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

EFFECTIVE 10/01/2014

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SECTION 1: INTRODUCTION AND BACKGROUND INFORMATION

The purpose of this manual is to guide the user in completing 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. The completion of the IRF-PAI is required for every Medicare Part A fee-for-service patient discharged on or after the IRF PPS implementation day of January 2, 2002. The completion of the IRF-PAI is also required for every Medicare Part C (Medicare Advantage) patient discharged on or after October 1, 2009 (see the fiscal year 2010 IRF PPS final rule (74 FR 39762) for more information).

NOTE: This manual is a guide and revisions will be made as the IRF PPS is refined. These revisions may include, but are not limited to, changes resulting from research supporting the IRF PPS, legislation, regulation and refinements. Please refer to the following web site to obtain the most recent updates: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html

BACKGROUND

- Medicare statute was originally enacted in 1965 providing for payment for hospital inpatient services based on the reasonable costs incurred in treating Medicare beneficiaries.
- The statute was amended in 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA), which placed limits on deliverable costs per discharge.
- Social Security Amendments of 1983 established a Medicare inpatient prospective payment system (IPPS) for the operating costs of an inpatient hospital stay. The following hospitals and hospital units are excluded from the IPPS:
    - Children's Hospitals
    - Psychiatric Hospitals
    - Long-term Care Hospitals
    - Rehabilitation Hospitals
    - Distinct part Psychiatric and Rehabilitation units of IPPS hospitals and critical access hospitals ; and
    - Cancer Hospitals
- TEFRA payments remained in effect for inpatient rehabilitation hospitals and distinct part rehabilitation units from 1982 - 2001. TEFRA payments are based upon costs incurred during a base period, which resulted in inequities in payment between older and newer facilities.
- The desire to control the 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 an Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
        - IRF PPS was implemented on January 1, 2002

- Research began on the development of an IRF PPS:
  - 1984: the FIM™ instrument was developed to address functional status measurement
  - 1987: RAND and the Medical College of Wisconsin investigated an IRF 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.
    - FRGs explained 50% of patient costs and 65% of facility costs.
    - FRGs could be used as a case mix methodology to establish an IRF 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 the IRF PPS.
  - 1997: CMS published the criteria for the IRF PPS.
- 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 IRFs to submit data to establish and administer the IRF PPS.
  - Provided a computerized data system to group patients for payment.
  - Provided software for data transmission.
  - Recommended that the Medicare hospital claim form contain appropriate CMG codes to support an IRF PPS.
- 2001: CMS established a patient assessment instrument following a comparison study of two proposed instruments.
- 2001: Final Rule for the IRF PPS was published.
- In order to be excluded from the IPPS and paid instead under the IRF PPS, an IRF is required to meet all applicable requirements in 42 Code of Federal Regulations 412.25 and 412.29.
- In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Social Security Act (the Act), the IRF claim must meet the requirements in 42 Code of Federal Regulations 412.622(a)(3), (4), and (5).
- 2012: Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for Inpatient Rehabilitation Facilities (IRFs). Please see below link to text of Section 3004 of the ACA.

- Section 3004 of the ACA requires the Secretary to publish, by no later than October 1, 2012, the selected quality measures that must be reported by IRFs. The ACA requires that CMS use nationally endorsed quality measures, but also allows CMS to specify measures that are not already endorsed if a feasible and practical measure in the area determined appropriate by the Secretary has not been endorsed.

SECTION 2: 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). For a complete list of voluntary and mandatory IRF-PAI items, refer to the tables in Section 9: Voluntary/Mandatory IRF-PAI Items of this manual. The CMS data system will accept a record if the voluntary items are not completed. However, as required by Section 3004(b) of the Affordable Care Act, failure to complete Quality Reporting Program items may result in payment reductions of two percentage points starting in FY 2014. For the remaining IRF-PAI items that are identified as mandatory, any 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 IRF 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" in Section 3: The FIM™ Instrument 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 the 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. 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.

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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.

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.

Below, chart 3 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).

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.

NOTE: For more information regarding the admission and discharge assessments, please refer to the IRF PPS Final Rules and other CMS publications for authoritative guidance. The CMS publications related to the IRF PPS can be found at the CMS IRF PPS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.

IDENTIFICATION INFORMATION

1. **Facility Information:**
   A. **Facility Name:** Enter the full name of the facility.
   B. **Facility Medicare Provider Number:** Enter the facility medicare provider number. Verify the number through the business office.

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

   NOTE: For those patients with a Medicare Replacement plan or Medicare Advantage Plan a Medicare number is still needed to complete this section of the IRF-PAI. For additional information regarding how to obtain this number, reference the IRF PPS FY 2010 final rule (74 FR 39799).

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

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through the business office.

NOTE: This item is mandatory if the patient is a Medicaid recipient.

4. Patient First Name: Enter the patient's first name. Verify this information through the business office.

5A. Patient Last Name: Enter the patient's last name. Verify this information through the business office.

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

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.

NOTE: If the patient is unwilling to disclose their social security number or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

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)

NOTE: If the patient is unwilling to disclose their race information or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

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)

NOTE: If the patient is unwilling to disclose their marital status or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

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

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ADMISSION INFORMATION

12. Admission Date: Enter the date that the patient was admitted to the IRF. 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., *2014*).

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., *2014*). **Example:** If Admission Date is 07/04/14, then the Assessment Reference Date is 07/06/14.

NOTE: 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).

NOTE: If the patient has an program interruption, the discharge date is not included as one of the 3 calendar days. Example: Patient was admitted to IRF on 7/4/14. Patient was discharged to Acute Care on 7/6/14. Patient returned to IRF on 7/7/14. The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/5/14 and Day 3 would be 7/7/14. Example: Patient was admitted to IRF 7/4/14. Patient was discharged to Acute Care on 7/5/14. Patient returned to IRF on 7/6/14. The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/6/14 and Day 3 would be 7/7/14.

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

1- Initial Rehab: This is the patient's first admission to any inpatient rehabilitation facility for this impairment.
2- THIS CODE IS NO LONGER VALID
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.

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

01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: Definitons of Patient Status Codes for Item 15, 16, and 44D can be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf

16. Pre-Hospital Living Setting: Enter the setting where the patient was living prior to being hospitalized.

01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

17. Pre-Hospital Living With: 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.
** Complete this item *only* if you selected code 01 (Home) in Item 16 (Prehospital Living Setting).

(01- Alone; 02- Family/Relative; 03- Friends; 04- Attendant; 05- Other)

18. DELETED

19. DELETED

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.

(02- Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99- Not Listed)

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

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 in the table listed Impairment Group Codes).

22. Etiologic Diagnosis: Enter the ICD code(s) to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Section 6 of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD coding books for exact codes.

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., *2014*).
NOTE: If a condition has an insidious onset, or if the exact onset date is unknown for any reason, follow these general guidelines:

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

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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.

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)

Pulmonary Disorders
-COPD
Date of initial diagnosis (not exacerbation)
-Pulmonary Transplant
Date of surgery

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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
-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.

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24. Comorbid Conditions: Enter up to twenty-five (25) ICD codes for comorbid conditions. A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF. Enter ICD codes which identify comorbid conditions that are not already included in the Impairment Group Code (IGC). The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' course of treatment for their primary diagnosis. 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.

NOTE: Providers should complete the number of spaces that coincides with the number of comorbid conditions the patient has. Providers do not need to complete all 25 spaces of this item, unless of course, the patient has 25 comorbid conditions.

Example: The patient has 15 comorbid conditions. The provider should complete 15 spaces for this item.

24A. **Arthritis Conditions:** Enter one of the following codes to indicate whether one or more of the arthritis conditions recorded in items #21(Impairment Group), #22(Etiologic Diagnosis), or #24(Comorbid Conditions) meet all of the applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).

(*0- No; 1- Yes)*

If the code *1- Yes* is entered into this item, then this claim may be selected by the MAC for review of the documentation in the IRF medical record to assure that the patient has met all of the applicable regulatory requirements, including that the patient has completed an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the IRF admission. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive settings and include these in the patient's medical record at the IRF (in a section for prior records). These prior records will be available to the MAC staff who reviews the medical records for compliance with the applicable regulatory requirements.

NOTE: Below references 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)) for additional information about the regulatory requirements.

(x) 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.

(xi) 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.

(xii) 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 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.)

NOTE: As discussed in Chapter 3, Section 140.1.1 of the Medicare Claims Processing Manual (Pub. 100-04), which can be downloaded from the CMS Website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, "an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation services" in these regulations means the following:

[A]n appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the MAC's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI/MAC has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the MAC considers is an appropriate,

aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the MAC with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. The outpatient therapy services (or services in other less intensive settings) must immediately precede the IRF admission or result from a systemic disease activation immediately before admission.

25A. Height on admission (in inches): Record the most recent height of measurement for the patient.

- Measure the patient's height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, et
- Use mathematical rounding (i.e., if height measurement is X.5 inches or grea round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.

26A. Weight on admission (in pounds): Record the initial weight measurement for the patient.

- Measure the patient's weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.).
- If the patient has been weighed multiple times during the assessment period, use the first weight.
- Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code ("-") and document the rationale on the patient's medical record.

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 substance. This includes patients who are unable to have any food by mouth (i.e., NPO).

28. DELETED

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.

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.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

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 3: The FIM™ Instrument: *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 3: The FIM™ Instrument*: 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 3: The FIM™ Instrument*: 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.

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.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

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 3: The FIM™ Instrument*: 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 3: The FIM™ Instrument*: 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.

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 3: The FIM™ Instrument*: 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.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

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 bed rest)

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)

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 3: The FIM™ Instrument*: 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.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

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 3: The FIM™ Instrument*: 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).

NOTE: In Item 39L, the mode of locomotion at admission must be the same as the mode of locomotion at discharge.

39. FIM™ INSTRUMENT

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 3: 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: The completion of the Goal section of the FIM Instrument is not required.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

DISCHARGE INFORMATION

40. Discharge Date: Enter the date that the patient is discharged from the IRF or, in the case of a patient that dies in the IRF, the date of expiration. 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., *2014*).

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

0- No
1- Yes

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 was discharged from 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., *2014*).

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

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

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

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

44C.Was patient discharged alive?

0- No
1- Yes

44D. Patient's discharge destination/living setting, using codes below:

(answer only if 44C= 1; if 44C= 0, skip to item 46)
01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: The IRF-PAI discharge date must be the same as the claim date.

45. Discharge to Living With:

(Code only if item 44C is 1- Yes and 44D is 01- Home; Code using 1- Alone; 2- Family/Relatives; 3- Friends; 4- Attendant; 5-Other)

46. Diagnosis for Interruption or Death: Code using the ICD 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 codes reflecting complications. The ICD 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 codes identify complications and/or comorbid conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Relationship Between Complications and Comorbid Conditions: All ICD 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.

THERAPY INFORMATION

O0401. Week 1: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology), during the first week of the IRF stay.

NOTE: Week- A week is a 7 consecutive calendar day period starting with the day of admission. This item should be completed regardless of whether the patient stays a full 7 days.

Example: Mr. W is admitted to the IRF on 8/1/2015 and is discharged on 8/5/2015. Week 1 should include therapy minutes provided beginning 8/1/2015 (Day 1 of the IRF stay) through 8/5/2015 (Day 5 of the IRF stay).

O0402. Week 2: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology), during the second week of the IRF stay.

NOTE: Week 2 begins on Day 8 of the IRF stay and this item is completed regardless of whether the week is a full 7 days. This item should be completed regardless of whether the patient stays a full 14 days.

Example: Mrs. C is admitted to the IRF on 8/1/2015 and is discharged on 8/14/2015. Week 1 should include therapy minutes provided beginning 8/1/2015 (Day 1 of the IRF stay) through 8/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 8/8/2015 (Day 8 of the IRF stay) through 8/14/2015 (Day 14 of the IRF stay).

Example: Mr. T is admitted to the IRF on 8/1/2015 and is discharged on 8/11/2015. Week 1 should include therapy minutes provided beginning 8/1/2015 (Day 1 of the IRF stay) through 8/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 8/8/2015 (Day 8 of the IRF stay) through 8/11/2015 (Day 11 of the IRF stay).

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

**The therapy items on the IRF-PAI are strictly a data collection exercise *only* for weeks 1 and 2 of the IRF stay and should not be used as a way of documenting the amount of therapy provided. While these therapy data collection items are not being used as verification to ensure providers are meeting the intensive therapy coverage requirements, providers should continue to ensure they are satisfying all coverage requirements regarding intensive therapy.

Helpful Terminology and Information

Individual Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) to one patient at a time (this is sometimes referred to as "one-on-one" therapy).

Concurrent Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2 patients at the same time who are performing different activities.

NOTE: Concurrent therapy sessions must begin and end at the same time for both patients involved.

Group Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2-6 patients at the same time who are performing the same or similar activities.

NOTE: The therapist may only provide therapy to one group at a time. Example: One therapist is not allowed to provide therapy to two groups of 6 patients. This will NOT meet the definition stated above.

Co-Treatment Therapy: The provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed therapist) from different therapy disciplines to 1 patient at the same time.

NOTE: Co-treatment is appropriate for specific clinical circumstances and would not be suitable for all patients; therefore, its use should be limited. Co-treatment may not be used for the accommodation of staffing schedules. The specific benefit to the patient of the co-treatment must be well-documented in the IRF medical record.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Examples of Modes of Therapy

Individual Therapy- A speech-language pathologist treats only Mr. A for 30 minutes for aphasia therapy following a stroke. Mr. A's speech- language therapy would be coded as 30 minutes of individual therapy on the IRF-PAI.

Concurrent Therapy- One physical therapist is treating Mr. F who is working on lower extremity strengthening exercises. The same physical therapist is also treating Ms. A who is working on upper extremity strengthening exercises. Both patients begin the therapy session at 9am and end at 10am. Both Mr. F and Ms. A's physical therapy would be coded as 60 minutes of concurrent therapy on the IRF-PAI.

Group Therapy- One physical therapist is working on a group balance activity with 5 IRF patients for 55 minutes. All patients begin and end the group therapy session at the same time. A total of 55 minutes of group physical therapy would be coded (on the IRF-PAI) for each patient present in the group.

Co-Treatment- A physical therapist and occupational therapist do a transfer exercise with Mr. D for 30 minutes. A total of 30 minutes of co-treatment time would be coded for each discipline (PT and OT) on the IRF-PAI for this session.

Coding Example

Ms. F. was admitted to the IRF on 10/19/2015 following a stroke. Her therapy regimen was as follows:

On 10/19/2015, she was evaluated by all three therapy disciplines. The Physical Therapist (PT) evaluation took 65 minutes, the Occupational Therapist (OT) evaluation took 50 minutes and the Speech-Language Pathologist (SLP) evaluation took 75 minutes.
Code: Individual PT: 65 minutes, Individual OT: 50 minutes, Individual SLP: 75 minutes

On 10/20/2015, Ms. F. was seen by PT alone in the morning for 30 minutes to work on gait training. Additionally, she worked on lower extremity strengthening in the afternoon at the same time as another patient who was working on upper extremity strengthening with PT for 40 minutes. OT and SLP saw Ms. F. at the same time for 60 minutes to work on feeding and swallowing respectively.
Code: Individual PT: 30 minutes, Concurrent PT: 40 minutes, OT Co-Treatment: 60 minutes, SLP Co-Treatment: 60 minutes

On 10/21/2015, Ms. F. was seen by PT along with 3 other patients in a group balance activity for 45 minutes. OT treated her to address cognitive perception for 60 minutes and she was treated by SLP during lunch for dysphagia for 68 minutes.

Code: Group PT: 45 minutes, Individual OT: 60 minutes, Individual SLP: 68 minutes

On 10/22/2015, Ms. F. was treated by PT in the morning for 50 minutes for gait training. She was then treated by PT in the afternoon for a transfer activity for 30 minutes. OT then saw her alone for 60 minutes to address ADLs. SLP then treated her during lunch for dysphagia for 58 minutes.
Code: Individual PT: 80 minutes, Individual OT: 60 minutes, Individual SLP: 58 minutes

On 10/23/2015, Ms. F. was seen by PT for endurance training for 65 minutes. She then attended an OT cooking group for 45 minutes along with 4 other patients. SLP treated her for 30 minutes to do oral motor exercises and another 40 minutes during lunch for swallowing therapy.
Code: Individual PT: 65 minutes, Group OT: 45 minutes, Individual SLP: 70 minutes

On 10/24/2015, PT saw Ms. F. for 60 minutes of gait training. OT and speech saw her together for dysphagia and feeding therapy during lunch for 70 minutes.
Code: Individual PT: 60 minutes, OT Co-Treatment: 70 minutes, SLP Co-Treatment: 70 minutes

On 10/25/2015, PT treated Ms. F for 65 minutes in a group of 6 people and they worked on upper and lower extremity strengthening. OT saw Ms. F. for ADL training for 45 minutes and Speech then saw her at the same time as one other person while she worked on oral motor exercises and the other patient was doing a cognitive exercise for 30 minutes.
Code: Group PT: 65 minutes, Individual OT: 45 minutes, Concurrent SLP: 30 minutes

Item O0401. Week 1: Total Number of Minutes Provided should be filled out as follows:

O0401A: Physical Therapy

a) Total minutes of Individual therapy	300
b) Total minutes of concurrent therapy	40
c) Total minutes of group therapy	110
d) Total minutes of co-treatment therapy	0

O0401B: Occupational Therapy

a) Total minutes of Individual therapy	215
b) Total minutes of concurrent therapy	0
c) Total minutes of group therapy	45
d) Total minutes of co-treatment therapy	130

O0401C: Speech-Language Pathology

a)	Total minutes of Individual therapy	271
b)	Total minutes of concurrent therapy	30
c)	Total minutes of group therapy	0
d)	Total minutes of co-treatment therapy	130

Coding Tips

- Therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF.
- Therapy evaluations do count as the initiation of therapy services.
- The time spent in family conferences does not count towards counting therapy minutes on the IRF-PAI.
- "Therapy time" is time spent in direct contact with the patient. Time spent documenting in the patient's medical record, unsupervised modalities, and significant periods of rest are examples of time not spent in direct contact with the patient and, therefore, may not be documented in this section of the IRF-PAI.
- If the patient has an interrupted stay, record the total number of minutes of therapy the patient received in the IRF for that week the same as if the interrupted stay did not occur. As long as the IRF records the interrupted stay in items 42 and 43 of the IRF-PAI, those days will be subtracted and the data will be compared to the data of for the same length of stay.

QUALITY INDICATORS

For information on scoring the IRF-PAI Quality Indicators, see Section 4: Quality Indicators in this manual.

SIGNATURE PAGE

Z0400A. Signature Page: Any staff member that has gathered information from a patient's medical record and used it to complete any section of the IRF-PAI is responsible for signing the signature page. Additionally, each time a staff member completes and/or updates information on the IRF-PAI, they are required to sign the signature page. For example, if a staff member completes an item on the IRF-PAI day 4 of the patients stay and then again on day 14, the staff member should sign the signature page twice, once with the date of day 4 and again with the date of day 14. The title column should be completed with the professional title of the staff person that is completing IRF-PAI

information. Lastly, the date column should be completed with the date in which the information was added to and/or updated on the IRF PAI.

The signature page is the last page of the IRF-PAI document. Providers are required to complete the signature page in order to stay in compliance with the IRF-PAI requirement. While the signature page will not be transmitted to CMS, it is a required document for providers to include in each patient's medical record, to ensure they are compliant with the hospital Conditions of Participation located in the Code of Federal Regulations (CFR) at 482.24(c)(1).

NOTE: This section does not need to be completed by every person that contributes to the patient's medical record. Only the person/people that are completing the IRF-PAI, using information compiled from the patient's medical record, are required to sign the signature page.

NOTE: IRFs may use electronic signatures for the IRF-PAI when permitted to do so by state and local law and when authorized by the IRFs policy. IRFs must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signatures by anyone other than the person to whom the electronic signature belongs.

SECTION 3: 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: 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 that 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.

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.

SECTION 3: THE FIM™ INSTRUMENT

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.

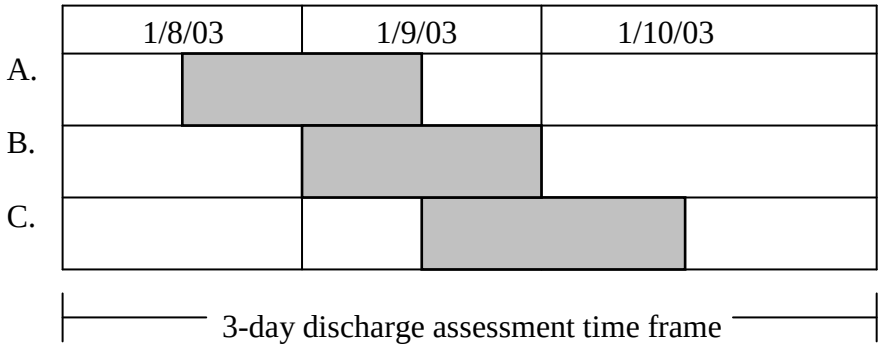
PROCEDURES FOR SCORING THE FIM™ INSTRUMENT AND FUNCTION MODIFIERS

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. The FIM rating should reflect the lowest functional score from treating disciplines during the assessment timeframe.

