatic

Date of injury.

Non-traumatic

More recent date of: Date of surgery (e.g., removal of brain tumor) or date of diagnosis.

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Neurological conditions

Multiple Sclerosis
Date of exacerbation.

All Remaining Neurological Conditions
Date of diagnosis.

Spinal Cord Dysfunction

Traumatic
Date of injury.

Non-traumatic
More recent date of: Date of surgery (e.g., tumor) or date of diagnosis.

Amputation

Date of most recent surgery

Arthritis

Date of diagnosis (if arthroplasty, see impairment group "Orthopaedic Conditions")

Pain Syndromes

Date of onset related to cause (e.g., fall, injury)

Orthopaedic Conditions

Fractures
Date of fracture

Replacement
Date of surgery

Cardiac Disorders

More recent date of: Date of diagnosis (event) or date of surgery (e.g., bypass, transplant)

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Pulmonary Disorders

COPD
Date of initial diagnosis (not exacerbation)

Pulmonary Transplant
Date of surgery

Burns

Date of burn(s)

Congenital Deformities

Date of birth

Other Disabling Impairment

Date of diagnosis

Major Multiple Trauma

Date of trauma

Developmental Disabilities

Date of birth

Debility*

Date of acute hospital admission

Medically Complex Conditions*

Infections
Date of admission to acute hospital

Neoplasms
Date of admission to acute hospital

Nutrition
Date of admission to acute hospital

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Medically Complex Conditions*(continued)

Circulatory
Date of admission to acute hospital

Respiratory
Date of admission to acute hospital

Terminal Care
Date of admission to acute hospital

Skin Disorders
Date of admission to acute hospital

Medical/Surgical
Date of admission to acute hospital

Other Medically Complex Conditions
Date of admission to acute hospital

*Note: If there was no admission to an acute hospital prior to the admission to the inpatient rehabilitation facility, record as the date of onset the date of diagnosis of the impairment which led to the admission to the rehabilitation facility.

24. Comorbid Conditions: Enter up to ten (10) ICD-9-CM codes for comorbid conditions. A comorbidity is a specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category. In accordance with the preceding statement, enter any ICD-9-CM codes which identify any comorbid conditions that are not already included in the Impairment Group Code. The ICD-9-CM codes entered here represent conditions diagnosed either during the admission assessment or after the admission assessment but not including ones occurring on the last two days of the stay. For the purposes of defining comorbidities used in the IRF-PPS, the comorbid conditions recognized or diagnosed on the day of discharge or on the day prior to the day of discharge should not be entered in this field. The ICD-9-CM codes may include E-codes and V-codes. Consult with health information management staff and current ICD-9-CM coding books for the exact format and definitions for ICD-9-CM codes.

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Note: For Item 24, enter ICD-9-CM codes for conditions diagnosed either during the admission assessment or anytime during the stay, except for conditions recognized or diagnosed either on the day prior to the day of discharge or on the day of discharge.

See Appendix C for a list of ICD-9-CM codes of the comorbid conditions that may affect Medicare payment. List in Item 24 **ALL** comorbid conditions, not just those conditions that may affect Medicare payment. This will enable CMS to identify additional conditions that may affect payment as part of their ongoing research and efforts at refinement. The more complete and accurate this information is, the more precisely the payment system can reflect patient resource use in IRFs over time.

Medical Needs

For information on scoring the IRF-PAI Medical Needs section (Items 25-28**)**, see *Section IV: Medical Needs / Quality Indicators* in this manual. Completion of the Medical Needs items is voluntary.

Function Modifiers

Function Modifiers (Items 29 – 38) should be completed prior to scoring the FIM™ instrument items (Items 39A – 39R). Function modifiers are to be coded both at the time of the admission and discharge.

General Information on Use of Function Modifiers to Determine FIM Scores

Function modifiers serve several purposes. One purpose is to assist in the scoring of related FIM instrument items. A second purpose is to provide explicit information as to how a particular FIM item score has been determined. This information is especially useful for those FIM items that contain multiple components. Note, however, that the way in which the function modifiers relate to the FIM item scores varies by item. These variations are listed in detail in the table that follows on the next page.

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Scoring Function Modifiers and Related FIM™ Items

Function Modifier	Function Modifier Scoring Rules	Relationship of Function Modifier to FIM Item Scores
29. Bladder Level of Assistance	Use FIM levels 1 - 7 to score this item, based upon the 3 calendar day assessment period. Do not use code 0.	Record in Item 39G. (Bladder) the lower score of Items 29 and 30.
30. Bladder Frequency of Accidents	Use scale listed on IRF-PAI to score frequency of accidents, based upon the 7 calendar day assessment period. Do not use code 0.	
31. Bowel Level of Assistance	Use FIM levels 1 - 7 to score this item, based upon the 3 calendar day assessment period. Do not use code 0.	Record in Item 39H. (Bowel) the lower score of Items 31 and 32.
32. Bowel Frequency of Accidents	Use scale listed on IRF-PAI to score frequency of accidents, based upon the 7 calendar day assessment period. Do not use code 0.	
33. Tub Transfer	Score either Item 33 or 34 but not both; leave the unscored item blank. Use FIM levels 1 - 7. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as 0 - Activity does not occur, and leave Item 34 blank. If both types of transfer occur during the assessment period, record the more frequent type of transfer.	Record in Item 39K (Transfers: Tub, Shower) whichever of the two Function Modifer Items (33 or 34) was scored.
34. Shower Transfer		
35. Distance Walked	Code these two items using the 3-level scale listed on the IRF-PAI to record the distance traveled, in feet.	The distance information is needed to determine the scores for Items 37 and 38.
36. Distance Traveled in Wheelchair		
37. Walk	Use FIM levels 1 - 7 to score these items; use 0 if Activity does not occur. Use information from Items 35 and 36 above to help determine scores.	Score Item 39L at Admission based upon the expected mode of locomotion at discharge. For example, if the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the score from Item 37. If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the score from Item 38.[1]
38. Wheelchair		

[1] This method of scoring the Walk/Wheelchair item is in accordance with § 412.610 "Assessment schedule" of the Final Rule (pages 41389-41930) that allows exceptions to the general rules for the admission and discharge assessments to be specified in this manual.

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Specifics for Scoring Function Modifiers and Relationship to FIM Item Scores

29. Bladder Level of Assistance: Score this item using FIM levels 1-7 (Do not use code "0"). See *Section III: Bladder Management – Level of Assistance* `in this manual for scoring definitions for this item. The admission assessment time frame for this item is the first 3 calendar days of the patient's inpatient rehabilitation admission. The discharge assessment time frame for this item is the last 3 calendar days of the patient's inpatient rehabilitation stay.

30. Bladder Frequency of Accidents: The assessment time frame for this item is 7 calendar days on admission and discharge. For admission assessments, this will include the four days prior to the rehabilitation admission, as well as the first 3 days in the inpatient rehabilitation facility. If information about bladder accidents prior to the rehabilitation admission is not available, record the scored based upon the number of accidents since the rehabilitation admission. For discharge assessments it includes the last 7 days of the inpatient rehabilitation stay with the day of discharge being the 7th day.

Use the following scores for this item:

7 No accidents
6 No accidents; uses device such as a catheter
5 One accident in the past 7 days
4 Two accidents in the past 7 days
3 Three accidents in the past 7 days
2 Four accidents in the past 7 days
1 Five or more accidents in the past 7 days

The definition of bladder accidents is the act of wetting linen or clothing with urine, and includes bedpan and urinal spills by the patient. If the helper spills the container, it is not counted as a patient accident. For more information, see *Section III: Bladder Management – Frequency of Accidents* in this manual.

31. Bowel Level of Assistance: Score this item using FIM levels 1-7 (Do not use code "0"). For more information, see *Section III: Bowel Management – Level of Assistance* in this manual. The admission assessment time frame for this item is the first 3 calendar days of the patient's inpatient rehabilitation admission. The discharge assessment time frame for this item is the last 3 calendar days of the patient's inpatient rehabilitation stay.

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32. Bowel Frequency of Accidents: The assessment time frame for this item is 7 calendar days on admission and discharge. For admission assessments, this will include the four days prior to the rehabilitation admission, as well as the first 3 days in the inpatient rehabilitation facility. If information about bowel accidents prior to the rehabilitation admission is not available, record the scored based upon the number of accidents since the rehabilitation admission. For discharge assessments it includes the last 7 days of the inpatient rehabilitation stay with the day of discharge being the 7th day.

Use the following scores for this item:

7 No accidents
6 No accidents; uses device such as an ostomy
5 One accident in the past 7 days
4 Two accidents in the past 7 days
3 Three accidents in the past 7 days
2 Four accidents in the past 7 days
1 Five or more accidents in the past 7 days

The definition of bowel accidents is the act of soiling linen or clothing with stool, and includes bedpan spills by the patient. If the helper spills the container, it is not counted as a patient accident. For more information, see *Section III: Bowel Management – Frequency of Accidents* in this manual.

33. Tub Transfer: Score this item using FIM levels 1 - 7 (A code of "0" if activity does not occur may be used for the admission assessment). For more information, see *Section III: Transfer: Tub* in this manual.

If the patient uses a tub for bathing during the assessment time period, record the associated FIM level (1 - 7) for Item 33. If a score is recorded in Item 33, do not score Item 34. That is, for each of the assessments (admission and discharge), a score should be recorded for Item 33 or 34 but not both items. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as "0" (Activity does not occur) and leave Item 34 blank. If the patient transfers into both the tub and shower during the assessment period, score the more frequent transfer activity.

If Item 33 is scored (i.e., tub is the mode of bathing), record the score for Item 33 in Item 39K (Transfers: Tub, Shower). Scores for Item 39K may range from 0 - 7 on Admission, and 1 - 7 on Discharge.

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*Note: For Tub/Shower Transfer, the mode on admission does NOT have to match the mode on discharge.

34. Shower Transfer: Score this item using FIM levels 1 - 7. For more information, see *Section III: Transfer: Shower* in this manual.

If the patient uses a shower for bathing during the assessment time period, record the associated FIM level (1 - 7) for Item 34. If a score is recorded in Item 34, do not score Item 33. That is, for each of the assessments (admission and discharge), a score should be recorded for Item 33 or 34 but not both items. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as "0" (Activity does not occur) and leave Item 34 blank. If the patient transfers into both the tub and shower during the assessment period, score the more frequent transfer activity.

If Item 34 is scored (i.e., shower is the mode of bathing), record the score for Item 34 in Item 39K (Transfers: Tub, Shower). Scores for Item 39K may range from 0 - 7 on Admission, and 1 - 7 on Discharge.

*Note: For Tub/Shower Transfer, the mode on admission does NOT have to match the mode on discharge.

35. Distance Walked: Code this item using:

3 150 feet or greater
2 50 to 149 feet
1 Less than 50 feet
0 Activity does not occur (e.g., patient uses only a wheelchair, patient on bedrest)

Scoring for Item 35 should be based upon the same episode of walking as that for Item 37 – Walk.

36. Distance Traveled in Wheelchair: Code this item using:

3 150 feet or greater
2 50 to 149 feet
1 Less than 50 feet
0 Activity does not occur (e.g., patient does not use wheelchair)

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Scoring for Item 36 should be based upon the same episode of wheelchair use as that for Item 38 – Wheelchair.

37. Walk: Score this item using FIM levels 1 - 7 (code "0" if activity does not occur). Scoring this item requires consideration of both the level of assistance and the distance walked. For more information, see *Section III: Locomotion: Walk* in this manual.

Admission: Score Item 39L based upon the expected mode of locomotion at discharge. For example, if the patient uses a wheelchair at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the FIM score from Item 38 (Wheelchair). If the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk).

Discharge: Score Item 39L based upon the more frequent mode of locomotion at discharge. If the patient walks, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair, enter in 39L the FIM score from Item 38 (Wheelchair).

Note: In Item 39L, the mode of locomotion at admission must be the same as the mode of locomotion at discharge.[1]

38. Wheelchair: Score this item using FIM levels 1 - 7 (code "0" if activity does not occur). Scoring this item requires consideration of both the level of assistance and the distance walked. For more information, see *Section III: Locomotion: Wheelchair* of this manual.

Admission: Score item 39L based upon the expected mode of locomotion at discharge. For example, if the patient uses a wheelchair at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the FIM score from Item 38 (Wheelchair). If the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk).

Discharge: Score Item 39L based upon the more frequent mode of locomotion at discharge. If the patient walks, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair, enter in 39L the FIM score from Item 38 (Wheelchair).

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Note: In Item 39L, the mode of locomotion at admission must be the same as the mode of locomotion at discharge.[1]

FIM™ Instrument

39. FIM™ Instrument: Score Items 39A through 39R at both admission and discharge using FIM levels 1 – 7. The following FIM items may be coded as "0" (Activity does not occur) on admission: Item 39A – Eating; 39B – Grooming; 39C – Bathing; 39D – Dressing-Upper; 39E – Dressing-Lower; 39F – Toileting; 39I – Transfers: Bed, Chair, Wheelchair; 39J – Transfers: Toilet; 39K – Transfers: Tub, Shower; 39L – Walk / Wheelchair; 39M – Stairs. If a patient expires while in the rehabilitation facility, record a score of Level 1 for all discharge FIM items. See *Section III: The FIM™ Instrument* of this manual for further information.

Scoring FIM Goals at Admission: At the time of the admission assessment, enter the patient's FIM goal (i.e., expected functional status at discharge) for each of the FIM items (39A – 39R). **Note, however, that completion of the Goal section of the FIM Instrument is not required.**

Discharge Information

40. Discharge Date: In accordance with §412.610(c)(2)(ii) for the IRF-PAI discharge assessment a Medicare patient in an inpatient rehabilitation facility is considered discharged when: 1) The patient is formally released; 2) The patient stops receiving Medicare-covered Part A fee-for-service inpatient rehabilitation services; or 3) The patient dies in the inpatient rehabilitation facility. In Item 40, enter the date the patient is discharged. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD is the day of the month (e.g., from 01 to 31),* and *YYYY* is the full year (e.g., *2002*).

41. Patient discharged against medical advice? Enter one of the following codes:

0 No
1 Yes

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42. Program Interruptions: A program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilition facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the 3rd calendar day. Use the following codes to indicate that a program interruption occurred:

0 No, there were no program interruptions
1 Yes, there was one or more program interruption(s)

43. Program Interruption Dates: If one or more program interruptions occurred (i.e., Item 42 is coded 1 – Yes), enter the interruption date and return date of each interruption. The interruption date is defined as the day when the interruption began (i.e, the day the patient leaves the inpatient rehabilitation facility). The return date is defined as the day when the interruption ended (i.e., the day the patient returned to the inpatient rehabilitation facility). As noted above for Item 42, a program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilition facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The dates should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD is the day of the month (e.g., from 01 to 31),* and *YYYY* is the full year (e.g., *2002*).

43A. 1st Interruption Date
43B. 1st Return Date

43C. 2nd Interruption Date
43D. 2nd Return Date

43E. 3rd Interruption Date
43F. 3rd Return Date

44A. Discharge to Living Setting: Enter the setting to which the patient is discharged.* See **Item 15** (Admit From) for definitions of codes.

01 Home
02 Board & Care
03 Transitional Living
04 Intermediate Care (nursing home)
05 Skilled Nursing Facility (nursing home)

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06 Acute unit of your own facility
07 Acute unit of another facility
08 Chronic Hospital
09 Rehabilitation Facility
10 Other (This also includes siuations where the patient remains in the inpatient rehabilitation facility but the stay is no longer covered by the Medicare Part A fee-for-service hospital insurance option).
11 Died – Patient expired in the inpatient rehabilitation facility.
12 Alternate Level of Care (ALC) unit
13 Subacute Setting†
14 Assisted Living Residence‡

† **Source: Joint Commission on Accreditation of Health Care Organizations**
‡ **Source: Assisted Living Facilities of America**

*Note: The federal regulation lists the discharge settings that trigger the transfer policy. For payment purposes, these discharge settings are documented on the claim form (UB-92). There may not be a 1-to-1 relationship between the labels and definitions used above for the IRF- PAI and the labels and definitions listed on the claim form. In addition, some of the labels and definitions listed in Item 44A, such as Subacute Setting, do not correspond to labels and definitions recognized by CMS. Nevertheless, since these labels and definitions have been used historically by the field of rehabilitation, it is important that the IRF-PAI item, Discharge To Living Setting (Item 44A), be coded using the codes listed above.

44B – Was patient discharged with Home Health Services? Complete this item only if the patient was discharged to a community-based setting (i.e., Item 44A - Discharge to Living Setting is coded: 01 - Home, 02 -Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence). Code using the following:

0 No
1 Yes

45. Discharge to Living With: Complete this item *only* if Item 44A is coded 01 - Home. Code using the following:

1 Alone
2 Family/Relatives
3 Friends
4 Attendant

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5 Other

46. Diagnosis for Interruption or Death: Code using the ICD-9-CM code indicating the reason for the program interruption or death (e.g., acute myocardial infarction, acute pulmonary embolus, sepsis, ruptured aneurysm, etc.). If the patient has more than one interruption, record the most significant diagnosis in this item.

47. Complications during rehabilitation stay: Enter up to six (6) ICD-9-CM codes reflecting complications. The ICD-9-CM codes entered here, including E-codes, represent complications or comorbidities that began after the rehabilitation stay started. To clarify the instructions on the IRF-PAI, the word "began" means any condition recognized or identified during the rehabilitation stay. These codes must not include the complications and/or comorbidities recognized on the day of discharge or the day prior to the day of discharge. These data will be used by CMS as part of its ongoing research and to determine what, if any, refinements should be made to the IRF-PPS payment rates. These ICD-9-CM codes identify complications and/or comorbid conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.

Relationship Between Complications and Comorbid Conditions: All ICD-9-CM codes listed as Complications (Item 47) may also appear in Item 24 as Comorbid Conditions. Coding conditions that were identified after the start of the rehabilitation stay separately from conditions identified at the start of the rehabilitation stay will allow CMS as part of its ongoing research to determine what, if any, refinements should be made to the IRF PPS.

Quality Indicators

For information on scoring the IRF-PAI Quality Indicators (Items 48A-50D**)**, see *Section IV: Medical Needs/Quality Indicators* in this manual. Completion of the Quality Indicators items is not currently required; however, failure to complete such items may result in payment reductions of two percentage points starting in FY 2014.

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SECTION III
THE FIM™ INSTRUMENT

UNDERLYING PRINCIPLES FOR USE OF THE FIM™ INSTRUMENT

By design, the FIM™ instrument includes only a minimum number of items. It is not intended to incorporate all the activities that could possibly be measured, or that might need to be measured, for clinical purposes. Rather, the FIM instrument is a basic indicator of severity of disability that can be administered comparatively quickly and therefore can be used to generate data on large groups of people. As the severity of disability changes during rehabilitation, the data generated by the FIM instrument can be used to track such changes and analyze the outcomes of rehabilitation.

The FIM instrument includes a seven-level scale that designates major gradations in behavior from dependence to independence. This scale rates patients on their performance of an activity taking into account their need for assistance from another person or a device. If help is needed, the scale quantifies that need. The need for assistance (burden of care) translates to the time/energy that another person must expend to serve the dependent needs of the disabled individual so that the individual can achieve and maintain a certain quality of life.

The FIM instrument is a measure of disability, not impairment. The FIM instrument is intended to measure what the person with the disability actually does, whatever the diagnosis or impairment, not what (s)he ought to be able to do, or might be able to do under different circumstances. As an experienced clinician, you may be well aware that a depressed person could do many things (s)he is not currently doing; nevertheless, the person should be assessed on the basis of what (s)he actually does. Note also that there is no provision to consider an item "not applicable." **All FIM instrument items (39A - 39R) must be completed.**

The FIM instrument was designed to be discipline-free. Any trained clinician, regardless of discipline, can use it to measure disability. Under a particular set of circumstances, however, some clinicians may find it difficult to assess certain activities. In such cases, a more appropriate clinician may participate in the assessment. For example, a given assessment can be completed by a speech pathologist who assesses the communication items, a nurse who is more knowledgeable with respect to bowel and bladder management, a physical therapist who has the expertise to evaluate transfers, and an occupational therapist who scores self-care and social cognition items.

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You must read the definitions of the items carefully before beginning to use the FIM instrument, committing to memory what each activity includes. Rate the subject only with respect to the specific item. For example, when rating the subject with regard to bowel and bladder management, do not take into consideration whether (s)he can get to the toilet. That information is measured during assessments of Walk/Wheelchair and Transfers: Toilet.

To be categorized at any given level, the patient must complete either all of the tasks included in the definition or only one of several tasks. If all must be completed, the series of tasks will be connected in the text of the definition by the word "and." If only one must be completed, the series of tasks will be connected by the word "or." For example, Grooming includes oral care, hair grooming, washing the hands, washing the face, and either shaving or applying make-up. Communication includes clear comprehension of either auditory or visual communication.

Implicit in all of the definitions, and stated in many of them, is a concern that the individual perform these activities with reasonable safety. With respect to level 6, you must ask yourself whether the patient is at risk of injury while performing the task. As with all human endeavors, your judgment should take into account a balance between an individual's risk of participating in some activities and a corresponding, although different risk if (s)he does not.

Because the data set is still being refined, your opinions and suggestions are considered very important. We are also interested in any problems you encounter in collecting and recording data.

The FIM instrument may be added to information that has already been gathered by a facility. This information may include items such as independent living skills, ability to take medications, to use community transportation, to direct care provided by an aide, or to write or use the telephone, and other characteristics such as mobility outdoors, impairments such as blindness and deafness, and pre-morbid status.

Do not modify the FIM instrument itself.

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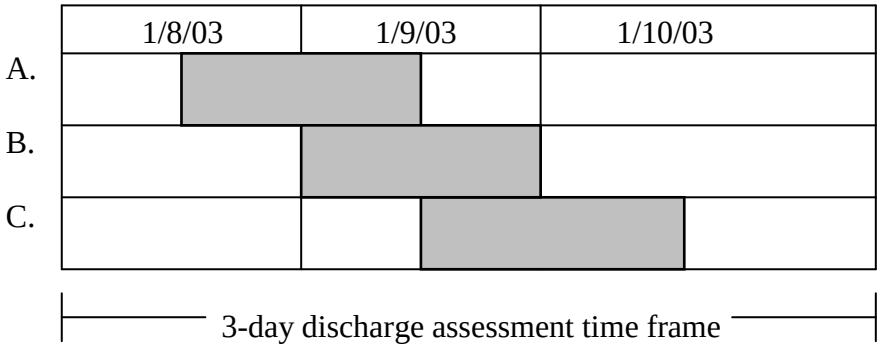
PROCEDURES FOR SCORING THE FIM™ INSTRUMENT AND FUNCTION MODIFIERS

Each of the 18 items comprising the FIM™ instrument has a maximum score of seven (7), which indicates complete independence. A score of one (1) indicates total assistance. A code of zero (0) may be used for some items to indicate that the activity does not occur. Use only whole numbers. For the Function Modifiers, the score range is a minimum of 1 and a maximum of 7, except for Items 35 and 36, where the maximum score is three (3), and for some Function Modifiers a code of 0 may be used. The following rules will help guide you in your administration of the FIM instrument.

1. Admission FIM scores must be collected during the first 3 calendar days of the patient's current rehabilitation hospitalization that is covered by Medicare. These scores must be based upon activities performed during the **entire** 3-calendar-day admission time frame.

2. The discharge assessment time frame encompasses the day of discharge and the two calendar days prior to the day of discharge. Completion of the FIM items at discharge, with the exception of items reflecting bowel and bladder function, should reflect the lowest functional score within any 24-hour period within the three calendar days comprising the discharge assessment. At discharge, all FIM items except bowel and bladder should be assessed within the same 24-hour period. The diagram below depicts three possible scenarios meeting this definition:

   Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03.



   In scenario A, the FIM items would be scored in a 24-hour period between 1/8 and 1/9/03. In scenario B, the FIM items would be scored in a 24-hour period, all on 1/9/03. In scenario C, the FIM items would be scored in a 24-hour period beginning on 1/9 and ending on 1/10/03. Note that in each of these examples, all FIM items (with an exception for bladder and bowel as listed below) were scored within the same 24-hour period, and the lowest level of function was scored for each item.

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Scoring the lowest level of function provides a way to measure the amount of assistance (burden of care) the individual requires from another person to carry out daily living activities.

Exception: Rather than assessing the bladder and bowel function modifiers and associated FIM items within a 24-hour period within the discharge assessment time frame, these items must be scored according to previously established look-back periods. At discharge, function modifiers concerning level of assistance for bladder and bowel (Items 29 and 31) have a look-back period of 3 days (the day of discharge and the two calendar days immediately prior to discharge). Function modifiers concerning frequency of accidents for bladder and bowel (Items 30 and 32) have a look-back period of 7 days (the day of discharge and the six calendar days immediately prior to discharge). The diagram below depicts how these items must be assessed at discharge:

Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03. The 3-day look-back period for bladder and bowel level of assistance would be 1/8, 1/9 and 1/10/03. The 7-day look-back period for bladder and bowel frequency of accidents would be 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/03.

	01/4/03	01/5/03	01/6/03	01/7/03	01/8/03	01/9/03	01/10/03
Bladder, Bowel Level of Assistance							
Bladder, Bowel Frequency of Accidents							

Note: As stated previously on page II-19 of this manual, comorbid conditions recognized or diagnosed on the day of discharge or on the day prior to the day of discharge are not allowed to be entered in item number 24. Therefore, if the 24-hour time period chosen to determine the score of most of the Function Modifiers and the associated elements of the FIM items encompasses the day of discharge or the day prior to the day of discharge then the comorbidities that are first recognized or diagnosed during such a 24-hour time period can't be recorded in item 24.

3. At admission, most **FIM items** use an assessment time period of 3 calendar days. For the **Function Modifiers** Bladder Frequency of Accidents and Bowel Frequency of Accidents (Items 30 and 32), a 7-day assessment time period is needed. The admission assessment for bladder and bowel accidents would include the 4 calendar days prior to the rehabilitation admission, as well as the first 3 calendar days in the

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rehabilitation facility.

In the event that information about bladder and/or bowel accidents prior to the rehabilitation admission is unavailable, record scores for items 30 and 32 that are based upon the number of accidents **since** the rehabilitation admission.

4. The **FIM scores** and **Function Modifier scores** should reflect the patient's actual performance of the activity, not what the patient should be able to do, not a simulation of the activity, or not what they are expected to do in a different environment (e.g., home).

5. If differences in function occur in different environments or at different times of the day, record the *lowest* (most dependent) score. In such cases, the patient usually has not mastered the function across a 24-hour period, is too tired, or is not motivated enough to perform the activity out of the therapy setting. There may be a need to resolve the question of what is the most dependent level by discussion among team members.

   Note: The patient's score on measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, a patient who can routinely ambulate more than 150 feet throughout the day with supervision (score of 5 for FIM Locomotion: Walk/Wheelchair item), but who is observed to ambulate only 20 feet at night to use the toilet because that is the distance from his/her bed, should receive a Walk score of 5 rather than a lower score.

6. The **FIM scores** and **Function Modifier scores** should be based on the best available information. Direct observation of the patient's performance is preferred; however, credible reports of performance may be gathered from the medical record, the patient, other staff members, family, and friends. The medical record may also provide additional information about bladder and bowel accidents and inappropriate behaviors.

7. Record a **Function Modifier score** for EITHER Tub Transfer (Item 33) OR Shower Transfer (Item 34) but not both. Leave the other transfer item blank. Please note that the mode for this item does not need to be the same at admission and discharge.

8. Record the **FIM score** that best describes the patient's level of function for *every* FIM item (Items 39A through 39R). No FIM item should be left blank.

9. For some **FIM items** (e.g., Walk/Wheelchair (39L), Comprehension (39N), and Expression (39O)) there are boxes next to the functional score box that are to be used to indicate the more frequent mode used by the patient for that item. To indicate the more frequent mode, place the appropriate letter in each box (i.e., W for Walk, C for Wheelchair, or B for Both for Item 39L (Walk/Wheelchair); A for Auditory, V for Visual, or B for Both for Item 39N (Comprehension); and V for Vocal, N for

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Nonvocal, and B for Both for Item 39O (Expression)).

Note: or items 39N (Comprehension) and 39O (Expression) the mode at admission does not have to match the mode at discharge.

10. The mode of locomotion for the **FIM item** Walk/Wheelchair (39L) must be the same on admission and discharge. Some patients may change the mode of locomotion from admission to discharge, usually wheelchair to walking. In such cases, you should code the admission mode and score based on the *more frequent mode of locomotion at discharge*. If, at discharge, the patient uses both modes (walk, wheelchair) equally, score Item 39L using the Walk scores from Item 37 for both admission and discharge.[1]

11. When the assistance of two helpers is required for the patient to perform the tasks described in an item, score level 1 - Total Assistance.

12. A code of 0 may be used for some **FIM items** and some **Function Modifiers** to indicate that the activity does not occur at any time during the assessment period. (For a summary of the scoring rules concerning the use of the 0 code, see the table at the end of this section). A code of 0 means that the patient does not perform the activity and a helper does not perform the activity for the patient, at any time during the assessment period. Use of this code should be rare for most items, and justification for the use of 0 should be documented in the medical record. Possible reasons why the patient does not perform the activity may include the following:
    - The patient does not attempt the activity because the clinician determines that it is unsafe for the patient to perform the activity (e.g., going up and down stairs for patient with lower extremity paralysis).
    - The patient cannot perform the activity because of a medical condition or medical treatment (e.g., walking for the patient who is unable to bear weight on lower extremities).
    - The patient refuses to perform an activity (e.g., the patient refuses to dress in clothing other than a hospital gown or the patient refuses to be dressed by a helper).

13. For certain **FIM items**, a code of 0 may be used on **admission** but not at **discharge**. However, code 0 may NOT be used for Bladder Management (Items 29, 30 and 39G), Bowel Management (Items 31, 32 and 39H), or the cognitive items (Items 39N through 39R) at either admission or discharge.

14. If a **FIM activity** does not occur at the time of **discharge** record a score of 1 – Total Assistance. If a patient expires while in the rehabilitation facility, record a score of Level 1 for all discharge FIM items.

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15. For the **Function Modifiers Items 33 through 38**, a code of 0 may be used on admission and discharge.

16. Prior to recording a code of 0, the clinician completing the assessment must consult with other clinicians, the patient's medical record, the patient, and the patient's family members to determine whether the patient did perform or was observed performing the activity. Do not use code "0" to indicate that the clinician **did not observe** the patient performing the activity; use the code only when the activity did not occur.

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Overview for Use of Code 0 - Activity Does Not Occur for FIM Instrument and Function Modifier Items on the IRF-PAI

IRF-PAI Item	Can code "0 - Activity does not occur", be used during the Admission Assessment?	Can code "0 - Activity does not occur", be used during the Discharge Assessment?
Function Modifiers		
29 Bladder Level of Assistance	No	No
30 Bladder Frequency of Accidents	No	No
31 Bowel Level of Assistance	No	No
32 Bowel Frequency of Accidents	No	No
33 Tub Transfer	Yes	Yes
34 Shower Transfer	No	No
35 Distance Walked	Yes	Yes
36 Distance Traveled in Wheelchair	Yes	Yes
37 Walk	Yes	Yes
38 Wheelchair	Yes	Yes
FIM Items*		
39A Eating	Yes	No
39B Grooming	Yes	No
39C Bathing	Yes	No
39D Dressing - Upper	Yes	No
39E Dressing - Lower	Yes	No
39F Toileting	Yes	No
39G Bladder	No	No
39H Bowel	No	No
39I Transfers: Bed, Chair, Wheelchair	Yes	No
39J Transfers: Toilet	Yes	No
39K Transfers: Tub, Shower	Yes	No
39L Walk/Wheelchair	Yes	No
39M Stairs	Yes	No
39N Comprehension	No	No
39O Expression	No	No
39P Social Interaction	No	No
39Q Problem Solving	No	No
39R Memory	No	No

*If activity does not occur at discharge, code FIM items using "1"

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DESCRIPTION OF THE LEVELS OF FUNCTION AND THEIR SCORES

INDEPENDENT - Another person is not required for the activity (NO HELPER).

7 Complete Independence—The patient safely performs all the tasks described as making up the activity within a reasonable amount of time, and does so without modification, assistive devices, or aids.

6 Modified Independence—One or more of the following may be true: the activity requires an assistive device or aid, the activity takes more than reasonable time, or the activity involves safety (risk) considerations.

DEPENDENT - Patient requires another person for either supervision or physical assistance in order to perform the activity, or it is not performed (REQUIRES HELPER).

Modified Dependence: The patient expends half (50%) or more of the effort. The levels of assistance required are defined below.

5 Supervision or Setup—The patient requires no more help than standby, cuing, or coaxing, without physical contact; alternately, the helper sets up needed items or applies orthoses or assistive/adaptive devices.