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. 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: 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 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. The patient's medical chart must substantiate each FIM rating.

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

   NOTE: For 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 labeled "Overview for Use of Code 0 – Activity Does Not Occur for FIM Instrument and Function Modifier Items on the IRF-PAI" 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.

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.

SECTION 3: THE FIM™ INSTRUMENT

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"

SECTION 3: THE FIM™ INSTRUMENT

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.

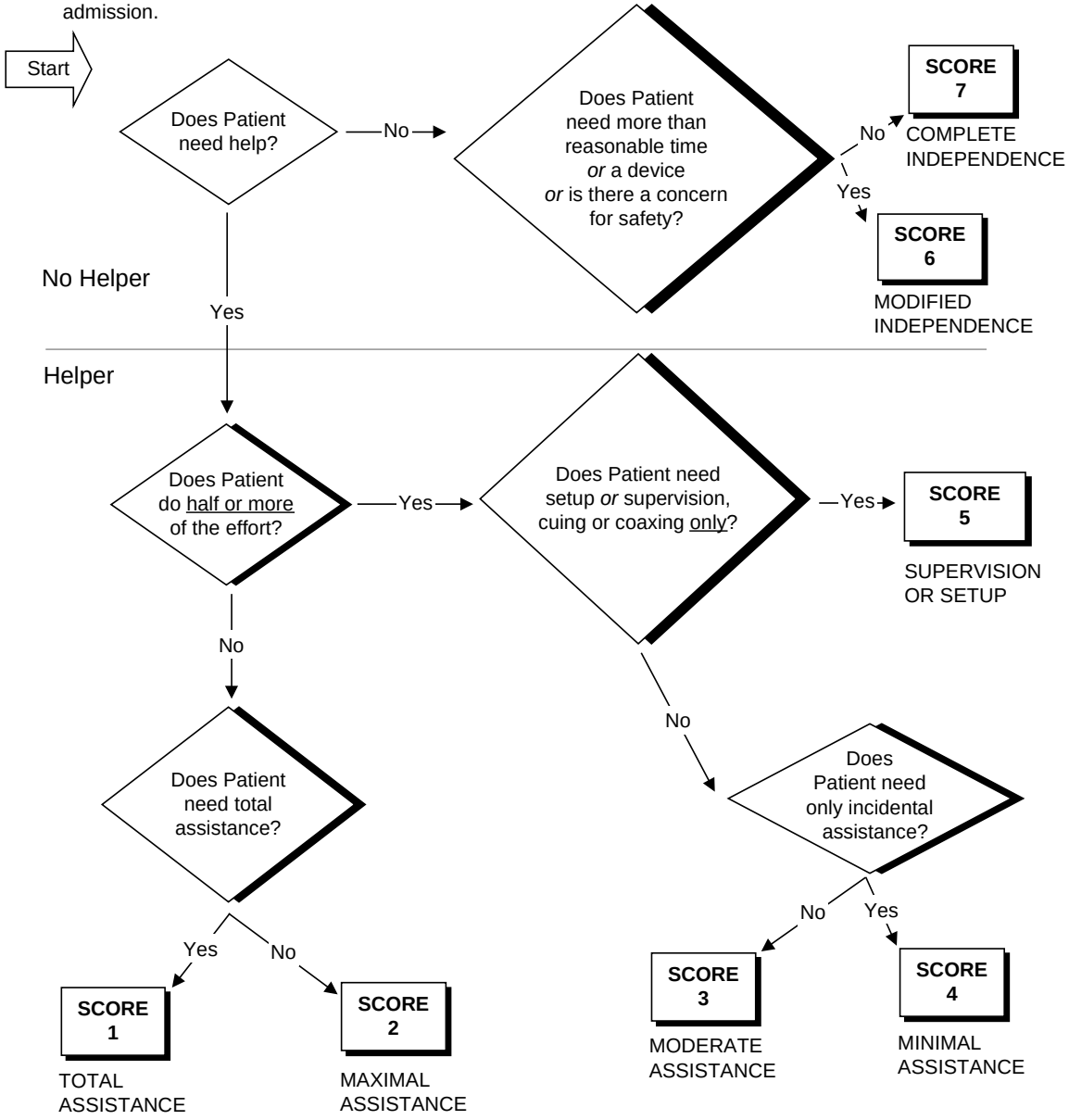
0 Activity Does Not Occur – The patient does not perform the activity, and a helper does not perform the activity for the patient during the entire assessment time frame. **NOTE**: Do *not* use this code only because you did not observe the patient perform the activity. In such cases, consult other clinicians,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

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

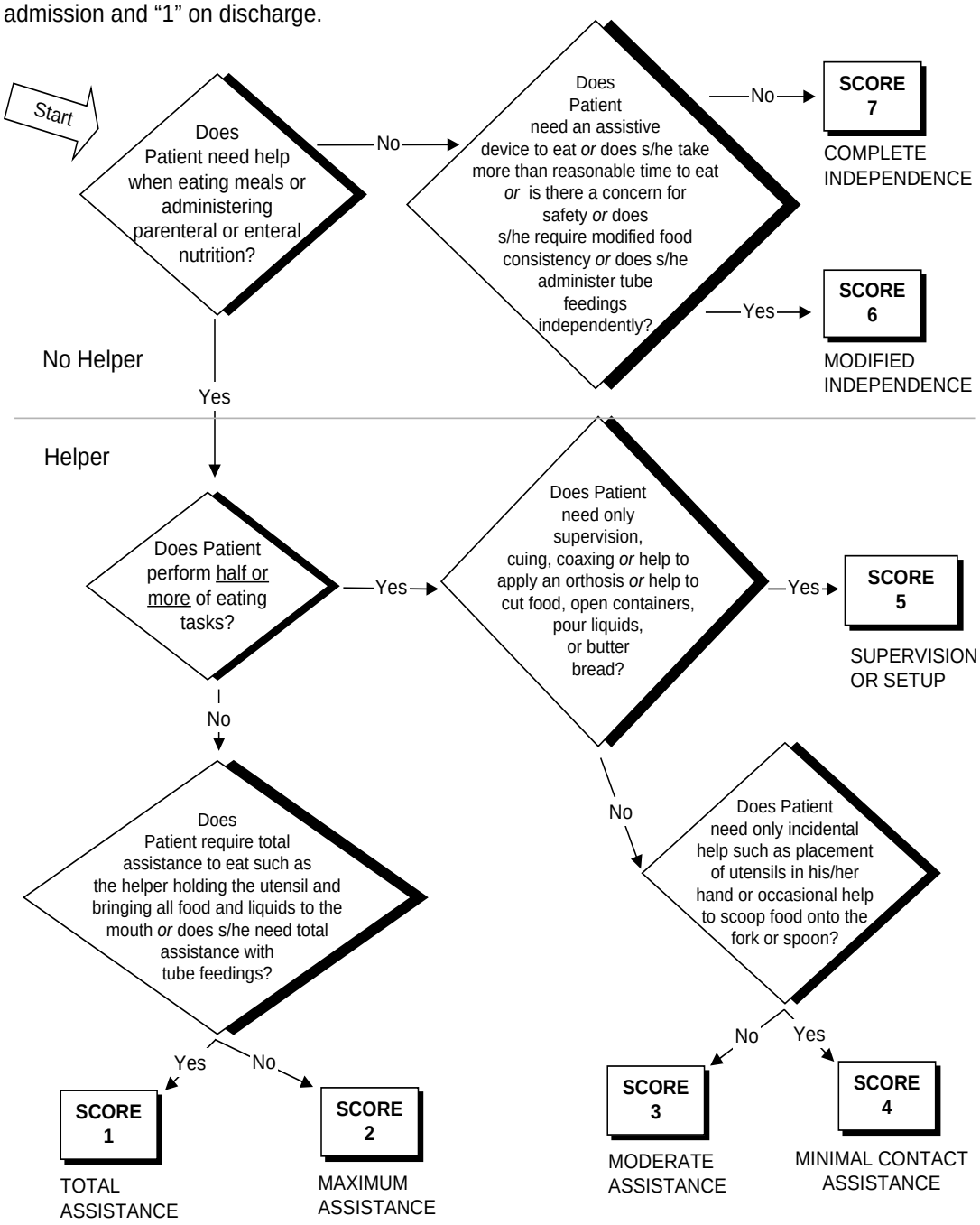
1 Total Assistance—The patient performs less than 25% of eating tasks, or the patient relies on parenteral or gastrostomy feedings (either wholly or partially) and does not self-administer the feedings.

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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

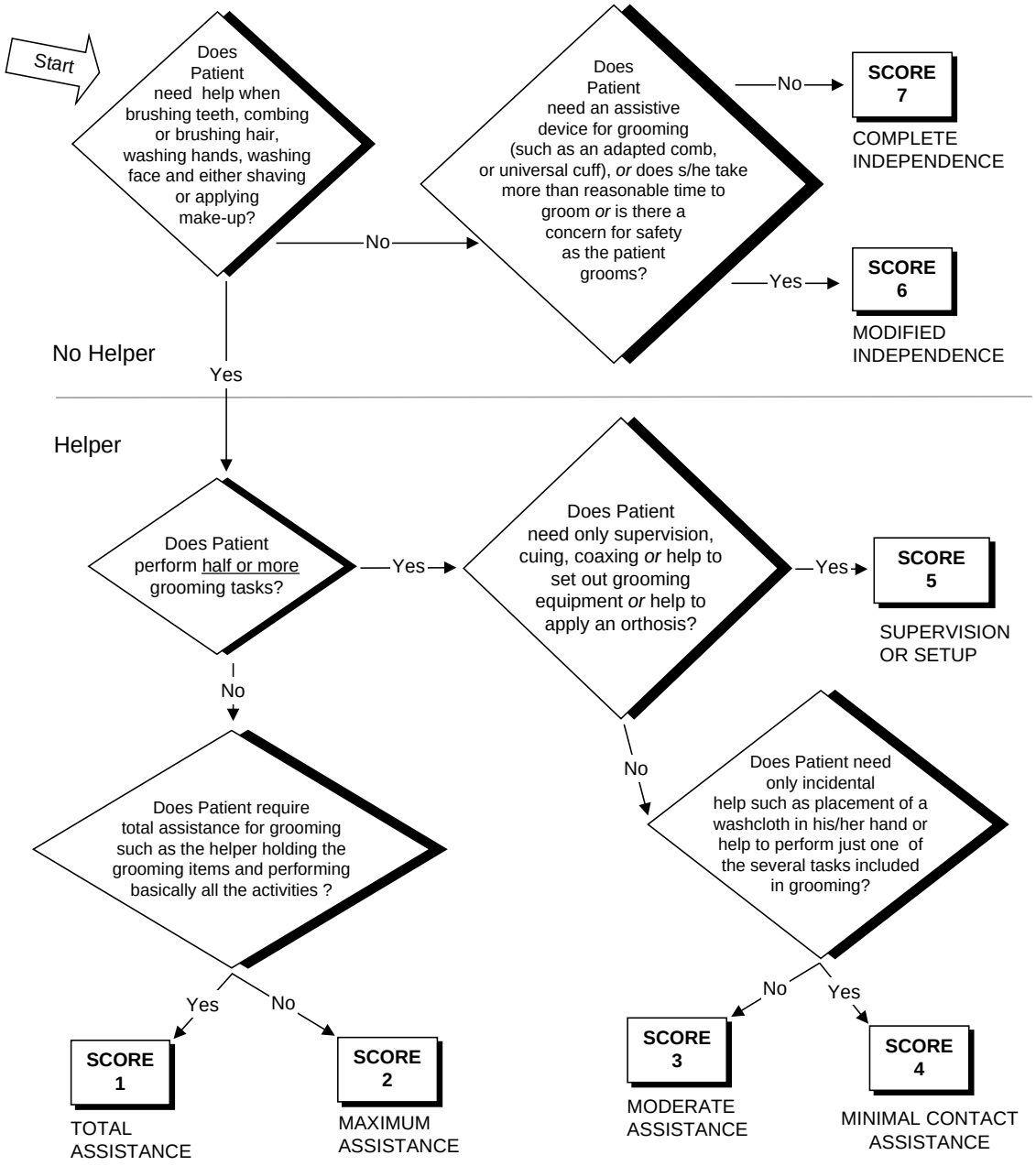
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform any grooming activities (oral care, hair grooming, washing the hands, washing the face, and either shaving the face or applying make-up), and is not groomed by a helper during the entire assessment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

NOTE: 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.

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

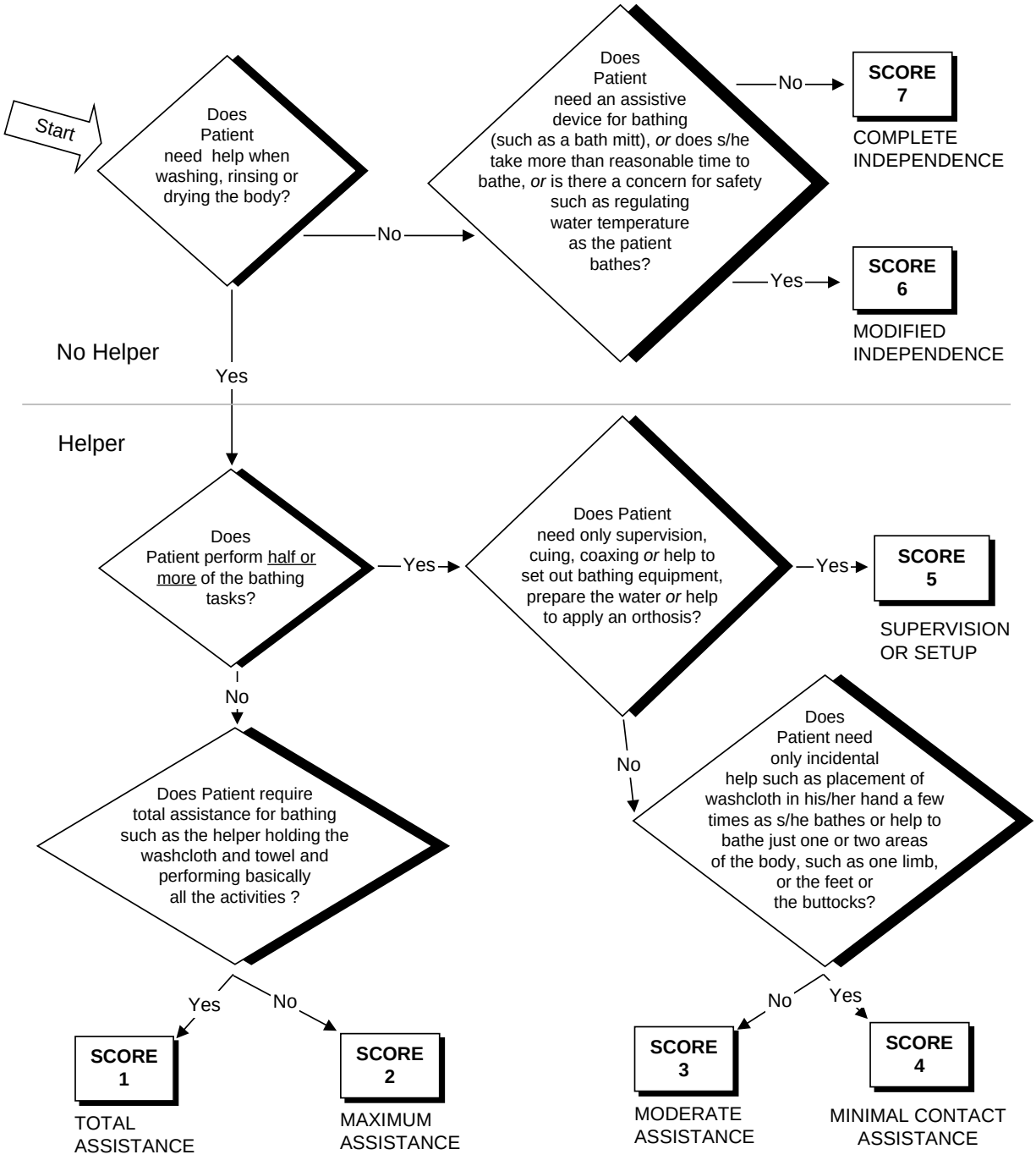
When scoring this item, consider the body as divided up into ten areas or parts. Evaluate how the patient bathes each of the ten areas or parts, with each accounting for 10% of the total:

- 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

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

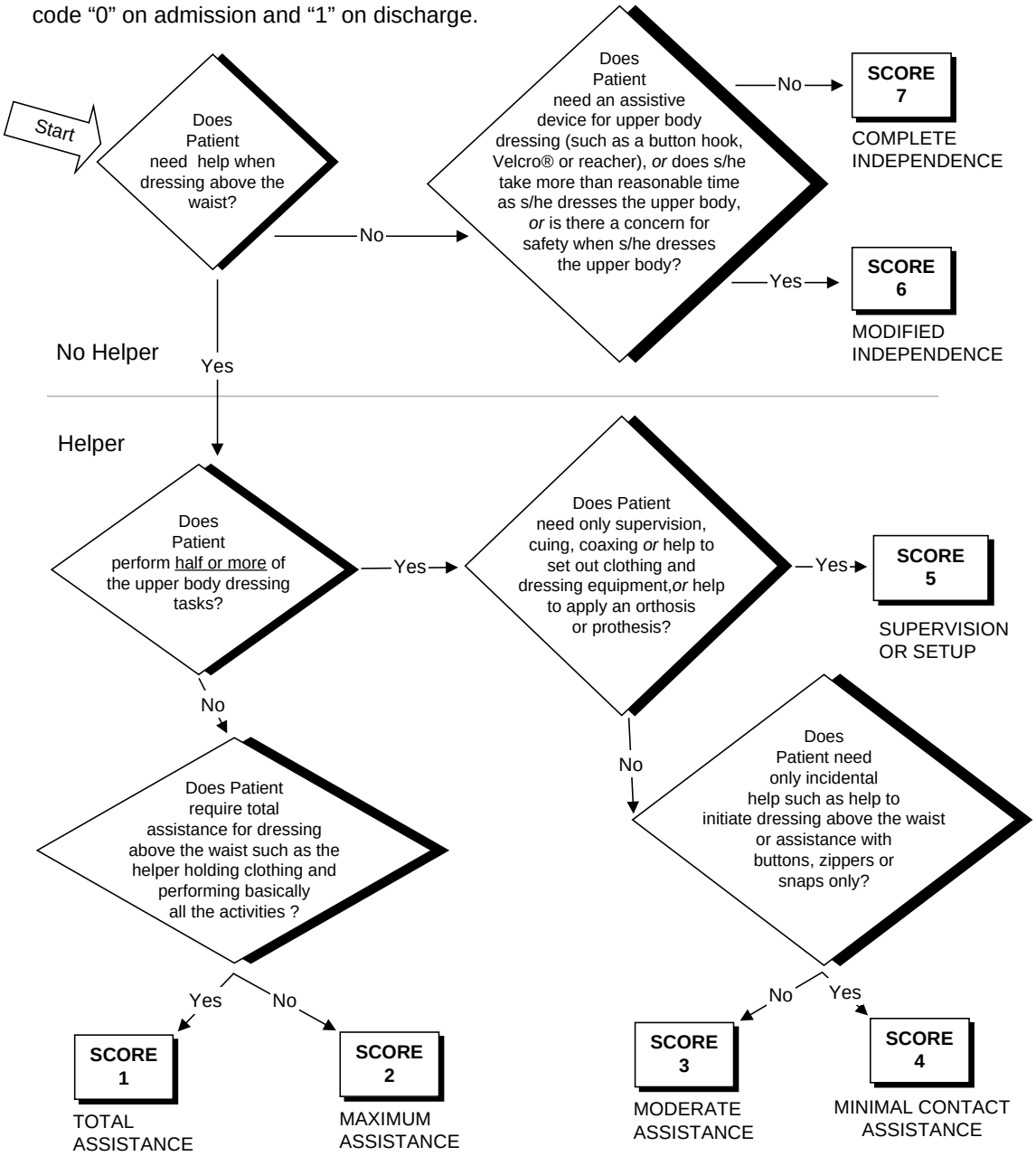
NOTE: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission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

SECTION 3: THE FIM™ INSTRUMENT

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.

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.



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.

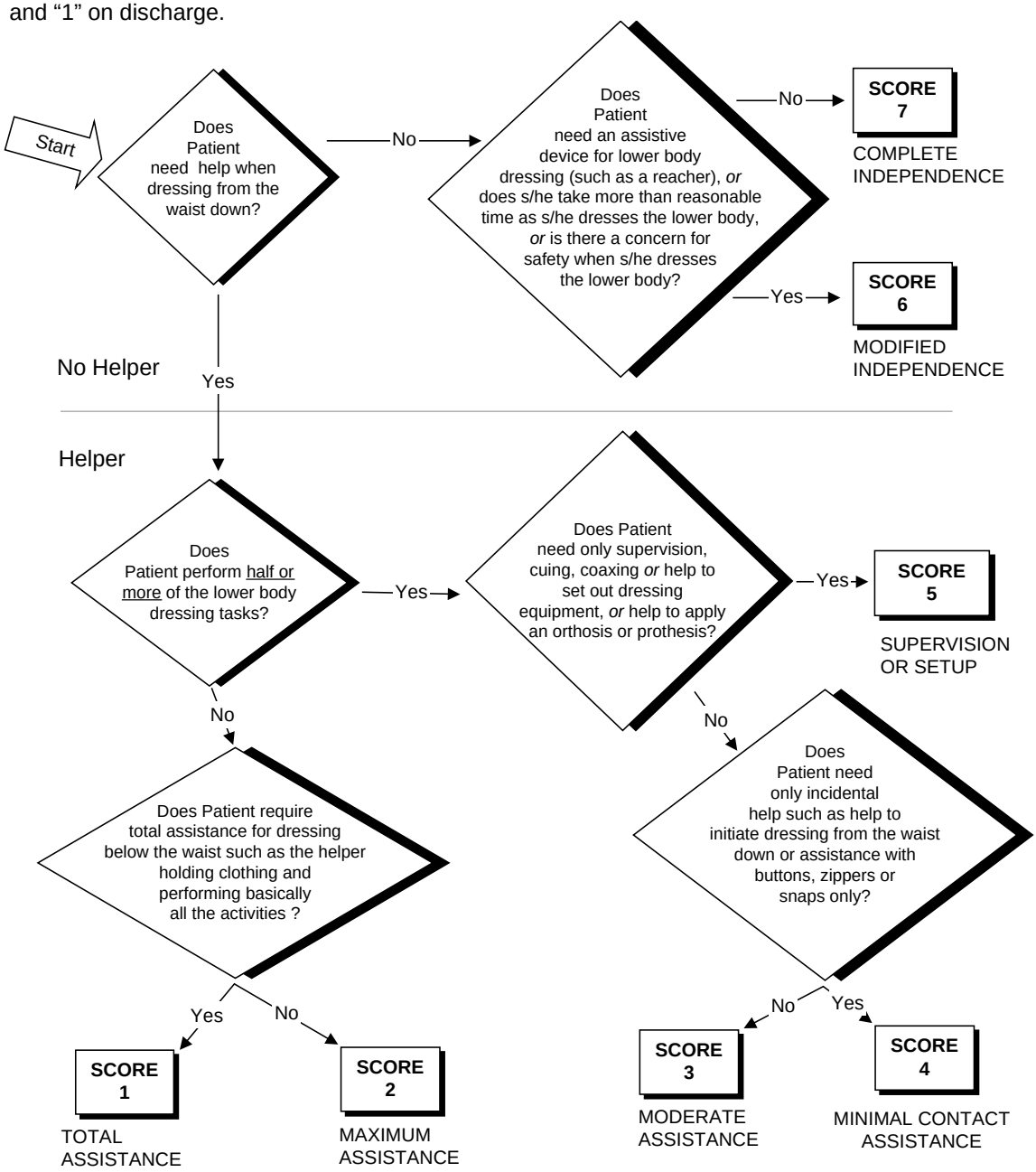
NOTE: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is

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. 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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

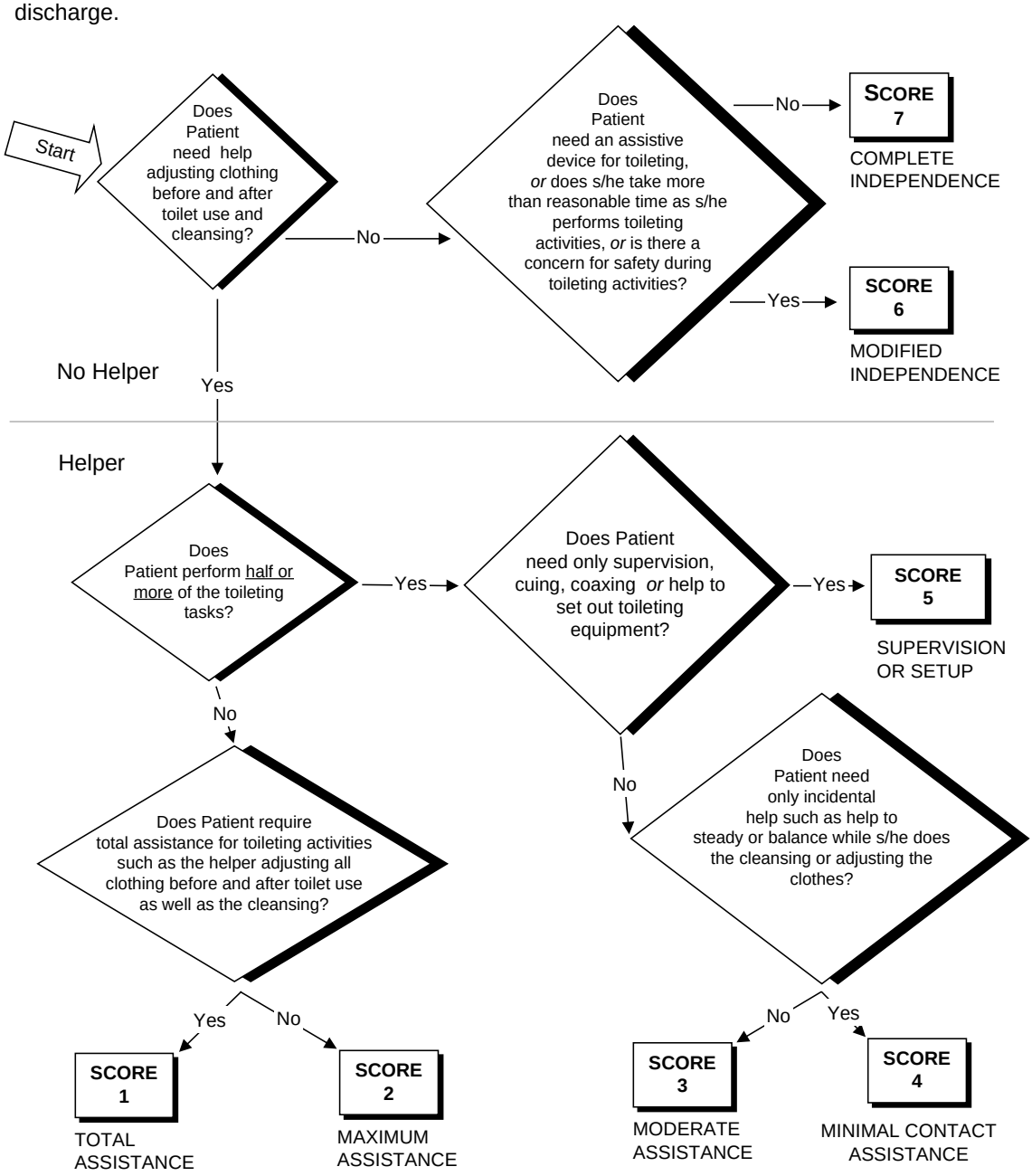
1 Total Assistance—The patient performs less than 25% of toileting tasks.

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.

SECTION 3: THE FIM™ INSTRUMENT

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.



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 note 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.

NOTE: 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.

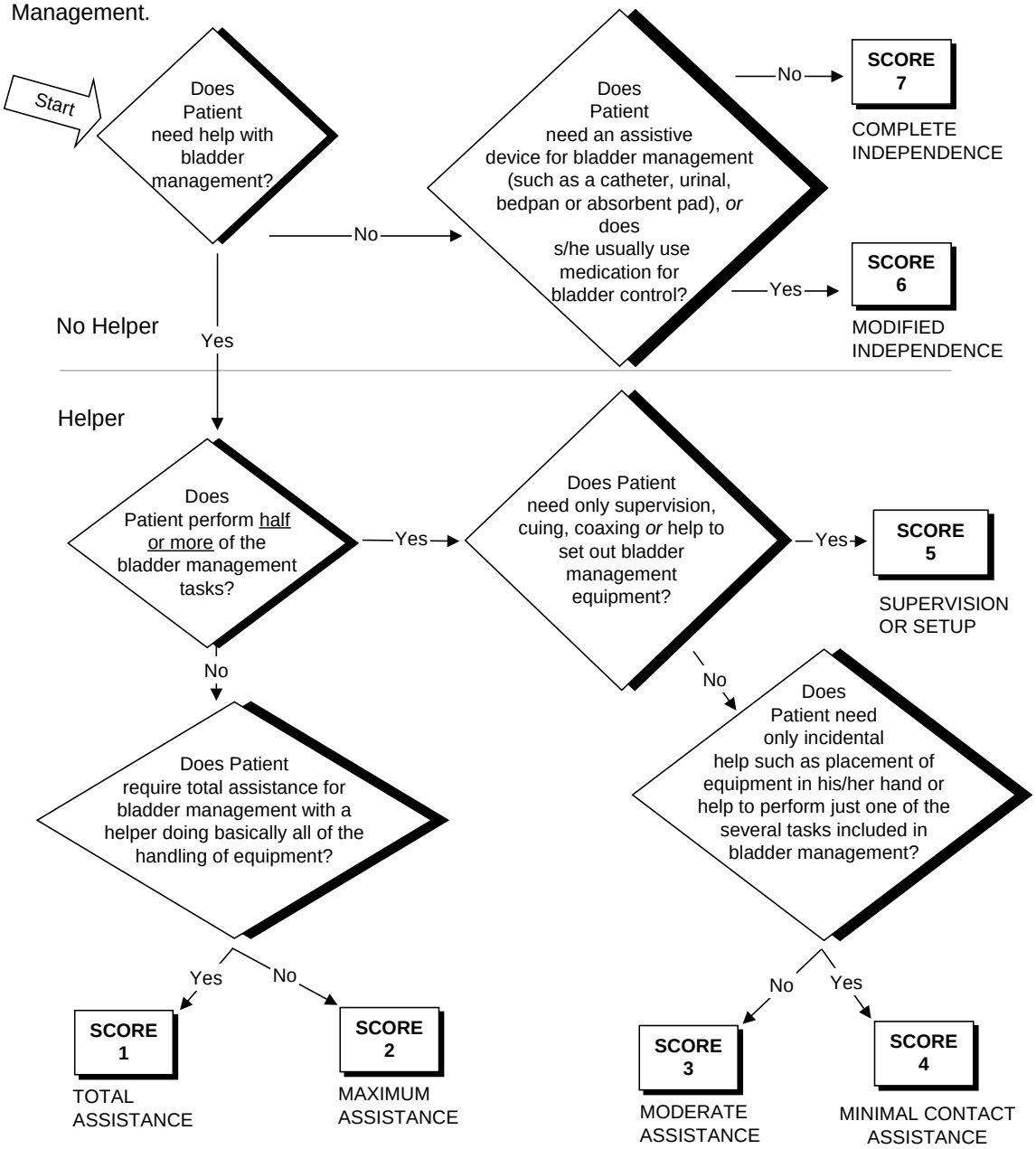
A separate Function Modifier, *Bladder Management—Frequency of Accidents* (Item 30), deals with the success of the bladder management program.

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

SECTION 3: THE FIM™ INSTRUMENT

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.



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 note 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. If the helper spills the container, it is not counted as a patient accident.

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.

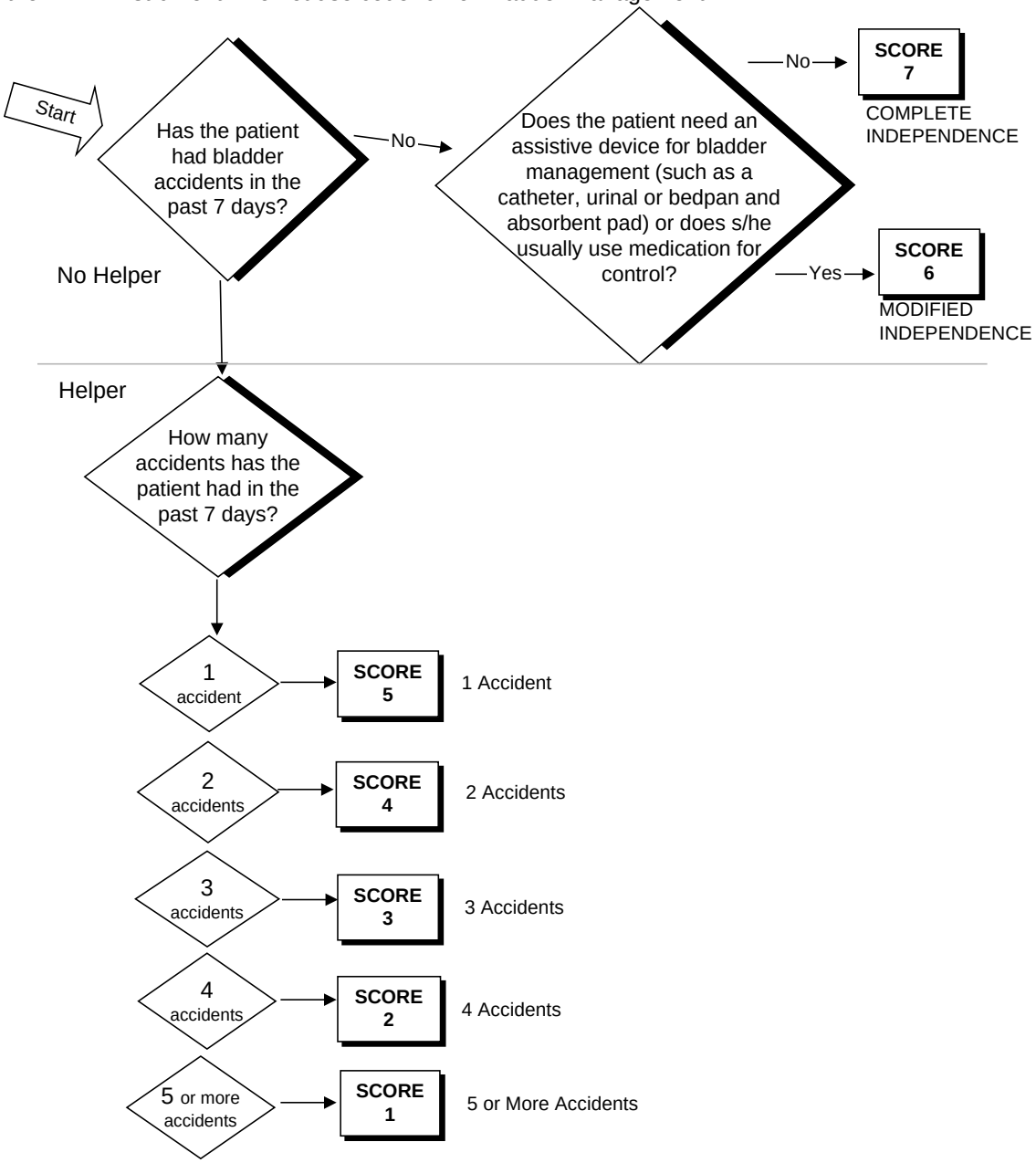
NOTE: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This item deals with the frequency of accidents required to complete bladder management tasks.

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).

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.



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 note 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.

NOTE: 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.

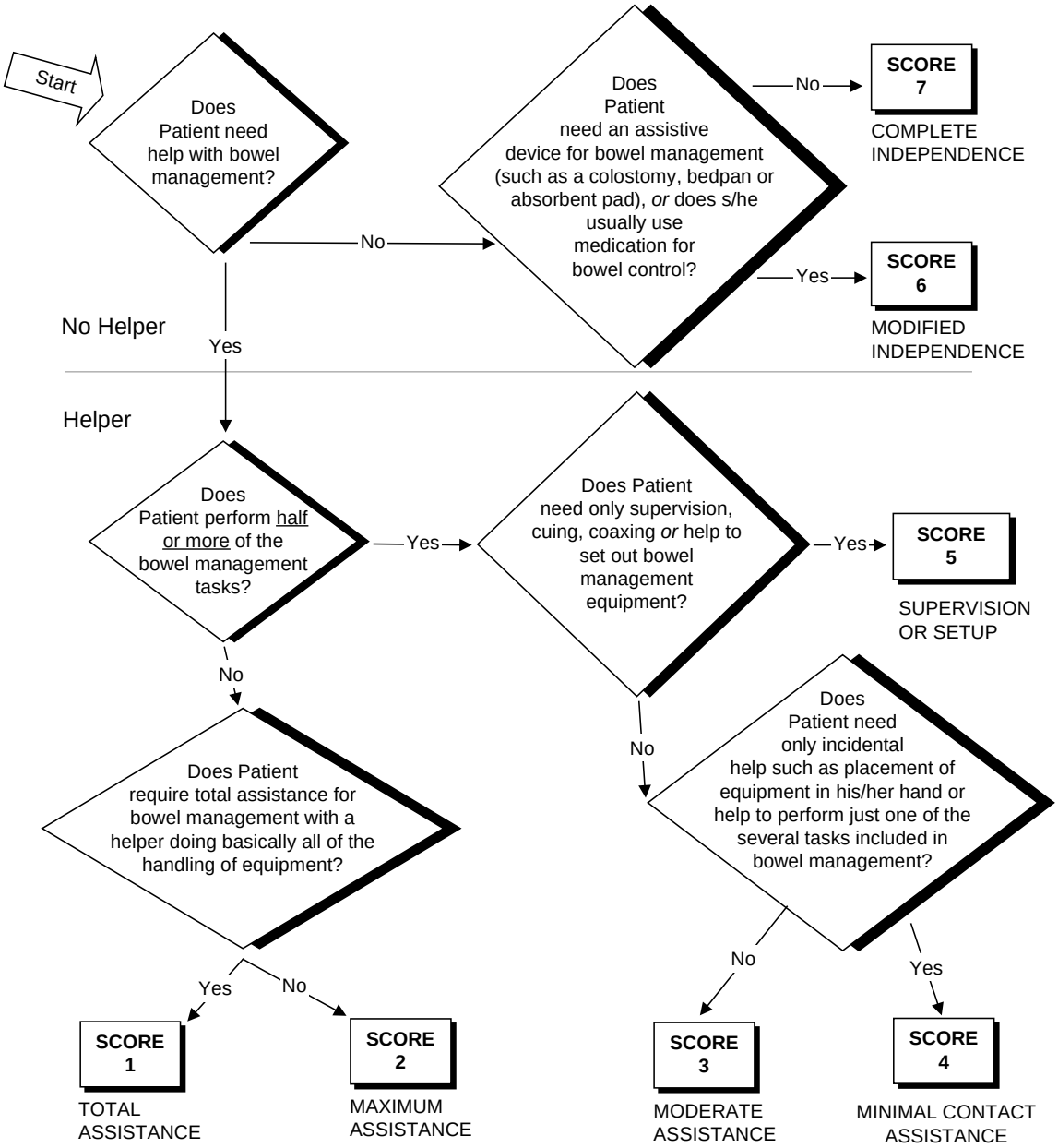
A separate Function Modifier, *Bowel Management—Frequency of Accidents* (Item 32), deals with frequency of bowel accidents.

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

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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 note 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. If the helper spills the container, it is not counted as a patient accident.

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.

NOTE: 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.

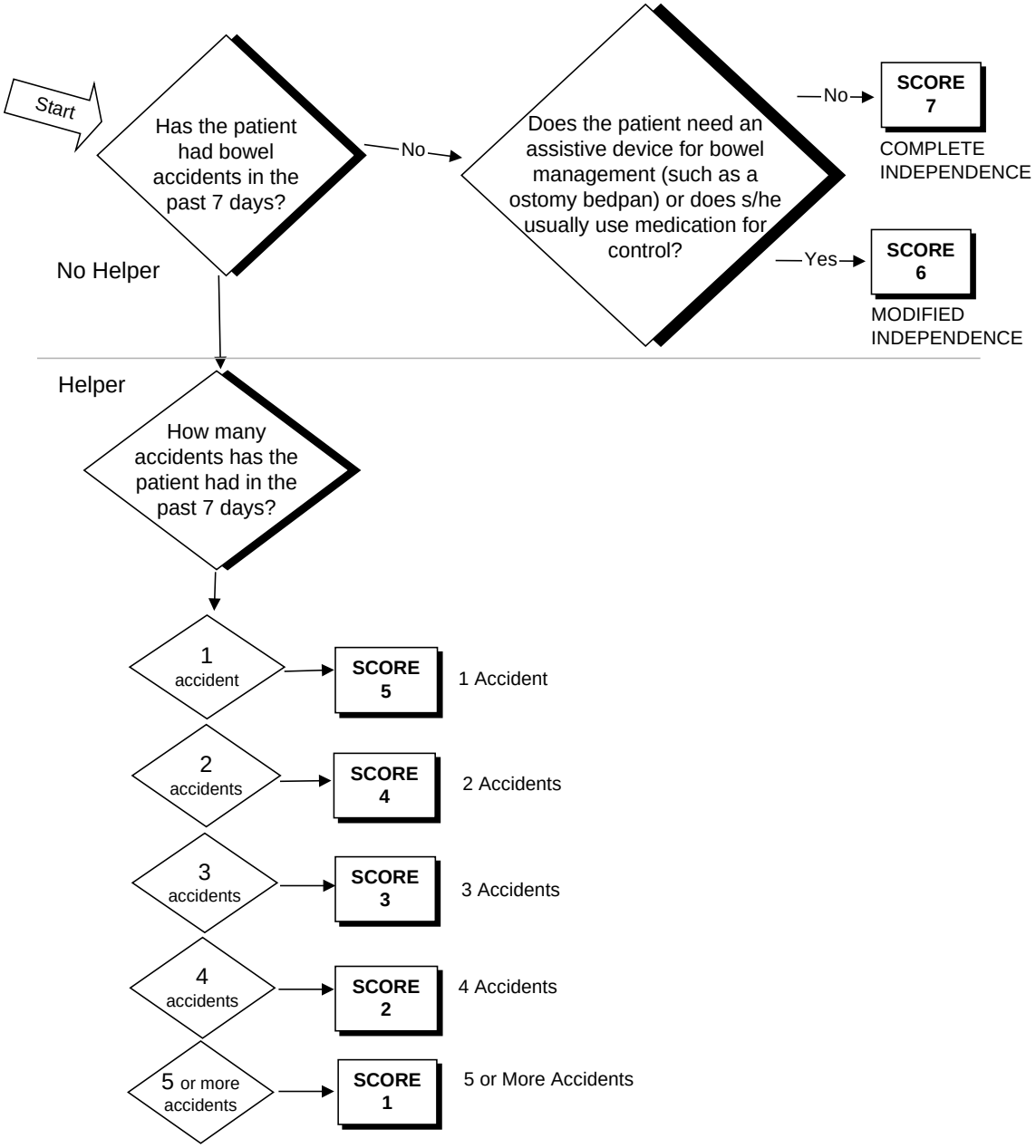
A separate Function Modifier, *Bowel Management—Level of Assistance* (Item 31), deals with level of assistance associated with bowel management.