4 Minimal Contact Assistance—The patient requires no more help than touching, and expends 75% or more of the effort.

3 Moderate Assistance—The patient requires more help than touching, or expends between 50 and 74% of the effort.

Complete Dependence: The patient expends less than half (less than 50%) of the effort. Maximal or total assistance is required. The levels of assistance required are defined below.

2 Maximal Assistance—The patient expends between 25 to 49% of the effort.

1 Total Assistance—The patient expends less than 25% of the effort.

0 Activity Does Not Occur – The patient does not perform the activity, and a helper does not perform the activity for the patient during the entire assessment time frame. NOTE: Do *not* use this code only because you did not observe the patient perform the activity. In such cases, consult other clinicians, the patient's medical record, the patient, and the patient's family members to discover whether others observed the patient perform the activity.

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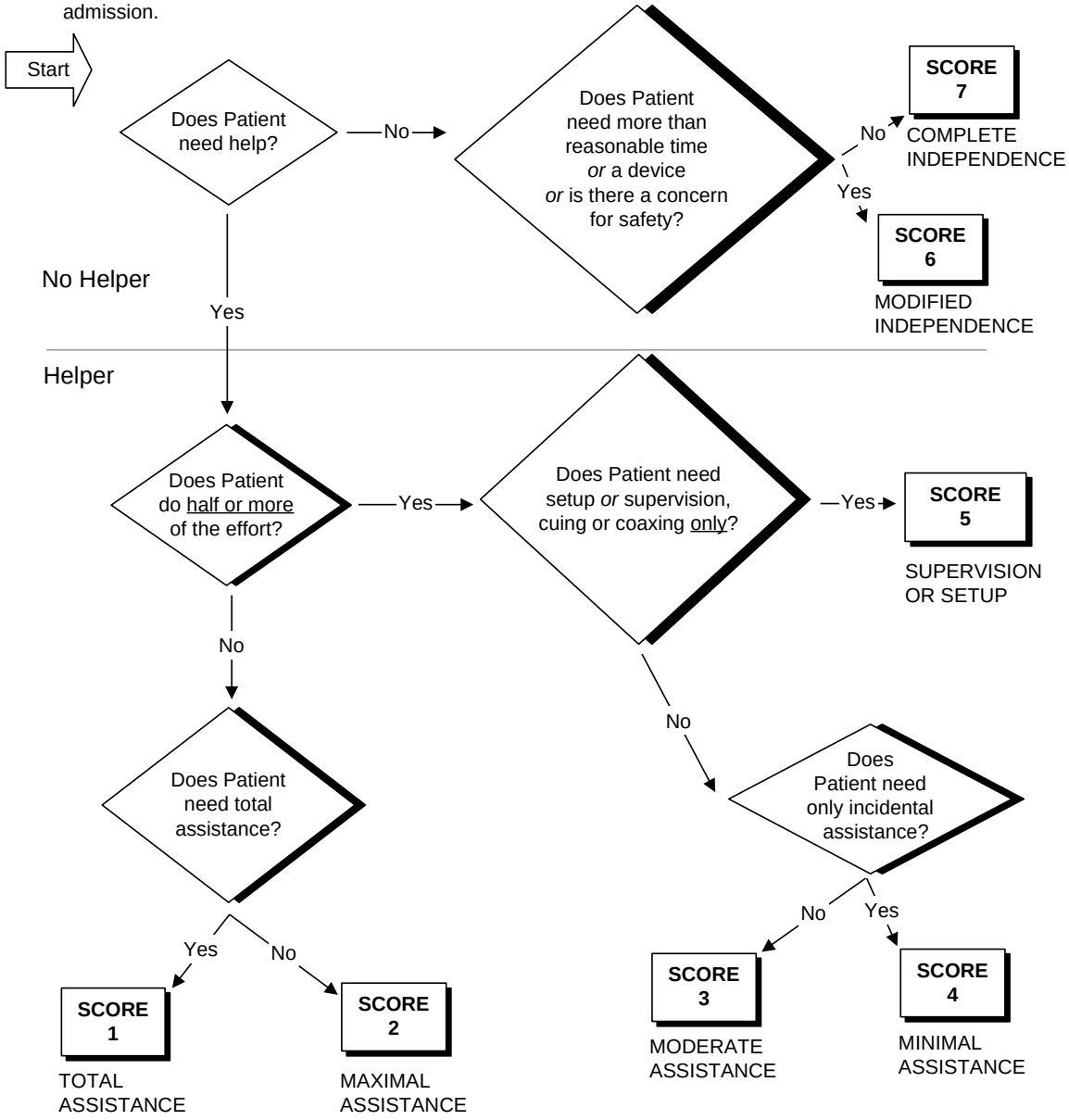
INSTRUCTIONS FOR THE USE OF THE FIM™ DECISION TREES

General Description of FIM Instrument Levels of Function and Their Scores

To use the FIM™ Decision Tree, begin in the upper left hand corner. Answer the questions and follow the branches to the correct score. You will notice that behaviors and scores above the line indicate that NO HELPER is needed, while behaviors and scores below the bottom line indicate that a HELPER is needed. If an activity does not occur for self care, transfer or locomotion items on admission, enter code "0" on admission.



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EATING: *Eating* includes the ability to use suitable utensils to bring food to the mouth, as well as the ability to chew and swallow the food once the meal is presented in the customary manner on a table or tray. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient eats from a dish while managing a variety of food consistencies, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The subject opens containers, butters bread, cuts meat, pours liquids, and uses a spoon or fork to bring food to the mouth, where it is chewed and swallowed. The patient performs this activity safely.

6 Modified Independence—Performance of the activity involves safety considerations, or the patient requires an adaptive or assistive device such as a long straw, spork, or rocking knife; requires more than a reasonable time to eat; or requires modified food consistency or blenderized food. If the patient relies on other means of alimentation, such as parenteral or gastrostomy feedings, then (s)he self-administers the feedings.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of orthoses or assistive/adaptive devices), or another person is required to open containers, butter bread, cut meat, or pour liquids.

4 Minimal Contact Assistance—The patient performs 75% or more of eating tasks.

3 Moderate Assistance—The patient performs 50% to 74% of eating tasks.

2 Maximal Assistance—The patient performs 25% to 49% of eating tasks.

1 Total Assistance—The patient performs less than 25% of eating tasks, or the patient relies on parenteral or gastrostomy feedings (either wholly or partially) and does not self-administer the feedings.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not eat *and* does not receive any parenteral/enteral nutrition during the entire assessment time frame. Use of this code should be rare.

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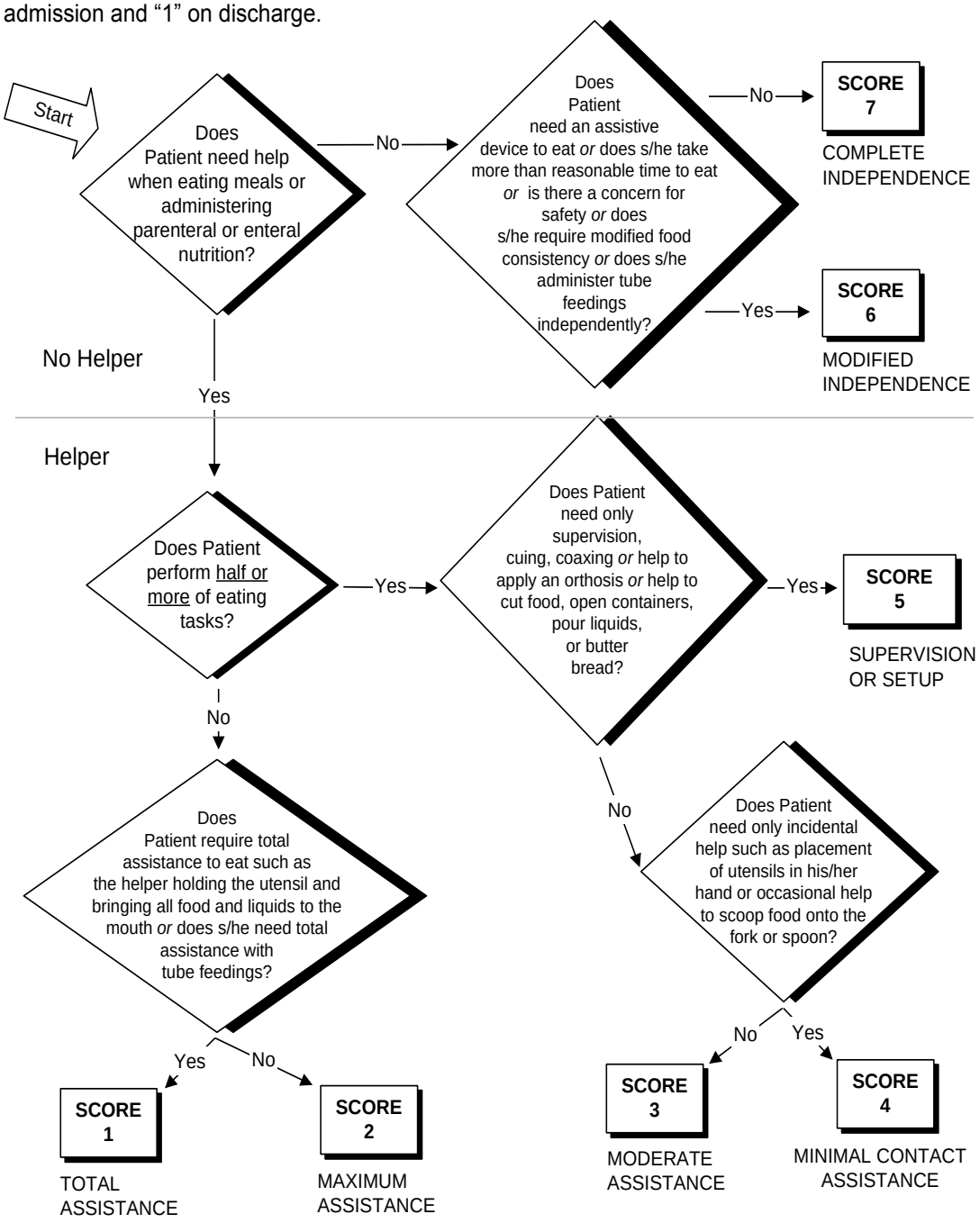
EATING

Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is presented in the customary manner on a table or tray. At level 7 the patient eats from a dish while managing all consistencies of food, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The patient uses suitable utensils to bring food to the mouth; food is chewed and swallowed. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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GROOMING: *Grooming* includes oral care, hair grooming (combing or brushing hair), washing the hands*, washing the face*, and either shaving the face or applying make-up. If the subject neither shaves nor applies make-up, Grooming includes only the first four tasks. The patient performs this activity safely. This item includes obtaining articles necessary for grooming.

NO HELPER

7 Complete Independence—The patient cleans teeth or dentures, combs or brushes hair, washes the hands*, washes the face*, and either shaves the face or applies make-up, including all preparations. The patient performs this activity safely.

6 Modified Independence—The patient requires specialized equipment (including prosthesis or orthosis) to perform grooming activities, or takes more than a reasonable time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of orthoses or adapted/assistive devices, setting out grooming equipment, or initial preparation such as applying toothpaste to toothbrush or opening make-up containers).

4 Minimal Contact Assistance—The patient performs 75% or more of grooming tasks.

3 Moderate Assistance—The patient performs 50% to 74% of grooming tasks.

2 Maximal Assistance—The patient performs 25% to 49% of grooming tasks.

1 Total Assistance—The patient performs less than 25% of grooming tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform any grooming activities (oral care, hair grooming, washing the hands, washing the face, and either shaving the face or applying make-up), and is not groomed by a helper during the entire assessment time frame. Use of this code should be rare.

COMMENT: Assess only the activities listed in the definition. Grooming does not include flossing teeth, shampooing hair, applying deodorant, or shaving legs. If the subject is bald or chooses not to shave or apply make-up, do not assess those activities.

*including rinsing and drying.

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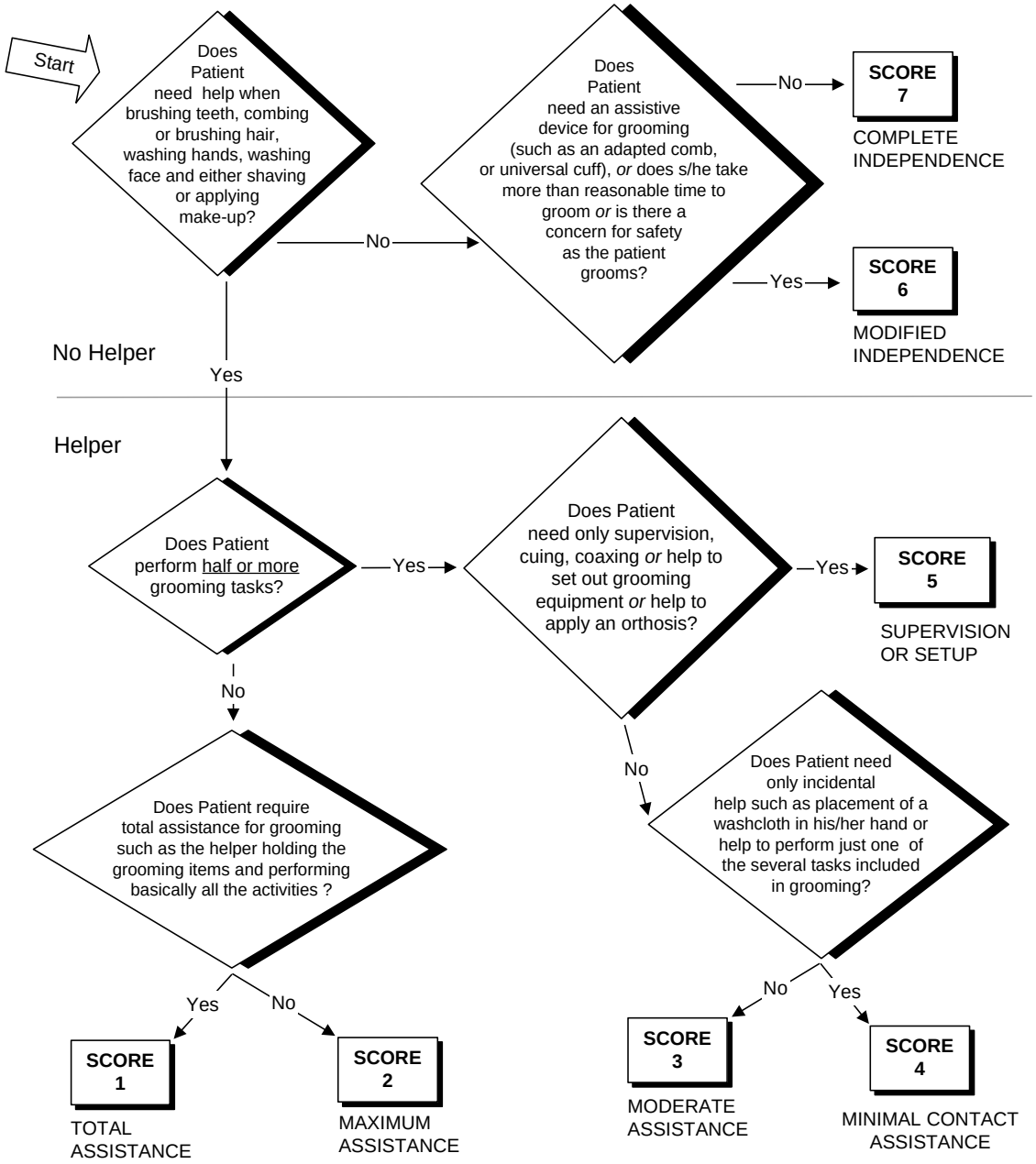
GROOMING

Grooming includes oral care, hair grooming (combing and brushing hair), washing the hands and washing the face, and either shaving the face or applying make-up. If the patient neither shaves nor applies makeup, Grooming includes only the first four tasks. At level 7 the patient cleans his/her teeth or dentures, combs or brushes his/her hair, washes his/her hands and face, and may shave or apply make-up, including all preparations. Performs independently and safely. If activity does not occur, score "0" on admission and "1" on discharge.



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BATHING: *Bathing* includes washing, rinsing, and drying the body from the neck down (excluding the back) in either a tub, shower, or sponge/bed bath. The patient performs the activity safely.

NO HELPER

7 Complete Independence—The patient safely bathes (washes, rinses and dries) the body.

6 Modified Independence—The patient requires specialized equipment (including prosthesis or orthosis) to bathe, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing or coaxing) or setup (application of assistive/adaptive devices, setting out bathing equipment, or initial preparation such as preparing the water or washing materials).

4 Minimal Contact Assistance—The patient performs 75% or more of bathing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of bathing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of bathing tasks.

1 Total Assistance—The patient performs less than 25% of bathing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not bathe self, and is not bathed by a helper. Use of this code should be rare.

When scoring this item, consider the body as divided up into ten areas or parts. Evaluate how the patient bathes each of the ten areas or parts, with each accounting for 10% of the total:

- chest
- left arm
- right arm
- abdomen
- perineal area
- buttocks
- left upper leg
- right upper leg
- left lower leg, including foot
- right lower leg, including foot

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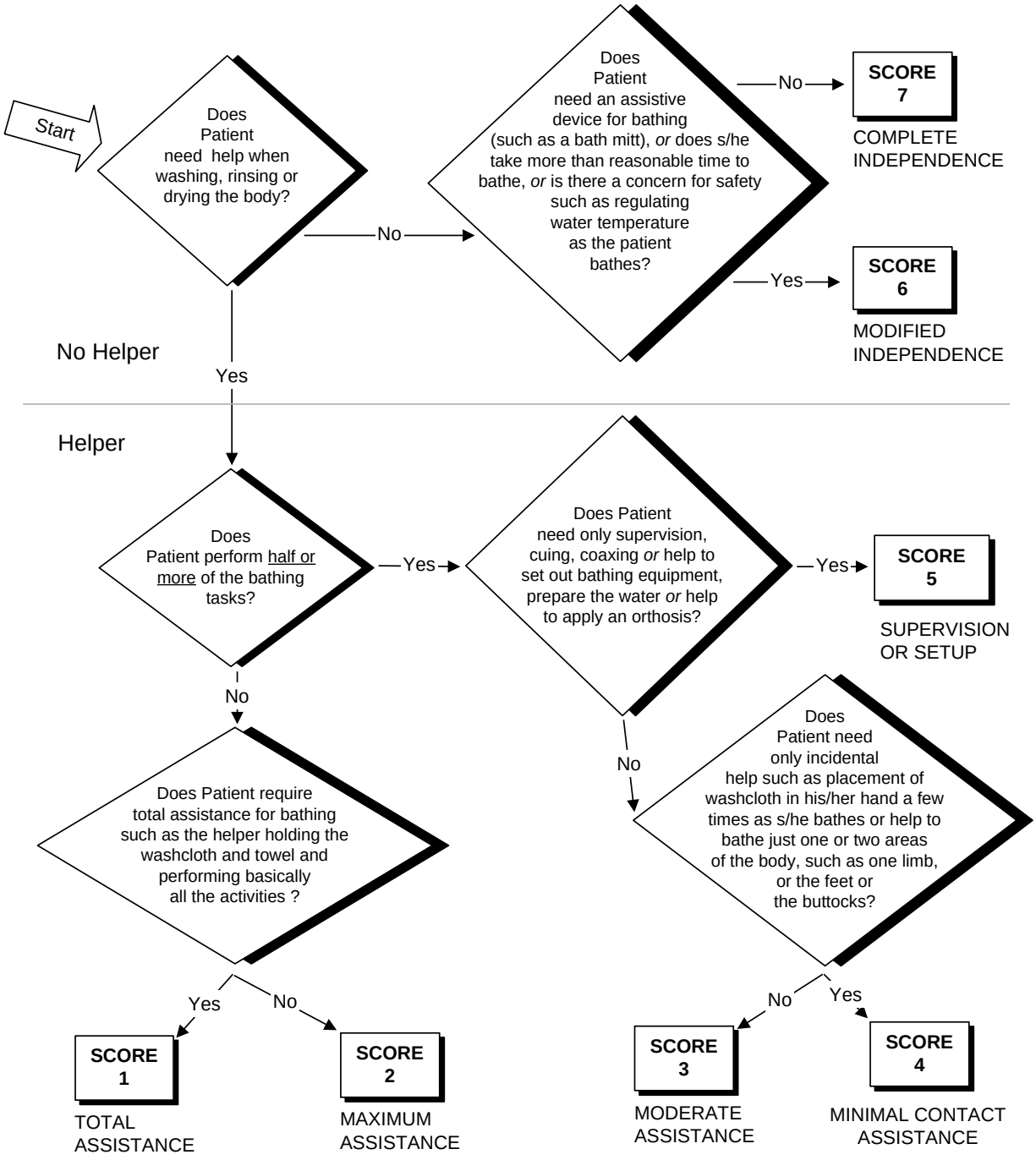
BATHING

Bathing includes bathing (washing, rinsing and drying) the body from the neck down (excluding the back); may be either tub, shower or sponge/bed bath. At level 7 the patient bathes (washes, rinses and dries) the body, excluding the back. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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DRESSING - UPPER BODY: *Dressing – Upper Body* includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses self. This includes obtaining clothes from their customary places (such as drawers and closets), and may include managing a bra, pullover garment, front-opening garment, zippers, buttons, or snaps, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for upper body dressing) when applicable. The patient performs this activity safely.

6 Modified Independence—The patient requires special adaptive closure such as a Velcro® Fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of an upper body or limb orthosis/prosthesis, application of an assistive/adaptive device, or setting out clothes or dressing equipment).

4 Minimal Contact Assistance—The patient performs 75% or more of dressing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of dressing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of dressing tasks.

1 Total Assistance—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. The subject who wears only a hospital gown would be coded "0 – Activity Does Not Occur." Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

COMMENT: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission assessment time period the IRF's staff must make every attempt to obtain from any source clothing for the patient.

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For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.

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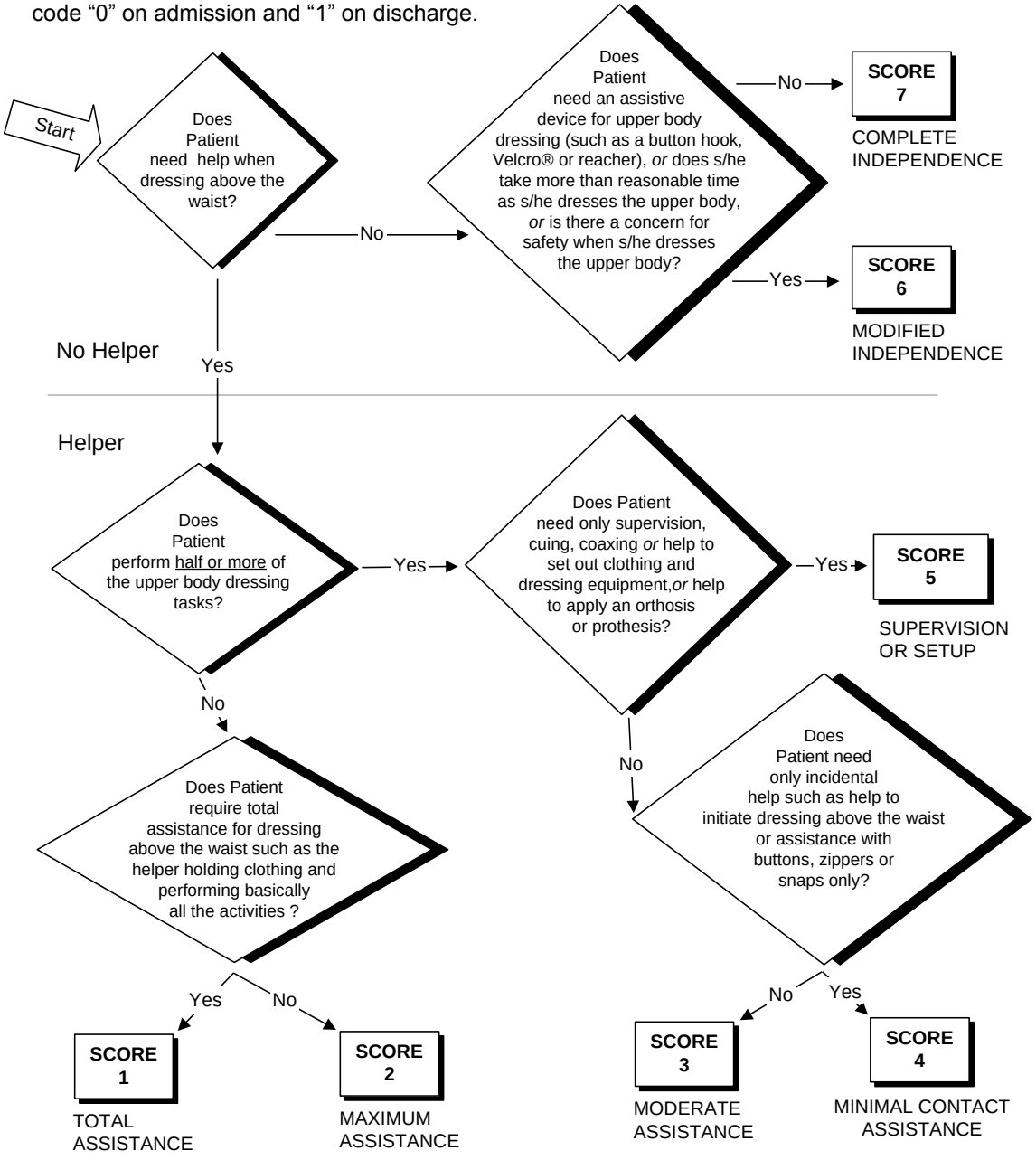
DRESSING - UPPER BODY

Dressing Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. Note: this item may include assessment of one to several activities, depending on whether the patient chooses to wear one piece of clothing (a sweatshirt for example) or several pieces of clothing (a bra, blouse and sweater). At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closets; manages bra, pullover garment; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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DRESSING - LOWER BODY: *Dressing – Lower Body* includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses safely. This includes obtaining clothes from their customary places (such as drawers and closets), and may also include managing underpants, slacks, skirt, belt, stockings, shoes, zippers, buttons, and snaps, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for lower body dressing) when applicable.

6 Modified Independence—The patient requires a special adaptive closure such as a Velcro® fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of a lower body or limb orthosis/prosthesis, application of an assistive/adaptive device or setting out clothes or dressing equipment).

4 Minimal Contact Assistance—The patient performs 75% or more of dressing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of dressing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of dressing tasks.

1 Total Assistance—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. For example, the patient who wears only a hospital gown and/or underpants and/or footwear would be coded "0 – Activity Does Not Occur" for this item. Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

COMMENT: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission assessment time period the

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IRF's staff must make every attempt to obtain from any source clothing for the patient. For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.

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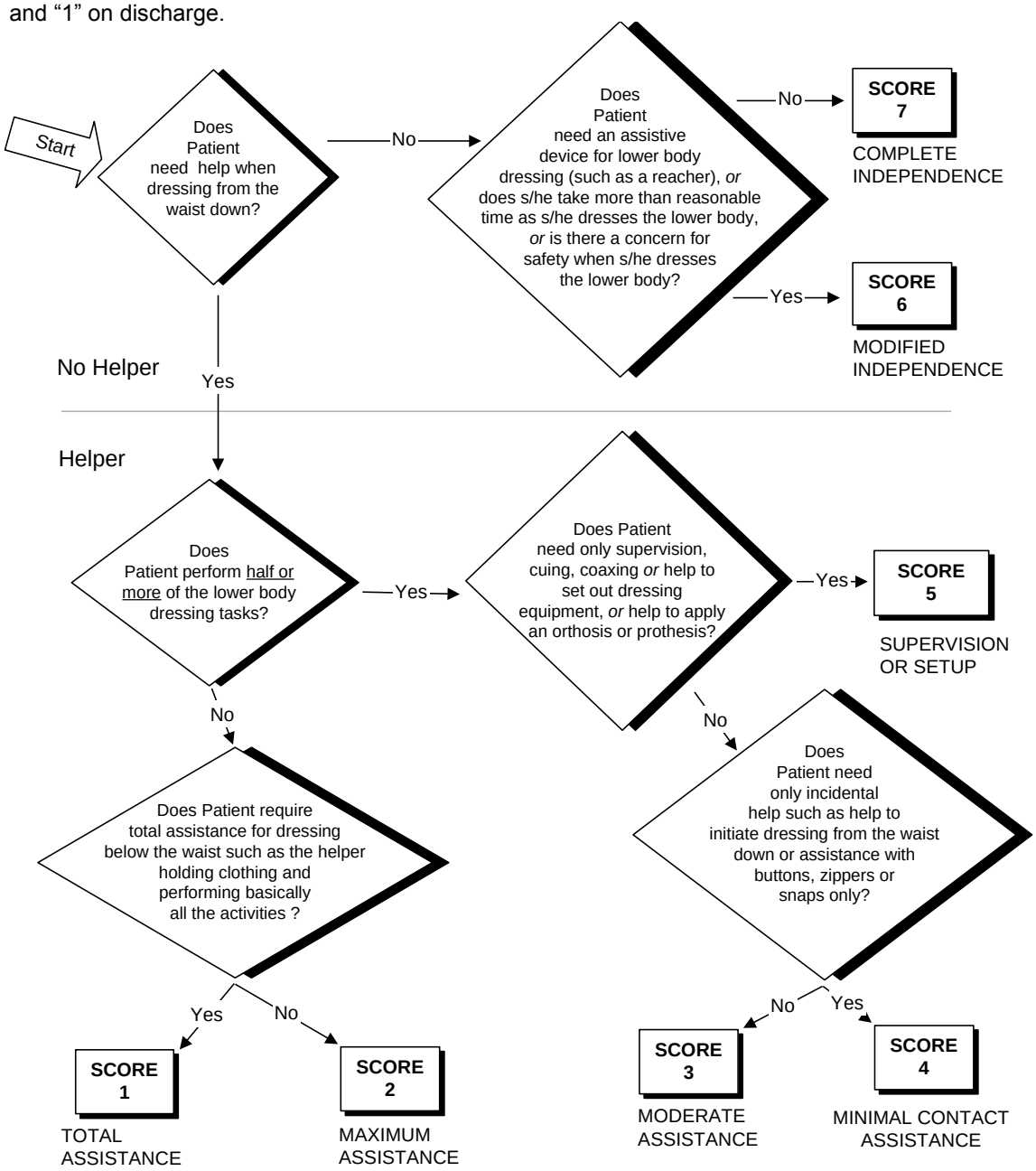
DRESSING - LOWER BODY

Dressing Lower Body includes dressing and undressing from the waist down as well as applying and removing a prosthesis or orthosis when applicable. Note: this item typically includes assessment of applying and removing several pieces of clothing. At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closets; manages underpants, slacks or skirt, socks, shoes; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur code "0" on admission and "1" on discharge.



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TOILETING: *Toileting i*ncludes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient safely cleanses self after voiding and bowel movements, and safely adjusts clothing before and after using toilet, bedpan, commode or urinal.

6 Modified Independence—The patient requires specialized equipment (including orthosis or prosthesis) during toileting, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of adaptive devices or opening packages).

4 Minimal Contact Assistance—The patient performs 75% or more of toileting tasks.

3 Moderate Assistance—The patient performs 50% to 74% of toileting tasks.

2 Maximal Assistance—The patient performs 25% to 49% of toileting tasks.

1 Total Assistance—The patient performs less than 25% of toileting tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform *any* of the toileting tasks (perineal cleansing, clothing adjustment before and after toilet use), and a helper does not perform *any* of these activities for the subject. Use of this code should be rare.