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

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

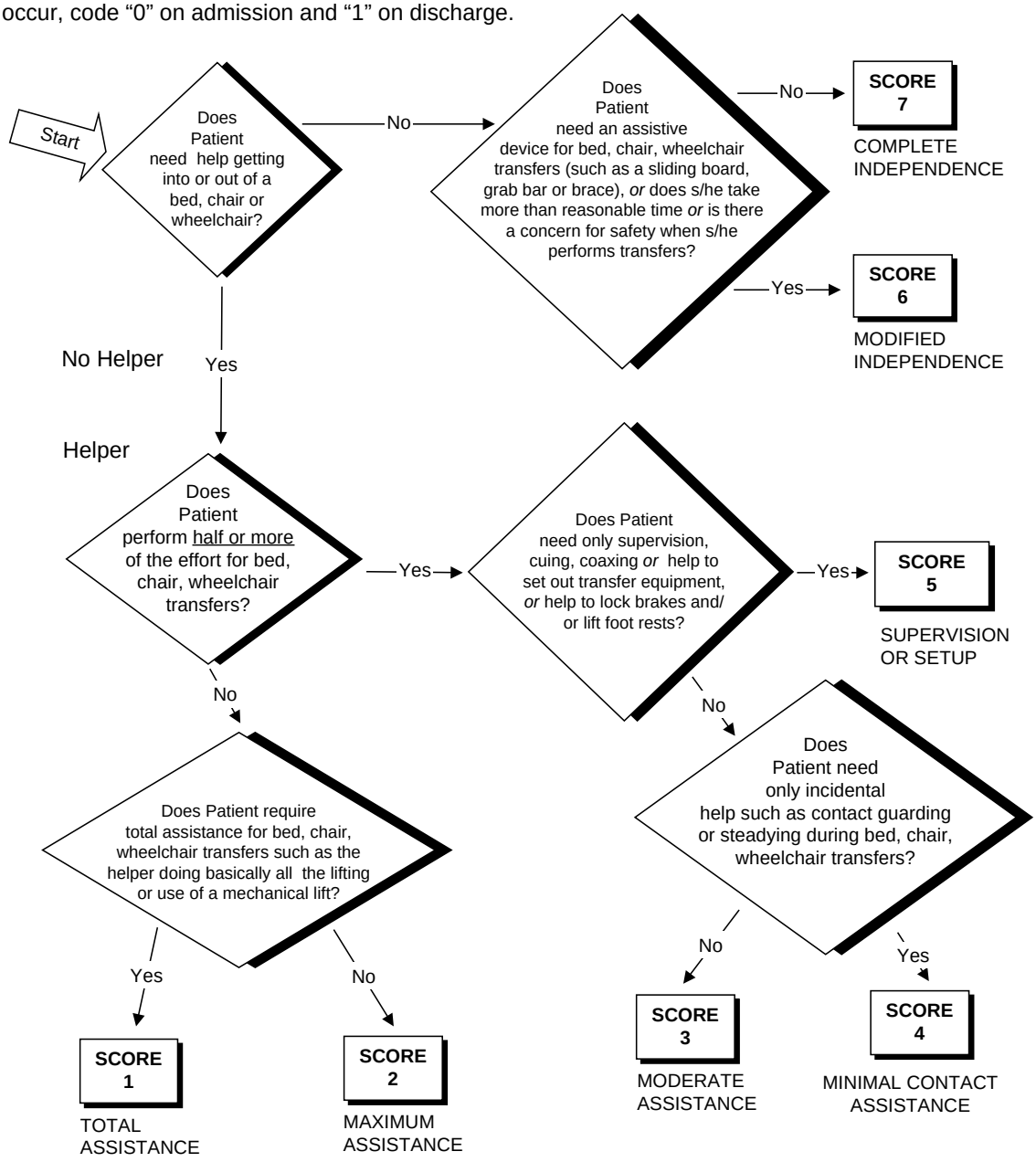
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer to or from the bed or a chair, and is not transferred to or from the bed or a chair by a helper or lifting device. Use of this code should be rare.

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

SECTION 3: THE FIM™ INSTRUMENT

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.



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.

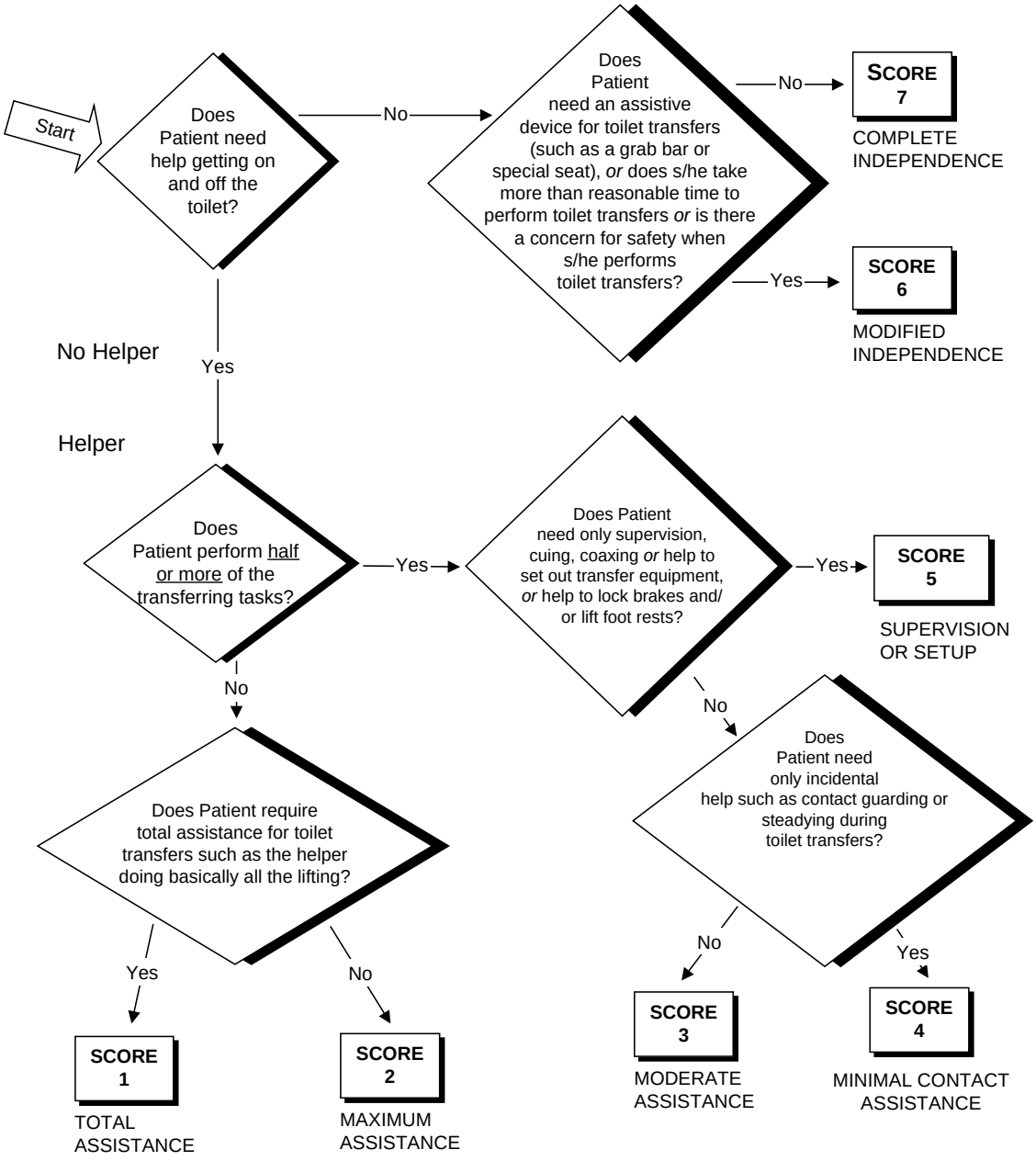
1 Total Assistance—The patient performs less than 25% of transferring tasks.

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.

SECTION 3: THE FIM™ INSTRUMENT

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.



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 note 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.

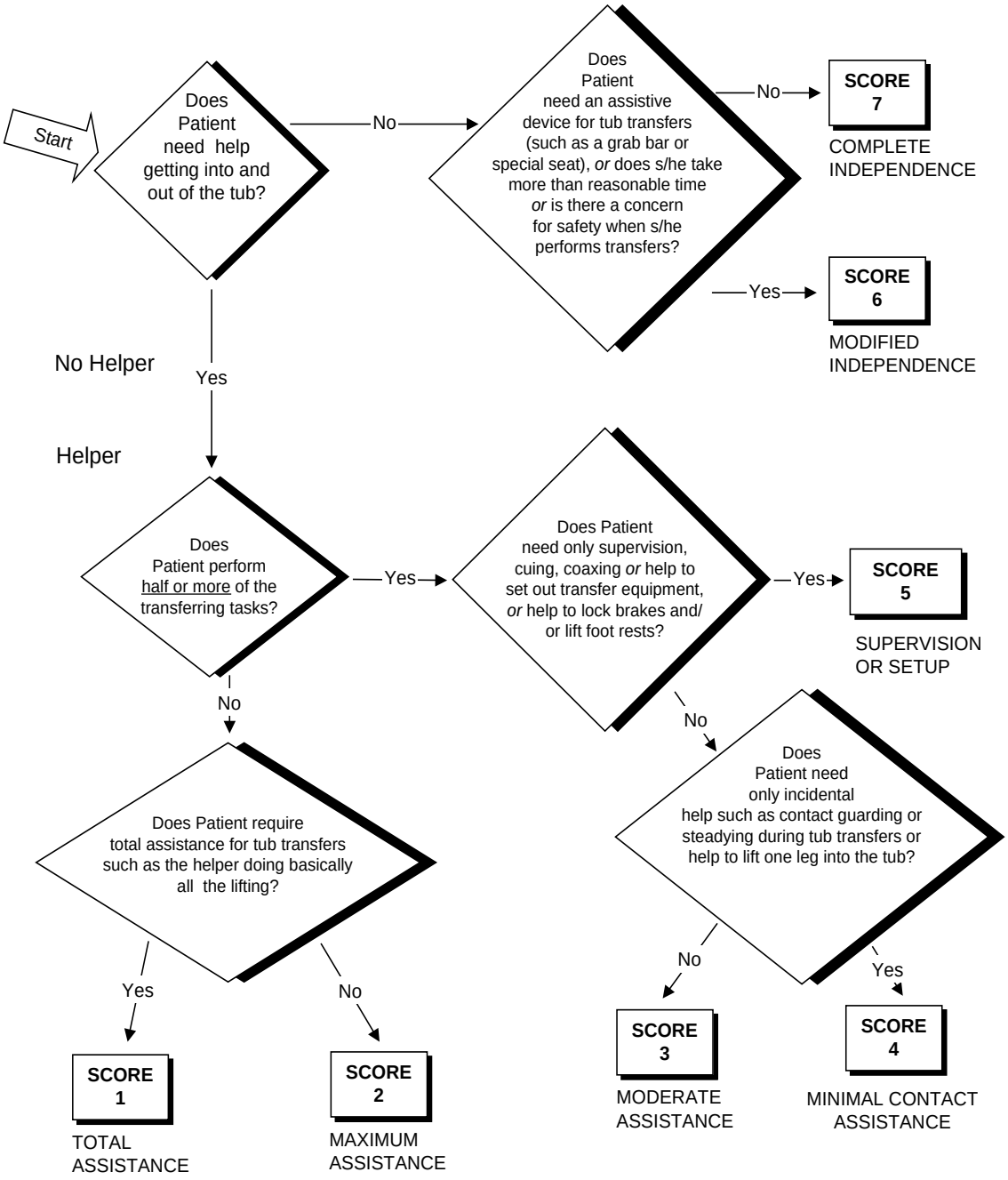
NOTE: There is a separate Function Modifier that addresses transfers into a shower stall. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 33, leave Item 34 blank. If the patient transfers into a tub and shower, record the score for the more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

SECTION 3: THE FIM™ INSTRUMENT

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.



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 note 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.

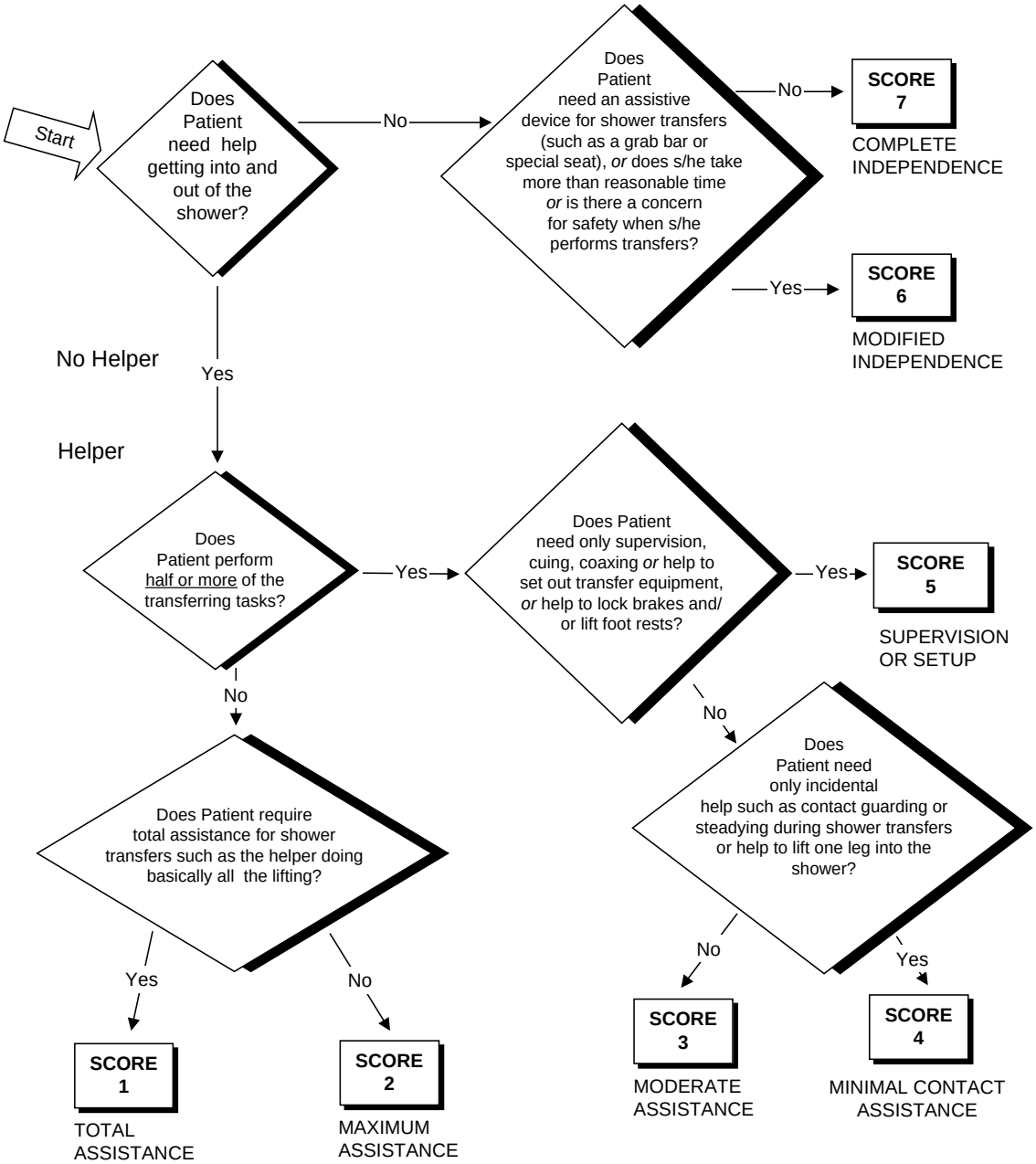
NOTE: There is a separate Function Modifier that addresses transfers into a tub. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 34, leave Item 33 blank. If the patient transfers into a tub and shower, record the score for the more frequent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

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

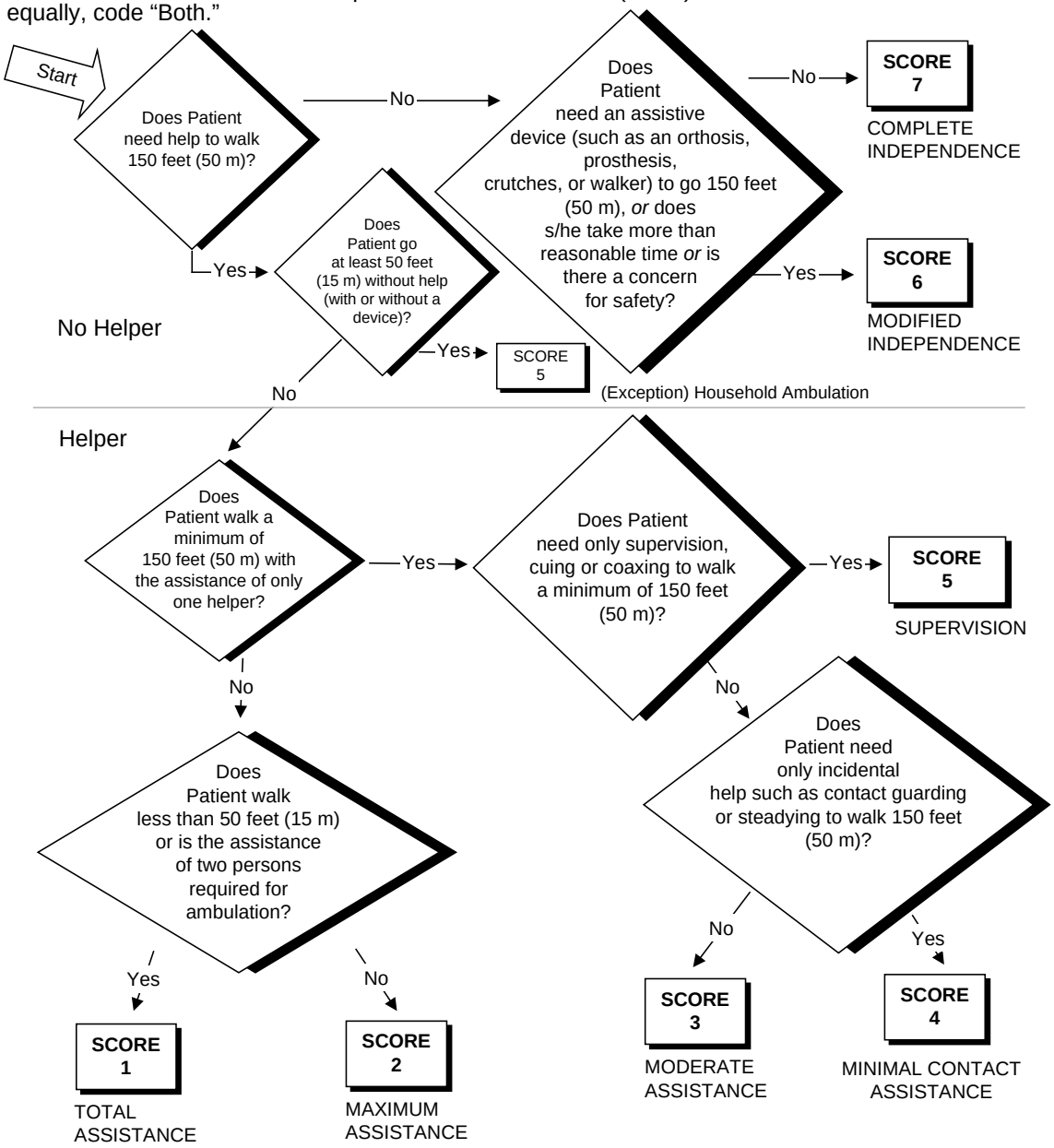
NOTE: If the patient requires an assistive device for locomotion (prosthesis, walker, cane, AFO, adapted shoe, etc.), then the Locomotion: Walk score can never be higher than level 6.

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."

SECTION 3: THE FIM™ INSTRUMENT

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."



SECTION 3: THE FIM™ INSTRUMENT

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).

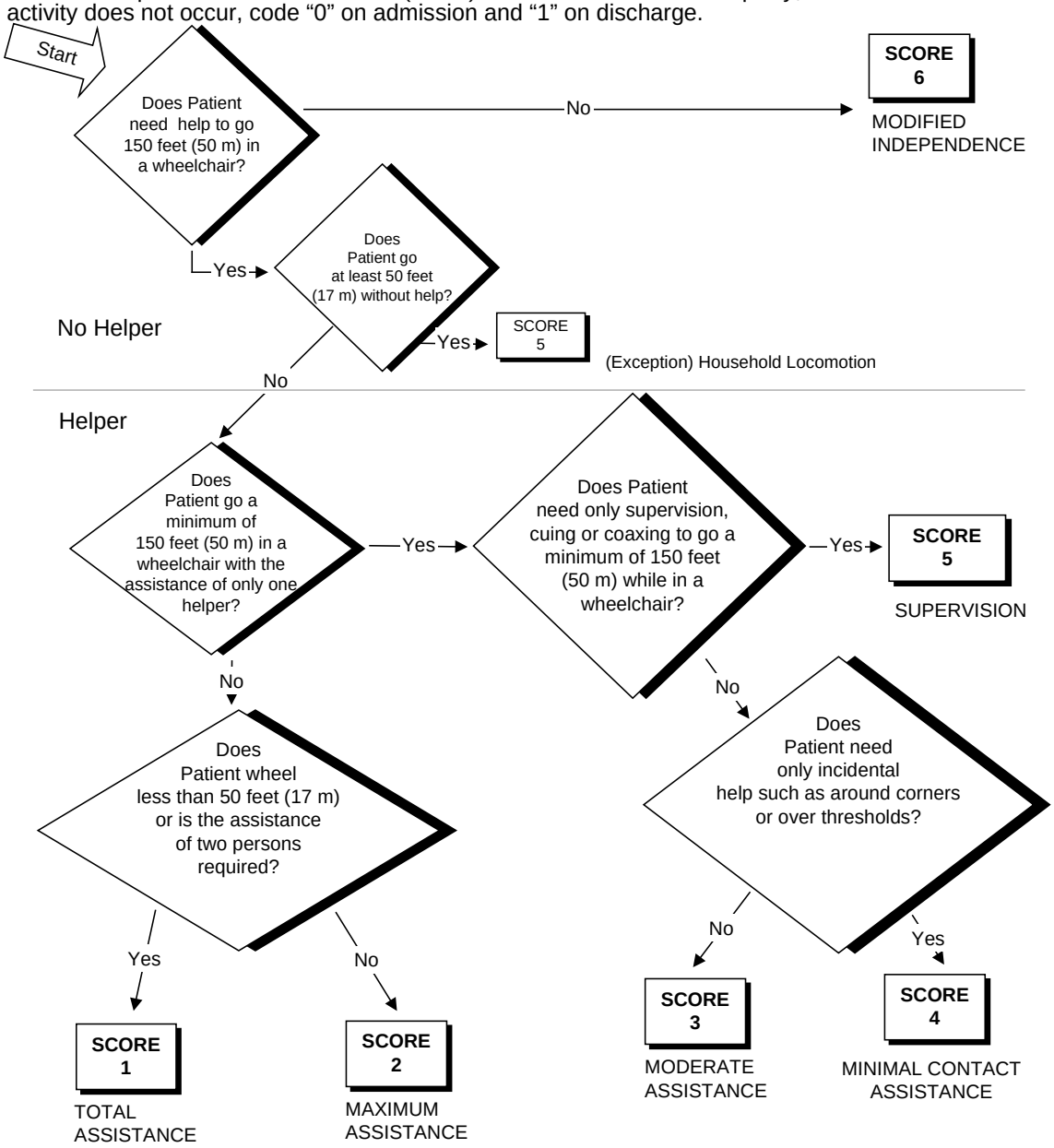
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not use a wheelchair, and is not pushed in a wheelchair by a helper.

NOTE: 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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

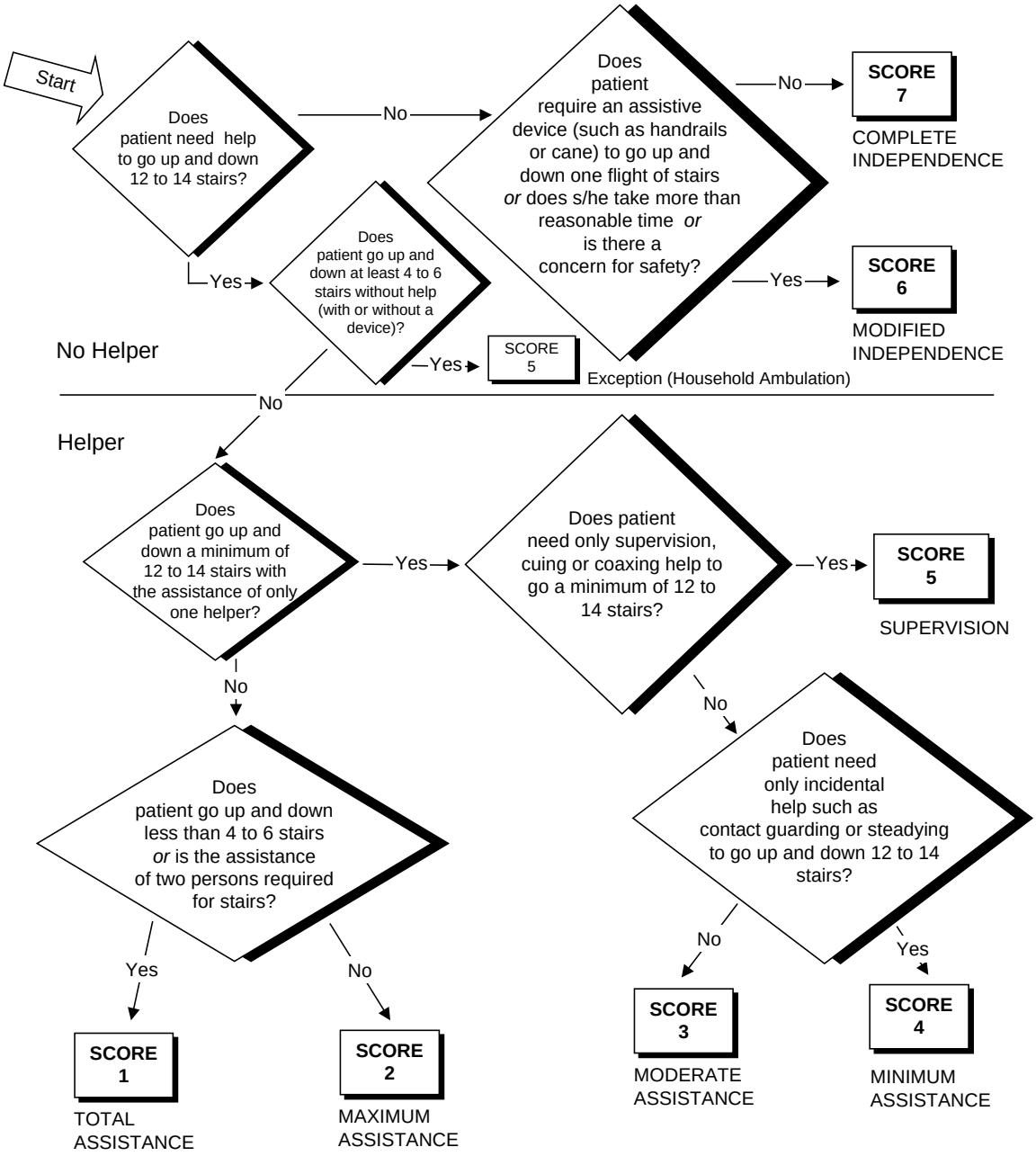
1 Total Assistance—The patient performs less than 25% of the effort, or requires the assistance of two people, or goes up and down fewer than 4 stairs.

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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

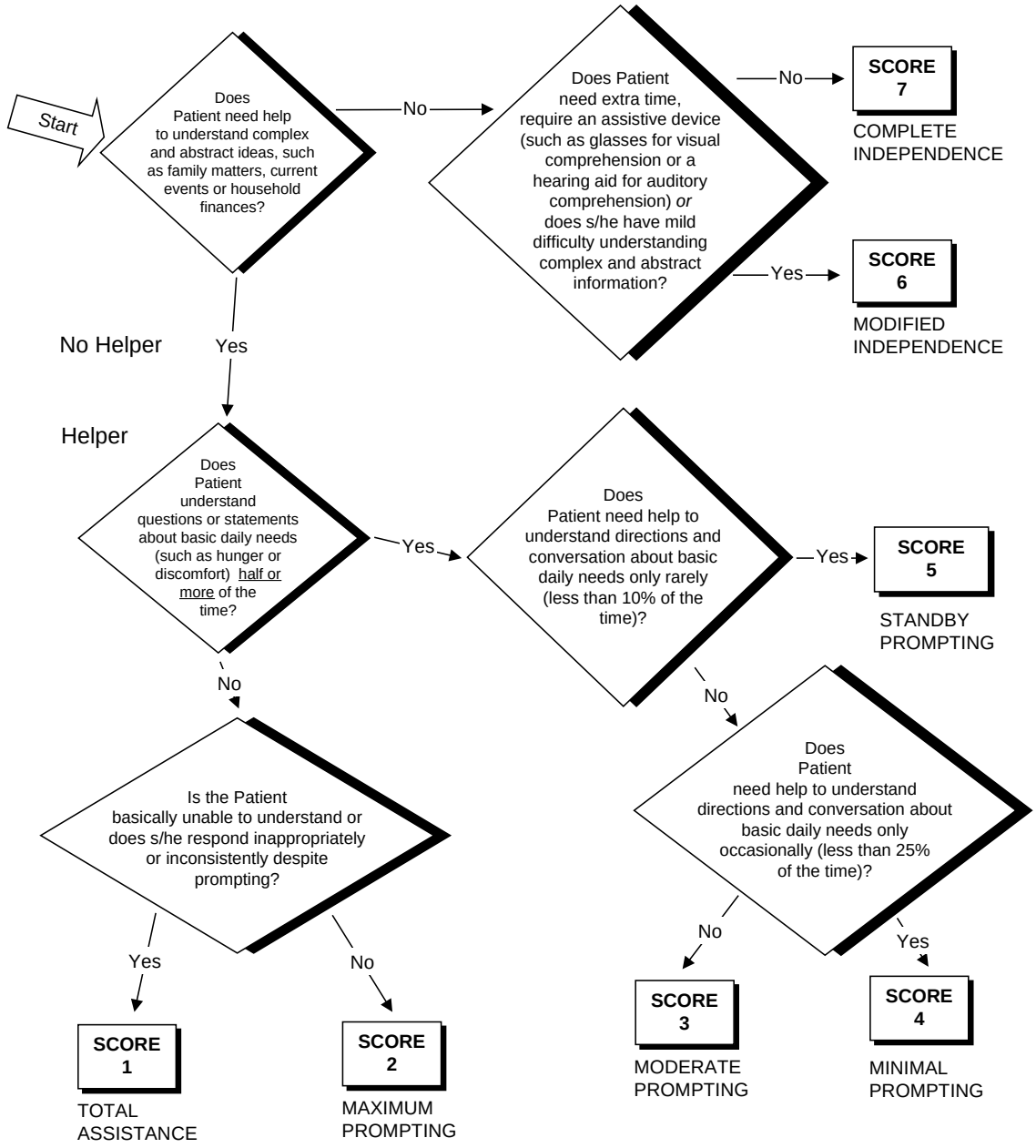
Do not use code "0" for Comprehension.

NOTE: *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).

SECTION 3: THE FIM™ INSTRUMENT

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.



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.

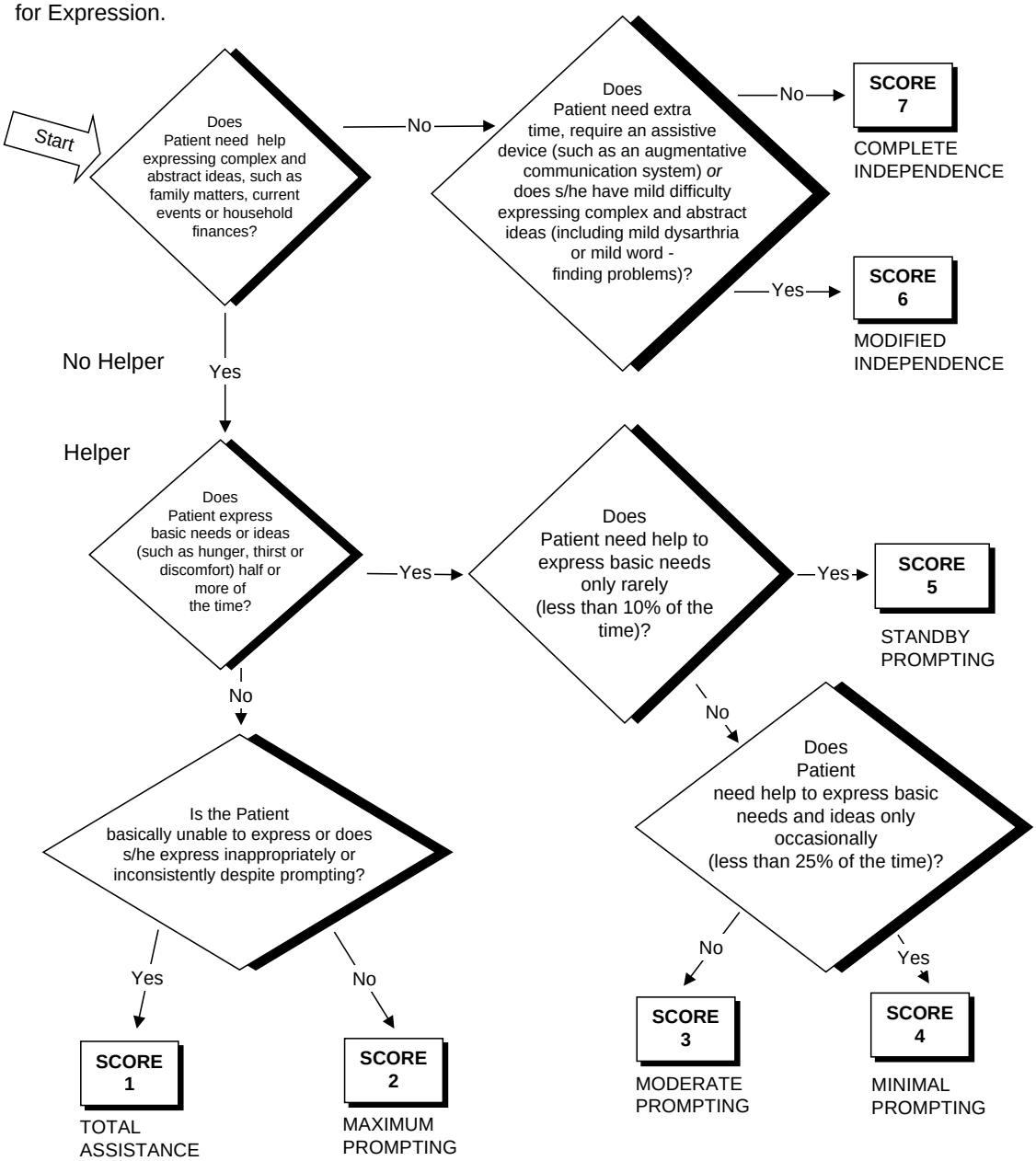
Do not use code "0" for Expression.

NOTE: 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).

SECTION 3: THE FIM™ INSTRUMENT

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.



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.

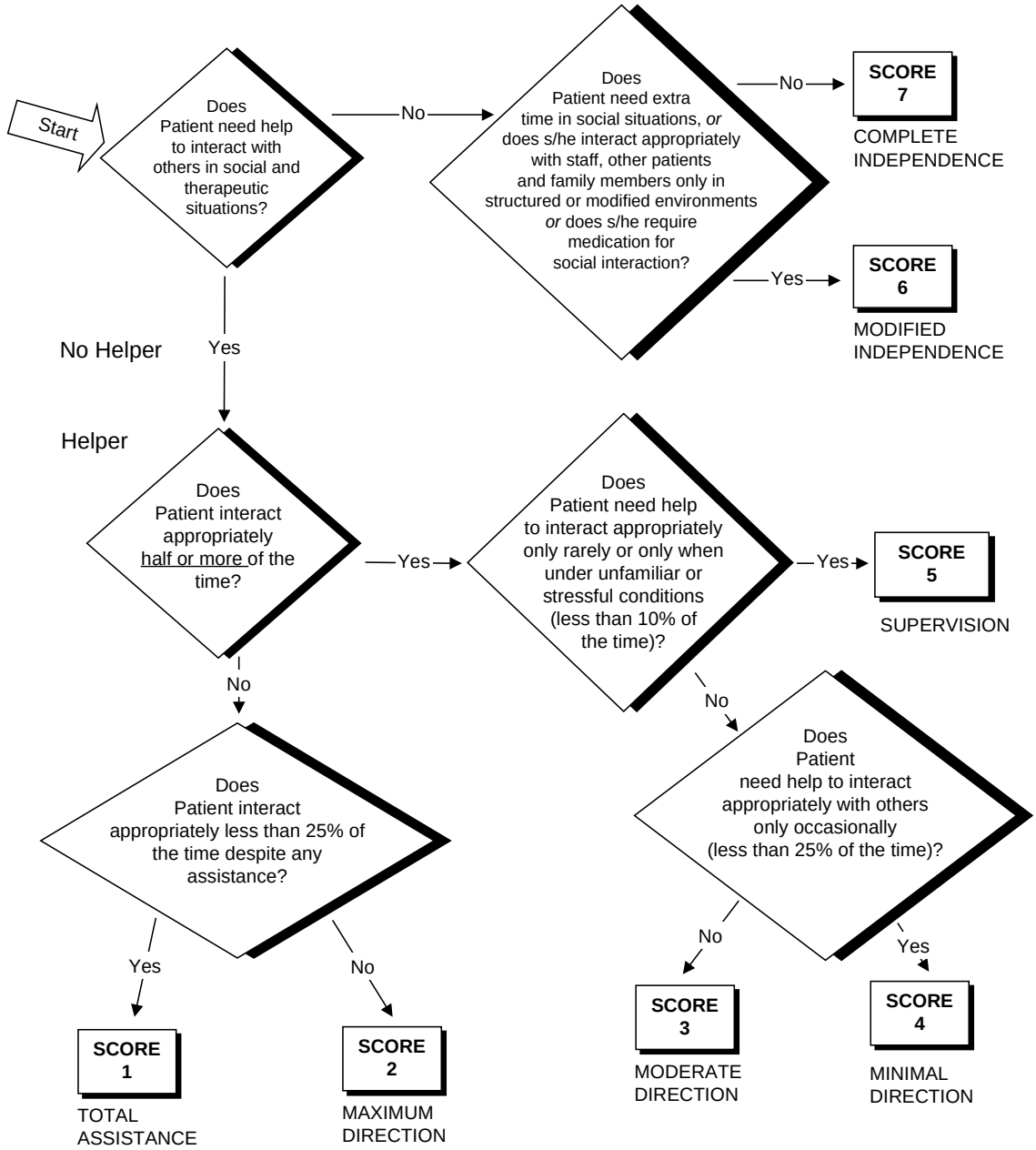
Do not use code "0" for Social Interaction

NOTE: 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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

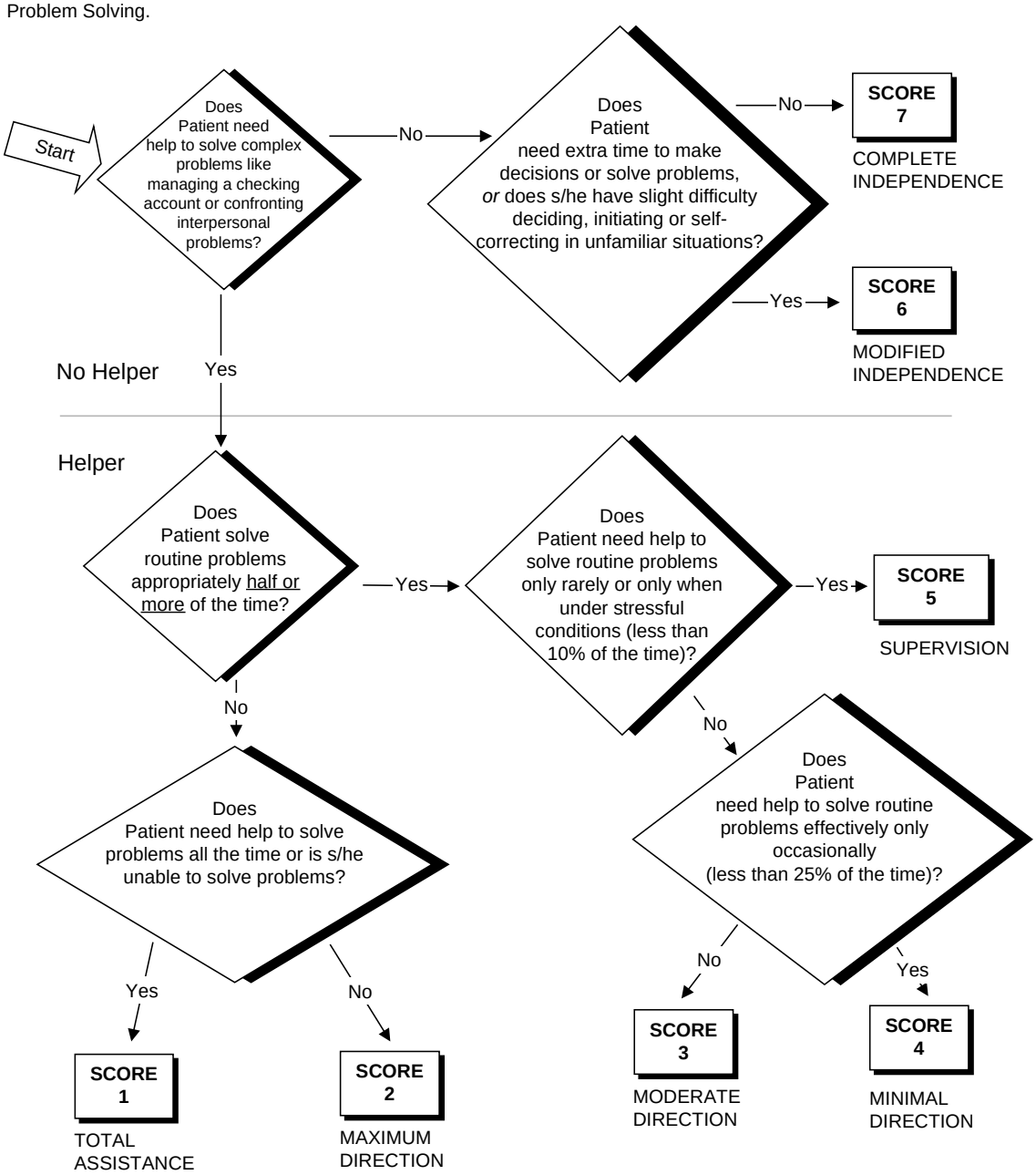
Do not use code "0" for Problem Solving.