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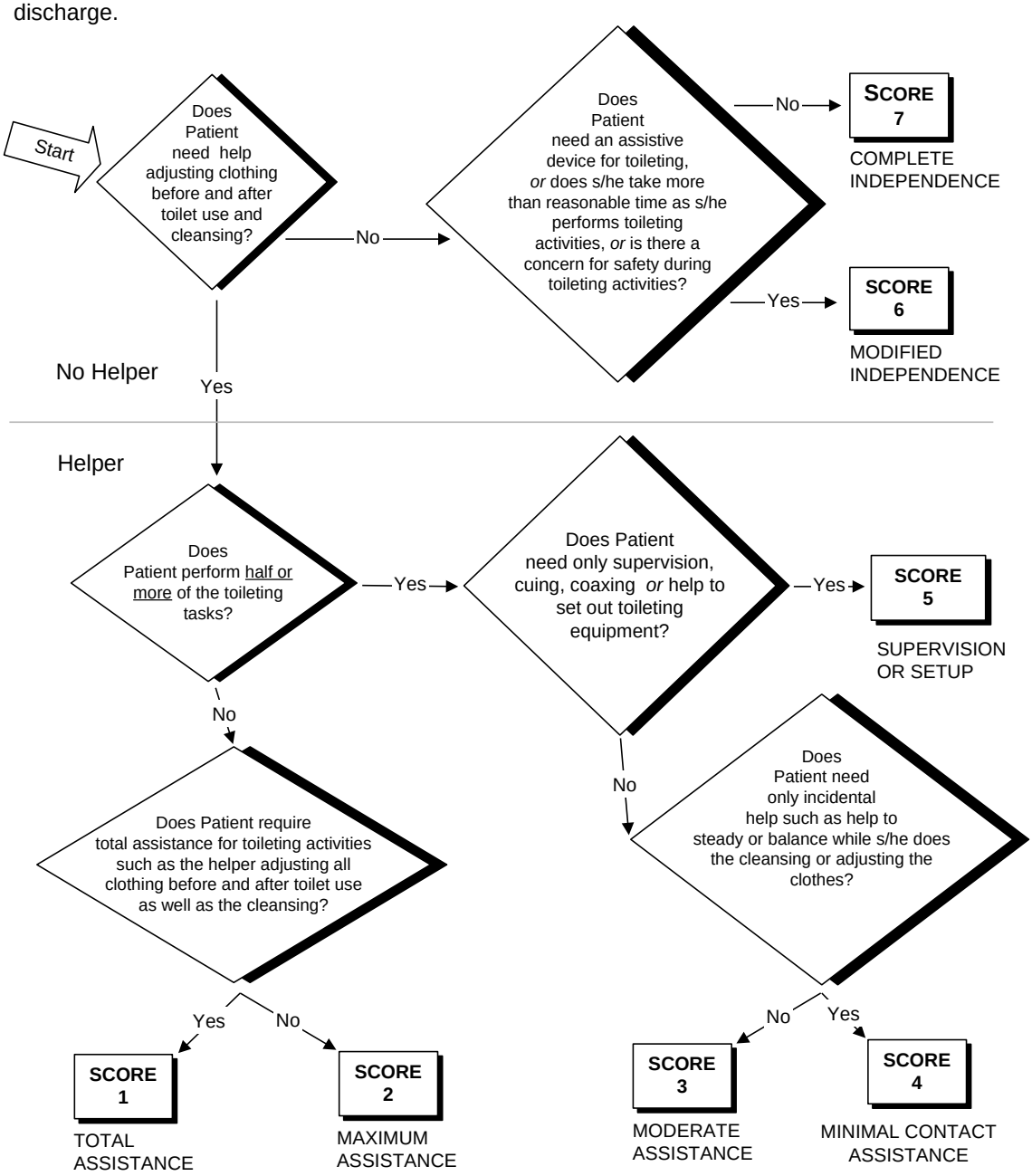
TOILETING

Toileting includes maintaining perineal hygiene and adjusting clothing before and after using toilet or bedpan. If level of assistance for care differs between voiding and bowel movements, record the lower score. At level 7 the patient cleanses self after voiding and bowel movements; adjusts clothing before and after using toilet or bedpan. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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BLADDER MANAGEMENT - Level of Assistance: *Bladder Management - Level of Assistance* includes the safe use of equipment or agents for bladder management. (Note: Use these definitions to score the Function Modifier, Item 29; refer to the comment below to score Item 39G).

NO HELPER

7 Complete Independence—The patient controls bladder completely and intentionally without equipment or devices, and is *never incontinent* (no accidents).

6 Modified Independence—The patient requires a urinal, bedpan, catheter, bedside commode absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. If catheter is used, the patient cleans, sterilizes, and sets up the equipment for irrigation without assistance. If the individual uses a device, (s)he assembles and applies an external catheter with drainage bags or an ileal appliance without assistance of another person; the patient also empties, puts on, removes, and cleans leg bag, or empties and cleans ileal appliance bag.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (placing or emptying) of equipment to maintain either a satisfactory voiding pattern or an external device in the past 3 days.

4 Minimal Contact Assistance—The patient requires minimal contact assistance to maintain an external device, and performs 75% or more of bladder management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain an external device, and performs 50% to 74% of bladder management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bladder management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bladder management tasks in the past 3 days.

Do not use code "0" for Bladder Management – Level of Assistance.

COMMENT: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance for some individuals. This item deals with the level of assistance required to complete bladder management tasks. If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence.

A separate Function Modifier, *Bladder Management—Frequency of Accidents* (Item 30), deals with the success of the bladder management program.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).

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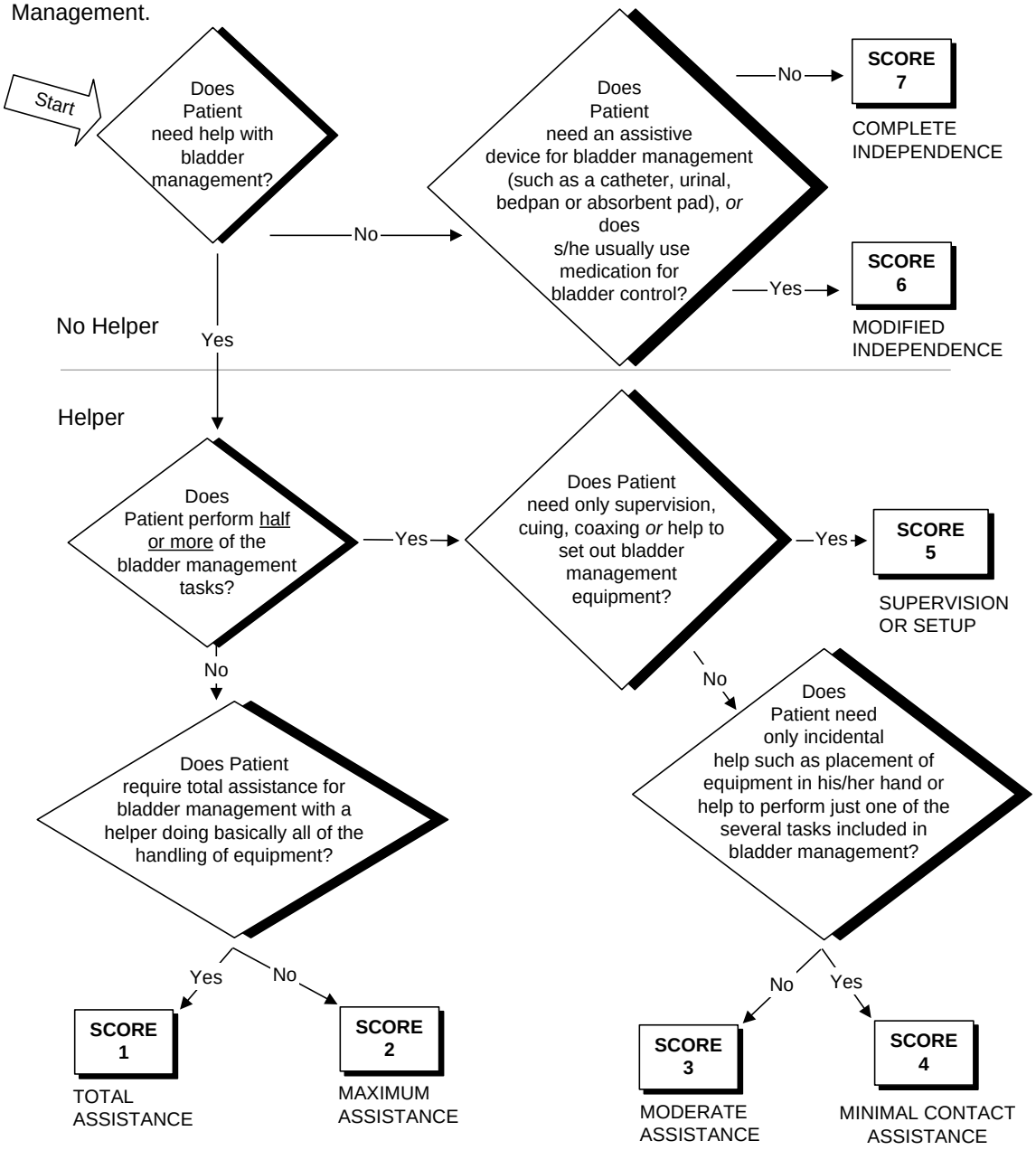
BLADDER MANAGEMENT - LEVEL OF ASSISTANCE

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the patient controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Bladder Management, with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bladder Management.



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BLADDER MANAGEMENT - Frequency of Accidents: *Bladder Management: Frequency of Accidents* includes complete intentional control of urinary bladder and, if necessary, use of equipment or agents for bladder control. (Note: Use these definitions to score the Function Modifier, Item 30; refer to the comment below to score Item 39G).

Definition of Bladder Accidents – Bladder accidents refers to the act of wetting linen or clothing with urine, and includes bedpan and urinal spills.

NO HELPER

7 No Accidents—The patient controls bladder completely and intentionally, and does not have any accidents.

6 No Accidents; uses device such as catheter—The patient requires a urinal, bedpan, catheter, beside commode, absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. *The patient has no accidents*.

HELPER

5 One (1) bladder accident, including bedpan and urinal spills, in the past 7 days.

4 Two (2) accidents, including bedpan and urinal spills, in the past 7 days.

3 Three (3) accidents, including bedpan and urinal spills, in the past 7 days.

2 Four (4) accidents, including bedpan and urinal spills, in the past 7 days.

1 Five (5) or more accidents, including bedpan and urinal spills, in the past 7 days.

Do not use code "0" for Bladder Management – Frequency of Accidents.

If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence.

COMMENT: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This item deals with the frequency of accidents required to complete bladder management tasks.

A separate Function Modifier, *Bladder Management—Level of Assistance* (Item 29), deals with assistance with bladder management.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).

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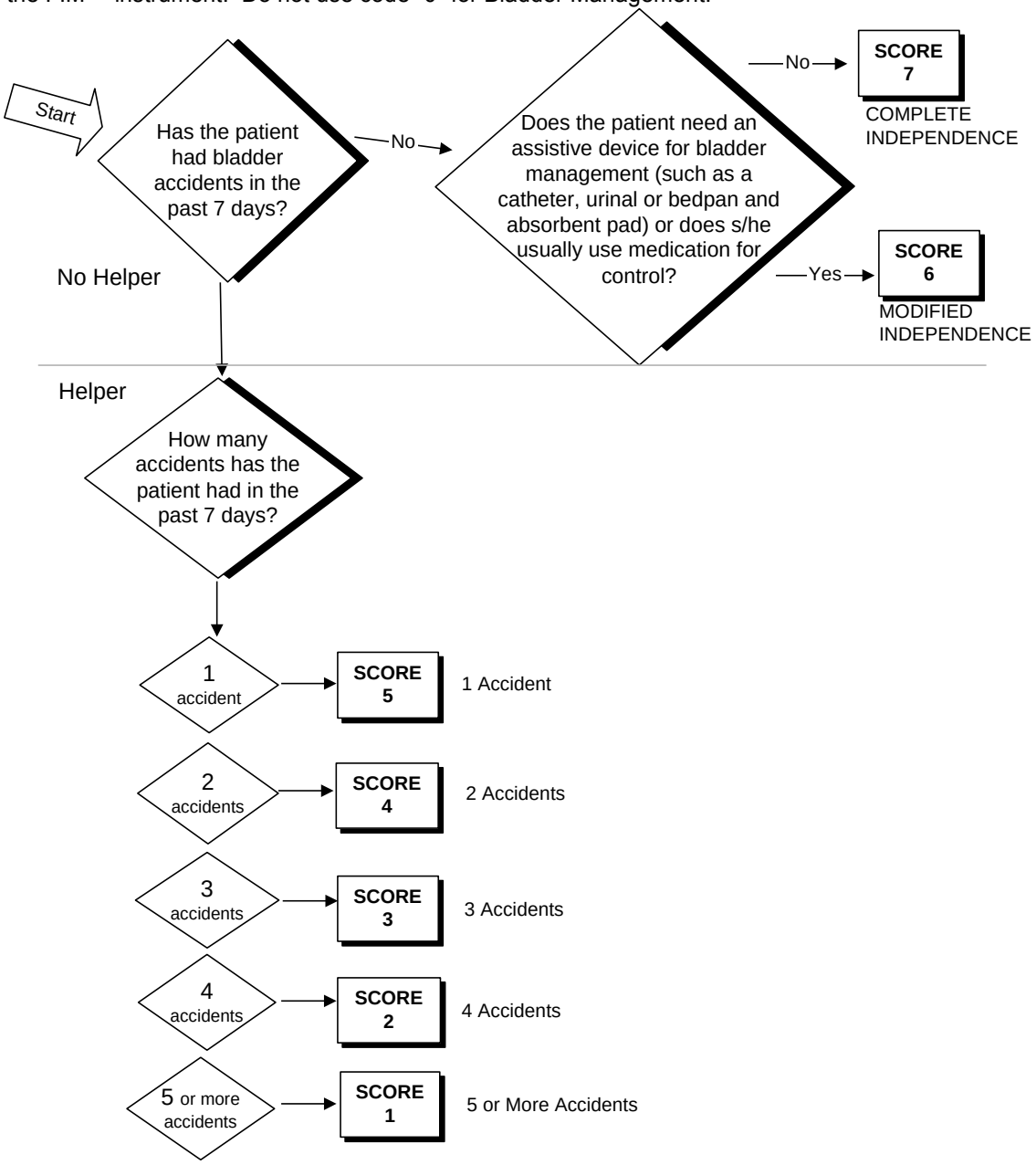
BLADDER MANAGEMENT - PART 2 FREQUENCY OF ACCIDENTS

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the subject controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bladder Management.



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BOWEL MANAGEMENT - Level of Assistance: *Bowel Management - Level of Assistance* includes use of equipment or agents for bowel management. (Note: Use these definitions to score the Function Modifier, Item 31; refer to the comment below to score Item 39H).

NO HELPER

7 Complete Independence—The patient controls bowels completely and intentionally without equipment or devices, and does not have any bowel accidents.

6 Modified Independence—The patient requires a bedpan, beside commode, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. If the individual has a colostomy, (s)he maintains it.

HELPER

5 Supervision or Setup—The patient has required supervision (e.g., standing by, cuing, or coaxing) or setup of equipment necessary for the individual to maintain either a satisfactory excretory pattern or an ostomy device at any time during the past 3 days.

4 Minimal Contact Assistance—Patient requires minimal contact assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. Patient performs 75% or more of bowel management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. The patient performs 50 to 74% of bowel management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bowel management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bowel management tasks in the past 3 days.

Do not use code "0" for Bowel Management – Level of Assistance.

COMMENT: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance in some individuals. This item deals with the level of assistance required to complete bowel management tasks.

A separate Function Modifier, *Bowel Management—Frequency of Accidents* (Item 32), deals with frequency of bowel accidents.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).

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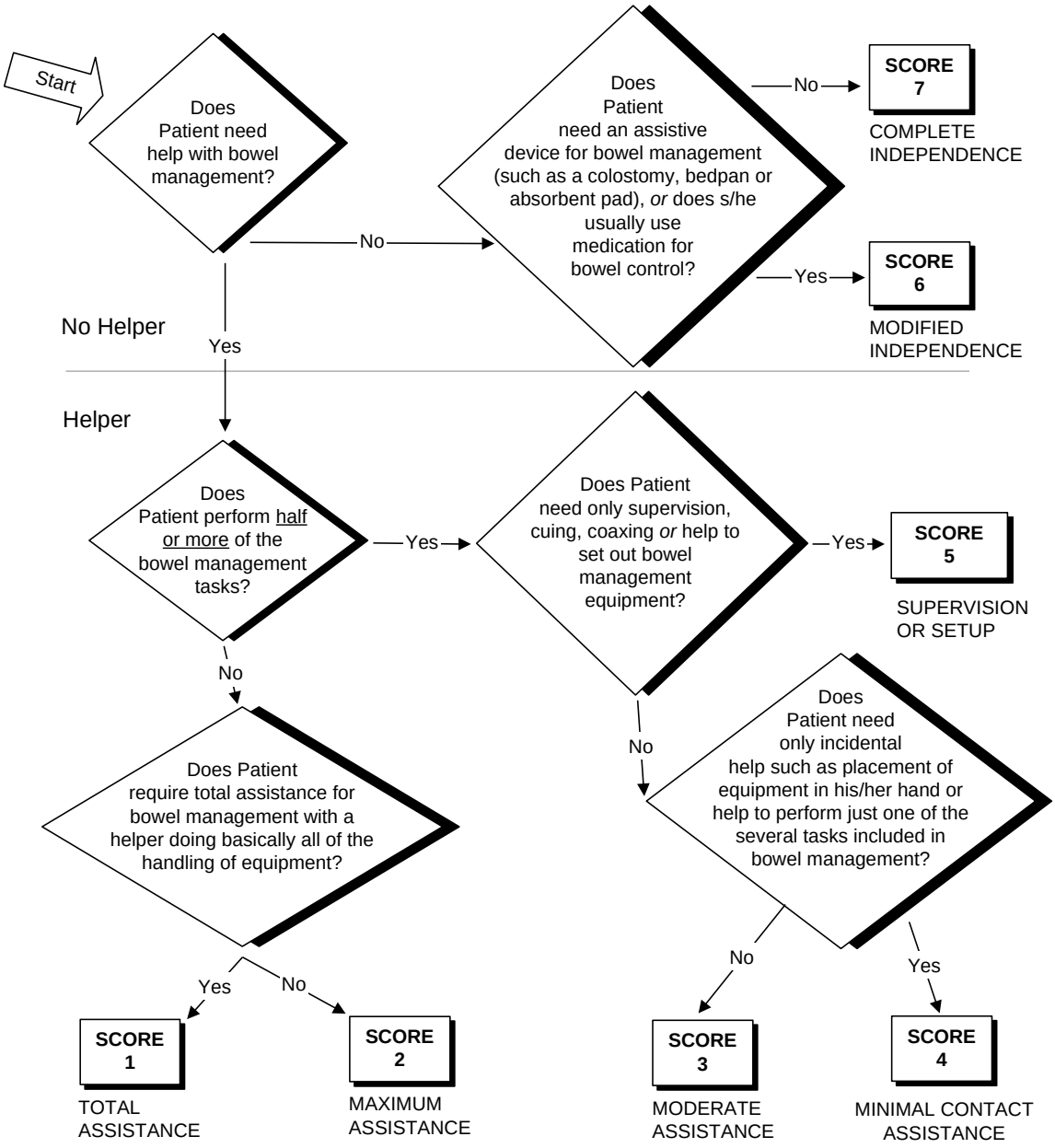
BOWEL MANAGEMENT - LEVEL OF ASSISTANCE

Bowel Management includes complete and intentional control of bowel movements and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowel completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two variables, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bowel Management.



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BOWEL MANAGEMENT - Frequency of Accidents: *Bowel Management - Frequency of Accidents* includes complete intentional control of bowel movements and (if necessary) use of equipment/agents for bowel control. (Note: Use these definitions to score the Function Modifier, Item 32; refer to the comment below to score Item 39H).

Definition of Bowel Accidents - Bowel accidents refer to the act of soiling linen or clothing with stool, and includes bedpan spills.

NO HELPER

7 No Accidents—The patient controls bowels completely and intentionally without equipment or devices, and is *never incontinent* (no accidents).

6 No Accidents; uses device such as ostomy—The patient requires a bedpan, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. *The patient has no accidents*.

HELPER

5 One (1) accident in the past 7 days.

4 Two (2) accidents in the past 7 days.

3 Three (3) accidents in the past 7 days.

2 Four (4) accidents in the past 7 days.

1 Five (5) or more accidents in the past 7 days.

Do not use code "0" for Bowel Management – Frequency of Accidents.

COMMENT: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This item deals with the frequency of accidents required to complete bowel management tasks.

A separate Function Modifier, *Bowel Management—Level of Assistance* (Item 31), deals with level of assistance associated with bowel management.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).

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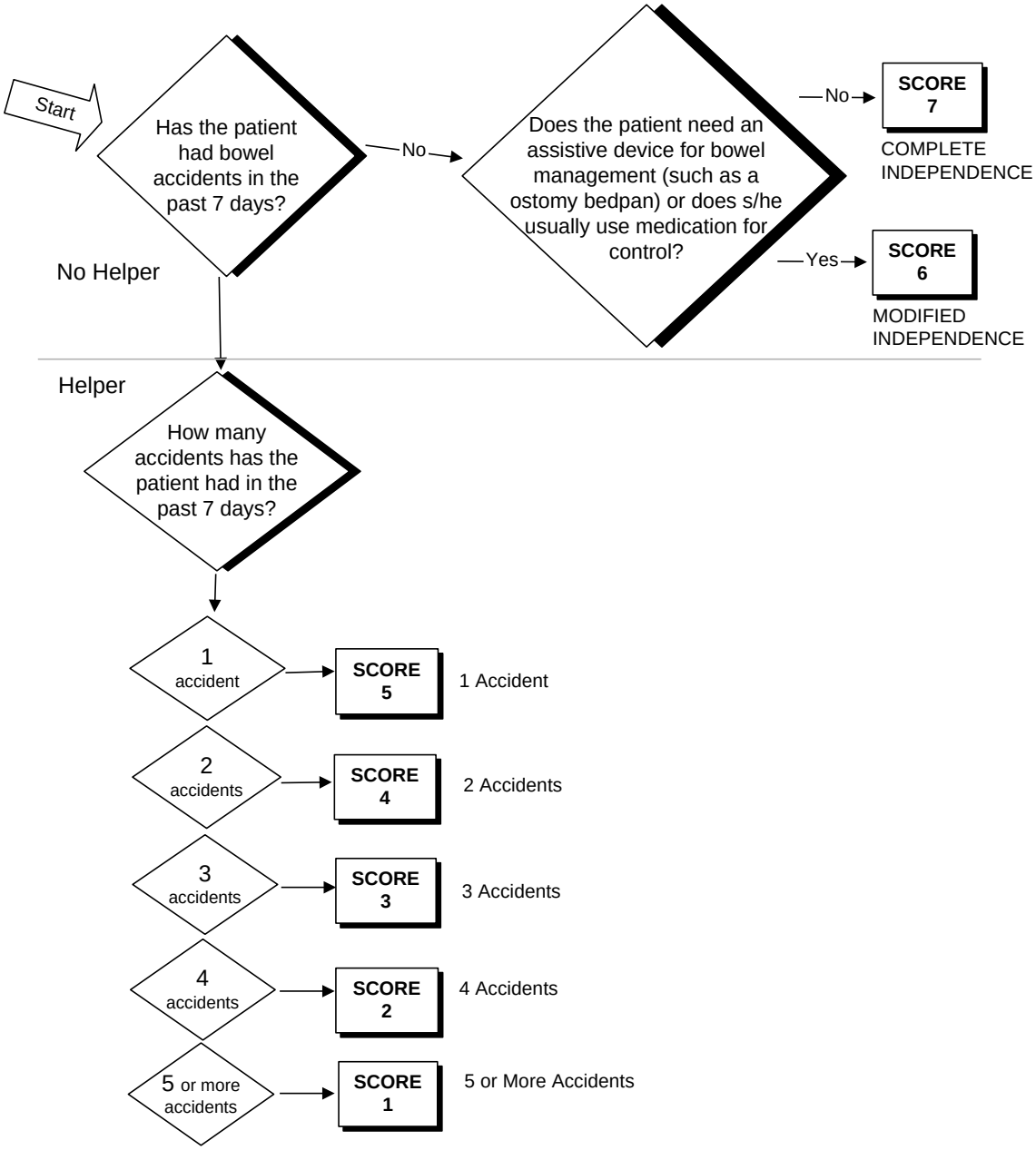
BOWEL MANAGEMENT - FREQUENCY OF ACCIDENTS

Bowel Management includes complete and intentional control of the bowels and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowels completely and intentionally and has no accidents. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bowel Management.



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TRANSFERS: BED, CHAIR, WHEELCHAIR: *Transfers: Bed, Chair, Wheelchair* includes all aspects of transferring from a bed to a chair and back, or from a bed to a wheelchair and back, or coming to a standing position if walking is the typical mode of locomotion. The patient performs the activity safely.

NO HELPER

7 Complete Independence:

If walking, patient safely approaches, sits down on a regular chair, and gets up to a standing position from a regular chair. Patient also safely transfers from bed to chair.

If in a wheelchair, patient approaches a bed or chair, locks brakes, lifts foot rests, removes arm rest if necessary, and performs either a standing pivot or sliding transfer (without a board) and returns. The patient performs this activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device such as a sliding board, a lift, grab bars, or a special seat/chair/brace/crutches; or the activity takes more than a reasonable amount of time; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer to or from the bed or a chair, and is not transferred to or from the bed or a chair by a helper or lifting device. Use of this code should be rare.

COMMENT*:* During the bed-to-chair transfer, the subject begins and ends in the supine position.

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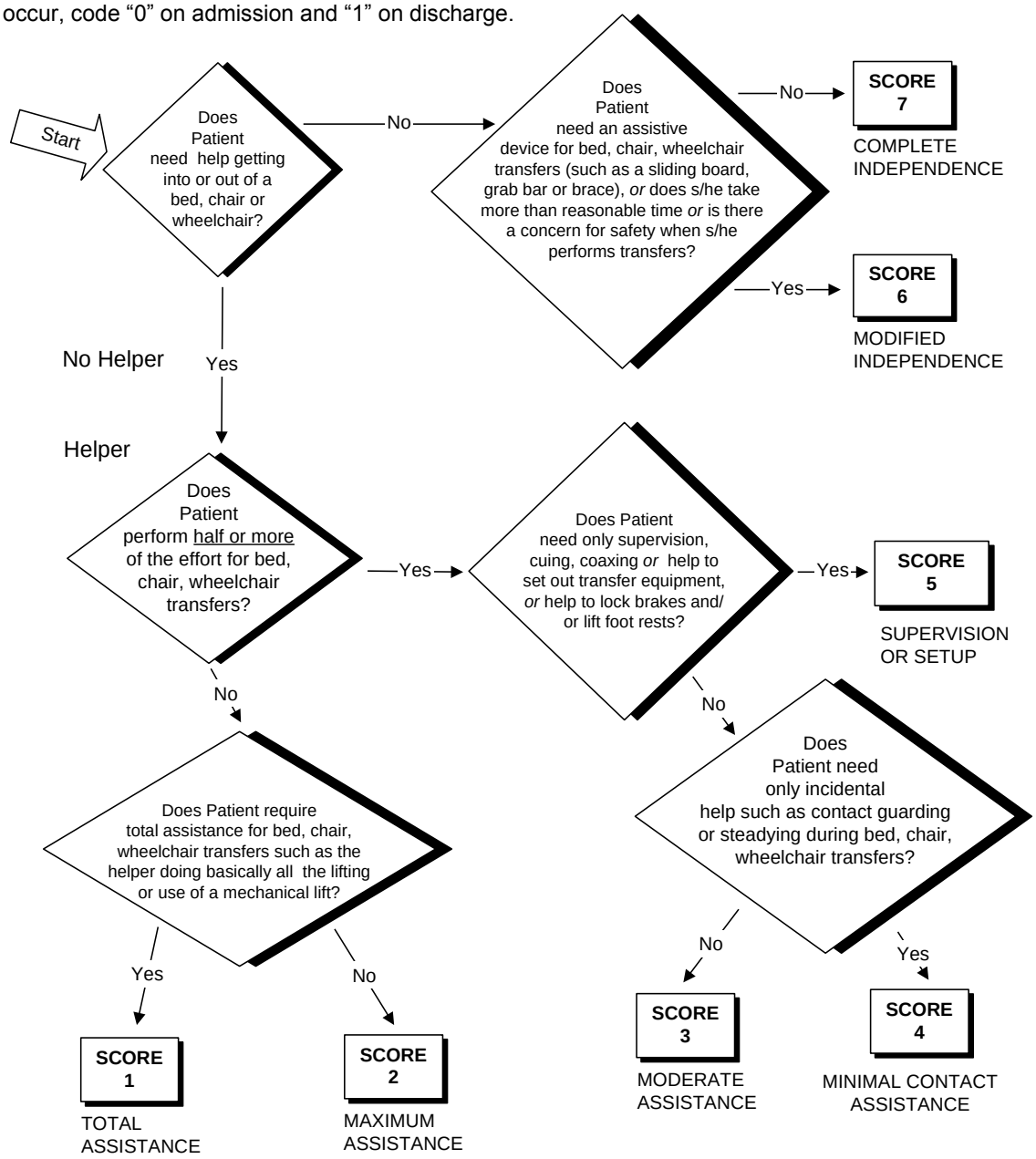
TRANSFERS: BED, CHAIR, WHEELCHAIR

Transfers: Bed, Chair, Wheelchair includes all aspects of transferring from bed to a chair, or wheelchair, or coming to a standing position, if walking is the typical mode of locomotion. At level 7 the subject approaches, sits down on and gets up to a standing position from a regular chair; transfers from bed to chair. Performs independently and safely. *If in a wheelchair*, approaches a bed or chair, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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TRANSFERS: TOILET: *Transfers: Toilet* includes safely getting on and off a standard toilet.

NO HELPER

7 Complete Independence

If walking, patient approaches, sits down on a standard toilet, and gets up from a standard toilet. The patient performs the activity safely.

If in a wheelchair, patient approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device such as a sliding board, a lift, grab bars, bedside commode, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer on or off the toilet/commode, and is not transferred on or off the toilet/commode by a helper or lifting device. For example, the patient uses only a bedpan and/or urinal. Use of this code should be rare.

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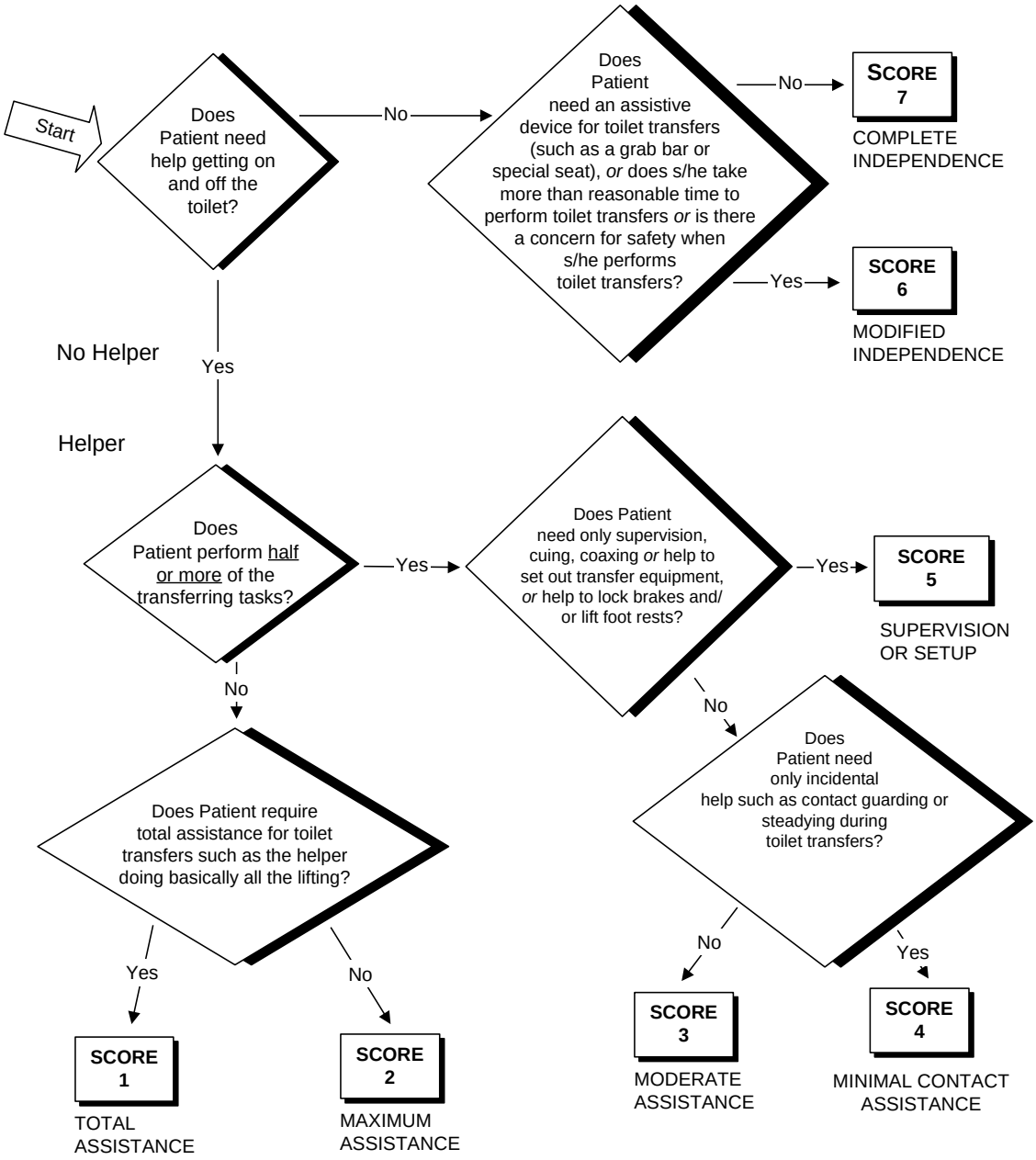
TRANSFERS: TOILET

Transfers: Toilet includes getting on and off a toilet. At level 7 the subject approaches, sits down on and gets up from a standard toilet. Performs independently and safely. *If in a wheelchair*, approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



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TRANSFERS: TUB: *Transfers: Tub* includes getting into and out of a tub. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 33; refer to the comment below to score Item 39K). Tub transfer is assessed before and after an actual (wet) bathing episode in a tub, not during a simulated episode.