NOTE: 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.

SECTION 3: THE FIM™ INSTRUMENT

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.



SECTION 3: THE FIM™ INSTRUMENT

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.

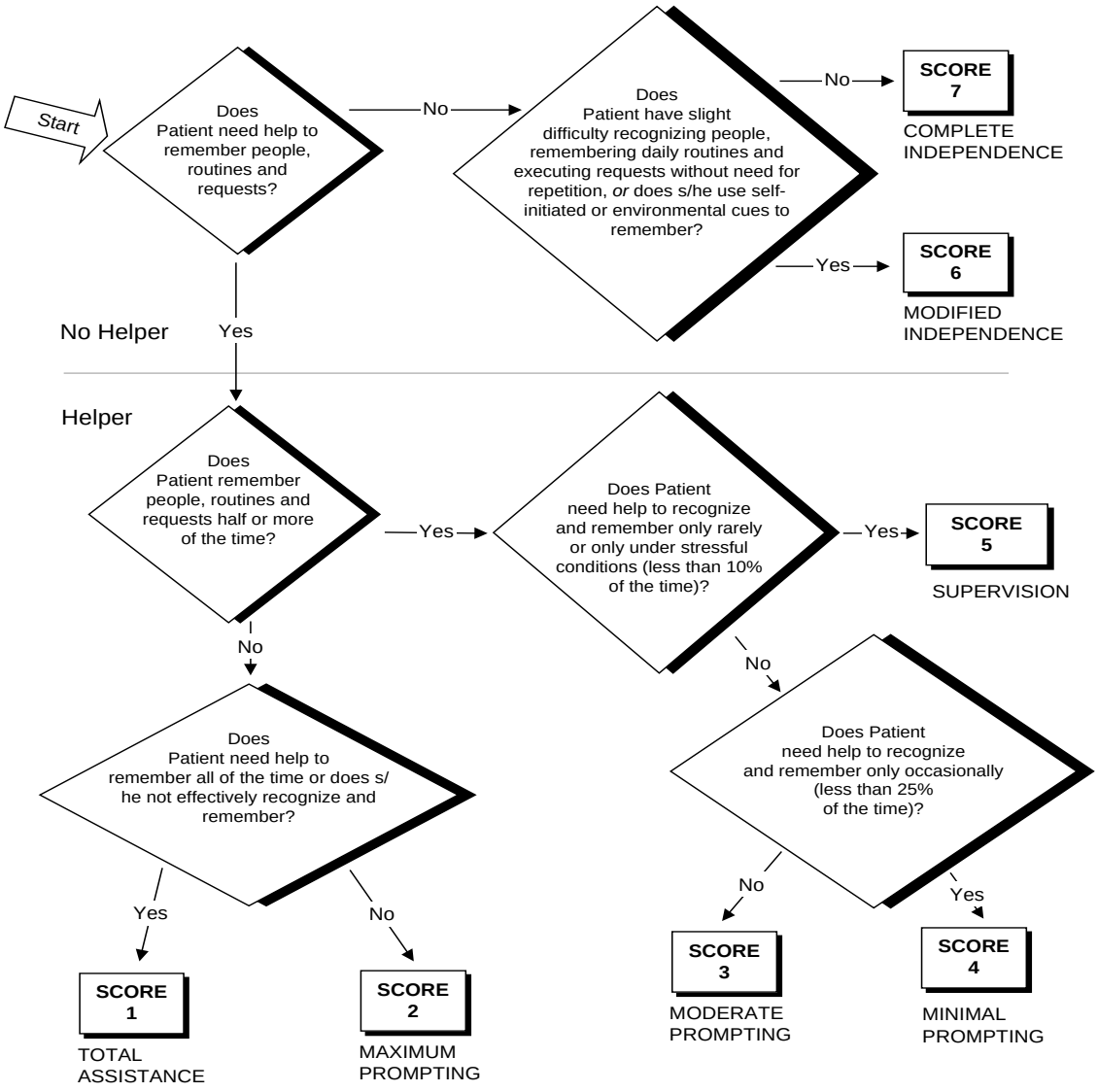
1 Total Assistance—The patient recognizes and remembers less than 25% of the time, or does not effectively recognize and remember.

Do not use code “0” for Memory.

SECTION 3: THE FIM™ INSTRUMENT

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



[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.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

BACKGROUND

Section 3004(b) of the Affordable Care Act added section 1886(j)(7) to the Act, which requires the Secretary to implement a Quality Reporting Program (QRP) for IRFs. This program applies to freestanding IRF hospitals as well as IRF units that are affiliated with acute care facilities, which includes critical access hospitals (CAHs).

In the FY 2012 IRF PPS Final Rule (76 FR 47836), a QRP for IRFs was established requiring IRFs to submit quality data. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Social Security Act requires that CMS reduce the applicable IRF PPS annual increase factor by 2 percentage points for any IRFs that fail to submit data on the mandatory quality items. In the FY 2015 IRF PPS Final Rule (79 FR 45873), CMS made revisions to the IRF QRP by adding new quality measures and updating others.

For general information about the IRF QRP: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Details.html

For the list of current quality measures: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html

The quality items on the IRF-PAI are Height and Weight on admission (Items 25A and 26A) and the items on the Quality Indicators section (Items M0210 through O0250). Although an IRF may decide not to submit data on the quality items, failure to submit data on the mandatory items may result in a payment reduction of two percentage points starting in Fiscal Year 2016 or 2017. A table listing the voluntary and mandatory quality reporting items is provided in this Manual.

Use of Dashes for Quality Items

If a quality item has not been assessed, record and submit a dash ("-") value for the item.

For example, if a skin assessment has not been completed, use dashes ("-") for the pressure ulcer items. CMS expects that this will be a rare occurrence. Use of dashes ("-") may result in a payment reduction. Some circumstances where CMS expects dashes to be utilized are as follows:

- A patient is admitted to and discharged from an IRF before the facility has completed the admission skin assessment;
- A patient is discharged unexpectedly and the clinicians have not completed a skin assessment within the 3 days before discharge.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Quality Indicator Pressure Ulcer Items (M0210 through M0900, I0900):

The pressure ulcer quality indicator items document the risk, presence, appearance, and change of pressure ulcers. If warranted by additional quality measures finalized by CMS for the IRF QRP through future rulemaking cycles, CMS may add additional items to this section to address other skin ulcers, wounds, or lesions, and to document treatment categories related to skin injury or avoiding skin injury.

CMS recognizes that, in addition to the pressure ulcer items included in this section of the IRF-PAI, a complete and ongoing assessment of patient's skin, guided by clinical standards, is essential to an effective pressure ulcer prevention and skin management program for all patients. Therefore, completion of this section does not replace a thorough assessment of each patient's risk factors for developing skin ulcers, wounds, or lesions. It is imperative to identify and evaluate each patient's risk factors and all areas at risk of constant pressure. It is also imperative to determine the etiology of all skin ulcers, wounds and lesions. This should determine and direct the proper treatment and appropriate skin management interventions for all patients.

Rationale for Quality Indicator Pressure Ulcer Items

Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer development. The underlying health of a patient's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers. Additional external factors, such as excess moisture and tissue exposure to urine or feces, can increase risk. Pressure ulcers affect quality of life for patients because they may limit activity, be painful, require time-consuming treatments and dressing changes, and can pose a risk of infection and sepsis. An existing pressure ulcer also identifies patients at risk for further complications or skin injury.

Helpful Terminology and Information

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. Pressure Ulcer Staging—Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

The pressure ulcer staging definitions used in the *IRF-PAI Training Manual* have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages. IRFs may adopt the NPUAP guidelines in their clinical practice and documentation. However, because CMS has *adapted* the NPUAP guidelines for IRF-PAI purposes, the definitions do not perfectly correlate with each stage as described by the NPUAP. Therefore, IRFs cannot use the NPUAP definitions to code the IRF-PAI. IRFs must code the IRF-PAI according to the instructions in this manual.

C. Healed Pressure Ulcer—A pressure ulcer that is completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

Throughout this section, terminology referring to "healed" vs. "unhealed" ulcers refers to whether or not the ulcer is "closed" vs. "open." For Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers (defined below), closed (i.e., may be covered with tissue, eschar, slough) would not be considered healed.

D. 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.

E. Slough Tissue—Nonviable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

F. Eschar Tissue—Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

G. Tunneling—A passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

H. 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.

I. Non-blanchable—Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

J. Fluctuance —The term used to describe the texture of wound tissue indicative of underlying unexposed fluid

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

K. Mucosal Pressure Ulcers—Mucosal pressure ulcers are not staged using the pressure ulcer staging system because anatomical tissue comparisons cannot be made. Mucosal ulcers are also not described as partial or full thickness ulcers because tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to rectal tubes) should not be reported in this section.

L. Reverse or Back Staging—Current clinical standards do not support reverse or back staging. For example, a Stage 4 pressure ulcer that has been healing such that it is less deep, wide, and long should continue to be documented as a Stage 4 pressure ulcer until it has completely healed.

Observation Period

The observation period for the admission and discharge pressure ulcer items is three calendar days. While CMS allows a 3-day observation period, the admission and discharge assessments should be completed as close to the time of admission and discharge as possible, to most accurately represent patients' admission and discharge status.

Clinical assessments performed on patients in IRFs should be completed according to accepted clinical practice and comply with facility policy, and State and Federal regulations.

The data reported on the IRF-PAI admission sections that involve patient assessment should be consistent with the initial admission clinical assessment. If a patient who is clinically assessed upon admission has a pressure ulcer identified and staged, that initial clinical assessment should be used when coding the IRF-PAI admission pressure ulcer items. If the pressure ulcer that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day IRF-PAI assessment period, the IRF-PAI admission assessment would not be changed, and the **initial identified** stage of the pressure ulcer would continue to be documented on the IRF-PAI admission items. This pressure ulcer would be captured on the IRF-PAI discharge assessment as worsened (unless it heals).

General Steps for Assessment and Coding Tips for Items M0210 through M0900

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse or wound care specialist to confirm conclusions and clarify any questions from the medical record review.

3. Examine the patient and determine whether any skin ulcers are present.
    - Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers.
    - Conduct a full-body head-to-toe skin assessment to ensure no pressure ulcers are missed. Focus on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters (hips), heels, ankles, elbows, etc.), as well as other areas at risk for pressure ulcers.
    - Examine the patient in a well-lit room. Adequate lighting is important for detecting skin changes.
    - 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. If an ulcer arises from a combination of factors and the primary cause is pressure, then the ulcer should be included in this section as a pressure ulcer.
4. Patients with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a person with diabetes has an ulcer that is caused by pressure or other factors.
5. If a pressure ulcer is surgically closed with a flap or graft, it should be considered a surgical wound, not a pressure ulcer. If the flap or graft fails, it should be considered a surgical wound until healed. It should not be reported as a pressure ulcer on the IRF-PAI.
6. Skin ulcers that develop in patients who have terminal illness or are at the end of life should be assessed and staged as pressure ulcers until it is determined that the ulcer is part of the dying process (also known as Kennedy ulcers). Kennedy ulcers can develop from 6 weeks to 2 to 3 days before death. These ulcers present as pear-shaped purple areas of skin with irregular borders that are often found in the sacrococcygeal areas. When an ulcer has been determined to be a Kennedy Ulcer, it should not be coded as a pressure ulcer.
7. Note that pressure ulcers should generally show some evidence of healing within 14 days. Pressure ulcers that fail to show some evidence toward healing within 14 days could indicate that there are potential complications. In this situation, the patient's overall clinical condition ought to be reassessed.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Proper Method of Assessment of Pressure Ulcers

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

Step 1: Determine Deepest Anatomical Stage

1. Observe or palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved. Assessment should be done in accordance with facility, State, and Federal requirements on which IRF staff members may complete patient assessments.

2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see items M0300E-M0300G below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.

3. IRFs that carefully document and track pressure ulcers will be able to code the pressure ulcer items more accurately.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.

2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg

3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.

4. A pressure ulcer with intact skin that is a sDTI should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg

5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) are classified as unstageable. "Known" refers to when

documentation is available that says a pressure ulcer exists under the non-removable dressing/device.

Step 3: Determine "Present on Admission"

*For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission and **not** acquired while the patient was in the care of the IRF. Consider current and historical levels of tissue involvement.*

1. Review the medical record for the history of the ulcer.

2. Review for location and stage at the time of admission. If the pressure ulcer was present on admission and subsequently increased in numerical stage during the patient's stay, that higher stage **should *not* be coded as "present on admission."**

3. If a patient is transferred to an acute care facility, and an existing pressure ulcer increases in numerical stage at the acute care facility, and the patient returns to the IRF within three days (interrupted stay), the pressure ulcer should **not** be coded as "present on admission" at the higher stage. The pressure ulcer would be reported as a 'worsened' pressure ulcer on discharge due to the progression in numerical stage, unless the pressure ulcer has healed by discharge. CMS considers acute care facilities and post-acute care facilities as having shared responsibility for patients' health, and encourages all healthcare providers to coordinate patient care in order to achieve the highest quality of care.

Unplanned Discharges

If a patient experiences an unplanned discharge (e.g., discharge to an acute care facility) and a full skin assessment was completed within the three days prior to the patient's unplanned discharge, that assessment may be used to complete the IRF-PAI discharge pressure ulcer items. However, if a full skin assessment had not been done within three days of the patient's unplanned discharge, dashes ("-") may be entered for the IRF-PAI discharge pressure ulcer items. Report the status of any known pressure ulcer that was assessed within the last three days.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Quality Indicator Pressure Ulcer Items—Admission Assessment

M0210: Unhealed Pressure Ulcer(s)—Admission

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at Admission?

> **Code 0** (**No)** If patient does not have any unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at admission, and then skip to question I0900 on Admission Assessment.
>
> **Code 1** (**Yes)** If patient has one or more unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at admission, and then continue to question M0300A on Admission Assessment.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage—Admission

M0300A. Stage 1. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones it may appear with persistent blue or purple hues. (*Non-blanchable*: reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device).

A Stage 1 pressure ulcer is defined as an observable, pressure-related alteration of intact skin, whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Item Rationale

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Steps for Assessment:

- Distinguish Stage 1 pressure ulcers from suspected deep tissue injury (see M0300G) and moisture-associated skin damage.
- Reliance on only one descriptor is inadequate to distinguish Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).

- Check any reddened areas for the ability to blanch by firmly pressing a finger into the reddened tissues and then releasing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
- Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared with adjacent tissue. Stage 1 pressure ulcers may be difficult to detect in individuals with dark skin tones. Assess for temperature or color changes.

Coding Instructions:

M0300A1: Enter the number of Stage 1 pressure ulcers noted at the time of admission. Enter 0 if no Stage 1 pressure ulcers are noted.

M0300B. 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.

Item Rationale

- Stage 2 pressure ulcers may worsen without proper interventions.
- These patients are at risk for further complications or skin injury.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher-stage pressure ulcers.

Steps for Assessment:

1. 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 suspected deep tissue injury rather than a Stage 2 Pressure Ulcer. See M0300G for further description of suspected deep tissue injury. When a deep tissue injury is determined, do NOT code as a Stage 2.

2. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a deep tissue injury.

Coding Instructions:

M0300B1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 2, that were present on admission. Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission.

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, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as 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.

M0300C. 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/or tunneling.

Item Rationale

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.

Coding Instructions:

M0300C1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 3, that were present on admission. Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission.

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.

M0300D. 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.

Item Rationale

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and care that may be more time or staff intensive.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.

Coding Instructions:

M0300D1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 4, that were present on admission. Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission.

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.
- In Stage 4 pressure ulcers, exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, non-mucosal pressure ulcers that have exposed cartilage should be classified as Stage 4 pressure ulcers.

M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device.
Pressure ulcers should be coded as unstageable when the wound bed cannot be visualized due to a non-removable dressing/device, and the pressure ulcer can thus not be numerically staged. Examples of non-removable dressing or device include a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.

Item Rationale

- Although the wound bed cannot be visualized due to the non-removable dressing/device, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit their activity and be painful.

- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to the touch, and the patient is monitored for adequate pain control.

Steps for Assessment:

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing/device. Do not assume that there is a pressure ulcer that is covered by a non-removable dressing/device.
2. Determine the number of unstageable pressure ulcers related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative pressure wound therapy [NPWT]), an orthopedic device, or a cast.

Coding Instructions:

M0300E1: Enter the number of unstageable pressure ulcers due to non-removable dressing/device that were present on admission. Enter 0 if no unstageable pressure ulcers due to non-removable dressing/device were first noted at the time of admission.

M0300F. Unstageable Pressure Ulcers due to slough and/or eschar. Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough and/or eschar.

Item Rationale

- Although the wound bed cannot be visualized and the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Visualization of the wound bed is necessary for accurate numerical staging.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

Coding Instructions:

M0300F1: Enter the number of unstageable pressure ulcers due to slough and/or eschar that were present on admission. Enter 0 if no unstageable pressure ulcers due to slough and/or eschar were first noted at the time of admission.

Coding Tips:

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the anatomic depth of soft tissue damage involved can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and in consultation with the patient's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. (*Fluctuance* is the term used to describe the texture of wound tissue indicative of underlying unexposed fluid).
- Once the pressure ulcer is debrided of enough slough and/or eschar such that the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for restaging of the ulcer to occur.

M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (sDTI) in evolution. Pressure ulcers that are unstageable due to suspected deep tissue injury in evolution. Pressure ulcers with sDTI present as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

Item Rationale

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer, even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a patient's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe tissue damage. Identification and management of a sDTI is imperative.
- Pressure ulcers that are unstageable due to sDTI require vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment:

1. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister *does not show* signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), **do not code as sDTI**.
2. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

Coding Instructions:

M0300G1: Enter the number of unstageable pressure ulcers with sDTI that were present on admission. Enter 0 if no unstageable pressure ulcers with sDTI were first noted at the time of admission.

Coding Tips:

- Once a sDTI has opened to an ulcer, the ulcer should be reassessed, staged numerically, and documented in the discharge IRF-PAI assessment at the appropriate stage.

I0900. Pressure Ulcer Risk Conditions—Admission

These items document the presence of pressure ulcer risk conditions. For any pressure ulcer risk conditions documented, you must also document the appropriate ICD code(s) in Item 24 "Comorbid Conditions."

I0900A. Peripheral Vascular Disease (PVD)
Code '0' for 'No' if the patient does not have Peripheral Vascular Disease (PVD) as a risk condition.
Code '1' for 'Yes' if the patient has PVD.

I0900B. Peripheral Arterial Disease (PAD)
Code '0' for 'No' if the patient does not have Peripheral Arterial Disease (PAD) as a risk condition.
Code '1' for 'Yes' if the patient has PAD.

I2900A. Diabetes Mellitus (DM)
Code '0' for 'No' if the patient does not have Diabetes Mellitus (DM) as a risk condition, and skip items I29000B-D.
Code '1' for 'Yes' if the patient does have DM.

I2900B. Diabetic Retinopathy
Code '0' for 'No' if the patient does not have Diabetic Retinopathy.
Code '1' for 'Yes' if the patient does have Diabetic Retinopathy.

I2900C. Diabetic Nephropathy
Code '0' for 'No' if the patient does not have Diabetic Nephropathy.
Code '1' for 'Yes' if the patient does have Diabetic Nephropathy.

I2900D. Diabetic Neuropathy
Code '0' for 'No' if the patient does not have Diabetic Neuropathy.
Code '1' for 'Yes' if the patient does have Diabetic Neuropathy.

Quality Indicator Pressure Ulcer Items—Discharge Assessment

M0210: Unhealed Pressure Ulcer(s)—Discharge

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge?

Code 0 (No) - If patient does not have any unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at discharge, and skip to question M0900A on Discharge Assessment.

Code 1 (Yes) - If patient has one or more unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at discharge, and continue to question M0300A on Discharge Assessment.

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage—Discharge

Item Rationale:

- This item documents whether skin status, overall, has worsened since the admission assessment. To track increasing skin damage, this item documents the number of new pressure ulcers, and whether any pressure ulcers have increased in numerical stage (worsened) since the admission assessment. Such tracking of pressure ulcers is consistent with good clinical care.
- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop and/or pressure ulcers worsen.

Steps for Assessment:

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to the admission stage to determine whether any pressure ulcer on

the current assessment is new or at an increased numerical stage when compared with the admission assessment.

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the admission assessment was completed.

Coding Tips:

1. Coding this item will be easier for facilities that document and follow pressure ulcer status on a routine basis.
2. If a numerically staged admission pressure ulcer increases in numerical staging at the time of discharge, it is considered worsened.
3. If two pressure ulcers at the same numerical stage merge into a single pressure ulcer also at the same stage, do not considered worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, the ulcer would need to have increased in numerical staging in order for it to be considered worsened.

M0300A. Stage 1. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones it may appear with persistent blue or purple hues. (*Non-blanchable*: reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device).

A Stage 1 pressure ulcer is defined as an observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Steps for Assessment:

- Distinguish Stage 1 pressure ulcers from suspected deep tissue injury (see M0300G) and moisture-associated skin damage.
- Reliance on only one descriptor is inadequate to distinguish Stage 1 and suspected Deep Tissue Injury ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).
- Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then releasing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.

- Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared with adjacent tissue. Stage 1 pressure ulcers may be difficult to detect in individuals with dark skin tones. Assess for temperature or color changes.

Coding Instructions:

M0300A1: Number of Stage 1 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 1. Enter 0 if no Stage 1 pressure ulcers are noted at the time of discharge, and skip to item M0300B1.

M0300A2: Number of Stage 1 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 1 pressure ulcers present at discharge (reported in M0300A1), enter the number that were: (a) present on admission at Stage 1, and (b) remained at Stage 1 at discharge.

M0300A3: Number of Stage 1 Pressure Ulcers at Discharge that are New Since Admission
Of these Stage 1 pressure ulcers present at discharge (reported in M0300A1), enter the number that were not present on admission (i.e., new Stage 1 pressure ulcers that developed during the IRF stay).

M0300B. 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.

Steps for Assessment:

1. 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 suspected deep tissue injury rather than a Stage 2 Pressure Ulcer. When a deep tissue injury is determined, do NOT code as a Stage 2.
2. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a deep tissue injury.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Coding Instructions:

M0300B1: Number of Stage 2 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 2. Enter 0 if no Stage 2 pressure ulcers are noted at the time of discharge, and skip to item M0300C1.

M0300B2: Number of Stage 2 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) present on admission at Stage 2, and (b) remained at Stage 2 at discharge.

M0300B3: Number of Stage 2 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) present on admission as unstageable pressure ulcer due to the presence of a non-removable dressing/device, and (b) when it became stageable, were staged as Stage 2, and (c) remained at Stage 2 at the time of discharge.

M0300B4: Number of Stage 2 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay.

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, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as 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.

M0300C. 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/or tunneling.

Coding Instructions:

M0300C1: Number of Stage 3 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 3. Enter 0 if no Stage 3 pressure ulcers are noted at the time of discharge, and skip to item M0300D1.

M0300C2: Number of Stage 3 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) present on admission at Stage 3, and (b) remained at Stage 3 at discharge.

M0300C3: Number of Stage 3 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) present at admission as an unstageable pressure ulcer, and (b) when they became stageable, was staged as a Stage 3, and (c) it remained at Stage 3 at the time of discharge.

M0300C4: Number of Stage 3 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay, or (c) were unstageable due to a non-removable dressing/device at admission, initially became stageable at a lesser stage, but then progressed to a Stage 3 by 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.

M0300D. 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.

Coding Instructions:

M0300D1: Number of Stage 4 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 4. Enter 0 if no Stage 4 pressure ulcers are noted at the time of discharge, and skip to item M0300E1.

M0300D2: Number of Stage 4 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) present on admission at Stage 4, and (b) remained at Stage 4 at discharge.

M0300D3: Number of Stage 4 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) present at admission as an unstageable pressure ulcer, and (b) when it became stageable, it was staged as a Stage 4, and (c) remained at Stage 4 at the time of discharge.

M0300D4: Number of Stage 4 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge, or (c) were unstageable on admission, initially became stageable at a lesser stage, and then progressed to a Stage 4 by 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.

- Cartilage serves the same anatomical function as bone. Therefore, non-mucosal pressure ulcers that have exposed cartilage should be classified as a Stage 4 pressure ulcer.

M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device.
Pressure ulcers should be coded as unstageable when the wound bed cannot be visualized due to a non-removable dressing/device, and the pressure ulcer can thus not be numerically staged. Examples of non-removable dressing or device include a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.

Steps for Assessment:

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing/device. *Documentation of an existing pressure ulcer is needed to complete this item*. Do not assume that there is a pressure ulcer that is covered by a non-removable dressing/device.
2. Determine the number of unstageable pressure ulcers related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative pressure wound therapy [NPWT]), an orthopedic device, or a cast.

Coding Instructions:

M0300E1: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge
Enter the total number of pressure ulcers currently (at discharge) unstageable due to a non-removable dressing or device. Enter 0 if the patient has no pressure ulcers unstageable due to a non-removable dressing/device at discharge, and skip to item M0300F1.

M0300E2: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge that were Present on Admission
Of these pressure ulcers unstageable due to non-removable dressing/device present at discharge (reported in M0300E1), enter the number that were: (a) present on admission as an unstageable pressure ulcer due to non-removable dressing or device, and (b) remained unstageable due to non-removable dressing or device until discharge.

M0300E3: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge that were Stageable at Admission
Of these pressure ulcers unstageable due to non-removable dressing/device present at discharge (reported in M0300E1), enter the number that were: (a)

present on admission as a stageable pressure ulcer and became unstageable due to non-removable dressing or device during the IRF stay, and (b) remained unstageable due to non-removable dressing or device until discharge.

M0300F. Unstageable Pressure Ulcers due to slough or eschar. Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough and/or eschar.

Coding Instructions:

M0300F1: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge
Enter the total number of pressure ulcers currently (at discharge) that are unstageable due to Slough and/or Eschar. Enter 0 if the patient has no pressure ulcers unstageable due to slough and/or eschar at discharge, and skip to item M0300G1.

M0300F2: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge that were Present on Admission
Of these pressure ulcers unstageable due to slough and/or eschar present at discharge (reported in M0300F1), enter the number that were: (a) present on admission as an unstageable pressure ulcer due to slough and/or eschar, and (b) remained unstageable due to slough and/or eschar until discharge.

M0300F3: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge that were Stageable at Admission
Of these pressure ulcers unstageable due to slough and/or eschar present at discharge (reported in M0300F1), enter the number that were: (a) present on admission as a stageable pressure ulcer and became unstageable due to slough and/or eschar during the IRF stay, and (b) remained unstageable due to slough and/or eschar until discharge.

Coding Tips:

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the anatomic depth of soft tissue damage involved can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and in consultation with the patient's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. (*Fluctuance* is

the term used to describe the texture of wound tissue indicative of underlying unexposed fluid).

- Once the pressure ulcer is debrided of enough slough and/or eschar such that the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for restaging of the ulcer to occur.
- If a sDTI is identified as present on admission, opens to an ulcer during the IRF stay, and becomes unstageable due to slough/eschar prior to discharge, it is documented in M0300F1 at discharge. In this specific scenario, both items M0300F2 and M0300F3 in the discharge IRF-PAI assessment would be coded as "0."

M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (sDTI) in evolution. Pressure ulcers that are unstageable due to suspected deep tissue injury in evolution. Pressure ulcers with sDTI present as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

Steps for Assessment:

1. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister *does not show* signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), **do not code as a sDTI.**
2. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

Coding Instructions:

M0300G1: Number of Unstageable Pressure Ulcers Due to Suspected Deep Tissue Injury
Enter the total number of pressure ulcers at discharge that are unstageable due to suspected deep tissue injury. Enter 0 if the patient has no unstageable pressure ulcers with suspected deep tissue injury at discharge, and skip to item M0900A.

M0300G2: **Number of** Uns**tage**able **Pressure Ulcers** Due to **Suspected Deep Tissue Injury that were Present on Admission**
Of the number of unstageable pressure ulcers with sDTI reported in M0300G1, enter the number that were: (a) present on admission as an unstageable pressure ulcer due to suspected DTI, and (b) remained unstageable due to suspected DTI until discharge.

M0900. Healed Pressure Ulcers—Discharge

This item documents the number of pressure ulcers that were present on admission and have healed by discharge.

Coding Instructions:

M0900A. Stage 1: Enter the number of Stage 1 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 1 pressure ulcers that have healed by discharge.

M0900B. Stage 2: Enter the number of Stage 2 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 2 pressure ulcers that have healed by discharge.

M0900C. Stage 3: Enter the number of Stage 3 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 3 pressure ulcers that have healed by discharge.

M0900D. Stage 4: Enter the number of Stage 4 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 4 pressure ulcers that have healed by discharge.

Coding Tips:

- If a sDTI is identified as present on admission, opens to an ulcer during the IRF stay, and heals prior to discharge, it is documented in Item M0900 - Healed Pressure Ulcers -- Discharge as the highest stage it was prior to its healing.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Quality Indicator Influenza Vaccine Item (O0250):

O0250. Influenza Vaccine—Discharge

This item assesses the influenza vaccination status of patients at discharge.

Item Rationale

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional influenza A outbreak can result in up to 60 % of the population becoming ill, with 25% of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immune-compromising diseases that can be exacerbated by influenza.
- As of 2013, the Advisory Committee on Immunization Practices (ACIP) continues to recommended annual influenza vaccination for all persons aged ≥6 months in the United States http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm

Influenza Vaccination Season Definitions:

- For the 2014–2015 influenza season, the influenza vaccination season is defined as beginning October 1st 2014 or when the influenza vaccine becomes available (whichever comes first) through March 31st 2015.
- For the 2015–2016 influenza season, the influenza vaccination season is defined as beginning October 1st 2015 or when the influenza vaccine becomes available (whichever comes first) through March 31st 2016.
- For subsequent influenza seasons, the influenza vaccination season is defined as beginning October 1st or when the influenza vaccine becomes available (whichever comes first) through March 31st.

Steps for Assessment:

1. Review the patient's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. . If the patient received the vaccine during a previous stay at the facility during the current influenza vaccination season, report the date of that vaccination. If vaccination status is unknown, proceed to the next step. Please also review (when

available) the patient's medical record from previous setting(s) (e.g., short-stay acute care hospital medical records).

2. Ask the patient if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If influenza vaccination status is still unknown, proceed to the next step.
3. If the patient is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
4. If vaccination status cannot be determined, please refer to the standards of clinical practice to determine whether or not to administer the vaccine to the patient.

O0250A. Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season?

Code 0 (No) - If the patient did not receive the influenza vaccine in this facility for this year's influenza vaccination season, and skip to O0250C.

Code 1 (Yes) - If the patient did receive the influenza vaccine in this facility for this year's influenza vaccination season, and continue to O0250B.

Code with a dash, ("-") - If the patient's influenza vaccination status cannot be determined. (**"-"** denotes that the information is not available/accessible or is unknown).

O0250B. Date influenza vaccine received.

- Enter the date the influenza vaccine was received in the facility and skip to Z0400A.
- Do not leave any boxes blank. If the month contains only a single digit, fill in the first box of the month with a "0." If the day contains only a single digit, then fill the first box of the day with the "0." For example, October 6, 2014, should be entered as 10-06-2014, and January 7, 2015, should be entered as 01-07-2015. A full 8-character date is required. If the date is unknown or the information is not available, a single dash needs to be entered in the first box.

O0250C. If influenza vaccine was not received, state reason why it was not received.

Code 1 - If the patient was not in this facility during this year's influenza vaccination season (October 1st through March 31st).

Code 2 - If the influenza vaccine was received outside of this facility, (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.

Code 3 - If the patient was not eligible due to medical contraindications, including (1) allergic reaction to eggs or other vaccine component(s), (2) a physician order not to immunize, or (3) an acute febrile illness is was present. However, the patient should be vaccinated if contraindications end.

Code 4 - If patient or responsible party/legal guardian had been informed that the influenza vaccine was being offered and chose not to accept the influenza vaccine.

Code 5 - If the patient or responsible party/legal guardian was not offered the influenza vaccine.

Code 6 - If the influenza vaccine was unavailable at the facility due to declared vaccine shortage. However, the patient should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.

Code 9 - If none of the above listed reasons describe why the influenza vaccine was not administered.

Code dash ("-") If the reason the vaccine was not administered is unknown or the information is not available.

Coding Tips and Special Populations:

- The influenza season varies annually. Information about the current Influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) Web site: http://www.cdc.gov/flu.
- Facilities should follow current ACIP recommendations to inform standard of practice and applicable patients. Annual influenza vaccination of all persons aged ≥6 months continues to be recommended.

Examples

1. Mrs. J. received the influenza vaccine in this IRF during this year's influenza vaccination season, on October 2, 2014.

   Coding: O0250A would be coded 1, yes; O0250B would be coded 10-02-2014, and O0250C would be skipped.

Rationale: Mrs. J. received the vaccine in the IRF on October 2, 2014, during this year's influenza vaccination season.

2. Mr. R. did not receive the influenza vaccine in the IRF during this year's influenza vaccination season because of his known allergy to egg protein.

   Coding: O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 3, not eligible-medical contraindication.

   Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Mr. R. did not receive the vaccine.

3. Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season. Her doctor provided documentation of Mrs. T.'s receipt of the vaccine to the IRF to place in Mrs. T.'s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks for the vaccine prior to administration.

   Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.

   Rationale: Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season.

4. Mrs. W. received the influenza vaccine during her acute care stay immediate prior to the IRF stay. The IRF staff should review her acute care record as part of the admission process and document in the IRF record that Mrs. W. has already received the influenza vaccine prior to admission.

   Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.

   Rationale: Mrs. W. received the influenza vaccine in the acute care hospital prior to the IRF stay during this year's influenza vaccination season.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

MEASURE SPECIFICATIONS FOR QUALITY MEASURES REPORTED USING IRF-PAI

QUALITY MEASURE RECORD SELECTION METHODOLOGY

The purpose of this section is to describe the methodology employed to select assessment records that are used to compute the quality measures (QMs) from data collected by IRFs and submitted to the CMS using the IRF-PAI under the IRF Quality Reporting Program.

Definitions

Target period. The span of time that defines the QM reporting period.

Target date. The target date for an assessment is defined as follows:

- The **admission target date** is equal to the admission date on IRF-PAI (Item 12).
- The **discharge target date** is equal to the discharge date on IRF-PAI (Item 40).

Patient data stream. The patient's data stream consists of all records that have target dates within the target period and that are for the specific patient at a specific IRF.

Sort order. The records in a patient's data stream must be sorted by target discharge date (descending). This will cause records to appear in reverse chronological order so that the most recent records appear first in the data stream.

Stay. The period of time between a patient's date of admission into an IRF and date of discharge from the IRF. A stay, thus defined, will include a patient stay during a set of contiguous days in an IRF, and will include program interruptions lasting up to 3 calendar days.

QM sample. The set of patient records that is selected in order to calculate a particular QM.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Record Selection

The QM is calculated by selecting eligible records from patient data streams and applying the QM definitions to the selected records. The purpose of this section is to describe how records are selected for each QM for the IRF QRP.

Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)

The eligible records for this QM are selected as follows:

1. Define the target period for the measure.
2. Select all IRF-PAI records with a discharge date (Item 40) within the target period.
3. Exclude all records in which the patient is not discharged alive (44C = 0).
4. For each record within each IRF, do the following:
    a. Sort the records according to the sort order defined on the previous page.
    b. Scan the sorted records in reverse chronological order.
    c. Select all records that meet the patient stay definition on previous page. These are ***target patient stay records***. If a patient has multiple patient stay records with a discharge target date within the target period, then include each qualifying patient stay in the measure.
5. Apply the QM definition (Table 1) to the eligible target patient stay records.

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
(NQF #0680)

The sample for this QM is selected as follows:

1. The target period for this measure is the influenza vaccination season: October 1 through March 31 (i. e., October 1, 2014 through March 31, 2015 for the 2014-2015 influenza vaccination season).
2. The measure includes all patients with one or more days in the IRF during the target period. Select all IRF -PAI records with an admission date (Item 12) ***or*** a discharge date (Item 40) within the target period. For example, the record of a patient admitted to an IRF on March 31st will be selected based on the admission date, regardless of the discharge date. The record of a patient discharged from an IRF on October 1st will be selected based on the discharge date, regardless of the admission date.

3. For each patient within each IRF, do the following:
    a. Sort the stay-level records according to the sort order defined above.
    b. Scan the sorted records in reverse chronological order.
    c. Select the patient stay-level records that meet all of the following conditions:
        i. Patient was in the IRF one or more days during the target period based on admission date ***or*** discharge date (i.e., either the admission date, the discharge date or both the admission and discharge date fall within the target period of October 1st to March 31st)
        ii. One or both the following apply:
            a. The discharge target date is on or after October 1st of the most recently completed influenza vaccination season OR on or before March 31st of the most recently completed influenza vaccination season
            b. The admission target date is on or after October 1st of the most recently completed influenza vaccination season OR on or before March 31st of the most recently completed influenza vaccination season.
        iii. A qualifying patient stay record is called an ***influenza vaccination assessment***. If the patient has multiple patient stay records during the target period, then include each influenza vaccination assessment from all qualifying patient stays in the measure.
    d. If no qualifying record is found for a patient, then the patient is excluded from the measure.
4. Apply the QM definition to the qualifying influenza vaccination assessment records.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Table 4-1

Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)[1]

Measure Description	Measure Specifications[2]	Covariates
This measure reports the percentage of patients with stage 2, stage 3 or stage 4 pressure ulcers that are new or worsened pressure ulcers since admission. The measure is calculated by reviewing a patient's IRF-PAI pressure ulcer discharge assessment data for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage at the time of the admission assessment.	***Numerator*** Patients for whom the discharge assessment indicates one or more new or worsened stage 2, stage 3 or stage 4 pressure ulcers: 1. M0300B4 (new or worsened Stage 2 pressure ulcers) > 0 OR 2. M0300C4 (new or worsened Stage 3 pressure ulcers) > 0 OR 3. M0300D4 (new or worsened Stage 4 pressure ulcers) > 0. ***Denominator*** Patients with IRF-PAI patient stay records during the target period, except those with exclusions. Note: IRF-PAI records are only submitted to CMS for Medicare patients. ***Exclusions*** 1. Patient stay is excluded if M0300B4=[-] and M0300C4=[-] and M0300D4=[-] on the discharge assessment. 2. Patient stay that ends with patient expiration (Item 44C=[0]) is excluded from the measure. 3. Patient stay is excluded if there is no admission risk adjustment data (covariates). ***Additional Exclusion for Future Public Reporting Program*** IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.	Data for each covariate is derived from the IRF-PAI admission assessment data included in the target patient stay records. 1. Indicator of minimal assistance or more assistance for the functional mobility item Transfers: Bed, Chair, Wheelchair (FIM® item 39I): Covariate = [1] (yes) if 39I = [0, 1,2,3,4] ([0]=Activity did not occur, [1]=Total assistance, [2]= Maximal assistance, [3]=Moderate assistance, [4]=Minimal assistance) Covariate = [0] (no) if 39I = [5, 6, 7, -] ([5]=Supervision, [6]=Modified Independence (Device), [7]=Complete Independence (Timely, Safely), [-]=No response available) 2. Indicator of any bowel incontinence in the past 7 days (Item 30): Covariate = [1] (yes) if item 30= [1, 2, 3, 4, 5] ([1]=Five or more accidents in the past 7 days, [2]=Four accidents in the past 7 days, [3]=Three accidents in the past 7 days, [4]=Two accidents in the past 7 days,[5]=One accident in the past 7 days) Covariate = [0] (no) if item 30 = [6, 7, -] ([6]=No accidents; uses device such as catheter, [7]=No accidents, [-]=No response available) 3. Have peripheral vascular disease or peripheral arterial disease or diabetes: Covariate = [1] (yes) if one or more of the following are true: a. I0900A = [1] b. I0900B = [1] c. I2900A = [1] Covariate = [0] (no) if I0900A = [0,-] AND I0900B = [0,-] AND I2900 = [0,-] ([0]=No, [-]=No response available) 4. Indicator of Low Body Mass Index, based on Height (Item 25A) and Weight (Item 26A): Covariate = [1] (yes) if BMI ≥ [12.0] AND ≤ [19.0] Covariate = [0] (no) if BMI > [19.0] Covariate = [0] (no) if 25A = [-] OR 26A = [-] OR BMI < [12.0] ([-]=No response available) Where: BMI = (weight * 703 / height^2) = ([26A] * 703) / (25A^2) and the resulting value is rounded to one decimal.