NO HELPER

7 Complete Independence

If walking, the patient approaches a tub, and gets into and out of it. The patient performs the activity safely.

If in a wheelchair, the patient approaches a tub, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device (including a prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching, and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Transfers: Tub as "0," and leave Transfers: Shower blank. Code "0" may be used for Transfers: Tub on admission and discharge.

COMMENT: There is a separate Function Modifier that addresses transfers into a shower stall. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 33, leave Item 34 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).

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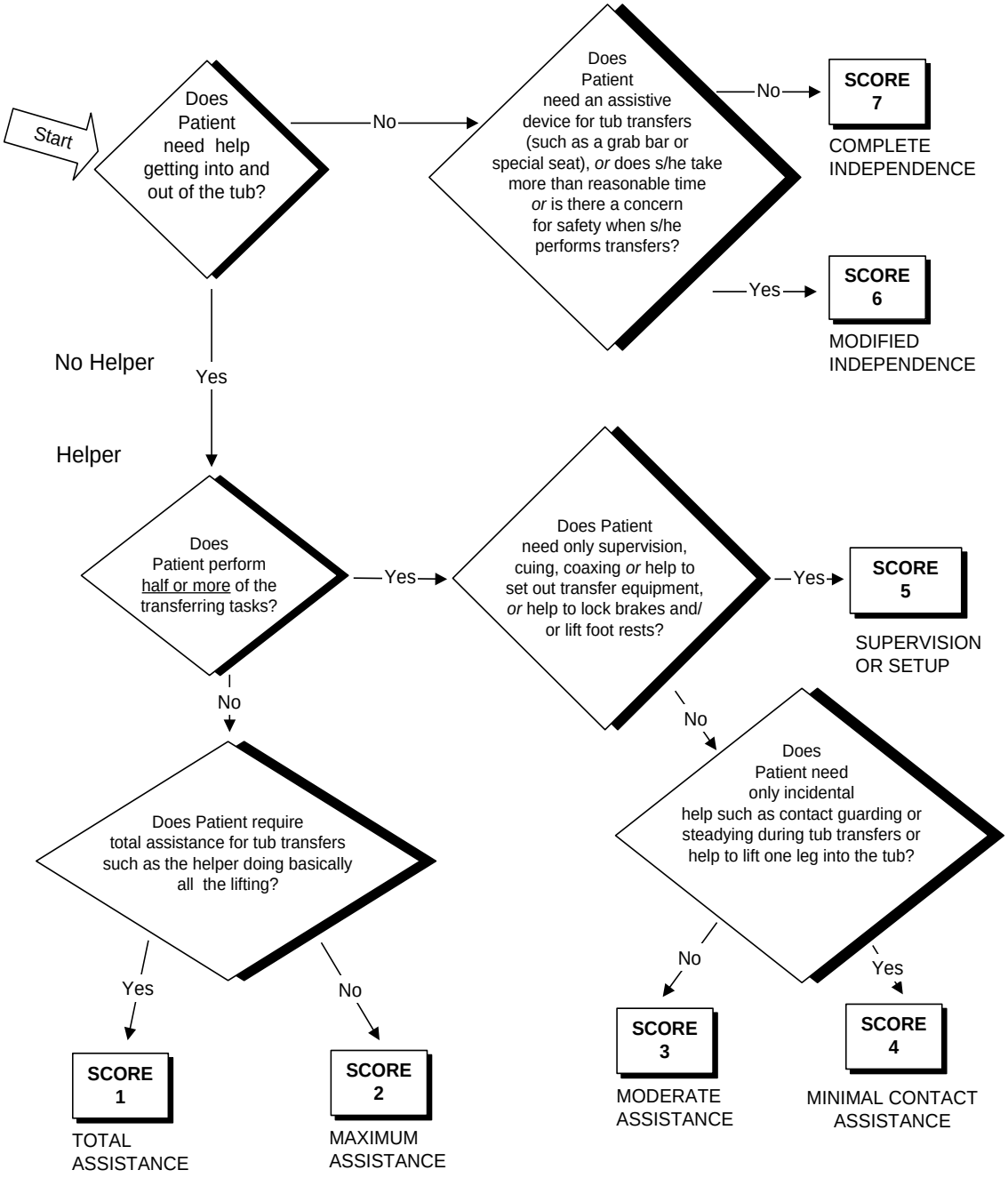
TRANSFERS: TUB

Transfers: Tub includes getting into and out of a tub. At level 7 the subject approaches, gets in and out of a tub. Performs independently and safely. *If in a wheelchair*, approaches tub or shower, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge. COMMENT: There is a separate function modifier that addresses transfers into a shower stall. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the lower score.



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TRANSFERS: SHOWER: *Transfers: Shower* includes getting into and out of a shower. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 34; refer to the comment below to score Item 39K). Shower transfer is assessed before and after an actual (wet) bathing episode in a shower, not during a simulated episode.

NO HELPER

7 Complete Independence

If walking, the patient approaches a shower stall, and gets into and out of it. The patient performs the activity safely.

If in a wheelchair, the patient approaches a shower stall, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device (including a prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient requires more help than touching or performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Tub Transfer as "0," and leave Shower Transfer blank. Do not use code "0" for Shower Transfer.

COMMENT: There is a separate Function Modifier that addresses transfers into a tub. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 34, leave Item 33 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).

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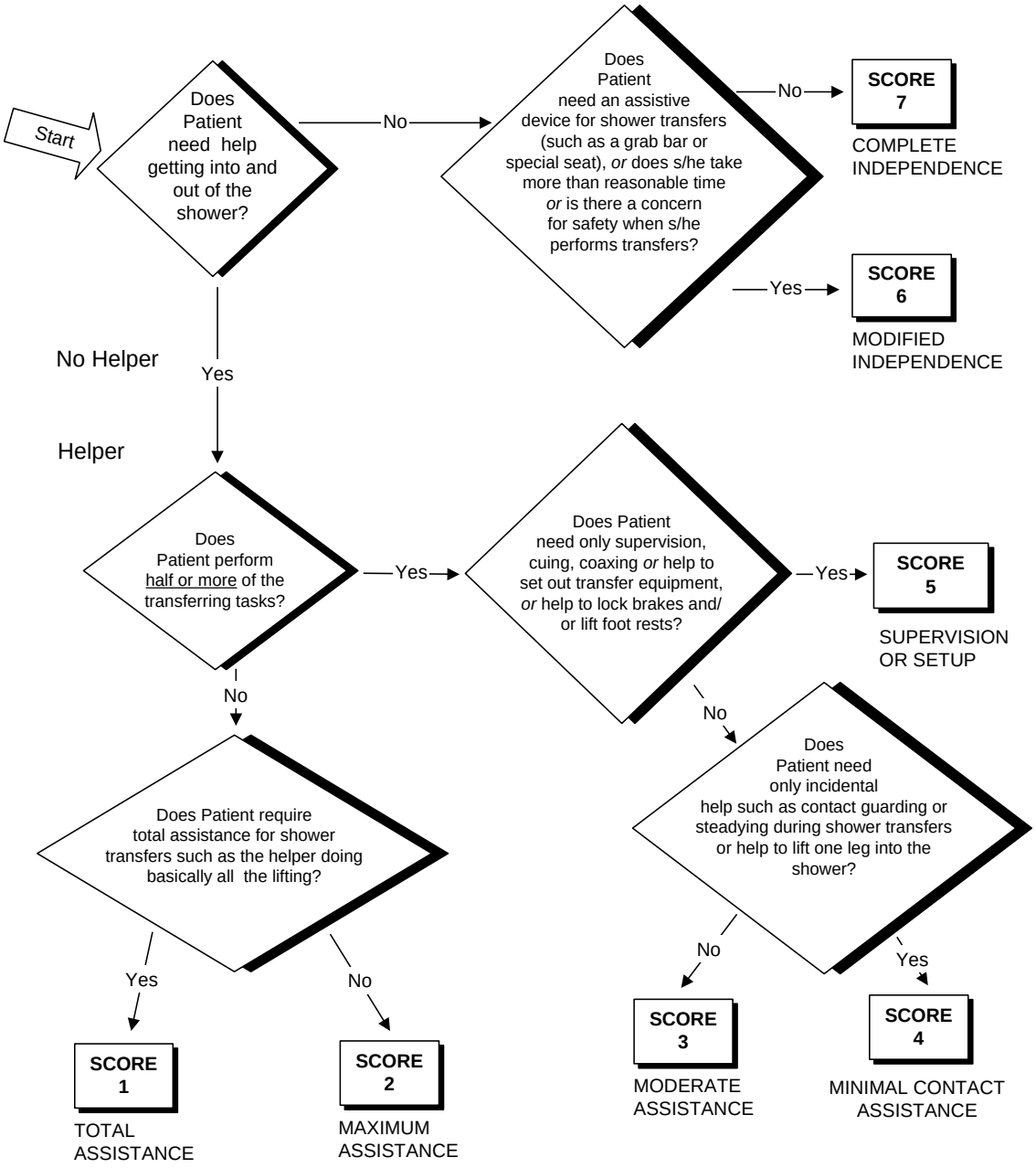
TRANSFERS: SHOWER

Transfers: Shower includes getting into and out of a shower stall. At level 7 the subject approaches, gets in and out of a shower stall. Performs independently and safely. *If in a wheelchair*, approaches shower, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. Do not use code "0" for Transfers: Shower. COMMENT: There is a separate function modifier that addresses transfers into a tub. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the lower score.



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LOCOMOTION: WALK: *Locomotion: Walk* includes walking on a level surface once in a standing position. The patient performs the activity safely. This is the first of two locomotion function modifiers.

NO HELPER

7 Complete Independence—The patient walks a minimum of 150 feet (50 meters) without assistive devices. The patient performs the activity safely.

6 Modified Independence—The patient walks a minimum of 150 feet (50 meters), but uses a brace (orthosis) or prosthesis on leg, special adaptive shoes, cane, crutches, or walkerette; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

5 Exception (Household Locomotion)—The patient walks only short distances (a minimum of 50 feet or 15 meters) *independently* with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision—The patient requires standby supervision, cuing, or coaxing to go a minimum of 150 feet (50 meters).

4 Minimal Contact Assistance—The patient performs 75% or more of walking effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of walking effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of walking effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or walks to less than 50 feet (15 meters).

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not walk. For example, use 0 if the patient uses only a wheelchair for locomotion or the patient is on bed rest.

COMMENT: If the patient requires an assistive device for locomotion (prosthesis, walker, cane, AFO, adapted shoe, etc.), then the Locomotion: Walk score can never be higher than level 6.

There are two locomotion function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument item 39L, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument.[1] Indicate the most frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code "Both."

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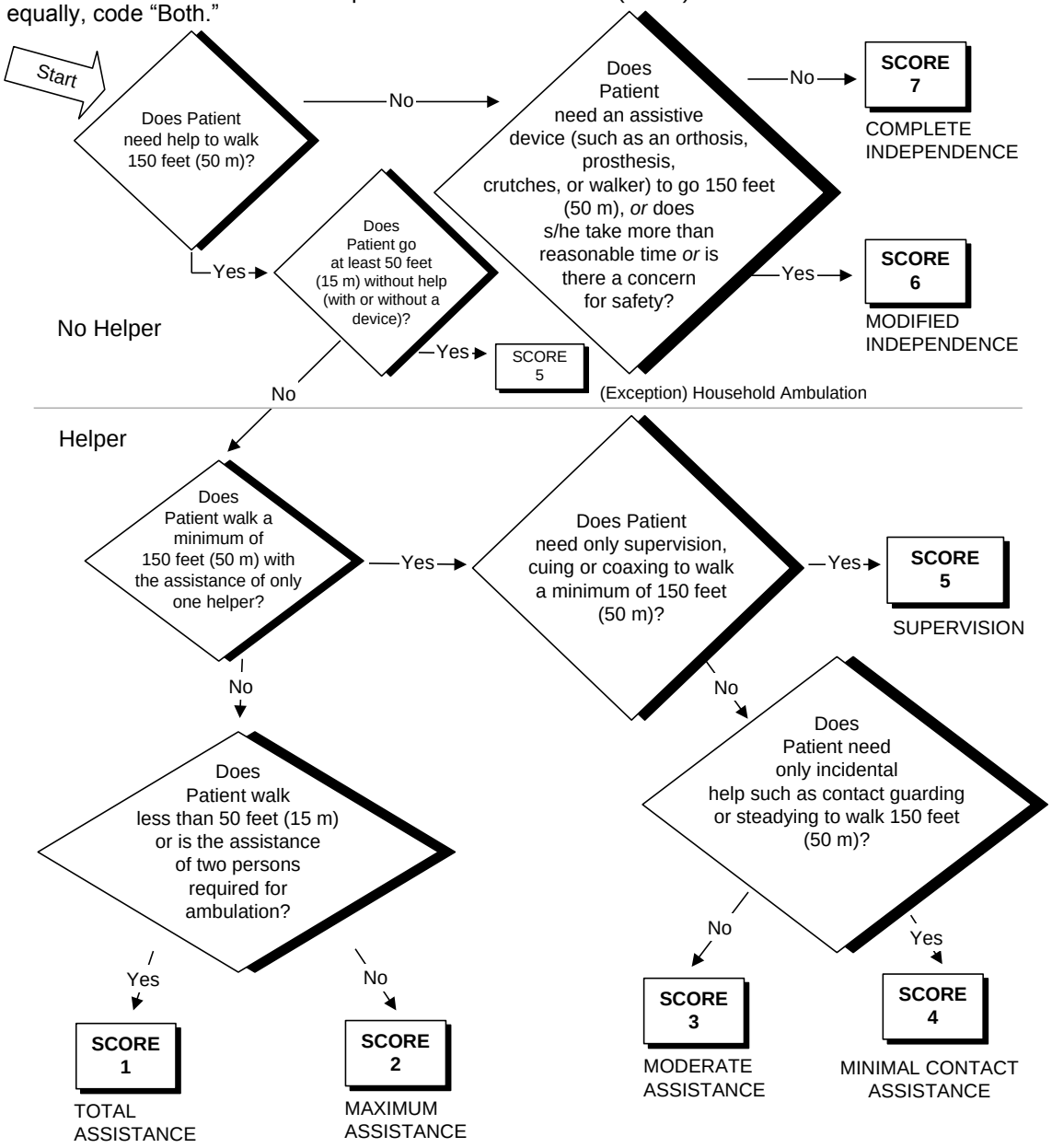
LOCOMOTION: WALK

Walk includes walking, once in a standing position, on a level surface. At level 7 the patient walks a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used about equally, code "Both."



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LOCOMOTION: WHEELCHAIR: *Locomotion: Wheelchair* includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. This is the second function modifier.

NO HELPER

7 This score is not to be used if the patient uses a wheelchair for Locomotion.

6 Modified Independence—The patient operates a manual or motorized wheelchair independently for a minimum of 150 feet (50 meters); turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3 percent grade; and maneuvers on rugs and over door sills.

5 Exception (Household Locomotion)—The patient operates a manual or motorized wheelchair *independently* only short distances (a minimum of 50 feet or 15 meters).

HELPER

5 Supervision—The patient requires standby supervision, cuing, or coaxing to go a minimum of 150 feet (50 meters) in a wheelchair.

4 Minimal Contact Assistance—The patient performs 75% or more of locomotion effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of locomotion effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of locomotion effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or wheels less than 50 feet (15 meters).

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not use a wheelchair, and is not pushed in a wheelchair by a helper.

COMMENT: There are two Locomotion function modifiers (Items 37 and 38). Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument.[1] Indicate the more frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code "Both." If both are used about equally at discharge, use the score for Walk (Item 37) to complete both the admission and discharge portions of Item 39L.

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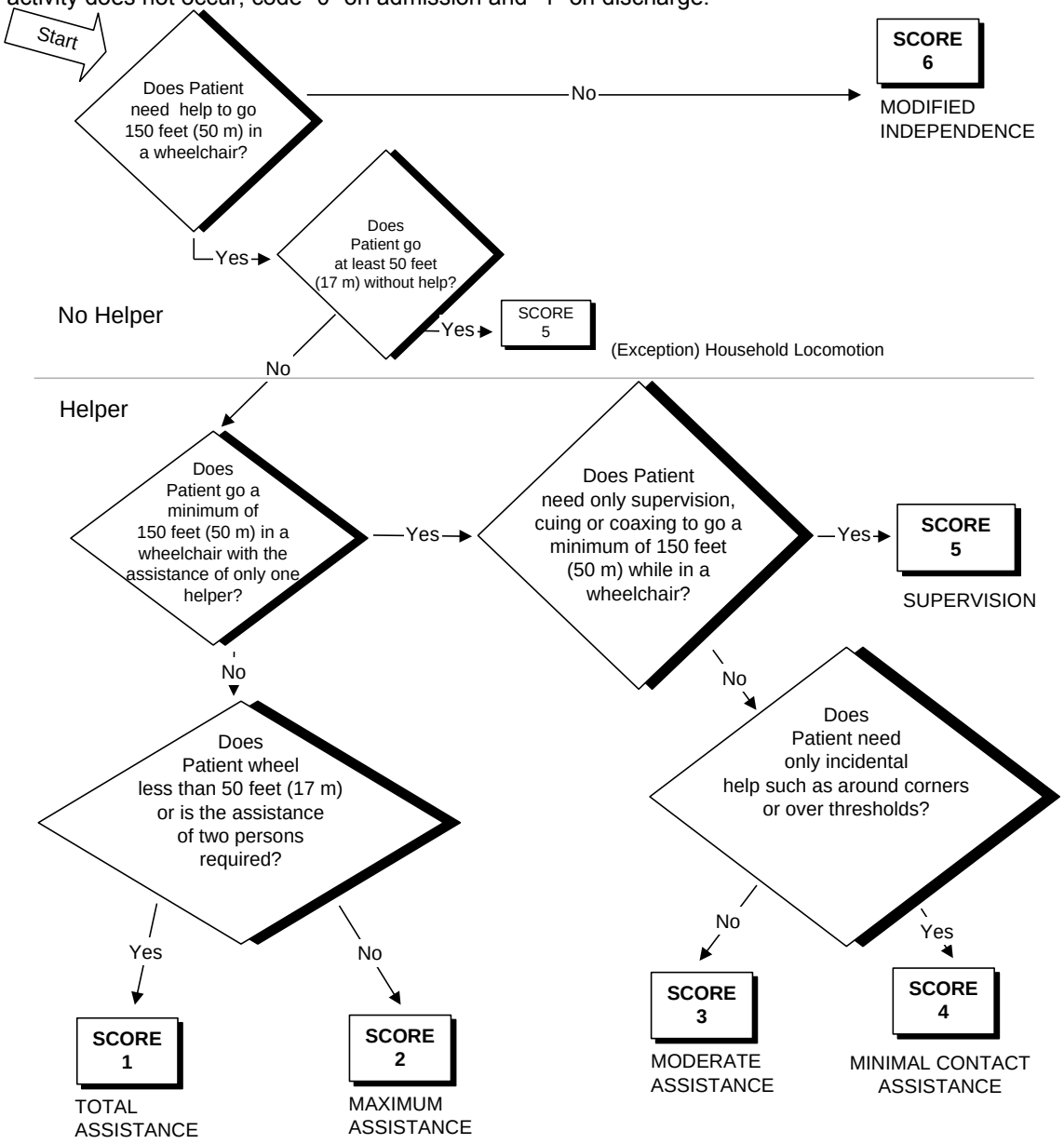
LOCOMOTION: WHEELCHAIR

Wheelchair includes, once in a seated position, on a level surface. At level 6 the subject wheels a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used about equally, code "Both." If activity does not occur, code "0" on admission and "1" on discharge.



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LOCOMOTION: STAIRS: *Locomotion: Stairs* includes going up and down 12 to 14 stairs (one flight) indoors in a safe manner.

NO HELPER

7 Complete Independence—The patient safely goes up and down at least one flight of stairs without depending on any type of handrail or support.

6 Modified Independence—The patient goes up and down at least one flight of stairs but requires a side support, handrail, cane, or portable supports; or the activity takes more than a reasonable amount of time; or there are safety considerations.

5 Exception (Household Ambulation)—The patient goes up and down 4 to 6 stairs *independently*, with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision—The patient requires supervision (e.g., standing by, cuing, or coaxing) to go up and down one flight of stairs.

4 Minimal Contact Assistance—The patient performs 75% or more of the effort to go up and down one flight of stairs.

3 Moderate Assistance—The patient performs 50 to 74% of the effort to go up and down one flight of stairs.

2 Maximal Assistance—The patient performs 25 to 49% of the effort to go up and down 4 to 6 stairs, and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of the effort, or requires the assistance of two people, or goes up and down fewer than 4 stairs.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The subject does not go up or down stairs, and a helper does not carry the subject up or down stairs.

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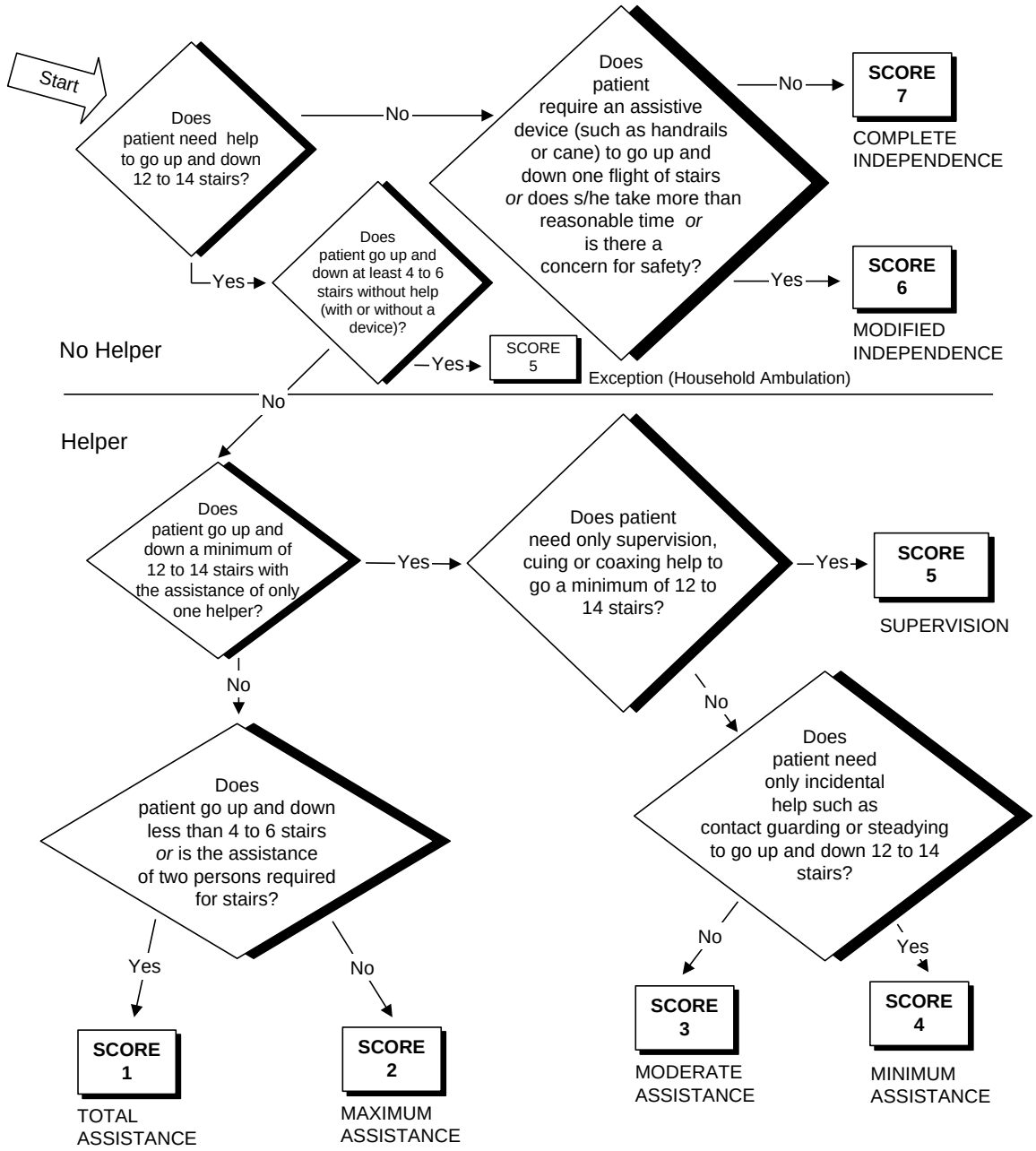
LOCOMOTION: STAIRS

Stairs includes going up and down 12 to 14 stairs (one flight). At level 7 the patient goes up and down one flight of stairs without any type of handrail or support. Performs independently and safely. If activity does not occur code "0" on admission and "1" on discharge.



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COMPREHENSION: ***Comprehension*** includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). Evaluate and indicate the more usual mode of comprehension ("Auditory" or "Visual"). If both are used about equally, code "Both."

NO HELPER

7 Complete Independence—The patient understands *complex or abstract directions and conversation*, and understands either spoken or written language (not necessarily English).

6 Modified Independence—In most situations, the patient understands readily or with only mild difficulty *complex or abstract directions and conversation.* The patient does not require prompting, though (s)he may require a hearing or visual aid, other assistive device, or extra time to understand the information.

HELPER

5 Standby Prompting—The patient understands *directions and conversation about basic daily needs* more than 90% of the time. The patient requires prompting (slowed speech rate, use of repetition, stressing particular words or phrases, pauses, visual or gestural cues) less than 10% of the time.

4 Minimal Prompting—The patient understands *directions and conversation about basic daily needs* 75 to 90% of the time.

3 Moderate Prompting—The patient understands *directions and conversation about basic daily needs* 50 to 74% of the time.

2 Maximal Prompting—The patient understands *directions and conversation about basic daily needs* 25 to 49% of the time. Understands only *simple, commonly used spoken expressions* (e.g., *hello*, *how are you*) or gestures (e.g., waving good-bye, thank you). Requires prompting more than half the time.

1 Total Assistance—The patient understands *directions and conversation about basic daily needs* less than 25% of the time, or does not understand *simple, commonly used spoken expressions* (e.g., *hello*, *how are you*) or gestures (e.g., waving good-bye, thank you), or does not respond appropriately or consistently despite prompting.

Do not use code "0" for Comprehension.

COMMENT: *Comprehension* of complex or abstract information includes (but is not limited to) understanding current events appearing in television programs or newspaper articles, or abstract information on subjects such as religion, humor, math, or finances used in daily living. Comprehension of *complex or abstract information* may also include understanding information given during a group conversation. Information about *basic daily needs* refers to conversation, directions, and questions or statements related to the patient's need for nutrition, fluids, elimination, hygiene or sleep (physiological needs).

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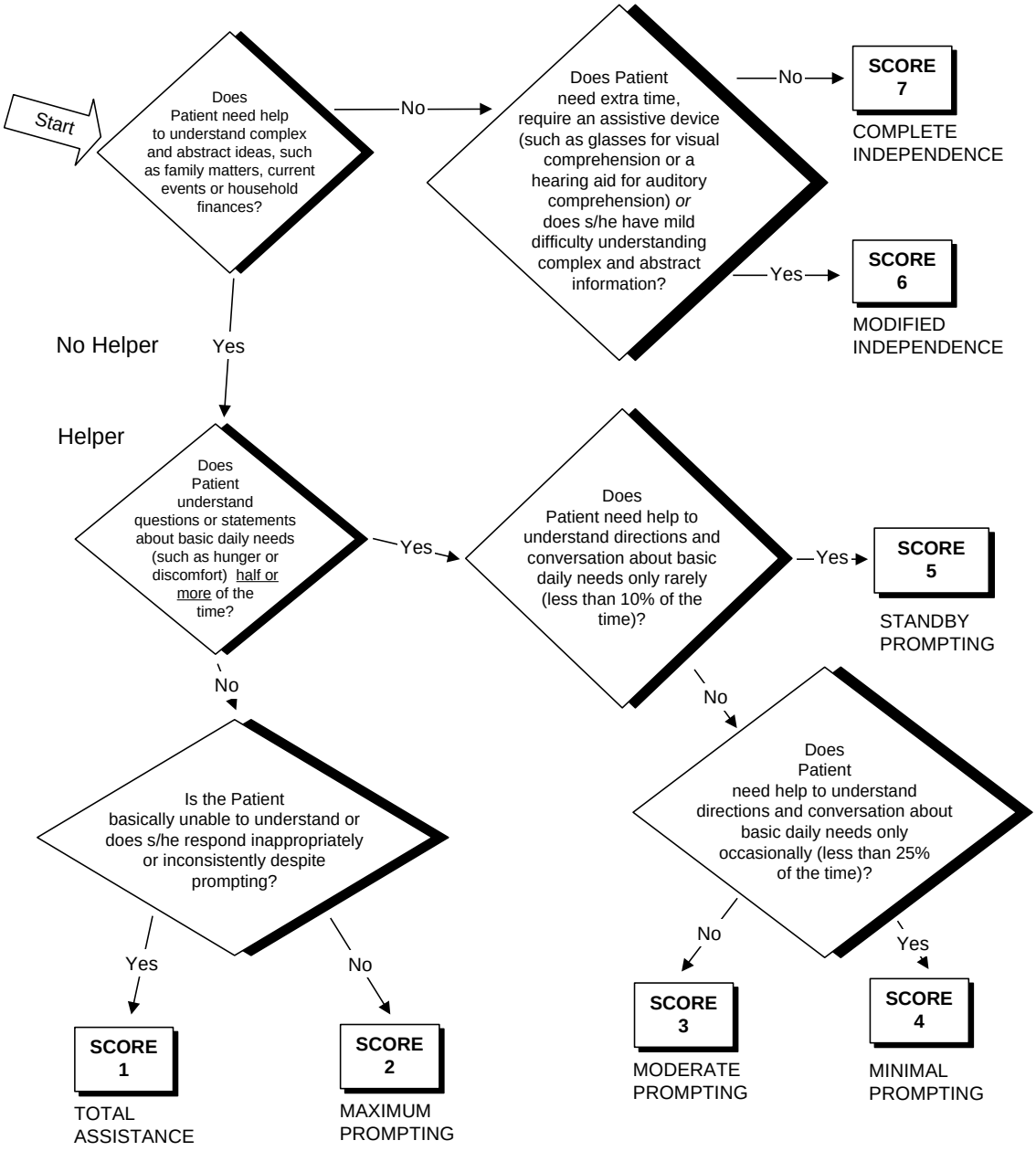
COMPREHENSION

Comprehension includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). At level 7 the subject understands directions and conversation that are complex or abstract; understands either spoken or written language, not necessarily English. Evaluate and indicate the more usual mode of comprehension ("Auditory" or "Visual"). If both are used about equally, code "Both." Do not use Code “0” for Comprehension.



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EXPRESSION: *Expression* includes clear vocal or nonvocal expression of language. This item includes either intelligible speech or clear expression of language using writing or a communication device. Evaluate and indicate the more usual mode of expression ("Vocal" or "Nonvocal"). If both are used about equally, code "Both".

NO HELPER

7 Complete Independence—The patient expresses *complex or abstract ideas* clearly and fluently (not necessarily in English).

6 Modified Independence—In most situations, the patient expresses *complex or abstract ideas* relatively clearly or with only mild difficulty. The patient does not need any prompting, but (s)he may require an augmentative communication device or system.

HELPER

5 Standby Prompting—The patient expresses *basic daily needs and ideas* more than 90% of the time. Requires prompting (e.g., frequent repetition) less than 10% of the time to be understood.

4 Minimal Prompting—The patient expresses *basic daily needs and ideas* 75 to 90% of the time.

3 Moderate Prompting—The patient expresses *basic daily needs and ideas* 50 to 74% of the time.

2 Maximal Prompting—The patient expresses *basic daily needs and ideas* 25 to 49% of the time. The patient uses only single words or gestures, and (s)he needs prompting more than half the time.

1 Total Assistance—The patient expresses *basic daily needs and ideas* less than 25% of the time, or does not express basic needs appropriately or consistently despite prompting.

Do not use code "0" for Expression.

COMMENT: Examples of *complex or abstract ideas* include (but are not limited to) discussing current events, religion, or relationships with others. Expression of *basic needs and ideas* refers to the patient's ability to communicate about necessary daily activities such as nutrition, fluids, elimination, hygiene, and sleep (physiological needs).

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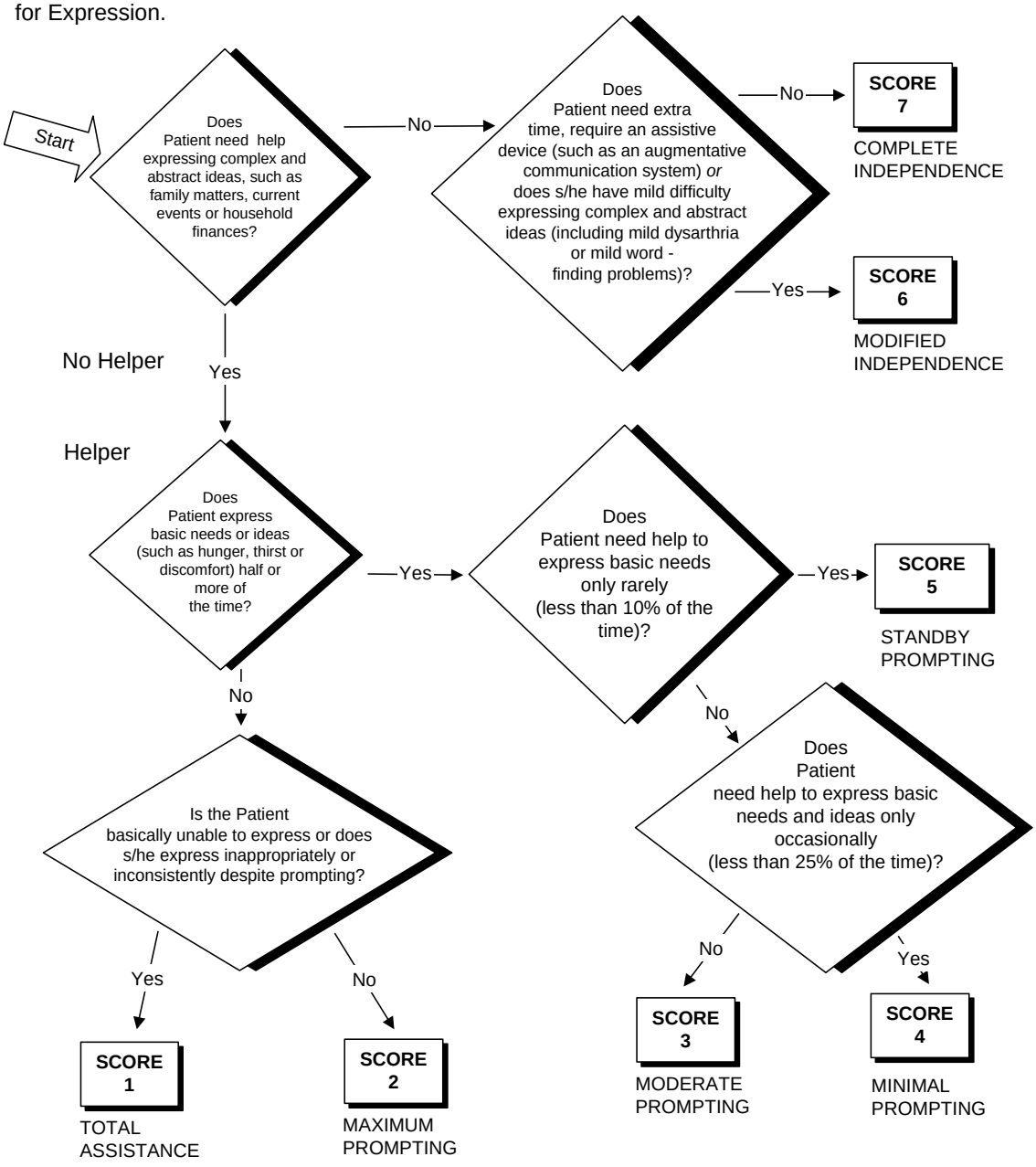
EXPRESSION

Expression includes clear vocal or nonvocal expression of language. This item includes either intelligible speech or clear expression of language using writing or a communication device. At level 7 the subject expresses complex or abstract ideas clearly and fluently. Evaluate and indicate the more usual mode of expression ("Vocal" or "Nonvocal"). If both are used about equally, code "Both". Code “0” is not available for Expression.



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SOCIAL INTERACTION: *Social Interaction* includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs *together with* the needs of others.

NO HELPER

7 Complete Independence—The patient interacts appropriately with staff, other patients, and family members (e.g., controls temper, accepts criticism, is aware that words and actions have an impact on others), and does not require medication for control.

6 Modified Independence—The patient interacts appropriately with staff, other patients, and family members in most situations, and only occasionally loses control. The patient does not require supervision, but may require more than a reasonable amount of time to adjust to social situations, or may require medication for control.

HELPER

5 Supervision—The patient requires supervision (e.g., monitoring, verbal control, cuing, or coaxing) only under stressful or unfamiliar conditions, but less than 10% of the time. The patient may require encouragement to initiate participation.

4 Minimal Direction—The patient interacts appropriately 75 to 90% of the time.

3 Moderate Direction—The patient interacts appropriately 50 to 74% of the time.

2 Maximal Direction—The patient interacts appropriately 25 to 49% of the time, but may need restraint due to socially inappropriate behaviors.

1 Total Assistance—The patient interacts appropriately less than 25% of the time, or not at all, and may need restraint due to socially inappropriate behaviors.

Do not use code "0" for Social Interaction

COMMENT: Examples of socially inappropriate behaviors include temper tantrums; loud, foul, or abusive language; excessive laughing or crying; physical attack; or very withdrawn or non-interactive behavior.

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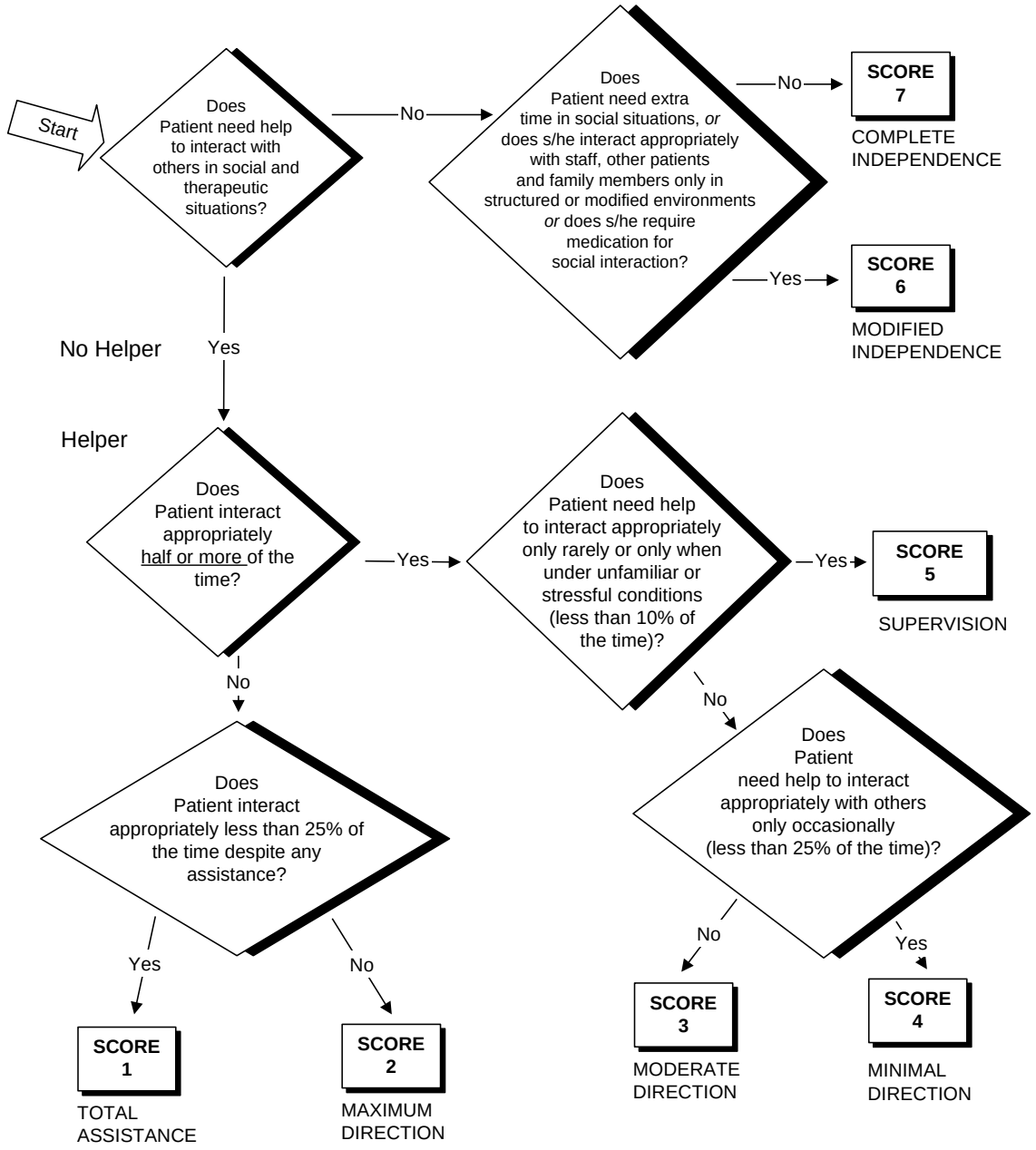
SOCIAL INTERACTION

Social interaction includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs *together with* the needs of others. At level 7 the subject interacts appropriately with staff, other patients, and family members (e.g., controls temper, accepts criticism, is aware that words and actions have an impact on others.) Subject does not require medication for control. Code "0" is not available for Social Interaction.



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PROBLEM SOLVING: *Problem Solving* includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, as well as the initiation, sequencing, and self-correcting of tasks and activities to solve problems.

NO HELPER

7 Complete Independence—The patient consistently recognizes problems when present, makes appropriate decisions, initiates and carries out a sequence of steps to solve *complex problems* until the task is completed, and self-corrects if errors are made.

6 Modified Independence—In most situations, the patient recognizes a present problem, and with only mild difficulty makes appropriate decisions, initiates and carries out a sequence of steps to solve *complex problems*, or requires more than a reasonable time to make appropriate decisions or solve complex problems.

HELPER

5 Supervision—The patient requires supervision (e.g., cuing or coaxing) to solve *routine problems* only under stressful or unfamiliar conditions, but no more than 10% of the time.

4 Minimal Direction—The patient solves *routine problems* 75 to 90% of the time.

3 Moderate Direction—The patient solves *routine problems* 50 to 74% of the time.

2 Maximal Direction—The patient solves *routine problems* 25 to 49% of the time. The patient needs direction more than half the time to initiate, plan, or complete simple daily activities, and may need restraint for safety.

1 Total Assistance—The patient solves *routine problems* less than 25% of the time. The patient needs direction nearly all the time, or does not effectively solve problems, and may require constant one-to-one direction to complete simple daily activities. The patient may need a restraint for safety.

Do not use code "0" for Problem Solving.

COMMENT: Examples of *complex problem-solving* includes activities such as managing a checking account, participating in discharge plans, self-administering medications, confronting interpersonal problems, and making employment decisions. *Routine problem-solving* includes successfully completing daily tasks or dealing with unplanned events or hazards that occur during daily activities. More specific examples of routine problems include asking for assistance appropriately during transfer, asking for a new milk carton if milk is sour or missing, unbuttoning a shirt before trying to put it on, and asking for utensils missing from a meal tray.

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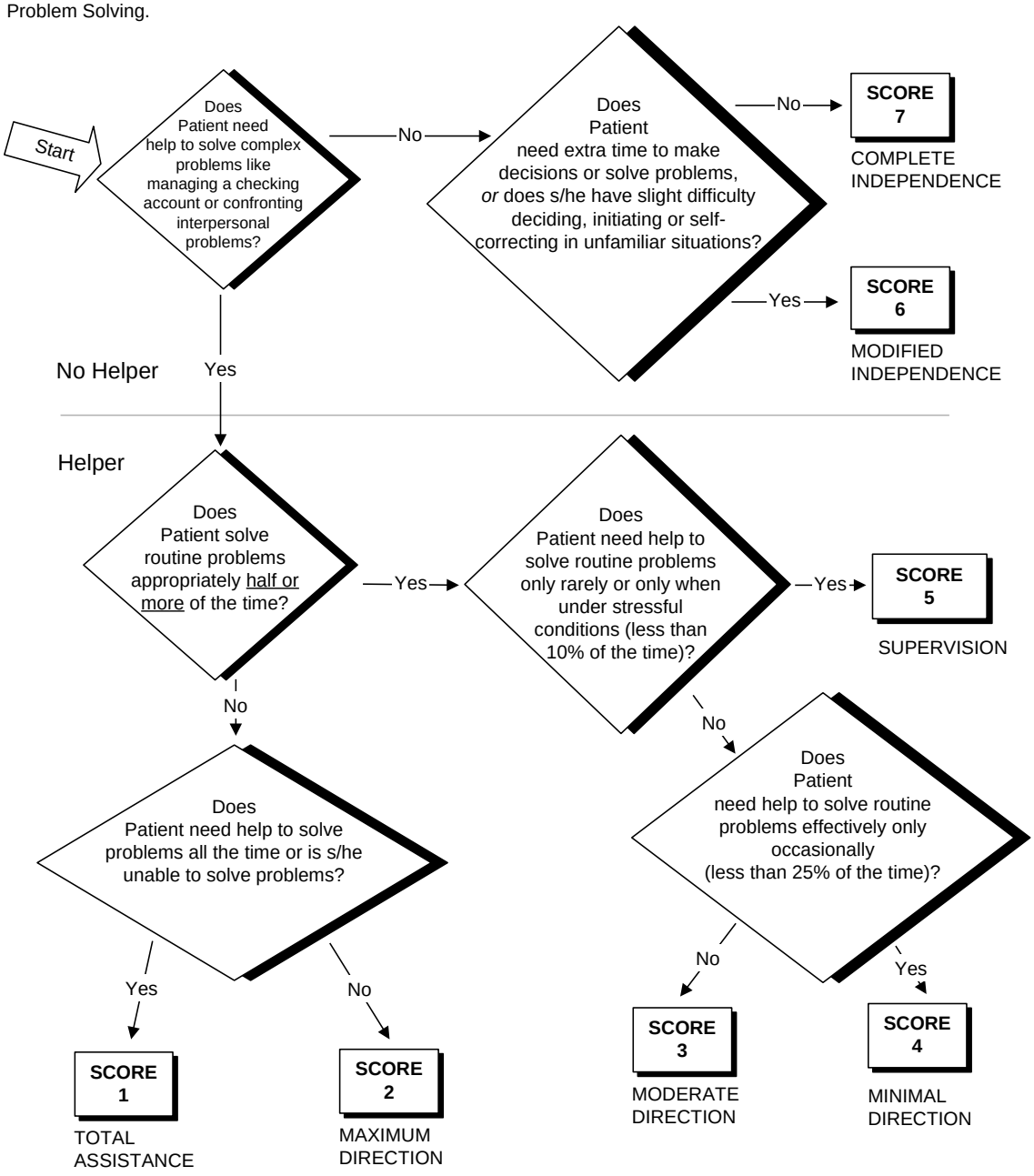
PROBLEM SOLVING

Problem Solving includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social and personal affairs, and initiating, sequencing and self-correcting tasks and activities to solve problems. At level 7 the subject consistently recognizes if there is a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems until the task is completed, and self-corrects if errors are made. Code "0" is not available for Problem Solving.



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MEMORY: *Memory* includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks.

NO HELPER

7 Complete Independence—The patient recognizes people frequently encountered, remembers daily routines, and executes requests of others without need for repetition.

6 Modified Independence—The patient appears to have only mild difficulty recognizing people frequently encountered, remembering daily routines, and responding to requests of others. The patient may use self-initiated or environmental cues, prompts, or aids.

HELPER

5 Supervision—The patient requires prompting (e.g., cuing, repetition, reminders) only under stressful or unfamiliar conditions, but no more than 10% of the time.

4 Minimal Prompting—The patient recognizes and remembers 75 to 90% of the time.

3 Moderate Prompting—The patient recognizes and remembers 50 to 74% of the time.

2 Maximal Prompting—The patient recognizes and remembers 25 to 49% of the time, and needs prompting more than half the time.

1 Total Assistance—The patient recognizes and remembers less than 25% of the time, or does not effectively recognize and remember.

Do not use code "0" for Memory.

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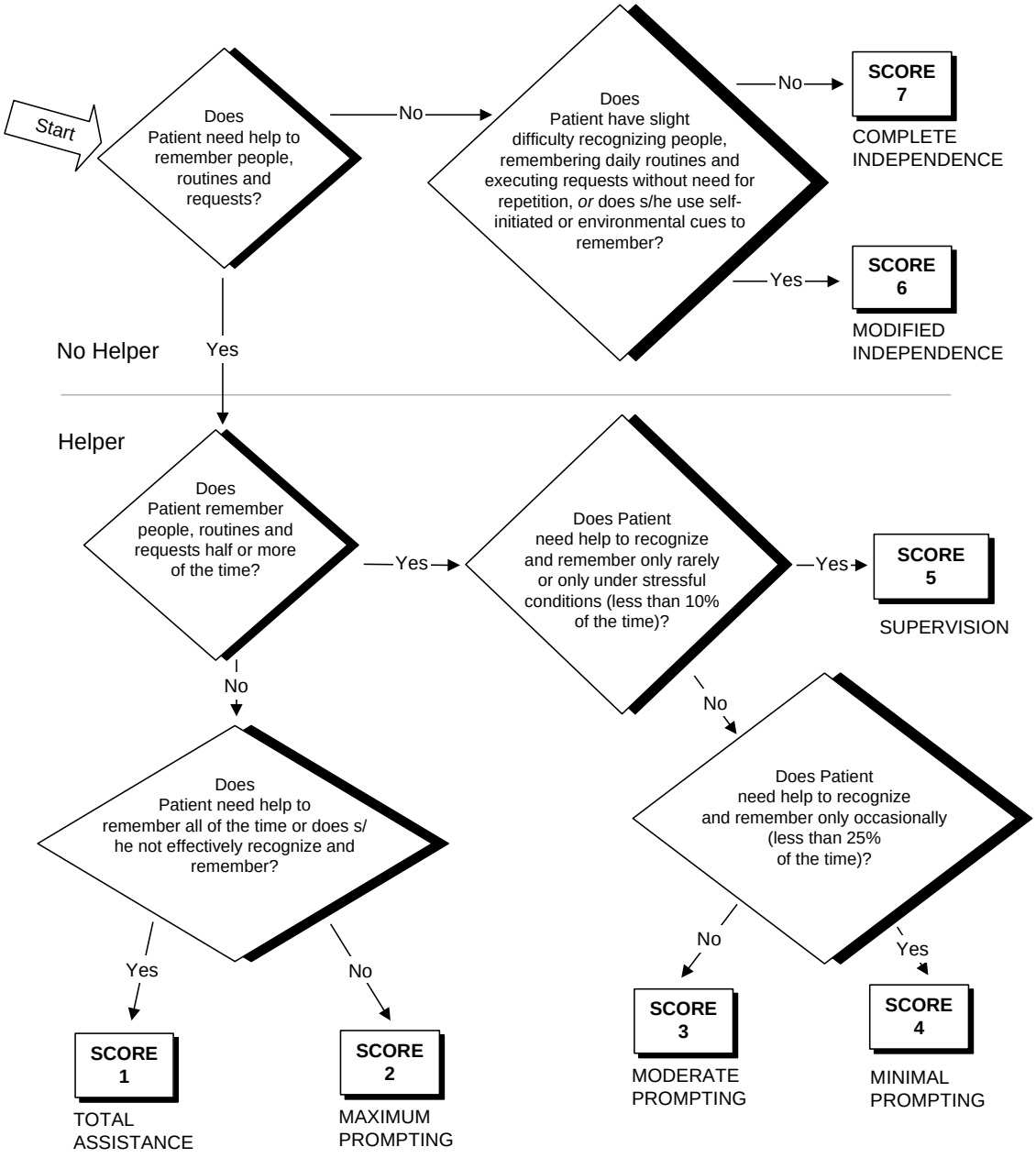
MEMORY

Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines and executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks. At level 7 the subject recognizes people frequently encountered, remembers daily routines, and executes requests of others without need for repetition. Code "0" is not available for Memory



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[1] This method of scoring the Walk/Wheelchair item is in accordance with section 412.610 "Assessment schedule" of the Final Rule (pages 41389-41930) that allows exceptions to the general rules for the admission and discharge assessments to be specified in this manual.

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SECTION IV
MEDICAL NEEDS/QUALITY INDICATORS

MEDICAL NEEDS

Completion of the "Medical Needs" items is voluntary.

25. Is patient comatose at admission? Has the patient been diagnosed as comatose or in a persistent vegetative state? Enter the appropriate code at the time of admission.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) of coma or persistent vegetative state in Comorbid Conditions (Item 24).

26. Is patient delirious at admission? Has the patient exhibited symptoms of delirium? Delirium may be manifested as disoriented thinking, being easily distracted, disorganized speech, restlessness, lethargy, or altered perceptions or awareness of surroundings. Enter the appropriate code at the time of admission.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) of delirium in Comorbid Conditions (Item 24).

27. Swallowing Status. Use the following codes to describe the patient's swallowing status. Enter the appropriate code at the time of admission and discharge.

3 Regular Food: Solids and liquids are swallowed safely without supervision or modified food or liquid consistency.

2 Modified Food Consistency/Supervision: Patient requires modified food or liquid consistency, such as a pureed diet, or the patient requires supervision during eating for safety reasons.

1 Tube/Parenteral Feeding: Tube/parenteral feeding used wholly or partially as a means of sustenance. This includes patients who are unable to have any food by mouth (i.e., NPO).

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28. Clinical signs of dehydration. Does the patient exhibit signs of clinical dehydration? Signs of clinical dehydration may include oliguria, dry skin, orthostatic hypotension, somnolence, agitation, sunken eyes, poor skin turgor, very dry mucous membranes, cyanosis, poor fluid intake, or excessive loss of fluid through vomiting or excessive urine, stools, or sweating (whereby the amount of output exceeds the amount of intake). Enter the appropriate code at the time of admission and discharge.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) related to dehydration in Comorbid Conditions (Item 24), or Complications (Item 47), or Both.

Quality Indicators – Questions 48A – 50D

The August 5, 2011 IRF PPS Final Rule (76 FR 47836) established a quality reporting program for IRFs. Although an IRF may decide not to submit data on Quality Indicators section (Items 48A through 50D), failure to complete such items may result in payment reduction of two percentage points starting in Fiscal Year 2014.

Definitions

A. Pressure Ulcer - A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

B. Healed Pressure Ulcer - Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

Current clinical standards do not support reverse staging or backstaging. For example, over time, a stage 4 pressure ulcer has been healing such that it is less deep, wide, and long. Previous standards using reverse or backstaging would have permitted identification of the pressure ulcer as a Stage 2 pressure ulcer when it reached a depth consistent with Stage 2 pressure ulcers. Current standards require that it continue to be documented as a Stage 4 pressure ulcer until it has completely healed.

C. Pressure Ulcer "Worsening"- Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1 and increasing in severity to stage 4) on an assessment as compared to a previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

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D. Tunneling - A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

E. Undermining - The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the surface.

F. Unstageable Pressure Ulcers - There are 3 types of unstageable pressure ulcers:

1. **Unstageable Pressure Ulcer - Deep Tissue Injury**
   a. Localized area of discolored (darker than surrounding tissue) intact skin.
   b. Related to damage of underlying soft tissue from pressure and/ or shear.
   c. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
   d. Deep tissue injury may be difficult to detect in individuals with dark skin tones
2. **Unstageable Pressure Ulcer - Slough and/ or Eschar**
   a. Known but not stageable related to coverage of wound bed by slough and/ or eschar.
   b. Full thickness tissue loss.
   c. Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed
3. **Unstageable Pressure Ulcer - Non-Removable Dressing**
   Known but not stageable because of the non-removable dressing

IRF-PAI Quality Indicator Pressure Ulcer Questions:

The observation period for the admission and discharge pressure ulcer items (items 48A through 50D) is three calendar days.

Proper Method of Assessment of Pressure Ulcers:

- For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission **or** acquired while the patient was in the care of the IRF.
- Consider current and historical levels of tissue involvement. Review the medical record for the history of the ulcer.
- Review for location and stage at the time of admission and discharge.
- You cannot assign a stage to a pressure ulcer that cannot be fully assessed.

DO NOT report unstageable pressure ulcers on the IRF-PAI. If the pressure ulcer was unstageable on admission, but becomes stageable later, it should be considered as present at the time of admission at the stage at which it first becomes stageable.

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We recognize that the number of pressure ulcers reported in the patient's medical record and ICD-9-CM codes reported on the IRF-PAI or on the UB-04 may not match the number of pressure ulcers reported in the IRF-PAI.

Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

48A. Stage 2. Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough.** May also present as an intact or open/ruptured blister.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters (hips), heels, ankles, elbows, etc).

2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT the primary cause, do not code here.
3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a deep tissue injury rather than a Stage 2 Pressure Ulcer.
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

Admission: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 2, that were present on admission and note the number under the admission assessment. Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission.

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 2, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 2 pressure ulcers are noted at the time of discharge.

Coding Tips:

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- Do NOT code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here.

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- When a lesion that is related to pressure presents with an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do NOT code as a Stage 2.

48B. Stage 3. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present, but does not obscure the depth of tissue loss. May include undermining or tunneling.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters, heels, ankles, elbows, etc).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT the primary cause, do NOT code here.

Admission: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 3, that were present on admission and note the number under the admission assessment. Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission.

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 3, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 3 pressure ulcers are noted at the time of discharge.

Coding Tips:

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

48C. Stage 4. Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).

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2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT the primary cause, do NOT code here.

Admission: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 4, that were present on admission and note the number under the admission assessment. Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission.

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 4, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 4 pressure ulcers are noted at the time of discharge.

Coding Tips:

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.

Worsening in Pressure Ulcer Status Since Admission

49A. Stage 2. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 2, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

49B. Stage 3. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 3, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

49C. Stage 4. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 4, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

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Coding Tips:

- Coding this item will be easier for facilities that document and follow pressure ulcer status on a routine basis.
- Coding unstageable pressure ulcers:
    - If an ulcer was unstageable on admission, do not consider it to be worse at discharge. If the ulcer became stageable, it should be considered present at the time of admission at the stage at which it first became stageable. However, if it worsens after it becomes stageable as noted on the admission assessment, it should be included.
    - If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.
    - If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable. If the pressure ulcer's stage has worsened, code it as such.

Healed Pressure Ulcers

50A. Were unhealed pressure ulcers present on admission? Enter 0 for no and leave items 50B-50D blank. Enter 1 for yes if any unhealed, stage 2 or greater, pressure ulcers were present at the time of admission.

50B. Stage 2. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 2 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**

50C. Stage 3. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 3 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**

50D. Stage 4. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 4 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**

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APPENDIX A
IMPAIRMENT GROUP CODES

Impairment Group Codes		
Impairment Group	**Code**	**Description**
Stroke	01.1	Left Body Involvement (Right Brain)
	01.2	Right Body Involvement (Left Brain)
	01.3	Bilateral Involvement
	01.4	No Paresis
	01.9	Other Stroke
Brain Dysfunction	02.1	Non-traumatic
	02.21	Traumatic, Open Injury
	02.22	Traumatic, Closed Injury
	02.9	Other Brain
Neurologic Conditions	03.1	Multiple Sclerosis
	03.2	Parkinsonism
	03.3	Polyneuropathy
	03.4	Guillain-Barré Syndrome
	03.5	Cerebral Palsy
	03.8	Neuromuscular Disorders
	03.9	Other Neurologic
Spinal Cord Dysfunction		
Non-Traumatic	04.110	Paraplegia, Unspecified
	04.111	Paraplegia, Incomplete
	04.112	Paraplegia, Complete
	04.120	Quadriplegia, Unspecified
	04.1211	Quadriplegia, Incomplete C1-4
	04.1212	Quadriplegia, Incomplete C5-8
	04.1221	Quadriplegia, Complete C1-4
	04.1222	Quadriplegia, Complete C5-8
	04.130	Other Non-Traumatic Spinal Cord Dysfunction
Traumatic	04.210	Paraplegia, Unspecified
	04.211	Paraplegia, Incomplete
	04.212	Paraplegia, Complete
	04.220	Quadriplegia, Unspecified
	04.2211	Quadriplegia, Incomplete C1-4
	04.2212	Quadriplegia, Incomplete C5-8
	04.2221	Quadriplegia, Complete C1-4
	04.2222	Quadriplegia, Complete C5-8
	04.230	Other Traumatic Spinal Cord Dysfunction

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Amputation	05.1 05.2 05.3 05.4 05.5 05.6 05.7 05.9	Unilateral Upper Limb Above the Elbow (AE) Unilateral Upper Limb Below the Elbow (BE) Unilateral Lower Limb Above the Knee (AK) Unilateral Lower Limb Below the Knee (BK) Bilateral Lower Limb Above the Knee (AK/AK) Bilateral Lower Limb Above/Below the Knee (AK/BK) Bilateral Lower Limb Below the Knee (BK/BK) Other Amputation
Arthritis	06.1 06.2 06.9	Rheumatoid Arthritis Osteoarthritis Other Arthritis
Pain Syndromes	07.1 07.2 07.3 07.9	Neck Pain Back Pain Limb Pain Other Pain
Orthopaedic Disorders	08.11 08.12 08.2 08.3 08.4 08.51 08.52 08.61 08.62 08.71 08.72 08.9	Status Post Unilateral Hip Fracture Status Post Bilateral Hip Fractures Status Post Femur (Shaft) Fracture Status Post Pelvic Fracture Status Post Major Multiple Fractures Status Post Unilateral Hip Replacement Status Post Bilateral Hip Replacements Status Post Unilateral Knee Replacement Status Post Bilateral Knee Replacements Status Post Knee and Hip Replacements (Same Side) Status Post Knee and Hip Replacements (Different Sides) Other Orthopaedic
Cardiac	09	Cardiac
Pulmonary Disorders	10.1 10.9	Chronic Obstructive Pulmonary Disease Other Pulmonary
Burns	11	Burns

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Congenital Deformities	12.1 12.9	Spina Bifida Other Congenital
Other Disabling Impairments	13	Other Disabling Impairments
Major Multiple Trauma	14.1 14.2 14.3 14.9	Brain + Spinal Cord Injury Brain + Multiple Fracture/Amputation Spinal Cord + Multiple Fracture/Amputation Other Multiple Trauma
Developmental Disability	15	Developmental Disability
Debility	16	Debility (Non-cardiac, Non-pulmonary)
Medically Complex	17.1 17.2 17.31 17.32 17.4 17.51 17.52 17.6 17.7 17.8 17.9	Infections Neoplasms Nutrition with Intubation/Parenteral Nutrition Nutrition without Intubation/Parenteral Nutrition Circulatory Disorders Respiratory Disorders – Ventilator Dependent Respiratory Disorders - Non-ventilator Dependent Terminal Care Skin Disorders Medical/Surgical Complications Other Medically Complex Conditions

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APPENDIX B
ICD-9-CM CODES
RELATED TO SPECIFIC IMPAIRMENT GROUPS

STROKE (01)

The STROKE Impairment Group includes cases with the diagnosis of cerebral ischemia due to vascular thrombosis, embolism, or hemorrhage.

NOTE: Do NOT use for cases with brain dysfunction secondary to non-vascular causes such as trauma, inflammation, tumor, or degenerative changes. These should be coded under BRAIN DYSFUNCTION (02) instead.

01.1 Left Body (Right Brain)
01.2 Right Body (Left Brain)
01.3 Bilateral
01.4 No Paresis
01.9 Other Stroke

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
STROKE	01.1 - 01.9 Stroke	**Stroke (01)**	430	Subarachnoid hemorrhage, including ruptured cerebral aneurysm
			431	Intracerebral hemorrhage
			432.0 – 432.9	Other and unspecified intracranial hemorrhage
			433.x1*	Occlusion and stenosis of precerebral arteries, with cerebral infarction
			434.x1*	Occlusion of cerebral arteries, with cerebral infarction
			436	Acute, but ill-defined, cerebrovascular disease
			438.0 – 438.9	Late effects of cerebrovascular disease ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same stroke prior to the current admission.***
	NOTE: DO NOT use codes 435.0 - 435.9 - Transient cerebral ischemia (TIA)			

* Throughout this Appendix, "x" denotes any digit 0-9.

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BRAIN DYSFUNCTION (02)

Non-traumatic Brain Dysfunction

Includes cases with such etiologies as neoplasm including metastases, encephalitis, inflammation, anoxia, metabolic toxicity, or degenerative processes.

NOTE: Do NOT use for cases with hemorrhagic stroke; use Impairment Codes 01.1 – 01.9 instead.

02.1 Non-traumatic Brain Dysfunction

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
BRAIN DYSFUNCTION	02.1, 02.9 Non-traumatic, Other Brain	**NTBI (03)**	036.0	Meningococcal meningitis
			036.1	Meningococcal encephalitis
			049.0 - 049.9	Viral encephalitis
			191.0 – 191.9	Malignant neoplasm of brain
			192.1	Malignant neoplasm of cerebral meninges
			198.3	Secondary malignant neoplasm of brain
			225.0	Benign neoplasm of brain
			225.1	Benign neoplasm of cranial nerves
			225.2	Benign neoplasm of cerebral meninges
			237.5	Neoplasm of brain, of uncertain behavior
			237.6	Neoplasm of cerebral meninges, of uncertain behavior
			239.6	Brain tumor of unspecified nature
			323.0 - 323.9	Encephalitis (except bacterial)
			324.0	Intracranial abscess
			331.0	Alzheimer's disease
			331.2	Senile degeneration of brain
			331.3	Communicating hydrocephalus
			348.1	Anoxic brain damage (Anoxic or hypoxic encephalopathy)

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Traumatic Brain Dysfunction

Includes cases with motor and/or cognitive disorders secondary to brain trauma.

02.21 Open Injury
02.22 Closed Injury

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
BRAIN DYSFUNCTION	02.21 Traumatic, open injury	**TBI (02)**	800.60 - 800.99	Skull fracture (vault)
			801.60 - 801.99	Skull fracture (base)
			803.60 - 803.99	Other and unqualified skull fractures
			851.10 - 851.19, 851.30 - 851.39, 851.50 - 851.59, 851.70 - 851.79, 851.90 - 851.99	Cerebral laceration and contusion, with open intracranial wound
			852.10 - 852.19, 852.30 - 852.39, 852.50 - 852.59	Subarachnoid, subdural, and extradural hemorrhage following injury
			853.10 - 853.19	Other and unspecified intracranial hemorrhage following injury
			854.10 - 854.19	Intracranial injury of other and unspecified nature
			905.0	Late effect of fracture of skull and face bones ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same injury prior to the current admission.***
			907.0	Late effect of intracranial injury without mention of skull fracture ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same injury prior to the current admission.***

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UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
BRAIN DYSFUNCTION	02.22 Traumatic, closed injury	**TBI (02)**	800.10 - 800.49	Skull fracture (vault)
			801.10 - 801.49	Skull fracture (base)
			803.10 - 803.49	Other and unqualified skull fractures
			850.0 - 850.9	Concussion
			851.00 - 851.09, 851.20 - 851.29, 851.40 - 851.49, 851.60 - 851.69, 851.80 - 851.89	Cerebral laceration and contusion
			852.00 - 852.09, 852.20 - 852.29, 852.40 - 852.49	Subarachnoid, subdural, and extradural hemorrhage following injury
			853.00 - 853.09	Other and unspecified intracranial hemorrhage following injury
			854.00 - 854.09	Intracranial injury of other and unspecified nature
			905.0	Late effect of fracture of skull and face bones ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same injury prior to the current admission.***
			907.0	Late effect of intracranial injury without mention of skull fracture ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same injury prior to the current admission.***

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NEUROLOGIC CONDITIONS (03)

Includes cases with neurologic or neuromuscular dysfunctions of various etiologies.

03.1 Multiple Sclerosis
03.2 Parkinsonism
03.3 Polyneuropathy
03.4 Guillain-Barré Syndrome
03.5 Cerebral Palsy
03.8 Neuromuscular Disorders
03.9 Other Neurologic Conditions

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
NEUROLOGIC CONDITIONS (except Guillain-Barré Syndrome)	03.1 Multiple Sclerosis	**Neuro (06)**	340	Multiple sclerosis
	03.2 Parkinsonism		332.0 - 332.1	Parkinsonism
	03.3 Polyneuropathy		356.0 - 356.8	Hereditary and idiopathic peripheral neuropathy
			357.5 - 357.8	Toxic neuropathy
	03.5 Cerebral Palsy		343.0 – 343.8	Infantile cerebral palsy
	03.8 Neuromuscular Disorders		138	Late effects of acute poliomyelitis
			335.20 - 335.9	Motor neuron disease
			358.0	Myasthenia gravis
			359.0 - 359.4	Muscular dystrophies and other myopathies
	03.9 Other Neurologic		333.0 - 333.7, 333.80 - 333.99	Other extrapyramidal disease and abnormal movement disorders
			334.0 - 334.3, 334.8	Spinocerebellar disease
			337.0, 337.20 – 337.29, 337.3, 337.9	Disorders of the autonomic nervous system
			341.0 - 341.8	Other demyelinating diseases of central nervous system

NEUROLOGIC CONDITIONS - GUILLAIN-BARRÉ SYNDROME	03.4 Guillain-Barré Syndrome	**GB (19)**	357.0	Acute infective polyneuritis (Guillain-Barré syndrome)

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SPINAL CORD DYSFUNCTION (04)

Includes cases with various forms of quadriplegia/paresis and paraplegia/paresis regardless of the etiology, whether non-traumatic (i.e., medical or post-operative - codes 4.110 – 4.130), or traumatic (– codes 4.210 – 4.230). **NOTE: Cases for which the impairment requiring rehabilitation can be definitively linked to a prior spinal cord dysfunction should be coded as spinal cord dysfunction.**

Non-traumatic Spinal Cord Dysfunction

Includes cases with quadriplegia/paresis and paraplegia/paresis of non-traumatic (i.e., medical or post-operative) origin.

04.110 Paraplegia, Unspecified
04.111 Paraplegia, Incomplete
04.112 Paraplegia, Complete
04.120 Quadriplegia, Unspecified
04.1211 Quadriplegia, Incomplete, C1-4
04.1212 Quadriplegia, Incomplete, C5-8
04.1221 Quadriplegia, Complete, C1-4
04.1222 Quadriplegia, Complete, C5-8
04.130 Other Non-traumatic Spinal Cord Dysfunction

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
SPINAL CORD DYSFUNCTION	04.110 - 04.130 Non-traumatic Spinal Cord Dysfunction	**NTSCI (05)**	015.0	Tuberculosis of vertebral column
			170.2	Malignant neoplasm of spinal column
			192.2 – 192.3	Malignant neoplasm of spinal cord, spinal meninges
			198.3	Secondary malignant neoplasm of spinal cord
			198.4	Secondary malignant neoplasm of spinal meninges
			225.3, 225.4	Benign neoplasm of spinal cord, spinal meninges
			237.5	Neoplasm of spinal cord, of uncertain behavior
			237.6	Neoplasm of spinal meninges, of uncertain behavior
			239.7	Neoplasm of other parts of nervous system, of unspecified nature
			323.9	Transverse myelitis
			324.1	Intraspinal abscess
			441.00 - 441.03	Dissection of aorta
			441.1, 441.3, 441.5, 441.6	Aortic aneurysm, ruptured
			721.1, 721.41, 721.42, 721.91	Spondylosis with myelopathy
			722.71 - 722.73	Intervertebral disc disorder with myelopathy
			723.0	Spinal stenosis in cervical region (if deficits include weakness)
			724.00 - 724.09	Spinal stenosis, other than cervical (if deficits include weakness)

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Traumatic Spinal Cord Dysfunction

Includes cases with quadriplegia/paresis and paraplegia/paresis secondary to trauma.

04.210 Paraplegia, Unspecified
04.211 Paraplegia, Incomplete
04.212 Paraplegia, Complete
04.220 Quadriplegia, Unspecified
04.2211 Quadriplegia, Incomplete, C1-4
04.2212 Quadriplegia, Incomplete, C5-8
04.2221 Quadriplegia, Complete, C1-4
04.2222 Quadriplegia, Complete, C5-8
04.230 Other Traumatic Spinal Cord Dysfunction

UDSMR℠ Impairment Group	**UDSMR℠ Impairment Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
SPINAL CORD DYSFUNCTION	04.210 - 04.230 Traumatic Spinal Cord Dysfunction	**TSCI (04)**	806.00 - 806.9	Fracture of vertebral column with spinal cord injury
			907.2	Late effect of spinal cord injury ***NOTE: Use only when an inpatient rehabilitation program has been completed for the same injury prior to the current admission.***
			953.0 - 953.8	Injury to nerve roots and spinal plexus
			952.00 - 952.8	Spinal cord injury without evidence of spinal bone injury

AMPUTATION OF LIMB (05)

Includes cases in which the major deficit is partial or complete absence of a limb.

05.1 Unilateral Upper Limb Above the Elbow (AE)
05.2 Unilateral Upper Limb Below the Elbow (BE)
05.3 Unilateral Lower Limb Above the Knee (AK)
05.4 Unilateral Lower Limb Below the Knee (BK)
05.5 Bilateral Lower Limb Above the Knee (AK/AK)
05.6 Bilateral Lower Limb Above/Below the Knee) (AK/BK)
05.7 Bilateral Lower Limb Below the Knee (BK/BK)
05.9 Other Amputation

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UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
AMPUTATION OF LIMB	05.1 - 05.2, 05.9 Amputation, upper limb or other	**AMP-NLE (11)**	170.4, 170.5	Malignant neoplasm of bones of upper limb
			171.2	Malignant neoplasm of cartilage and other soft tissue of upper limb
			198.5	Secondary neoplasm of bone
			440.20 - 440.29	Atherosclerosis of native arteries of the extremities
			443.81	Peripheral angiopathy in diseases classified elsewhere (*Use additional code to identify underlying disease - for example, 250.70 - 250.73 - Diabetes with peripheral circulatory disorder, in list of comorbidities*)
			443.9	Peripheral vascular disease, unspecified
			444.21	Arterial embolism and thrombosis, extremities
			447.0 – 447.2 447.5 – 447.8	Other disorders of arteries and arterioles
			459.0 - 459.89	Other disorders of circulatory system
			730.0x - 730.3x	Osteomyelitis (*Use additional code to identify underlying disease - for example, 250.80 - 250.83 - Diabetes with other specified manifestations, in list of cormorbidities*)
			733.40, 733.41, 733.49	Aseptic necrosis of bone (*Use additional code to identify underlying disease in list of comorbidities*)
			736.89	Acquired deformity of other parts of limbs, not elsewhere classified
			747.63	Upper limb vessel anomaly

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UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
AMPUTATION OF LIMB (continued)	05.1 - 05.2, 05.9 Amputation, upper limb or other	**AMP-NLE (11)**	755.21 - 755.29	Reduction deformities of upper limb
			785.4	Gangrene (*Use additional code to identify underlying disease - for example, 250.70 - 250.73 - Diabetes with peripheral circulatory disorder, in list of comorbidities*)
			887.0 - 887.7	Traumatic amputation of arm and hand (complete) (partial)
			997.60 - 997.69	Amputation stump complication
	05.3 – 05.7 Amputation, lower limb	**AMPLE (10)**	170.7, 170.8	Malignant neoplasm of bones of lower limb
			171.3	Malignant neoplasm of cartilage and other soft tissue of lower limb
			198.5	Secondary neoplasm of bone
			356.0 – 356.9	Hereditary and idiopathic peripheral neuropathy
			357.0 – 357.9	Inflammatory and toxic neuropathy (*Use additional code to identify the underlying disease - for example, 250.60 - Diabetes with neurological manifestations, in list of comorbidities*)
			440.20 – 440.29	Atherosclerosis of native arteries of the extremities
			443.81	Peripheral angiopathy in diseases classified elsewhere (*Use additional code to identify underlying disease - for example, 250.70 - 250.73 - Diabetes with peripheral circulatory disorder, in list of comorbidities*)
			444.22	Arterial embolism and thrombosis, extremities
			447.0 – 447.2 447.5 – 447.8	Other disorders of arteries and arterioles
			459.0 – 459.89	Other disorders of circulatory system
			681.10 – 681.11	Toe cellulitis and abscess
			707.1x	Ulcer of lower limbs, except decubitus

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UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
AMPUTATION OF LIMB (continued)	05.3 – 05.7 Amputation, lower limb	**AMPLE (10)**	730.05 – 730.07 730.15 – 730.17 730.25 – 730.27	Osteomyelitis (*Use additional code to identify underlying disease - for example, 250.80 - 250.83 - Diabetes with other specified manifestations, in list of cormorbidities*)
			733.40, 733.42 – 733.49	Aseptic necrosis of bone (*Use additional code to identify underlying disease in list of cormorbidities*)
			736.89	Acquired deformity of other parts of limbs, not elsewhere classified
			747.64	Lower limb vessel anomaly
			755.31 – 755.39	Reduction deformities of lower limb
			785.4	Gangrene (*Use additional code to identify underlying disease - for example, 250.70 - 250.73 - Diabetes with peripheral circulatory disorder, in list of comorbidities*)
			896.0 – 896.3	Traumatic amputation of foot (complete) (partial)
			897.0 – 897.7	Traumatic amputation of leg
			997.60 – 997.69	Amputation stump complication

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ARTHRITIS (06)

Includes cases in which the major disorder is arthritis of all etiologies.

NOTE: Do NOT use for cases entering rehabilitation immediately after joint replacement, even if the procedure was performed secondary to arthritis. Instead, use one of the joint replacement Impairment Codes (08.51 – 08.72) for Item #21 (Impairment Group), and enter the arthritis ICD-9-CM code in Item #22 (Etiologic Diagnosis).

06.1 Rheumatoid Arthritis
06.2 Osteoarthritis
06.9 Other Arthritis

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
ARTHRITIS	06.1 Rheumatoid Arthritis	**RheumA (13)**	714.0 – 714.2	Rheumatoid arthritis
			714.30 – 714.33	Juvenile chronic polyarthritis
			714.4	Chronic postrheumatic arthropathy
	06.2 Osteoarthritis	**OsteoA (12)**	715.00 – 715.99	Osteoarthrosis and allied disorders
	06.9 Other Arthritis	**RheumA (13)**	696.0	Psoriatic arthropathy
			710.0	Systemic lupus erythematosus
			710.1	Systemic sclerosis (includes generalized scleroderma)
			710.3	Dermatomyositis
			710.4	Polymyositis
			711.0	Pyogenic arthritis *(Use additional code to identify infectious organism [041.0 – 041.8])*
			716.00 – 716.99	Other and unspecified arthropathies
			720.0	Ankylosing spondylitis

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PAIN SYNDROMES (07)

Includes cases in which the major disorder is pain of various etiologies, unaccompanied by a neurologic deficit.

NOTE: If there is a neurologic deficit for which the patient is receiving rehabilitation, use one of the codes listed under NEUROLOGIC CONDITIONS (03) or SPINAL CORD DYSFUNCTION (04).

07.1 Neck Pain
07.2 Back Pain
07.3 Extremity Pain
07.9 Other Pain

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
PAIN SYNDROMES	07.1 – 07.3, 07.9 Pain syndromes	**Pain (16)**	721.0 – 721.91	Spondylosis and allied disorders
			722.0 – 722.93	Intervertebral disc disorders
			723.0 – 723.8	Other disorders of cervical region
			724.00 – 724.9	Other and unspecified disorders of back
			729.0 – 729.5	Other disorders of soft tissues
			846.0 – 846.9	Sprains and strains of sacroiliac region
			847.0 – 847.4	Sprains and strains of other and unspecified parts of back

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ORTHOPAEDIC DISORDERS (08)

Includes cases in which the major disorder is post-fracture of bone or post-arthroplasty (joint replacement).

NOTE: If hip replacement is secondary to hip fracture, code as Hip Fracture (codes 08.11 – 08.12). If hip replacement is secondary to arthritis, code as Hip Replacement (08.51 – 08.52 or 08.71 – 08.72).

08.11 Unilateral Hip Fracture
08.12 Bilateral Hip Fractures
08.2 Femur (Shaft) Fracture
08.3 Pelvic Fracture
08.4 Major Multiple Fractures
08.51 Unilateral Hip Replacement
08.52 Bilateral Hip Replacements
08.61 Unilateral Knee Replacement
08.62 Bilateral Knee Replacements
08.71 Knee and Hip Replacements (same side)
08.72 Knee and Hip Replacements (different sides)
08.9 Other Orthopaedic

UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
ORTHOPAEDIC CONDITIONS	08.11, 08.12 Hip Fracture(s)	**FracLE (07)**	820.00 – 820.9	Fracture of neck of femur
	08.2 Femur (Shaft) Fracture		821.00 – 821.11	Fracture of shaft or unspecified part of femur
			821.20 – 821.39	Fracture of lower end of femur
	08.3 Pelvic Fracture		808.0 – 808.9	Fracture of pelvis
	08.4 Major Multiple Fractures	**MMT-NBSCI (17)**	823.02 – 823.92 (5^{th} digit should = 2)	Fractures of tibia and fibula
			827.0 – 827.1	Fracture of multiple bones of same lower limb
			828.0 – 828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum

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UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
ORTHOPAEDIC CONDITIONS (continued)	08.51, 08.52 Hip Replacement(s)	**ReplLE (08)**	*NOTE: If replacement is secondary to arthritis, use the appropriate Orthopaedic Impairment Group code (08.51 – 08.72) in Item 21 but with an arthritis ICD-9 code for Etiologic Diagnosis in Item 22 – e.g.:*	
	or		696.0	Psoriatic arthropathy
			711.0	Pyogenic arthritis
	08.61, 08.62 Knee Replacement(s)		714.0 – 714.2	Rheumatoid arthritis
			714.30 – 714.33	Juvenile chronic polyarthritis
			714.4	Chronic postrheumatic arthropathy
	or		715.x5, 715.x6	Osteoarthrosis and allied disorders
			716.x5, 716.x6	Other and unspecified arthropathies
	08.71, 08.72 Hip and Knee Replacements		720.0	Ankylosing spondylitis
			NOTE: If admission is following revision of implant, use:	
			996.4	Mechanical complication of internal orthopedic device, implant, and graft
			996.66, 996.67	Infection and inflammatory reaction due to internal orthopedic device, implant and graft
			996.77 – 996.79	Other complications due to internal orthopedic or prosthetic device, implant and graft
	08.9 Other Orthopaedic	**Ortho (09)**	170.2 – 170.8	Malignant neoplasm of bone and articular cartilage
			198.5	Secondary malignant neoplasm of bone
			719.00 – 719.89	Other and unspecified disorders of joint
			733.11 – 733.19	Pathologic fracture
			754.2	Congenital postural lordosis or scoliosis
			823.00 – 823.91	Fracture of tibia or fibula

CARDIAC (09)

Includes cases in which the major disorder is poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to a cardiac disorder.

09 Cardiac Disorders

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
CARDIAC DISORDERS	09 Cardiac Disorders	**Cardiac (14)**	410.00 – 410.92	Acute myocardial infarction, within 8 weeks
			411.0 – 411.89	Other acute and subacute forms of ischemic heart disease
			414.00 – 414.07	Coronary atherosclerosis
			414.10 – 414.9	Other forms of chronic ischemic heart disease
			427.0 – 427.9	Cardiac dysrhythmias

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UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
CARDIAC DISORDERS (Continued)	09 Cardiac Disorders	**Cardiac (14)**	428.0 – 428.9	Heart failure

PULMONARY DISORDERS (10)

Includes cases in which the major disorder is poor activity tolerance secondary to pulmonary insufficiency.

10.1 Chronic Obstructive Pulmonary Disease
10.9 Other Pulmonary Disorders

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
PULMONARY DISORDERS	10.1, 10.9 Pulmonary Disorders	**Pulmonary (15)**	491.0 – 491.8	Chronic bronchitis
			492.0 – 492.8	Emphysema
			493.00 – 493.92	Asthma
			494.0 – 494.1	Bronchiectasis
			496	Chronic obstructive pulmonary disease, not elsewhere classified

BURNS (11)

Includes cases in which the major disorder is thermal injury to major areas of the skin and/or underlying tissue.

11 Burns

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
BURNS	11 Burns	**Burns (21)**	941.00 – 941.59	Burns of face, head, and neck
			942.00 – 942.59	Burns of trunk
			943.00 – 943.59	Burns of upper limb, except wrist and hand
			944.00 – 944.58	Burns of wrist(s) and hand(s)
			945.00 – 945.59	Burns of lower limb(s)
			946.0 – 946.5	Burns of multiple specified sites

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CONGENITAL DEFORMITIES (12)

Includes cases in which the major disorder is an anomaly or deformity of the nervous or musculoskeletal system that has been present since birth.

12.1 Spina Bifida
12.9 Other Congenital Deformities

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
CONGENITAL DEFORMITIES	12.1 Spina Bifida	**Misc (20)**	741.00 –741.03, 741.90 – 741.93	Spina bifida
	12.9 Other Congenital		728.3	Arthrogryposis
			742.0 – 742.8	Other congenital anomalies of nervous system
			754.1 – 754.89	Certain congenital musculoskeletal deformities
			755.0 – 755.9	Other congenital deformities of limb
			756.0 – 756.9	Other congenital musculoskeletal anomalies

OTHER DISABLING IMPAIRMENTS (13)

This category is to be used **only** for cases that **cannot be classified** into any of the other Impairment Groups.

13 Other Disabling Impairments

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
OTHER DISABLING IMPAIRMENTS	13 Other Disabling Impairments	**Misc (20)**		*Conditions not elsewhere defined*

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MAJOR MULTIPLE TRAUMA (14)

Includes TRAUMA cases with more COMPLEX management due to involvement of **multiple systems or sites**. Enter the ICD-9 code for the **primary** trauma in Item 22 – Etiologic Diagnosis, and ICD-9 codes for **secondary** trauma in Item 24 – Comorbid Conditions.

***Note: if only multiple fractures are present, code impairment group under Orthopaedic Disorders as 08.4 Major Multiple Fractures.**

14.1 Brain + Spinal Cord
14.2 Brain + Multiple Fracture/Amputation
14.3 Spinal Cord + Multiple Fracture/Amputation
14.9 Other Multiple Trauma

UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
MAJOR MULTIPLE TRAUMA	14.1, 14.2, 14.3 Major Multiple Trauma with Brain Injury and/or Spinal Cord Injury	**MMT-BSCI (18)**		*Two or more ICD-9-CM codes appropriate for the Traumatic Impairment Codes (Traumatic Brain Dysfunction + Traumatic Spinal Cord Dysfunction; Traumatic Brain Dysfunction + Multiple Fractures/Amputation; Traumatic Spinal Cord Dysfunction + Multiple Fractures/Amputation)*
	14.9 Other Multiple Trauma	**MMT-NBSCI (17)**		*Two or more ICD-9-CM codes for trauma to multiple systems or sites, but not brain or spinal cord*

DEVELOPMENTAL DISABILITY (15)

Includes cases in which the major disorder is impaired cognitive and/or motor function resulting in developmental delay.

15 Developmental Disability

UDSMR℠ Impairment Group	**UDSMR℠ Impairment Group Code (Item 21)**	**RIC**	**ICD-9-CM Code (Item 22)**	**Etiologic Diagnosis**
DEVELOPMENTAL DISABILITY	15 Developmental Disability	**Misc (20)**	317, 318.0 – 318.2, 319	Mental retardation

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DEBILITY (16)

Includes cases with generalized de-conditioning not attributable to any of the other Impairment Groups.

16 Debility

NOTE: Do NOT use for cases with debility secondary to:
CARDIAC CONDITIONS (use Impairment Code 09 instead)
PULMONARY CONDITIONS (use Impairment Code 10.x instead).

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
DEBILITY	16 Debility	**Misc (20)**	xxx.xx	Code the specific medical condition primarily responsible for the patient's debility
			728.2	Muscular wasting and disuse atrophy, not elsewhere classified
			728.9	Unspecified disorder of muscle, ligament and fascia
			780.71	Chronic fatigue syndrome
			780.79	Other malaise and fatigue

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MEDICALLY COMPLEX CONDITIONS (17)

Includes cases with multiple medical and functional problems and complications prolonging the recuperation period. Medically complex cases require medical management of a principal condition and monitoring of comorbidities and potential complications. **Rehabilitation treatments are secondary to the management of the medical conditions.**

INFECTIONS

Includes cases admitted primarily for medical management of infections.

17.1 Infections

NOTE: Do NOT use for:

Respiratory infections (use Impairment Code 17.5x: Respiratory)
Meningitis (use Impairment Code 2.1: Non-traumatic Brain Dysfunction)
Encephalitis (use Impairment Code 2.1: Non-traumatic Brain Dysfunction)
Post-op infections (use Impairment Code 17.8: Medical/Surgical Complications).

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS	17.1 Infections	**Misc (20)**	013.0 – 013.9	Tuberculosis of meninges and central nervous system
			038.0 – 038.9	Septicemia
			041.00 – 041.09	Streptococcus infection
			041.10 – 041.19	Staphylococcus infection
			041.81 – 041.9	Other and unspecified bacterial infection
			042	Human immunodeficiency virus (HIV) disease *(if your state permits release of this information)*

NEOPLASMS

Includes cases that require continuing care after surgery, chemotherapy, radiation, immunotherapy or hormone therapy as a result of a neoplasm. Care may include management of complications from the illness or the treatment.

17.2 Neoplasms

NOTE: Do NOT use for:

Persons in a hospice/terminal care program (use Impairment Code 17.7: Terminal Care)
Neoplasms of brain (use Impairment Code 2.1: Non-traumatic Brain Dysfunction)
Neoplasms of spinal cord (use Impairment Code 4.1xx or 4.1xxx: Non-traumatic Spinal Cord Dysfunction)
Neoplasms of skeletal system (use Impairment Code 5.x: Amputation of Limb or Impairment Code 8.9 – Other Orthopaedic)

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UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.2 Neoplasms	**Misc (20)**	140.0 - 149.9	Malignant neoplasm of lip, oral cavity, and pharynx
			150.0 - 159.9	Malignant neoplasm of digestive organs and peritoneum
			160.0 - 165.9	Malignant neoplasm of respiratory and intrathoracic organs
			170.0 - 170.9	Malignant neoplasm of bone and articular cartilage
			171.0 - 171.9	Malignant neoplasm of connective and other soft tissue
			172.0 - 172.9	Malignant melanoma of skin
			173.0 - 173.9	Other malignant neoplasm of skin
			174.0 - 174.9	Malignant neoplasm of female breast
			175.0 – 175.9	Malignant neoplasm of male breast
			176.0 - 176.9	Kaposi's sarcoma
			179 - 189.9	Malignant neoplasm of genitourinary tract
			200.00 - 200.88	Lymphosarcoma and reticulosarcoma
			201.00 - 201.98	Hodgkin's disease
			202.00 - 202.98	Other malignant neoplasms of lymphoid and histiocytic tissue
			203.00 -203.81	Multiple myeloma and immunoproliferative neoplasms
			204.00 - 204.91	Lymphoid leukemia
			205.00 - 205.91	Myeloid leukemia
			206.00 - 206.91	Monocytic leukemia
			207.00 - 208.91	Other and unspecified leukemia

NUTRITION

Includes cases who require care and monitoring related to fluids and nutrition. Care may include management of complications from endocrine, metabolic or neoplastic disorders.

17.31 Nutrition **with** intubation/parenteral nutrition
17.32 Nutrition **without** intubation/parenteral nutrition

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.31, 17.32 Nutrition	**Misc (20)**	250.00 - 250.93	Diabetes mellitus
			276.0 - 276.9	Disorders of fluid, electrolyte, and acid-base balance

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CIRCULATORY DISORDERS

Includes cases who have complications of the circulatory system (heart, blood vessels) or need continuing management after surgery or treatment for circulatory conditions. May include acute myocardial infarction and cerebrovascular disease (stroke) if the time since onset of the circulatory disorder is greater than 2 months.

17.4 Circulatory Disorders

NOTE: Do NOT use for cases admitted for cardiac rehabilitation (post-myocardial infarction, coronary artery bypass graft, etc.) if time since onset is 2 months or less; use Impairment Code 09: Cardiac instead.

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.4 Circulatory Disorders	**Misc (20)**	403.00 - 403.91	Hypertensive renal disease
			404.00 - 404.93	Hypertensive heart and renal disease
			414.00 - 414.07	Coronary atherosclerosis
			428.0 - 428.9	Heart failure
			443.0 - 443.9	Other peripheral vascular disease
			453.0 - 453.9	Other venous embolism and thrombosis
			NOTE: May include acute myocardial infarction and cerebrovascular disease (stroke) if onset > 2 months.	

RESPIRATORY DISORDERS - VENTILATOR DEPENDENT

Includes respiratory cases who are dependent on a ventilator **upon admission**, regardless of whether a weaning program is planned or is in effect.

17.51 Respiratory Disorders – Ventilator Dependent

RESPIRATORY DISORDERS – NON-VENTILATOR DEPENDENT

Includes respiratory cases who are **not** dependent on a ventilator.

17.52 Respiratory Disorders – Non-ventilator Dependent

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UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.51, 17.52	**Misc (20)**	480.0 – 480.9	Viral pneumonia
			481.0 – 486	Pneumonia due to bacteria or other or unspecified organism
			507.0 – 507.8	Pneumonitis due to solids and liquids
			518.0 – 518.89	Other diseases of lung, including pulmonary collapse, pulmonary insufficiency and respiratory failure

TERMINAL CARE

Includes, but is not limited to, cases at the end stages of cancer, Alzheimer's disease, renal failure, congestive heart failure, stroke, acquired immunodeficiency syndrome (AIDS), Parkinsonism and emphysema. Care typically focuses on comfort measures and pain relief as desired by the person.

17.6 Terminal Care

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.6 Terminal Care	**Misc (20)**		*End-stage conditions - e.g., cancer, Alzheimer's disease, renal failure, congestive heart failure, stroke, acquired immunodeficiency syndrome (AIDS), Parkinsonism, emphysema.*

SKIN DISORDERS

Includes cases with open wounds, pressure-related, circulatory and decubitus ulcers, as well as cases with poorly healing wounds due to surgery, cancer or immune disorders.

17.7 Skin Disorders

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UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.7 Skin Disorders	**Misc (20)**	681.10 - 681.11	Cellulitis and abscess of toe
			682.0 - 682.8	Other cellulitis and abscess
			707.0	Decubitus ulcer
			707.10 - 707.8	Chronic ulcer of lower limbs, except decubitus
			870.0 - 879.9	Open wound of head, neck and trunk
			890.0 - 894.2	Open wound of lower limb (except traumatic amputation)

MEDICAL/SURGICAL COMPLICATIONS

Includes cases with complications of medical and surgical care.

17.8 Medical/Surgical Complications

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.8 Medical/Surgical Complications	**Misc (20)**	996.00 - 996.79	Complications of internal device, implant and graft
			996.80 - 996.89	Complications of transplanted organ
			996.90 - 996.99	Complications of reattached extremity or body part
			997.00 - 997.99	Complications affecting specified body systems, not elsewhere classified
			998.0 - 998.9	Other complications of procedures, not elsewhere classified

OTHER MEDICALLY COMPLEX CONDITIONS

Includes medically complex cases not elsewhere classified.

17.9 Other Medically Complex Conditions

UDSMR℠ Impairment Group	UDSMR℠ Impairment Group Code (Item 21)	RIC	ICD-9-CM Code (Item 22)	Etiologic Diagnosis
MEDICALLY COMPLEX CONDITIONS (continued)	17.9 Other Medically Complex Conditions	**Misc (20)**	584.5 - 584.9	Acute renal failure
			585.x	Chronic kidney disease
			595.0 - 595.89	Cystitis
			597.0 - 597.89	Urethritis, not sexually transmitted, and urethral syndrome

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APPENDIX C
LIST OF COMORBIDITIES
THAT MAY AFFECT MEDICARE PAYMENT

Introduction

Comorbid Conditions are to be listed in item 24 of the IRF-PAI. Up to ten (10) ICD-9-CM codes, including E-codes and V-codes may be recorded.

A comorbid condition is defined as a specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category. Analyses by The Centers for Medicare and Medicaid Services (CMS) found that the presence of a comorbidity could have a major effect on the cost of furnishing inpatient rehabilitation care, and that the effect of comorbidities varied across the RICs. When comorbidities were separated into three categories based on whether the costs associated with the comorbidities were considered high, medium, or low, the extent to which payment matched cost improved.

Comorbidities that are identified on the day prior to the day of the rehabilitation discharge or the day of discharge should *not* be listed on the discharge assessment, since these comorbidities have less effect on the resources consumed during the entire stay.

A payment adjustment will be made if one of the comorbidities listed Appendix C on the IRF PPS website is recorded in Item 24 in accordance with criteria specified in the IRF PPS August 7, 2001 Final Rule. If more than one comorbidity is present, the comorbidity that results in the highest payment will be used to adjust payment.

Appendix C can be found as a download for each fiscal year on the "Data Files" page of the CMS IRF PPS website - http://www.cms.gov/InpatientRehabFacPPS/

Both ICD-9-CM codes and category numbers are used to identify the CMG comorbidity tiers. ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with 3 digits are occasionally complete ICD-9-CM codes. Codes with 3 digits are also included in the ICD-9-CM coding system as the heading of a category of codes that may be further subdivided by the use of a fourth and/or fifth digit to provide greater detail. In most cases, it is inappropriate to report a category number in Item 24. However, for the specific list of codes and category numbers shown on the CMS IRF PPS website, record in Item 24:

- A three-digit code if Appendix C has no four-digit or fifth-digit sub-classifications for that category.
- A four-digit sub-classification code if the code number in Appendix C has only four digits.

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- A fifth-digit sub-classification code if the code number in Appendix C has five digits.

For other codes that are not specifically shown in Appendix C it would be incorrect to report only 3 or 4 digits of a 5 digit code. It would similarly be incorrect to report only 3 digits of a four digit code.

The Grouper software also specifies the comorbidity codes used to modify the basic CMG code. In order to conform the comorbidity ICD-9-CM codes used by the IRF-PAI Grouper software to the ICD-9-CM codes that are used to specify the same medical condition, the Grouper software is updated. **The updated Grouper software may be downloaded from the "Sofware" page of the CMS IRF PPS website - http://www.cms.gov/InpatientRehabFacPPS/**.

Refer to the IRF PPS Final Rules and other CMS publications, such as program memoranda, for authoritative guidance. The CMS publications related to the IRF PPS can be located at the CMS IRF PPS website, which is http://www.cms.gov/InpatientRehabFacPPS/

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APPENDIX D
SAMPLE CASE STUDIES

PRACTICE CASE STUDY #1

Name: Mr. G. **Patient Code:** 999-88-9999

Mr. G. is a 72-year-old white male. He is married and lives with his wife. He is English-speaking.

Mr. G. fell down a flight of stairs and was admitted to General Hospital on 11/20/00 with confused sensorium and incomplete motor and sensory tetraplegia due to a fracture dislocation at C6-7. The majority of key muscles had a grade of 3 and 4. There was no loss of consciousness. He had cervical traction applied. An emergency room CT scan of the head showed a right parietal subdural hematoma. Burrhole evacuation of the subdural hematoma was performed under local anesthesia. Two days later the cervical spine was reduced and fused posteriorly.

He was transferred to the rehabilitation unit on 11/30/00. Functional assessment **on admission** to rehabilitation is as follows:

Eating
Mr. G. eats a regular diet after the helper applies a universal cuff and scoops each spoonful of food onto Mr. G.'s spoon. Mr. G. brings the food from the plate into his mouth. He chews and swallows the food without difficulty.

Grooming
Mr. G. washes his left hand after having a wash mitt applied to his right hand. Mr. G. also washes his face, combs his hair, and brushes his teeth. The helper washes his right hand and assists him with shaving.

Bathing
Mr. G. washes, rinses and dries his chest and left arm. The helper completes the rest of the bath.

Dressing - Upper Body
Mr. G. typically wears a pullover sweatshirt. The helper places the shirt over Mr. G.'s head and threads both his arms. Mr. G. then leans forward so the helper can pull the shirt down over his trunk.

Dressing - Lower Body
Mr. G. usually wears sweat pants with an elastic waist, antiembolic stockings, socks and sneakers. The helper applies his antiembolic stockings and then threads both pant legs to Mr. G.'s knees. Mr. G. then shifts from side to side so the helper can pull the pants up over his hips. The helper then puts on Mr. G.'s socks and sneakers.

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Toileting
Mr. G. shifts from side to side as the helper adjusts Mr. G.'s clothing before and after his intermittent catheterizations and bowel movements. Mr. G. wipes himself.

Bladder Management
Mr. G. is on a bladder training program and empties his bladder through an intermittent catheterization program. Mr. G. is dependent on the staff to perform the intermittent catheterization procedure. Mr. G. does not have accidents.

Bowel Management
Mr. G. is not on a bowel program, but has had episodes of incontinence requiring assistance from a helper. He has had 3 accidents during the past 7 days.

Transfers: Bed, Chair, Wheelchair
Mr. G. requires assistance from two staff members to get into and out of bed.

Transfers: Toilet
Mr. G. requires help from two staff members to get on and off the toilet.

Transfers: Tub/Shower
Mr. G. does not perform bath or shower transfers. He bathes in bed each morning.

Walk/Wheelchair
Mr. G. does not walk. The helper pushes Mr. G. in the wheelchair. The therapist expects Mr. G. to walk by discharge.

Stairs
Stair climbing has not been attempted because of risk of injury.

Comprehension
Mr. G. consistently understands questions that the staff asks him about routine everyday matters such as meals and need for pain medication. He watches television programs, but cannot understand abstract information such as the plot of a movie, current events, or humor.

Expression
Mr. G. consistently expresses information about daily needs clearly, but cannot discuss abstract information such as financial and insurance matters. He expresses such things as menu choices, and makes statements about activities in which he is involved during occupational and physical therapy.

Social Interaction
Mr. G. is cooperative with staff during therapy, and participates in all activities. He interacts appropriately and has had no inappropriate behaviors or outbursts.

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Problem Solving
Mr. G. consistently recognizes and solves routine problems, such as asking for help when unable to reach something, or putting on his call light when he needs help, but he cannot make decisions about such things as household finances, discharge plans, or transportation arrangements.

Memory
Mr. G. recognizes the rehab staff who treat him but cannot always recall their names. He can list his daily activities to the staff. He responds to requests appropriately, but needs repetition (less than 10% of the time) in a stressful or unfamiliar circumstance.

At discharge, the functional assessment is as follows:

Eating
Mr. G. eats by himself after the helper opens cartons and cuts up his meat.

Grooming
He combs his hair and brushes his teeth by himself. He washes his hands and face using a wash mitt without difficulty. He begins shaving by himself, but he needs assistance to shave under his chin.

Bathing
He washes in the tub using a tub bench and hand-held shower. He needs the water temperature and pressure adjusted and help to wash both lower legs (including the feet).

Dressing - Upper Body
The helper sets out Mr. G.'s clothing. Mr. G. typically wears a sweatshirt on his upper body. He threads both the left and right arms, and then pulls the sweatshirt over his head and down over his trunk.

Dressing - Lower Body
Mr. G. threads his left and right legs and pulls up the right and left side of his underwear and pants over his hips. The helper then puts on both of Mr. G.'s socks and both of his shoes. Mr. G. no longer wears anti-embolic stockings.

Toileting
Mr. G. wipes himself and adjusts his clothing before and after using the toilet. He does these tasks independently, but holds onto a grab bar to maintain his balance.

Bladder Management
Mr. G. no longer requires intermittent catheterizations at discharge. However, he does require medication to prevent urinary retention. He uses the toilet during the day, but prefers to use a urinal at night (which nursing staff empties). He has had one accident in the past 3 days requiring assistance form nursing for changing of linen and clothing.

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Bowel Management
Mr. G. has developed better control of bowel function using a suppository every other day. He positions himself in bed and inserts the suppository. After breakfast, he ambulates to the bathroom and uses the toilet. Mr. G. has had no episodes of bowel incontinence (soiling linen and clothing) in the past seven days.

Transfers: Bed, Chair, Wheelchair
Mr. G. gets in and out of bed by himself, but needs someone present to supervise the transfer because of the height of the bed.

Transfers: Toilet
In the bathroom, he is able to transfer to the toilet using a grab bar. He no longer requires supervision during this transfer.

Transfers: Tub/Shower
Mr. G. transfers onto the tub bench by himself, but requests supervision for getting out of the tub because of the wet surfaces.

Walk/Wheelchair
Mr. G. walks over 150 feet (over 50 meters) using Lofstrand crutches in a safe and timely manner.

Stairs
Mr. G. goes up and down four stairs with touching assistance of one therapist for balance.

Comprehension
Mr. G. understands all information about activities of daily living. He watches the news every night and understands complex and abstract information. Mr. G. understands the social worker without difficulty when she discusses insurance coverage for his hospitalization.

Expression
He speaks with friends about common interests of all kinds and has begun discussing discharge plans. He talks about current events and often jokes appropriately with the nursing staff.

Social Interaction
Mr. G. is very cooperative with the rehab staff.

Problem Solving
Mr. G. has become involved in his discharge planning. He is coordinating the delivery of equipment to his home prior to his discharge. He has made his own arrangements for returning to the hospital for a follow-up appointment. The social worker has met with Mr. G. twice during his last week at the hospital.

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Memory
Mr. G. has no difficulty recognizing the nurses or therapists. He is always in the therapy gym at least 5 minutes before his therapy sessions without any reminders from the hospital staff. He remembers three-step unrelated commands without repetition.

ANSWERS AND RATIONALE FOR PRACTICE CASE STUDY #1 ADMISSION FIM™ SCORES

Item	Score	Rationale
Eating	3	The helper scoops each spoonful of food onto the utensil. Mr. G. brings food up to his mouth, chews and swallows the food - Moderate Assistance.
Grooming	3	Mr. G. completes 3 of 5 (60%) tasks independently, needs help with 2 – Moderate Assistance.
Bathing	1	Mr. G. washes and dries his left chest and arm only. Less than 25% of the effort - Total Assistance.
Dressing-UB	1	Mr. G. leans forward only as the helper dresses him. Less than 25% of the effort - Total Assistance.
Dressing-LB	1	Mr. G. shifts from side to side only as the helper dresses him. Less than 25% of the effort - Total Assistance.
Toileting	2	Mr. G. shifts from side to side only as the helper adjusts Mr. G.'s pants. Perineal hygiene is performed by Mr. G. – Maximal Assistance.
Bladder Mgmt	1	The staff does intermittent catheterizations and requires assistance from nursing. - Total Assistance.
Bowel Mgmt	1	Mr. G. has had 3 accidents over the past 3 days requiring clean up by nursing . - Total Assistance.
Trans: B,C,WC	1	Two staff are required to get Mr. G. into and out of bed - Total Assistance.
Trans: Toil	1	Two staff are required to get Mr. G. on and off the toilet - Total Assistance.
Trans: T or S	0	Activity does not occur.
Walk/WChair	0	Activity does not occur. The score for walking is used because Mr. G. is expected to walk at discharge.
Stairs	0	Activity does not occur.
Comprehens	5	Mr. G. understands conversation about daily activities consistently, but not complex/abstract information - Standby Prompting.
Expression	5	Mr. G. expresses routine needs clearly, but not complex/abstract information - Standby Prompting.
Soc Inter	7	Mr. G. is cooperative with staff and needs no redirection. He interacts appropriately – Complete Independence.
Prob Solv	5	Mr. G. recognizes and solves routine problems consistently, but cannot handle complex problems - Supervision/Standby Prompting.

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Memory	5	Mr. G. recognizes therapists, lists his daily activities, follows two thoughts or activities, needs prompting in stressful or unfamiliar circumstances less than 10% of the time– Supervision/Standby Prompting.

ANSWERS AND RATIONALE FOR PRACTICE CASE STUDY #1 DISCHARGE FIM™ SCORES

Item	Score	Rationale
Eating	5	The helper provides setup assistance (cutting up meat and opening containers) only. Mr. G. then eats by himself – Setup.
Grooming	4	Mr. G. is independent with four of the five grooming activities. The helper shaves Mr. G. under the chin only - Minimal Assistance.
Bathing	4	The helper washes Mr. G.'s lower legs only - Minimal Assistance.
Dressing-UB	5	The helper provides setup assist only (setting out clothes) – Setup.
Dressing-LB	3	Mr. G. is independent in putting on his underwear and pants. He needs help putting on both socks and both shoes - Moderate Assistance.
Toileting	6	Mr. G. uses a grab bar (device) during toileting tasks - Modified Independence.
Bladder Mgmt	1	Staff empties his urinal at night (level 5). Mr. G. is also on medication (level 6). He has had 1 accident in the past 3 days requiring clean up by nursing (level 1) Total Assistance.
Bowel Mgmt	6	Mr. G. inserts his own suppository after positioning himself (level 6). Mr. G. has had no episodes of incontinence - Modified Independence.
Trans: B,C,WC	5	The helper supervises Mr. G.'s transfers into and out of bed - Supervision.
Trans: Toil	6	Mr. G. uses a grab bar for independent toilet transfers - Modified Independence.
Trans: T or S	5	The helper supervises transfer out of tub due to wet surface - Supervision.
Walk/WChair	6	Mr. G. walks over 150 feet (50 meters) with Lofstrand crutches (assistive device) - Modified Independence.
Stairs	2	Mr. G. walks up and down 4 stairs with touching assistance from one person - Maximal Assistance.
Comprehens	7	Mr. G. understands routine and complex information without difficulty - Complete Independence.
Expression	7	Mr. G. expresses routine and complex information without difficulty - Complete Independence.

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Soc Inter	7	Mr. G. is cooperative with staff. He has had no inappropriate behaviors - Complete Independence.
Prob Solv	7	Mr. G. solves routine and complex problems independently - Complete Independence.
Memory	7	Mr. G. remembers the staff and his daily routine. Executes requests without repetition - Complete Independence.

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PRACTICE CASE STUDY #2

Name: Mr. H. **Patient Code:** 969-99-9999

Mr. H., a 77-year-old white male, was admitted to General Hospital at 11:00 a.m. on 1/30/01. Mr. H. is a retired accountant, widowed approximately five years, who lives alone in a second-story apartment. He has had adult-onset diabetes for 10 years and has a history of hypertension.

His neighbor explained that during the past few days Mr. H. complained of tingling sensations (paresthesias) in his extremities, dizziness, shortness of breath, and an overall tired or weak feeling. Mr. H. was discovered unconscious on his bedroom floor at 10:15 a.m. on the day of admission. Insulin reaction was ruled out as the cause of the patient's admission condition since blood glucose was 220. The patient's primary care physician informed the admitting physician that Mr. H. had previously suffered congestive heart failure.

The primary findings on physical examination at admission included ability to respond to questions with eye movements but inability to speak, flaccid paralysis of his right extremities, pain, numbness and impaired sensation on the right side of the body, dysphagia, and a diminished gag reflex.

Remarkable laboratory findings: elevated cholesterol and triglycerides, hyperglycemia.

Diagnosis: Left brain stroke due to atherosclerosis, resulting in right body hemiplegia.

After five days, the insulin dose was stabilized, and urine output through an indwelling catheter was adequate. A nasogastric feeding tube was in place. Mr. H. was transferred to the rehabilitation unit on 2/4/01.

Functional assessment **on admission** to rehabilitation is as follows:

Eating
Mr. H. is NPO; staff administers continuous nasogastric feeds.

Grooming
After he is handed a washcloth, Mr. H. washes his face, but requires the staff to wash his hands, comb his hair, shave him and do oral care (brush teeth).

Bathing
Mr. H. uses a bath mitt and washes his right arm, chest and right upper leg. A helper completes the rest of bathing for him.

Dressing-Upper Body
Mr. H. typically wears a sweatshirt; he requires a helper to thread both sleeves. Mr. H. pulls the shirt over his head. He requires a helper to pull the shirt down and to adjust it.

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Dressing-Lower Body
Mr. H. wears antiembolic stockings, underwear, pants and shoes. He turns side to side as staff pulls his pants and underwear up. A helper applies the antiembolic stockings.

Toileting
Mr. H. is dependent on staff to pull his pants up and down and to provide perineal hygiene.

Bladder Management
Mr. H. has an indwelling catheter which is managed by the nursing staff.

Bowel Management
Mr. H. has been on a bowel program and has had 2 bowel accidents (soiling linen and clothing) in the past 3 days. The nursing staff changes Mr. H. after each episode of incontinence.

Transfers: Bed, Chair, Wheelchair; Transfers: Toilet; Transfers: Tub or Shower
Transfers out of bed to a chair are accomplished with use of a mechanical lift and two helpers. He does not transfer to a toilet or to a tub or shower.

Walk/Wheelchair
Mr. H. does not ambulate. He manages to propel a wheelchair 30 feet. The therapist expects Mr. H. to walk upon discharge.

Stairs
His ability to manage stairs is not assessed because of the risk of injury.

Comprehension
When asked such questions as: "Do you want another pillow?", "Are you comfortable?" and "Do you want to get back to bed?"- he signifies a positive response by nodding his head. When asked simple questions such as: "Is this 2001?", "Are you in a hospital?"- he gives correct responses. He is unable to understand complex or abstract questions.

Expression
Mr. H. expresses himself with difficulty. He uses single words such as "tired," "yes" and "pain".

Social Interaction
Mr. H. is cooperative with staff and visitors, and participates in therapy each day.

Problem Solving
Mr. H. manages to solve simple problems but cannot solve complex problems.

Memory
He recognizes his primary nurse and therapists most of the time, and appears to remember his routine therapy exercises and executes requests such as remembering numbers and commands, just over half of the time.

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Functional assessment **on discharge** from rehabilitation is as follows:

Eating
Mr. H. no longer requires tube feedings. He feeds himself after the helper cuts up his meat and opens his milk cartons.

Grooming
He washes his hands and face after a towel and washcloth are placed in front of him. He removes his dentures and places them in his denture cup. The helper opens the packet of denture cleanser, and then Mr. H. puts the cleansing tablet into the denture cup. He shaves himself using an electric razor. The helper plugs in the shaver and places it within his reach. The helper combs his hair, as Mr. H. has limited range of motion.

Bathing
Mr. H. bathes in the tub on most days. He uses a hand-held shower and a tub bench. The helper adjusts the water temperature before Mr. H. gets into the tub. He needs help only to wash and dry his feet.

Dressing - Upper Body
A helper gathers Mr. H.'s clothes together and brings them to him each morning. His typical clothing is an undershirt and front-buttoning shirt. He puts on his undershirt and shirt by himself, but needs assistance to button his shirt.

Dressing - Lower Body
The helper starts to put on Mr. H.'s underwear by threading the left and right legs. Mr. H. then pulls the underwear up over his left and right hips. The helper then threads the left and right pant legs. Mr. H. pulls his pants up over his hips. The helper then zips up the pants. The helper puts on both socks and left shoe. Mr. H. dons his right shoe.

Toileting
Mr. H. pulls his pants down before using the toilet. After Mr. H. voids, the helper provides perineal hygiene. Mr. H. then pulls up his pants, with the helper providing assistance to zipper his pants only.

Bladder Management
During the day, Mr. H. voids independently. At night, he uses a urinal. The nurses leave the urinal at his bedside, and empty it for him. Mr. H. has had three accidents in the past 3 days requiring nursing to clean up and change linen and clothing.

Bowel Management
A satisfactory bowel program has been established using a stool softener. He has had no bowel accidents.

Transfer: Bed, Chair, Wheelchair
Mr. H.'s transfers in and out of bed are supervised.

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Transfer: Toilet
Mr. H. transfers to the toilet while holding onto a grab bar. A nurse always supervises his transfers.

Transfer: Tub/Shower
A helper supervises Mr. H.'s transfer into the tub. Once he completes bathing, he puts on his call light. He then transfers out of the tub as the helper provides steadying assistance.

Walk/Wheelchair
Mr. H. walks over 150 feet (50 meters) with a walker and with supervision from a helper.

Stairs
He goes up and down a full flight of stairs (12 stairs) while holding onto a handrail, with the steadying assistance of one person.

Comprehension
Mr. H. understands information discussed in a group. He has had no difficulty understanding information about activities of daily living, discharge plans and financial affairs.

Expression
He expresses his basic needs using brief phrases. He becomes very frustrated when he understands complex information about his discharge plans and his financial status, but is unable to speak fluently or clearly and thus is unable to express complex information. Mr. H. expresses his basic needs over 90% of the time.

Social Interaction
He is actively involved in therapy sessions, appears to enjoy recreation (e.g., cards, bingo, "exercise to music," activities) and is congenial toward staff, visitors and fellow patients.

Problem Solving
Mr. H. handles his personal finances and pays for his television and newspapers. He manages his own medication program with ease.

Memory
Mr. H. refers to his therapists by name, is aware of his daily routine, and can remember a three-step unrelated command without difficulty. He does not have any difficulty with his memory.

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ANSWERS AND RATIONALE FOR PRACTICE CASE STUDY #2 ADMISSION FIM™ SCORES

Item	Score	Rationale
Eating	1	The staff administers the NG feedings - Total Assistance.
Grooming	1	Mr. H. performs 1 of the 5 tasks (20%) - Total Assistance.
Bathing	2	Mr. H. is able to bathe 3 out of 10 body parts (30%) - Maximal Assistance.
Dressing-UB	2	Mr. H. is dependent on a helper; only pulls shirt over his head - Maximal Assistance.
Dressing-LB	1	Mr. H. is dependent on a helper; does less than 25% - Total Assistance.
Toileting	1	Mr. H. is dependent on a helper - Total Assistance.
Bladder Mgmt	1	The staff manages the indwelling catheter - Total Assistance.
Bowel Mgmt	1	Mr. H. is incontinent of stool, soiling linen and clothing twice in the past 3 days. Total Assistance.
Trans: B,C,WC	1	Mr. H. needs two staff members to get into and out of bed - Total Assistance.
Trans: Toil	0	Activity does not occur.
Trans: T or S	0	Activity does not occur.
Walk/WChair	0	Mr. H. is able to propel a wheelchair only 30 feet – Total Asssitance (1). Ambulation did not occur and is expected to be the mode at discharge - 0 - Activity did not occur.
Stairs	0	Activity does not occur.
Comprehens	5	Mr. H. understands conversations about daily activities, but not complex/abstract information - Standby Prompting.
Expression	2	Mr. H. is able to say single words - Maximal Prompting.
Soc Inter	7	Mr. H. acts appropriately and participates in therapy – Complete Independence.
Prob Solv	5	Mr. H. is able to solve simple problems but unable to solve complex problems – Supervision.
Memory	3	Mr. H. recognizes therapists most of the time, and remembers his therapy routines just over half of the time - Moderate Assistance.

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ANSWERS AND RATIONALE FOR PRACTICE CASE STUDY #2 DISCHARGE FIM™ SCORES

Item	Score	Rationale
Eating	5	The helper provides setup assistance (cutting up meat and opening containers) only. Mr. H. then eats by himself – Setup.
Grooming	4	Mr. H. is independent with four of the five grooming tasks after setup assistance. Mr. H. needs help combing his hair - Minimal Assistance.
Bathing	4	Mr. H. bathes himself except for his feet (80%). - Minimal Contact Assistance.
Dressing-UB	4	Mr. H. puts on his own undershirt and shirt. The helper assists with buttoning the shirt only - Minimal Contact Assistance.
Dressing-LB	2	The helper threads Mr. H.'s underwear and pants. Mr. H. pulls up his underwear and pants. The helper puts on his socks and left shoe. Mr. H. dons his right shoe - Maximal Assistance.
Toileting	3	Mr. H. is dependent with perineal hygiene and zipping up the pants. He pulls his pants up and down - Moderate Assistance.
Bladder Mgmt	1	Mr. H. uses a urinal after setup (level 5). Mr. H. has had 3 accidents in the past 3 days requiring assistance from nursing(level 3). - Total Assistance.
Bowel Mgmt	6	Mr. H. uses stool softeners for bowel management (level 6). He is not incontinent of stool (level 7). Record lower score - Modified Independence.
Trans: B,C,WC	5	The helper supervises Mr. H.'s bed-chair transfers – Supervision.
Trans: Toil	5	The helper supervises Mr. H.'s toilet transfers – Supervision.
Trans: T or S	4	The helper provides steadying assistance during the transfer out of the tub - Minimal Contact Assistance.
Walk/WChair	5	Mr. H. walks 150 feet (50 meters) with a walker (assistive device) and supervision by a helper – Supervision.
Stairs	4	Mr. H. walks up and down a full flight of stairs with steadying assistance of one person - Minimal Contact Assistance.
Comprehens	7	Mr. H. understands complex/abstract information - Complete Independence.
Expression	5	Mr. H. expresses basic information over 90% of the time. He does not express complex or abstract information - Standby Prompting.
Soc Inter	7	Mr. H. is cooperative with staff. He has had no inappropriate behaviors - Complete Independence.
Prob Solv	7	Mr. H. solves routine/complex problems without difficulty - Complete Independence.
Memory	7	Mr. H. remembers the staff and his daily routine. Executes requests without repetition – Complete Independence.

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Appendix E

IRF PAI Coding Form

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Form Approved
OMB No. 0938-0842

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information
   A. Facility Name
   _____
   _____
   _____
   B. Facility Medicare
   Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

6. Birth Date _____/_____/_____
   MM / DD / YYYY

7. Social Security Number _____

8. Gender (*1 - Male; 2 - Female*) _____

9. Race/Ethnicity *(Check all that apply)*
   American Indian or Alaska Native A. _____
   Asian B. _____
   Black or African American C. _____
   Hispanic or Latino D. _____
   Native Hawaiian or Other Pacific Islander E. _____
   White F. _____

10. Marital Status _____
    (*1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced*)

11. Zip Code of Patient's Pre-Hospital Residence _____

Admission Information*

12. Admission Date _____/_____/_____
    MM / DD / YYYY

13. Assessment Reference Date _____/_____/_____
    MM / DD / YYYY

14. Admission Class _____
    (*1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)*

15. Admit From _____
    (*01 - Home; 02 - Board & Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 12 - Alternate Level of Care Unit; 13 – Subacute Setting; 14 - Assisted Living Residence*)

16. Pre-Hospital Living Setting _____
    (*Use codes from item 15 above*)

17. Pre-Hospital Living With _____
    (*Code only if item 16 is 01 - Home; Code using 1 - Alone; 2 - Family/Relatives; 3 - Friends; 4 - Attendant; 5 - Other*)

18. Pre-Hospital Vocational Category _____
    (*1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability*)

19. Pre-Hospital Vocational Effort _____
    (*Code only if item 18 is coded 1 - 4; Code using 1 - Full-time; 2 - Part-time; 3 - Adjusted Workload*)

Paver Information*

20. Payment Source
    A. Primary Source _____

    B. Secondary Source _____

    (*01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers' Compensation; 07 - Crippled Children's Services; 08 – Developmental Disabilities Services; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 – No-Fault Auto Insurance; 51 – Medicare MCO; 52 - Medicaid MCO)*

Medical Information*

21. Impairment Group _____ _____
    Admission Discharge
    Condition requiring admission to rehabilitation; code according to Appendix A, attached.

22. Etiologic Diagnosis _____
    (*Use an ICD-9-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation*)

23. Date of Onset of Impairment _____/_____/_____
    MM / DD / YYYY

24. Comorbid Conditions; Use ICD-9-CM codes to enter up to ten medical conditions

    A. _____ B. _____

    C. _____ D. _____

    E. _____ F. _____

    G. _____ H. _____

    I. _____ J. _____

Medical Needs

25. Is patient comatose at admission? _____
    0 - No, 1 - Yes

26. Is patient delirious at admission? _____
    0 - No, 1 - Yes

27. Swallowing Status _____ _____
    Admission Discharge

    3 - Regular Food: solids and liquids swallowed safely without supervision or modified food consistency
    2 - Modified Food Consistency/ Supervision: subject requires modified food consistency and/or needs supervision for safety
    1 - Tube /Parenteral Feeding: tube / parenteral feeding used wholly or partially as a means of sustenance

28. Clinical signs of dehydration _____ _____
    Admission Discharge

    (Code 0 – No; 1 – Yes) e.g., e*vidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation*

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INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

	ADMISSION	DISCHARGE
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)		
30. Bladder Frequency of Accidents (Score as below)		

7 - No accidents
6 - No accidents; uses device such as a catheter
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.

	ADMISSION	DISCHARGE
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)		
32. Bowel Frequency of Accidents (Score as below)		

7 - No accidents
6 - No accidents; uses device such as an ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.

	ADMISSION	DISCHARGE
33. Tub Transfer		
34. Shower Transfer		

(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) *See training manual for scoring of Item 39K (Tub/Shower Transfer)*

	ADMISSION	DISCHARGE
35. Distance Walked		
36. Distance Traveled in Wheelchair		

(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 – activity does not occur)

	ADMISSION	DISCHARGE
37. Walk		
38. Wheelchair		

(*Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/ Wheelchair)*

39. FIM™ Instrument*

	ADMISSION	DISCHARGE	GOAL
SELF-CARE			
A. Eating			
B. Grooming			
C. Bathing			
D. Dressing - Upper			
E. Dressing - Lower			
F. Toileting			
SPHINCTER CONTROL			
G. Bladder			
H. Bowel			
TRANSFERS			
I. Bed, Chair, Whlchair			
J. Toilet			
K. Tub, Shower			
LOCOMOTION (W - Walk; C - wheelChair; B - Both)			
L. Walk/Wheelchair			
M. Stairs			
COMMUNICATION (A - Auditory; V - Visual; B - Both)			
N. Comprehension			
O. Expression (V - Vocal; N - Nonvocal; B - Both)			
SOCIAL COGNITION			
P. Social Interaction			
Q. Problem Solving			
R. Memory			

FIM LEVELS

No Helper

7 Complete Independence (Timely, Safely)

6 Modified Independence (Device)

Helper - Modified Dependence

5 Supervision (Subject = 100%)

4 Minimal Assistance (Subject = 75% or more)

3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence

2 Maximal Assistance (Subject = 25% or more)

1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission

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INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Discharge Information*

40. Discharge Date _____/_____/_____
MM / DD / YYYY

41. Patient discharged against medical advice? _____
(*0 - No, 1 -Yes)*

42. Program Interruption(s) _____
(*0 - No; 1 - Yes*)

43. Program Interruption Dates
(Code only if Item 42 is 1 - Yes)

A. 1st Interruption Date
MM / DD / YYYY

B. 1st Return Date
MM / DD / YYYY

C. 2nd Interruption Date
MM / DD / YYYY

D. 2nd Return Date
MM / DD / YYYY

E. 3rd Interruption Date
MM / DD / YYYY

F. 3rd Return Date
MM / DD / YYYY

44A. Discharge to Living Setting _____
(*01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)*

44B. Was patient discharged with Home Health Services? _____
(0 - No; 1 - Yes)
(Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)

45. Discharge to Living With _____
(*Code only if Item 44A is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other*

46. Diagnosis for Interruption or Death _____
(Code using ICD-9-CM code)

47. Complications during rehabilitation stay
(*Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay*)

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

Quality Indicators

Pressure Ulcers

Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage.

48A. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

Number of Stage 2 pressure ulcers _____ _____
Admission Discharge

48B. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Number of Stage 3 pressure ulcers _____ _____
Admission Discharge

48C. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Number of Stage 4 pressure ulcers _____ _____
Admission Discharge

Worsening in Pressure Ulcer Status Since Admission
Indicate the number of current pressure ulcers that were not present or were at a lesser stage at admission. If no current pressure ulcer at a given stage, enter 0.

49A. Stage 2. Enter Number: _____

49B. Stage 3. Enter Number: _____

49C. Stage 4. Enter Number: _____

Healed Pressure Ulcers.

50A. Were pressure ulcers present on admission? _____
(0 – No; 1 – Yes)

Indicate the number of pressure ulcers that were noted on admission that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since admission, enter 0.
(Code only if item 50A is 1 – yes)

50B. Stage 2 Enter Number _____

50C. Stage 3 Enter Number _____

50D. Stage 4 Enter Number _____

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APPENDIX F
GLOSSARY

Accreditation - Official approval to an organization determined by a set of industry-derived standards and granted by a recognized accreditation agency.

Activities of Daily Living (ADL) - Activities performed as part of a person's daily routine such as self-care, bathing, dressing, eating, and toileting.

Activity - The performance of a task or action by an individual (definition from the World Health Organization ICIDH-2).

Activity Limitation - A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person for the same age, culture, and education. Formerly known as *Disability*.

Acute Care Discharge - The number or percent of patients discharged to an acute inpatient care hospital setting.

Adaptive Devices - Items used during the performance of everyday activities that improve function and compensate for physical, sensory, or cognitive limitations.

Admission FIM™ Score - The baseline functional assessment done using the FIM™ instrument at the time of admission to the rehabilitation program. The FIM instrument should be administered during the first 3 days of admission.

Ancillary Services - Health services other than room and board. These may include x-ray, laboratory, and therapy services.

Assessment Reference Date - The specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period. For the admission assessment, the Assessment Reference Date is the third calendar day that the patient has been in the inpatient rehabilitation facility. For the discharge assessment, the Assessment Reference Date is the date that the patient is discharged from the inpatient rehabilitation facility, or the date that the patient ceases to receive Medicare Part A fee-for-service inpatient rehabilitation services.

Assisted Living Residence - A community-based setting that combines housing, private quarters, freedom of entry and exit, supportive services, personalized assistance, and health care designed to respond to individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours a day to meet scheduled and unscheduled needs in a way that promotes maximum dignity and independence for each resident. These services involve the resident's family, neighbors, and friends.

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Balanced Budget Act (BBA) of 1997 - Enacted legislation that changed many government programs in order to assure a balanced federal budget. The BBA of 1997 has changed many payment systems in Medicare and created the prospective payment system for rehabilitation facilities.

Bathing - Includes bathing (washing, rinsing, and drying) the body from the neck down (excluding the neck and back); may be performed in a tub, shower, or sponge/bed bath.

Benchmarking - Measuring products and services for comparison.

Bladder Accidents – the act of wetting linen or clothing with urine, and includes bedpan and urinal spills.

Bladder Management - Includes complete and intentional control of the urinary bladder, and, if necessary, use of equipment or agents for bladder control.

Bowel Accidents – the act of soiling linen or clothing with stool, and includes bedpan spills.

Bowel Management - Includes intentional control of bowel movements and use of equipment or agents necessary for bowel control.

CARF: The Rehabilitation Accreditation Commission - A private, not-for-profit agency founded in 1966 that establishes standards of quality for rehabilitation services to persons with disabilities.

Case Mix Group (CMG) - A patient classification system that groups together inpatient medical rehabilitation patients who are expected to have similar resource utilization needs and outcomes.

Clinical Indicator - A variable used to monitor and evaluate care to assure desirable outcomes (or prevent undesirable ones).

CMS - Centers for Medicare and Medicaid Services. Formerly known as Health Care Finance Administration (HCFA).

Cognitive Subscale - The last five items of the FIM™ instrument: *Comprehension*, *Expression, Social Interaction, Problem Solving,* and *Memory*.

Community Discharge - The number or percent of patients discharged to a community-based setting, including a home (of the patient, relative, or another person), transitional living setting, board and care setting, or assisted living residence.

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Comorbidity - A specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.

Complete Dependence - The subject expends less than half (less than 50%) of the effort. Maximal or total assistance is required, or the activity is not performed. This includes the rating levels *Maximal Assistance* and *Total Assistance*.

Complete Independence - All of the tasks described as making up an activity on the FIM™ instrument are typically performed safely without modification, assistive devices, or aids, and within a reasonable amount of time.

Complication - A specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category, and which began after the rehabilitation stay started.

Comprehension - Includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures).

Comprehensive Medical Rehabilitation (CMR) - Intensive medical rehabilitation in an inpatient setting.

Contact Guard - Placing one hand on the patient to ensure the patient's safety.

Continuing Rehabilitation - Part of a rehabilitation stay that began in another rehabilitation unit/facility. The patient was admitted directly from a rehabilitation program, either subacute or comprehensive medical rehabilitation (CMR).

Cueing - A gesture, facial expression, verbal instruction, or reminder provided to the subject just before or during the performance of an activity.

Dehydration – Signs of clinical dehydration may include urinating infrequently or in small amounts, dry skin, othostatic hypotension (having a lower blood pressure when sitting or standing than when lying down), somnolence (sleepiness, or being difficult to arouse during the daytime), agitation, sunken eyes, poor skin turgor, very dry mucous membranes (for example, in the mouth), cyanosis, poor fluid intake, or may be caused by excessive loss of fluid through vomiting or excessive urine, stools or sweating (whereby the amount of output exceeds the amount of intake).

Discharge - A Medicare patient in a inpatient rehabilitation facility is considered discharged when one of the following occurs:

1. The patient is formally released.
2. The patient stops receiving Medicare-covered Part A inpatient rehabilitation services.
3. The patient dies in the inpatient rehabilitation facility.

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Discharge FIM™ Score - The assessment of the patient's functional status using the FIM™ instrument at discharge. The FIM instrument should be administered within 3 days of the discharge from the rehabilitation program.

Dressing - Lower Body - Includes dressing and undressing below the waist, as well as putting on and removing a lower body or limb prosthesis or orthosis (when applicable).

Dressing - Upper Body - Includes dressing and undressing above the waist, as well as putting on and removing an upper body or limb prosthesis or orthosis (when applicable).

Eating - Includes the use of suitable utensils to bring food to the mouth, in addition to chewing and swallowing once a meal is appropriately prepared.

Effectiveness - The degree to which care is provided to achieve the desired outcome for the patient.

Efficiency - The effects or end results achieved in relation to the effort expended in terms of resources, time, and money.

Evaluation - A pre-planned stay of fewer than 10 days on the rehabilitation service for evaluation **OR** a rehabilitation stay that lasts fewer than 10 days because of medical complications or an AMA discharge. Evaluation is *not* used for a patient who completes rehabilitation within 10 days.

Expression - Includes clear vocal and nonvocal expression of language. This item includes clear intelligible speech or clear expression of language using writing or a communication device.

Falls - Unintentionally coming to rest on the ground, floor, or other lower surface.

Far/Distant Supervision - The subject is observed or monitored from a distance by a caregiver.

FIM™ instrument - The functional assessment instrument included in the Uniform Data Set for Medical Rehabilitation. It is composed of 18 items rated on a seven-level scale that represents gradations in function from independence (7) to complete dependence (1).

Grooming - Includes oral care, hair grooming (combing or brushing hair), washing the hands and washing the face, and either shaving or applying make-up. If the subject neither shaves nor applies make-up, Grooming includes only the first four tasks.

Healed Pressure Ulcer - Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

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Health Care Financing Administration (HCFA) - The former name of the Centers for Medicare and Medicaid Services (CMS).

ICIDH-2 - International Classification of Impairment, Disability, and Handicap; now referred to as International Classification of Functioning, Disability, and Health.

Impairment - Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Impairment Group Code– Describes the primary reason that the patient is being admitted to the rehabilitation program, and relates directly to the goals of the rehabilitation program.

Independence - The ability to perform a task within a reasonable amount of time *without* physical or cognitive assistance or supervision.

Initial Rehabilitation - A patient's first admission to a rehabilitation program for this impairment.

International Classification of Diseases, 9th Edition, Clinical Management - A listing of diagnoses and identifying codes used to report diagnoses for individuals.

Interrupted Stay - A stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay begins with the day of discharge from the inpatient rehabililatation facility and ends on midnight of the third day.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - A private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care, and long-term care services.

Length of Stay (LOS) - The number of days a patient spends in the rehabilitation program.

Locomotion: Walk/Wheelchair - Includes walking once in a standing position (or using a wheelchair once in a seated position) on a level surface.

Long-Term Care Discharge - The number or percent of patients discharged to a long-term care setting, including an intermediate care setting, a skilled nursing facility, or a chronic hospital.

Maximal Assistance - The patient expends less than 25% of the effort to perform an activity assessed by the FIM^{TM} instrument, resulting in a score of 1 for that activity.

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Medicaid - A federally-funded, state-administered program of medical assistance for people with low incomes.

Medicare - A federal government program serving persons over 65 years of age and persons who are disabled and eligible for social security disability payments.

Memory - Includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information (particularly verbal and visual information). The functional evidence of memory includes (1) recognizing people frequently encountered, (2) remembering daily routines, and (3) executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks.

Minimal Contact Assistance - The subject requires no more help than touching and expends 75% or more of the effort to perform an activity assessed by the FIM™ instrument, resulting in a score of 4 for that activity.

Moderate Assistance - The subject requires more help than touching or expends half (50%) or more (but less than 75%) of the effort to perform an activity assessed by the FIM™ instrument, resulting in a score of 3 for that activity.

Modified Dependence - The subject expends half (50%) or more of the effort to perform an activity assessed by the FIM™ instrument. This includes the levels *Supervision or Setup*, *Minimal Contact Assistance*, and *Moderate Assistance*.

Modified Independence - In the performance of an activity assessed by the FIM™ instrument, one or more of the following may be true: the activity requires an assistive device, the activity takes more than reasonable time, or there are safety (risk) considerations. This level is scored a 6.

Motor Subscale - The first thirteen items of the FIM™ instrument: *Eating*; *Grooming*; *Bathing*; *Dressing - Upper Body*; *Dressing - Lower Body*; *Toileting*; *Bladder Management*; *Bowel Management*; *Transfers: Bed/Chair, Wheelchair*; *Transfers: Toilet*; *Locomotion: Walk, Wheelchair*; and *Stairs*.

Onset Days - The number of days from acute onset of the impairment to admission to the rehabilitation program.

Orthosis - An appliance (device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Anti-embolic (and other) stockings, abdominal binders, and Ace wraps are examples of orthoses.

ORYX™ Program - An initiative that identifies and uses core standardized performance measures that can be applied across accredited health care organizations in each of JCAHO's accreditation programs.

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Outlier - Observation outside a certain range differing widely from the rest of the data.

Outlier Payment - An additional payment beyond the standard federal prospective payment for cases with unusually high costs.

Outcome - The result or end point achieved by a defined point following delivery of services.

Pain – refers to any type of physical pain or discomfort in any part of the body.

Participation - An individual's involvement in life situations in relation to health conditions, body functions, and structures, activities and contextual factors (definition from the World Health Organization's ICIDH-2). Formerly known as *Handicap*.

Patient Assessment Instrument - A document that contains clinical, demographic, and other information on a patient.

Pressure Ulcer - A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Pressure Ulcer "Worsening"- Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1 and increasing in severity to stage 4) on an assessment as compared to a previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

Problem Solving - Includes skills related to solving problems of daily living. Problem Solving involves making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, as well as initiation, sequencing, and self-correction of tasks and activities required to solve problems.

Program Evaluation - A recognized method of determining quality, effectiveness, and efficiency of services. Program Evaluation allows an organization to identify the results of services and the effects of the program on the persons served.

Prospective Payment System (PPS) - A system of payments to a health care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.

Prosthesis - A device that replaces a body part.

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PUSH Scale© - The Pressure Ulcer Scale for Healing, developed by the National Pressure Ulcer Advisory Panel as a quick, reliable tool used to monitor the change in pressure ulcer status over time.

Readmission - A patient's readmission to any rehabilitation program.

Rehabilitation Impairment Category (RIC) – The highest level of classification for the payment (Case Mix Group) categories. The RIC is not recorded on the IRF-PAI, but is assigned by the software based on the admission impairment group code.

Reliability - The degree to which results obtained by a measurement can be replicated.

Risk Adjusted - A statistical process for reducing, removing, or clarifying influences of confounding factors that differ among groups.

Self-Care Activities - Basic activities necessary for daily personal care, including the FIM™ items Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, and Toileting.

Setup - Assistance with preparation before the subject performs an activity (prior preparation), or removal and disposal of equipment/materials after the subject performs an activity.

Shortness of breath at rest – The patient reports one or more episodes of feeling "breathless: or out of breath (dyspneic); the patient is observed to be short of breath while at rest (e.g. while sitting talking) on at least one occasion.

Shortness of breath with exertion – The patient reports one or more episodes of becoming "breathless" or short of breath (dyspneic); the patient is observed to be short of breath with mild exertion, such as during bathing or transferring, on at least one occasion.

Social Interaction - Includes skills related to getting along with others and participating in therapeutic and social situations. Social Interaction represents how one deals with one's own needs together with the needs of others.

Stairs - Going up and down 12-14 stairs (one flight) indoors.

Standby Supervision - For safety reasons, the caregiver stays within one arm's reach of the subject.

Subacute - Subacute care is goal-oriented comprehensive inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after (or instead of) acute hospitalization to treat one or more specific active, complex medical conditions and overall situation. Generally, the condition of an individual receiving subacute care is such that the care does not depend heavily on high-technology monitoring or complex diagnostic procedures. Subacute care

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requires the coordinated service of an interdisciplinary team, including physicians, nurses, and other relevant professional disciplines who are knowledgeable and trained to assess and manage these specific conditions and perform the necessary procedures. It is given as part of a specifically designed program, regardless of site. Subacute care is generally more intensive than traditional nursing facility care and generally less intensive than acute inpatient care. It requires frequent (daily to weekly) patient assessment and review of the clinical course and treatment plan for a limited time period (several days to several months) until a condition is stabilized or a predetermined course is completed. Note: Subacute level of care is not a recognized entity by CMS, and is retained here in the interests of maintaining links with the historic database as well as providing information for future research.

Supervision or **Setup** - For safety reasons, the caregiver monitors a subject. Supervision may be *standby* (close) or *distant*. In regard to assessing activities with the FIM™ instrument, Supervision or Setup refers to help such as standby or distant supervision, cuing or coaxing without physical contact, setup of needed items, or application of orthoses. Performance of an activity at this level is scored a 5.

Tissue Type –

Closed/Resurfaced – The wound is completely covered with epithelium (new skin).

Epithelial Tissue – For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as island on the ulcer surface.

Granulation Tissue – Pink or beefy red tissue with a shiny, moist, granular appearance.

Slough – Yellow or white tissue that adheres to the ulcer bed in strings or clumps and is mucinous.

Necrotic Tissue (eschar) – Black, brown or tan tissue that adheres firmly to the wound bed or ulcer tissue.

Toileting - Includes the safe and timely maintainence of perineal hygiene and adjusting clothing before and after toilet or bedpan use.

Total Assistance - The subject expends less than 25% of the effort to perform an activity assessed by the FIM™ instrument, resulting in a score of 1.

Touching Assistance - The caregiver provides touching to prompt the subject to perform the desired physical movement.

Transfer - The release of a Medicare inpatient from one inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term hospital, a long-term care hospital, or a nursing home that qualifies to receive Medicare or Medicaid payments.

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Transfers: Bed, Chair, Wheelchair - Includes all aspects of transferring to and from a bed, chair, and wheelchair, or coming to a standing position if walking is the typical mode of locomotion. The patient should perform this activity safely.

Transfers: Toilet - Includes getting on and off a toilet.

Transfers: Tub or Shower - Includes getting in and out of a tub or shower stall.

Tunneling - A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

Typical Case – Patients who stay more than 3 days, receive a full course of inpatient rehabilitation care and are discharged to the community.

Undermining - The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the surface.

Unstageable Pressure Ulcers - There are 3 types of unstageable pressure ulcers:

1. **Unstageable Pressure Ulcer - Deep Tissue Injury**
   a. Localized area of discolored (darker than surrounding tissue) intact skin.
   b. Related to damage of underlying soft tissue from pressure and/ or shear.
   c. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
   d. Deep tissue injury may be difficult to detect in individuals with dark skin tones
2. **Unstageable Pressure Ulcer - Slough and/ or Eschar**
   a. Known but not stageable related to coverage of wound bed by slough and/ or eschar.
   b. Full thickness tissue loss.
   c. Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed
3. **Unstageable Pressure Ulcer - Non-Removable Dressing**
   Known but not stageable because of the non-removable dressing

Validity - The degree to which a measurement instrument measures what it is intended to measure.

Visual Cue - Any visible gesture, posture, or facial expression used to aid in the performance of a task.

Weak cough and difficulty clearing airway secretions – The patient reports being or is observed to be unable to cough effectively to expel respiratory secretions or sputum from the mouth (e.g. secondary to viscosity of sputum, inability to physically remove secretions from tracheostomy entrance) on at least one occasion.

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APPENDIX G
CODING THE CMS PATIENT DATA SYSTEM

CODING FORMS

Blank hardcopies of the Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) are provided in Appendix E of this guide. The input software for payment, IRVEN, uses the instrument on a question by question basis. Therefore, it is critical to complete the questions on the IRF-PAI carefully and accurately. All questions should be answered, except those that have been identified as voluntary. As shown in the IRVEN data flow diagram below, patient data are collected within the facility and entered into the software. These data are used for payment purposes. In addition, the data will be used to develop an analytical database for monitoring, and assessing implementation of the prospective payment system.

CMS PATIENT DATA SYSTEM FLOW

IRVEN software is a powerful computer program provided to all IRFs and is available on the CMS website: http://www.cms.gov/InpatientRehabFacPPS/06_Software.asp#TopOfPage. The diagram below illustrates the role of IRVEN software in the flow of data within an IRF. Instructions are available as part of the software and assistance is available from the CMS Help Desk:

Phone: 1-800-339-9313
Fax: 1-888-477-7871
Email: HELP@QTSO.COM
Coverage Hours: 8:00am (ET) to 8:00pm (ET) Monday through Friday

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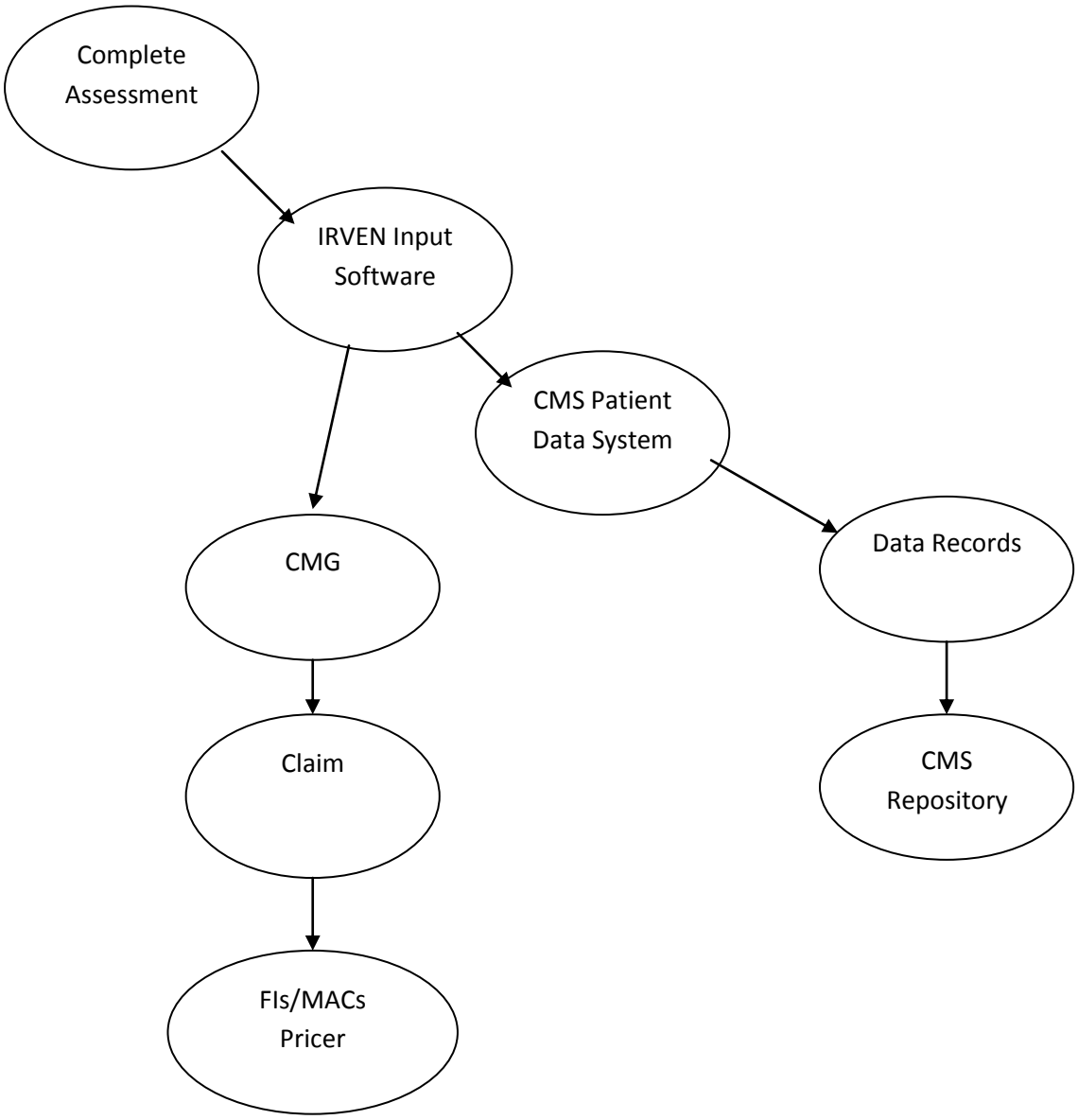
CMS PATIENT DATA SYSTEM FLOW



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APPENDIX H
RELATIVE WEIGHTS FOR CASE MIX GROUPS (CMGS)

INTRODUCTION
The IRF PPS August 7, 2001 Final Rule specifies that data from the IRF-PAI will be used to classify a patient into a CMG. Each CMG/comorbidity tier combination is assigned a relative weight, which is multiplied by the budget neutral conversion factor to arrive at a Federal prospective payment. Applicable case- and facility-level adjustments are then applied to the Federal prospective payment to determine the reimbursement that the inpatient rehabilitation facility (IRF) receives for Medicare Part A fee-for-service covered services furnished by the IRF during the Medicare beneficiary's episode of care.

The case-level adjustments include those that apply for interrupted stays, transfer patients, short stays, patients who expire, and outlier patients. Facility-level adjustments are those that account for geographic variation in wages (wage index), disproportionate share hospital (DSH) percentages or low income patients (LIP), whether the IRF is a teaching facility, and location in a rural area.

A set of relative weights accounts for the relative differences in resource use across the 100 CMGs. Ninety-five of these CMGs (those for typical patients*) may have 4 different relative weights each, one for each of 3 comorbidity tiers, and one for no comorbidities. Five special CMGs for atypical patients, which are unaffected by comorbidity status, have only one relative weight each.

Methodology to Classify Patients into CMGs
Data needed to classify a **typical patient** into a distinct CMG includes:

- the patient's **admission Impairment Group Code** (item 21 on the IRF-PAI), which the Grouper software will recode into a **Rehabilitation Impairment Category (RIC)**. See Appendix B of this Training Manual for the list of Impairment Group Codes and the associated Rehabilitation Impairment Category (RIC) codes and ICD-9-CM codes.
- the patient's **admission motor score**, which is the sum of admission scores for 12 FIM™ items: Eating (item 39A) + Grooming (item 39B) + Bathing (item 39C) + Dressing – Upper (item 39D) + Dressing – Lower (item 39E) + Toileting (item 39F) + Bladder Management (item 39G) + Bowel Management (item 39H) + Transfers: Bed, Chair, Wheelchair (item 39I) + Transfers: Toilet (item 39J) + Walk/Wheelchair (item 39L) + Stairs (item 39M). Note: Any motor item with a code of "0" will be recoded to a "1" in the grouper software. The motor score may range from 12 to 84.

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- the patient's **admission cognitive score**, which is the sum of admission scores for 5 FIM items: Comprehension (item 39N) + Expression (item 39O) + Social Interaction (item 39P) + Problem Solving (item 39Q) + Memory (item 39R). The cognitive score may range from 5 to 35.
- the patient's **age at admission**.

IRFs will enter one of the 95 CMGs for typical patients, as well as the comorbidity tier on the claim form.

As noted above, the transfer rule may apply if the patient is discharged early (i.e., LOS is less than average LOS for the given CMG) to an institutional site (based on data submitted on the claim form).

Five special CMGs are used for patients who have a length of stay of 3 days or less (not including transfer patients), and patients who expire. The 5 special CMGs will be assigned by the PRICER software in special situations. Providers will never need to enter the special CMGs (5001, 5101, 5102, 5103, 5104) on a claim.

* A **typical** patient has a length of stay of more than three days, receives a full course of inpatient rehabilitation care, and is discharged to the community.

Refer to the IRF PPS Final Rules and other CMS publications, such as program memoranda, for authoritative guidance. The CMS publications related to the IRF PPS can be located at the CMS IRF PPS website, which is http://www.cms.gov/InpatientRehabFacPPS.

The relative weight and average length of stay values for each CMG/comorbidity tier combination are typically updated each year. The most current relative weight and average length of stay for each CMG can be found in the data files for each fiscal year on the CMS IRF PPS website, which is: http://www.cms.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage.

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APPENDIX I

PATIENT PRIVACY AND PRIVACY RIGHTS UNDER THE INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM (IRF PPS)

In order to participate in the Medicare program a hospital must comply with specific conditions of participation. These conditions are stipulated at Title 42 of the Code of Federal Regulations, Subchapter G, Part 482. Section 482.13 which is entitled "Condition of participation: Patients' rights" at paragraph (d)(1) states the following:

> The patient has the right to the confidentiality of his or her clinical records.

Section 482.24 which is entitled "Condition of participation: Medical record services" at paragraph (b)(3) states the following:

> The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.

Before performing an assessment using the IRF-PAI a clinician of the IRF must give a Medicare inpatient a document entitled "Privacy Act Statement-Health Care Records" and a document entitled "Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities." The Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities is the simplified plain language description of the Privacy Act Statement-Health Care Records. Giving the Medicare inpatient these documents informs the inpatient of his or her privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3) which include the following patient rights:

- The right to be informed of the purpose of the patient assessment data collection;
- The right to have any patient assessment information that is collected remain confidential and secure;
- The right to be informed that the patient assessment information will not be disclosed to others except as allowed by the Federal Privacy Act and as permitted or required by Federal or State privacy and security laws;
- The right to refuse to answer patient assessment data questions; and
- The right to see, review, and request changes to their patient assessment instrument data.

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The IRF must document in the Medicare inpatient's medical record that prior to performing the patient's assessment using the IRF-PAI the Medicare inpatient was given the Privacy Act Statement – Health Care Records form and the Data Collection Information Summary for Patient in Inpatient Rehabilitation Facilities form. These forms are on the last 3 pages of this appendix.

You may also view and then print or download an English language version and a Spanish language version of the forms entitled "Privacy Act Statement-Health Care Records" and "Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities" from a link on the main IRF-PAI webpage: http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage.

The IRF-PAI System of Records Notice specifies the safeguards CMS implemented for protecting the privacy and security of the IRF-PAI data. The IRF-PAI System of Records Notice was initially published in the Federal Register on November 20, 2006 (71 FR 67143), and updated in the Federal Register on June 26, 2009 (74 FR 30606). The System of Records Notice may be also be viewed and printed from a link on the main IRF-PAI webpage.

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PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This statement gives you notice of a data collection as required by law (section 552a(e)(3) of the Privacy Act of 1974).
This statement is not a consent form. It will not be used to release or to use your health care information.

I. The authority for this data collection is given under section 1886(j)(2)(D) of the Social Security Act, which authorizes the Secretary to collect the data necessary to establish and administer the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS).

Medicare participating inpatient rehabilitation facilities must do a complete assessment that accurately reflects your current clinical status and includes information that can be used to show your progress toward your rehabilitation goals. The inpatient rehabilitation facility (IRF) must use the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IFR-PAI) as part of that assessment, when evaluating your clinical status. The IRF-PAI must be used to assess every Medicare Part A (Fee-for-Service) and Part C (Medicare Advantage) inpatient, and it may be used to assess other types of inpatients. The information that is collected on the IRF-PAI is submitted to the Centers for Medicare & Medicaid Services (CMS), which uses the information to be sure that the IRF is paid appropriately for the services that they furnish you, and to help evaluate whether the IRF meets quality standards and gives appropriate health care to its patients.

CMS safeguards the IRF-PAI data in a data system. The system limits data access to authorized users and monitors such users to ensure against unauthorized data access or disclosures. This system conforms to all applicable Federal laws and regulations as well as Federal government, Department of Health & Human Services (HHS), and CMS policies and standards as they relate to information security and data privacy. The applicable laws and regulations include, but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002; the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003; and the corresponding implementing regulations.

While you have the right to refuse to provide information to the IRF for the assessment, this information is very important in ensuring that the IRF is paid appropriately for the services it provides, meets quality standards, and furnishes appropriate health care to its patients. We hope that you will cooperate with your IRF in gathering the necessary data. As explained below, any information that you provide to the federal government through this assessment will be protected under the Federal Privacy Act of 1974 in accordance with the IRF-PAI System of Records Notice. Furthermore, you will always have the right to see, copy, review, and request correction of inaccurate or missing personal health information in the IRF-PAI System of Records.

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II. PRINCIPAL PURPOSE FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the IRF-PAI System of Records No. 09-70-0521. The information will primarily be used to support payments for Fee-for-Service care provided to Medicare Part A beneficiaries by IRFs under the IRF PPS. This information may also be used or disclosed for additional purposes that are related to the principal purpose for which the data was collected. These additional uses are called "routine uses," which are discussed in detail below.

III. ROUTINE USES

The following "routine uses" specify the circumstances when CMS may release your information from the IRF-PAI System of Records without your consent. Prior to receiving data under one of these routine uses, each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Furthermore, disclosures of protected health information authorized by these routine uses may be made only if, and as, permitted or required by the 'Standards for Privacy of Individually Identifiable Health Information.' (45 CFR Parts 160 and 164, which are commonly referred to as the "HIPAA Privacy Rule.") The routine uses are:

1. To support agency contractors, consultants, or grantees who have been engaged by the agency to assist in the performance of a service related to this System of Records and who need to have access to the records in order to perform the activity.
2. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.
3. To assist another Federal and/or state agency, agency of a state government, agency established by state law, or its fiscal agent to:
    a. Contribute to the accuracy of CMS's proper payment of Medicare benefits;
    b. Enable such agency or agent to administer a Federal health benefits program, or as necessary to enable such agency or agent to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; or
    c. To improve the state survey process for investigation of complains related to health and safety or quality of care and to implement a more outcome oriented survey and certification program.
4. To an individual or organization for a research, evaluation, or epidemiological projects related to the prevention of disease or disability, the restoration or maintenance of health, or for understanding and improving payment projects.
5. To support the Department of Justice (DOJ), a court or an adjudicatory body when:
    a. The agency or any component thereof;
    b. Any employee of the agency in his or her official capacity;
    c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee; or
    d. The United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant

and necessary to the litigation and the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

6. To a CMS contractor (including, but not necessarily limited to fiscal intermediaries, carriers and Medicare administrative contractors) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.
7. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in whole or part by Federal funds, when disclosure is deemed reasonable necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat frauds or abuse in such programs.
8. To assist a national accrediting organization that has been approved for deeming authority for Medicare requirements for inpatient rehabilitation services (e.g., the Joint Commission for the Accreditation of Healthcare Organizations, the American Osteopathic Association and the Commission of Accreditation of Rehabilitation Facilities). Data will be released to these organizations only for those facilities that participate in Medicare by virtue of their accreditation status, and even then, only if they meet the following requirements:
    a. Provide identifying information for IRFs that have an accreditation status with the requesting deemed organization;
    b. Submission of a finder file identifying beneficiaries/patients receiving IRF services;
    c. Safeguard the confidentiality of the data and prevent unauthorized access; and
    d. Upon completion of a signed data exchange agreement or a CMS data use agreement.
9. To assist insurance companies, third party administrators (TPA), employers, self-insurers, manage care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (i.e., health maintenance organizations (HMO) or a competitive medical plan (CMP)) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:
    a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a third party administrator;
    b. Utilize the information solely for the purpose of processing the individual's insurance claims; and
    c. Safeguard the confidentiality of the data and prevent unauthorized access.
10. To appropriate Federal agencies, Department officials and contractors, as well as CMS contractors, to respond to a suspected or confirmed breach of the security or confidentiality of the information maintained in this System of Records.

IV. EFFECT ON YOU IF YOU DO NOT PROVIDE INFORMATION

The IRF needs the information contained in the IRF-PAI in order to comply with the Medicare regulations. Your IRF will also use the IRF-PAI to assist in providing you with quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it difficult to evaluate if the facility is giving you quality services. While this information is important, there is no federal law basis for your IRF refusing you services if you refuse to provide the requested information.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal health information, which that Federal agency maintains in its IRF-PAI System of Records: Call 1-800-MEDICARE, toll free, for assistance in contacting the IRF-PAI System of Records Manager. TTY for the hearing and speech impaired: 1-800-820-1202

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Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities

This notice is a simplified plain language summary of the information contained in the attached "Privacy Act Statement-Health Care Records"

As a hospital rehabilitation inpatient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**
  - We are required by federal law to collect health information to make sure:
    1) you get quality health care, and
    2) payment for Medicare patients is correct.
- **You have the right to have your personal health care information kept confidential and secure.**
  - You will be asked to tell us information about yourself so that we can provide the most appropriate, comprehensive services for you.
  - We keep anything we learn about you confidential and secure. This means only those who are legally permitted to use or obtain the information collected during this assessment will see it.
- **You have the right to refuse to answer questions.**
- You do not have to answer any questions to get services.
- **You have the right to look at your personal health information.**
  - We know how important it is that the information we collect about you is correct.
  - You may ask to review the information you provided. If you think we made a mistake, you can ask us to correct it.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal health information which that Federal agency maintains in its IRF-PAI System of Records: Call 1-800-MEDICARE, toll free, for assistance in contacting the IRF-PAI System of Records Manager.
TTY for the hearing and speech impaired: 1-800-820-1202

Note: The rights listed above are in concert with the rights listed in the hospital conditions of participation and the rights established under the Federal Privacy Rule.

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