[1] This measure is NQF-endorsed for use in the Inpatient Rehabilitation Facility (IRF) setting (http://www.qualityforum.org/QPS/0678) (in addition to Long Term Care Hospital and Skilled Nursing Facility/Nursing Home (SNF/NH) settings) and finalized for reporting by IRFs under the IRF Quality Reporting Program (*Federal Register* 78 (6 August 2013): 47903-47919. Web. http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18770.pdf and *Federal Register* 79 (6 August 2014): 45908-45918. Web. http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf). The use of the words "resident" and "short-stay" in the title of this measure refer to the use of this measure in the SNF/NH setting. CMS's use of these words does not imply that the IRF patient is a "resident" or that a stay in an IRF is a "short stay".

[2] Beginning on October 1, 2012, IRFs began to use the "Inpatient Rehabilitation Facility - Patient Assessment Instrument" IRF as the vehicle by which to collect and submit the pressure ulcer data for the IRF Quality Reporting Program. An updated version of the IRF-PAI will become effective on October 1st, 2014. A copy of IRF -PAI V 1.2 is included in Section 8 of the IRF PAI Training Manual l V 1.2.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Table 4-2
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)[1]

Measure Description	Measure Specifications	Covariates
This measure reports the percentage of residents or patients who are assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season. The measure score is computed and reported for the three numerator components separately. The Patient Influenza Vaccination measure is calculated only once per year.	***Numerator*** Patients meeting any of the following criteria on the selected influenza vaccination assessment: 1. Patient received the influenza vaccine during the most recent influenza vaccination season, either in the facility (O250A=1) or outside the facility (O0250C=2) (computed and reported separately); or 2. Patient was offered and declined the influenza vaccine (O0250C=4) (computed and reported separately); or 3. Patient was ineligible due to contraindication(s) (O0250C=3) (computed and reported separately). ***Denominator*** 1. All patients with a selected influenza vaccination assessment during the target period (i.e., influenza vaccination period), except those with exclusions. Note: IRF-PAI assessments are only submitted to CMS for Medicare patients. ***Exclusions*** Patient's age on target date of selected influenza vaccination assessment is 179 days or less. ***Additional Exclusion for Future Public Reporting Program*** IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.	Not applicable.

[1] This measure is NQF-endorsed for use in the Inpatient Rehabilitation Facility (IRF) setting (http://www.qualityforum.org/QPS/0680) (in addition to Long Term Care Hospital and Skilled Nursing Facility/Nursing Home (SNF/NH) settings) and finalized for reporting by IRFs under the IRF Quality Reporting Program (*Federal Register* 78 (6 August 2013): 47903-47919. Web. http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18770.pdf and *Federal Register* 79 (6 August 2014): 45908-45918. Web. http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf). The use of the words "resident" and "short-stay" in the title of this measure refer to the use of this measure in the SNF/NH home setting. CMS's use of these words does not imply that the IRF patient is a "resident" or that a stay in a IRF is a "short stay."

[2] A copy of IRF -PAI V 1.2, including items for patient influenza vaccination measure, is included in Section 8 of the IRF PAI Training Manual.

SECTION 5: IMPAIRMENT GROUP CODES (IGC)

For the admission assessment, enter the code that best describes the primary reason for admission to the IRF (codes for this item are listed in the table on the following page). Each Impairment Group Code (IGC) consists of a two-digit number (indicating the major Impairment Group) followed by a 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 IRF 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 patients stay.

SECTION 5: IMPAIRMENT GROUP CODES (IGC)

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

SECTION 5: IMPAIRMENT GROUP CODES (IGC)

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
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	09	Cardiac
Pulmonary Disorders	10.1	Chronic Obstructive Pulmonary Disease
	10.9	Other Pulmonary
Burns	11	Burns

SECTION 5: IMPAIRMENT GROUP CODES (IGC)

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

The Impairment Group Code (IGC) represents the primary condition for which the patient requires treatment in an IRF. The patient's IGC should be filled in at item 21 of the IRF-PAI. The Etiologic Diagnosis is the problem that led to the condition represented by the IGC, and should be filled in at Item 22 using an ICD code. The table on the following page provides a crosswalk for mapping a particular Etiologic Diagnosis to an IGC. Additionally, the chart provides information on what Rehabilitation Impairment Category (RIC) an IGC will be assigned to for payment purposes. The presence of an ICD code (or the IGC) in this table does not mean that the Etiologic Diagnosis (or the IGC) meets the criteria for admission to an IRF. Additionally, it does not imply that the Etiologic Diagnosis (or the IGC) will meet the IRF 60 percent rule requirements.

The presence of a code in this table signifies a potential diagnosis a patient could receive. The table then guides the clinician in assigning the IGC associated with any given Etiologic Diagnosis code. Whether or not the patient meets the criteria for admission to an IRF must be determined by a medical review of the patient's IRF medical record. Similarly, whether or not the patient's condition satisfies the 60 percent rule requirements is determined either through a presumptive methodology review (see Chapter 3, Section 140 of the Medicare Claims Processing Manual (Pub. 100-04), which is available on the CMS website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html for more details) or through a medical review.

SECTION 6: 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 section, “x” denotes any digit 0-9.

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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)

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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.***

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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.***

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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)

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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)

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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*

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*

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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)

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

CIRCULATORY DISORDERS
Includes cases that 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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 6: ICD-9-CM CODES RELATED TO SPECIFIC IMPAIRMENT GROUPS

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

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

Comorbid Conditions are to be listed in Item 24 of the IRF-PAI. Up to twenty-five (25) ICD codes may be recorded.

A patient comorbidity is defined as a secondary condition a patient has in addition to the primary diagnosis for which the patient was admitted to the IRF. The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' course of treatment for their primary diagnosis.

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 in the List of Tier Comorbidities (located at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html)** is recorded in Item 24. If more than one comorbidity is present, the comorbidity that results in the highest payment will be used to adjust payment.

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
478.31	Vocal paral unilat part	1	15				
478.32	Vocal paral unilat total	1	15				
478.33	Vocal paral bilat part	1	15				
478.34	Vocal paral bilat total	1	15				
478.6	Edema of larynx	1	15				
V44.0	Tracheostomy status	1					
V45.11	Renal dialysis status	1					
V55.0	Atten to tracheostomy	1					
008.42	Pseudomonas enteritis	2					
008.45	Int inf clstrdium dfcile	2					
041.7	Pseudomonas infect NOS	2					
438.82	Late ef CV dis dysphagia	2	01				
579.3	Intest postop nonabsorb	2					
787.20	Dysphagia NOS	2	01				
787.21	Dysphagia, oral phase	2	01				
787.22	Dysphagia, oropharyngeal	2	01				
787.23	Dysphagia, pharyngeal	2	01				
787.24	Dysphagia,pharyngoesoph	2	01				
787.29	Dysphagia NEC	2	01				
011.00	TB lung infiltr-unspec	3	15				
011.01	TB lung infiltr-no exam	3	15				
011.02	TB lung infiltr-exm unkn	3	15				
011.03	TB lung infiltr-micro dx	3	15				
011.04	TB lung infiltr-cult dx	3	15				
011.05	TB lung infiltr-histo dx	3	15				
011.06	TB lung infiltr-oth test	3	15				
011.10	TB lung nodular-unspec	3	15				
011.11	TB lung nodular-no exam	3	15				
011.12	TB lung nodul-exam unkn	3	15				
011.13	TB lung nodular-micro dx	3	15				
011.14	TB lung nodular-cult dx	3	15				
011.15	TB lung nodular-histo dx	3	15				
011.16	TB lung nodular-oth test	3	15				
011.20	TB lung w cavity-unspec	3	15				
011.21	TB lung w cavity-no exam	3	15				
011.22	TB lung cavity-exam unkn	3	15				
011.23	TB lung w cavit-micro dx	3	15				
011.24	TB lung w cavity-cult dx	3	15				
011.25	TB lung w cavit-histo dx	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
011.26	TB lung w cavit-oth test	3	15				
011.30	TB of bronchus-unspec	3	15				
011.31	TB of bronchus-no exam	3	15				
011.32	TB of bronchus-exam unkn	3	15				
011.33	TB of bronchus-micro dx	3	15				
011.34	TB of bronchus-cult dx	3	15				
011.35	TB of bronchus-histo dx	3	15				
011.36	TB of bronchus-oth test	3	15				
011.40	TB lung fibrosis-unspec	3	15				
011.41	TB lung fibrosis-no exam	3	15				
011.42	TB lung fibros-exam unkn	3	15				
011.43	TB lung fibros-micro dx	3	15				
011.44	TB lung fibrosis-cult dx	3	15				
011.45	TB lung fibros-histo dx	3	15				
011.46	TB lung fibros-oth test	3	15				
011.50	TB bronchiectasis-unspec	3	15				
011.51	TB bronchiect-no exam	3	15				
011.52	TB bronchiect-exam unkn	3	15				
011.53	TB bronchiect-micro dx	3	15				
011.54	TB bronchiect-cult dx	3	15				
011.55	TB bronchiect-histo dx	3	15				
011.56	TB bronchiect-oth test	3	15				
011.60	TB pneumonia-unspec	3	15				
011.61	TB pneumonia-no exam	3	15				
011.62	TB pneumonia-exam unkn	3	15				
011.63	TB pneumonia-micro dx	3	15				
011.64	TB pneumonia-cult dx	3	15				
011.65	TB pneumonia-histo dx	3	15				
011.66	TB pneumonia-oth test	3	15				
011.70	TB pneumothorax-unspec	3	15				
011.71	TB pneumothorax-no exam	3	15				
011.72	TB pneumothorx-exam unkn	3	15				
011.73	TB pneumothorax-micro dx	3	15				
011.74	TB pneumothorax-cult dx	3	15				
011.75	TB pneumothorax-histo dx	3	15				
011.76	TB pneumothorax-oth test	3	15				
011.80	Pulmonary TB NEC-unspec	3	15				
011.81	Pulmonary TB NEC-no exam	3	15				
011.82	Pulmon TB NEC-exam unkn	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
011.83	Pulmon TB NEC-micro dx	3	15				
011.84	Pulmon TB NEC-cult dx	3	15				
011.85	Pulmon TB NEC-histo dx	3	15				
011.86	Pulmon TB NEC-oth test	3	15				
011.90	Pulmonary TB NOS-unspec	3	15				
011.91	Pulmonary TB NOS-no exam	3	15				
011.92	Pulmon TB NOS-exam unkn	3	15				
011.93	Pulmon TB NOS-micro dx	3	15				
011.94	Pulmon TB NOS-cult dx	3	15				
011.95	Pulmon TB NOS-histo dx	3	15				
011.96	Pulmon TB NOS-oth test	3	15				
012.00	TB pleurisy-unspec	3	15				
012.01	TB pleurisy-no exam	3	15				
012.02	TB pleurisy-exam unkn	3	15				
012.03	TB pleurisy-micro dx	3	15				
012.04	TB pleurisy-cult dx	3	15				
012.05	TB pleurisy-histolog dx	3	15				
012.06	TB pleurisy-oth test	3	15				
012.10	TB thoracic nodes-unspec	3	15				
012.11	TB thorax node-no exam	3	15				
012.12	TB thorax node-exam unkn	3	15				
012.13	TB thorax node-micro dx	3	15				
012.14	TB thorax node-cult dx	3	15				
012.15	TB thorax node-histo dx	3	15				
012.16	TB thorax node-oth test	3	15				
012.20	Isol tracheal tb-unspec	3	15				
012.21	Isol tracheal tb-no exam	3	15				
012.22	Isol trach tb-exam unkn	3	15				
012.23	Isolat trach tb-micro dx	3	15				
012.24	Isol tracheal tb-cult dx	3	15				
012.25	Isolat trach tb-histo dx	3	15				
012.26	Isolat trach tb-oth test	3	15				
012.30	TB laryngitis-unspec	3	15				
012.31	TB laryngitis-no exam	3	15				
012.32	TB laryngitis-exam unkn	3	15				
012.33	TB laryngitis-micro dx	3	15				
012.34	TB laryngitis-cult dx	3	15				
012.35	TB laryngitis-histo dx	3	15				
012.36	TB laryngitis-oth test	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
012.80	Resp TB NEC-unspec	3	15				
012.81	Resp TB NEC-no exam	3	15				
012.82	Resp TB NEC-exam unkn	3	15				
012.83	Resp TB NEC-micro dx	3	15				
012.84	Resp TB NEC-cult dx	3	15				
012.85	Resp TB NEC-histo dx	3	15				
012.86	Resp TB NEC-oth test	3	15				
013.00	TB meningitis-unspec	3	03,05				
013.01	TB meningitis-no exam	3	03,05				
013.02	TB meningitis-exam unkn	3	03,05				
013.03	TB meningitis-micro dx	3	03,05				
013.04	TB meningitis-cult dx	3	03,05				
013.05	TB meningitis-histo dx	3	03,05				
013.06	TB meningitis-oth test	3	03,05				
013.10	Tubrclma meninges-unspec	3	03,05				
013.11	Tubrclma mening-no exam	3	03,05				
013.12	Tubrclma menin-exam unkn	3	03,05				
013.13	Tubrclma mening-micro dx	3	03,05				
013.14	Tubrclma mening-cult dx	3	03,05				
013.15	Tubrclma mening-histo dx	3	03,05				
013.16	Tubrclma mening-oth test	3	03,05				
013.20	Tuberculoma brain-unspec	3	03				
013.21	Tubrcloma brain-no exam	3	03				
013.22	Tubrclma brain-exam unkn	3	03				
013.23	Tubrcloma brain-micro dx	3	03				
013.24	Tubrcloma brain-cult dx	3	03				
013.25	Tubrcloma brain-histo dx	3	03				
013.26	Tubrcloma brain-oth test	3	03				
013.30	TB brain abscess-unspec	3	03				
013.31	TB brain abscess-no exam	3	03				
013.32	TB brain absc-exam unkn	3	03				
013.33	TB brain absc-micro dx	3	03				
013.34	TB brain abscess-cult dx	3	03				
013.35	TB brain absc-histo dx	3	03				
013.36	TB brain absc-oth test	3	03				
013.40	Tubrclma sp cord-unspec	3	05				
013.41	Tubrclma sp cord-no exam	3	05				
013.42	Tubrclma sp cd-exam unkn	3	05				
013.43	Tubrclma sp crd-micro dx	3	05				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
013.44	Tubrclma sp cord-cult dx	3	05				
013.45	Tubrclma sp crd-histo dx	3	05				
013.46	Tubrclma sp crd-oth test	3	05				
013.50	TB sp crd abscess-unspec	3	05				
013.51	TB sp crd absc-no exam	3	05				
013.52	TB sp crd absc-exam unkn	3	05				
013.53	TB sp crd absc-micro dx	3	05				
013.54	TB sp crd absc-cult dx	3	05				
013.55	TB sp crd absc-histo dx	3	05				
013.56	TB sp crd absc-oth test	3	05				
013.60	TB encephalitis-unspec	3	03				
013.61	TB encephalitis-no exam	3	03				
013.62	TB encephalit-exam unkn	3	03				
013.63	TB encephalitis-micro dx	3	03				
013.64	TB encephalitis-cult dx	3	03				
013.65	TB encephalitis-histo dx	3	03				
013.66	TB encephalitis-oth test	3	03				
013.80	Cns TB NEC-unspec	3	03,05				
013.81	Cns TB NEC-no exam	3	03,05				
013.82	Cns TB NEC-exam unkn	3	03,05				
013.83	Cns TB NEC-micro dx	3	03,05				
013.84	Cns TB NEC-cult dx	3	03,05				
013.85	Cns TB NEC-histo dx	3	03,05				
013.86	Cns TB NEC-oth test	3	03,05				
013.90	Cns TB NOS-unspec	3	03,05				
013.91	Cns TB NOS-no exam	3	03,05				
013.92	Cns TB NOS-exam unkn	3	03,05				
013.93	Cns TB NOS-micro dx	3	03,05				
013.94	Cns TB NOS-cult dx	3	03,05				
013.95	Cns TB NOS-histo dx	3	03,05				
013.96	Cns TB NOS-oth test	3	03,05				
014.00	TB peritonitis-unspec	3					
014.01	TB peritonitis-no exam	3					
014.02	TB peritonitis-exam unkn	3					
014.03	TB peritonitis-micro dx	3					
014.04	TB peritonitis-cult dx	3					
014.05	TB peritonitis-histo dx	3					
014.06	TB peritonitis-oth test	3					
014.80	Intestinal TB NEC-unspec	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
014.81	Intestin TB NEC-no exam	3					
014.82	Intest TB NEC-exam unkn	3					
014.83	Intestin TB NEC-micro dx	3					
014.84	Intestin TB NEC-cult dx	3					
014.85	Intestin TB NEC-histo dx	3					
014.86	Intestin TB NEC-oth test	3					
015.00	TB of vertebra-unspec	3	03,09				
015.01	TB of vertebra-no exam	3	03,09				
015.02	TB of vertebra-exam unkn	3	03,09				
015.03	TB of vertebra-micro dx	3	03,09				
015.04	TB of vertebra-cult dx	3	03,09				
015.05	TB of vertebra-histo dx	3	03,09				
015.06	TB of vertebra-oth test	3	03,09				
015.10	TB of hip-unspec	3	09				
015.11	TB of hip-no exam	3	09				
015.12	TB of hip-exam unkn	3	09				
015.13	TB of hip-micro dx	3	09				
015.14	TB of hip-cult dx	3	09				
015.15	TB of hip-histo dx	3	09				
015.16	TB of hip-oth test	3	09				
015.20	TB of knee-unspec	3	09				
015.21	TB of knee-no exam	3	09				
015.22	TB of knee-exam unkn	3	09				
015.23	TB of knee-micro dx	3	09				
015.24	TB of knee-cult dx	3	09				
015.25	TB of knee-histo dx	3	09				
015.26	TB of knee-oth test	3	09				
015.50	TB of limb bones-unspec	3	09,10,11				
015.51	TB limb bones-no exam	3	09,10,11				
015.52	TB limb bones-exam unkn	3	09,10,11				
015.53	TB limb bones-micro dx	3	09,10,11				
015.54	TB limb bones-cult dx	3	09,10,11				
015.55	TB limb bones-histo dx	3	09,10,11				
015.56	TB limb bones-oth test	3					
015.60	TB of mastoid-unspec	3					
015.61	TB of mastoid-no exam	3					
015.62	TB of mastoid-exam unkn	3					
015.63	TB of mastoid-micro dx	3					
015.64	TB of mastoid-cult dx	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
015.65	TB of mastoid-histo dx	3					
015.66	TB of mastoid-oth test	3					
015.70	TB of bone NEC-unspec	3	09				
015.71	TB of bone NEC-no exam	3	09				
015.72	TB of bone NEC-exam unkn	3	09				
015.73	TB of bone NEC-micro dx	3	09				
015.74	TB of bone NEC-cult dx	3	09				
015.75	TB of bone NEC-histo dx	3	09				
015.76	TB of bone NEC-oth test	3	09				
015.80	TB of joint NEC-unspec	3	09				
015.81	TB of joint NEC-no exam	3	09				
015.82	TB joint NEC-exam unkn	3	09				
015.83	TB of joint NEC-micro dx	3	09				
015.84	TB of joint NEC-cult dx	3	09				
015.85	TB of joint NEC-histo dx	3	09				
015.86	TB of joint NEC-oth test	3	09				
015.90	TB bone/joint NOS-unspec	3	09				
015.91	TB bone/jt NOS-no exam	3	09				
015.92	TB bone/jt NOS-exam unkn	3	09				
015.93	TB bone/jt NOS-micro dx	3	09				
015.94	TB bone/jt NOS-cult dx	3	09				
015.95	TB bone/jt NOS-histo dx	3	09				
015.96	TB bone/jt NOS-oth test	3	09				
016.00	TB of kidney-unspec	3					
016.01	TB of kidney-no exam	3					
016.02	TB of kidney-exam unkn	3					
016.03	TB of kidney-micro dx	3					
016.04	TB of kidney-cult dx	3					
016.05	TB of kidney-histo dx	3					
016.06	TB of kidney-oth test	3					
016.10	TB of bladder-unspec	3					
016.11	TB of bladder-no exam	3					
016.12	TB of bladder-exam unkn	3					
016.13	TB of bladder-micro dx	3					
016.14	TB of bladder-cult dx	3					
016.15	TB of bladder-histo dx	3					
016.16	TB of bladder-oth test	3					
016.20	TB of ureter-unspec	3					
016.21	TB of ureter-no exam	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
016.22	TB of ureter-exam unkn	3					
016.23	TB of ureter-micro dx	3					
016.24	TB of ureter-cult dx	3					
016.25	TB of ureter-histo dx	3					
016.26	TB of ureter-oth test	3					
016.30	TB urinary NEC-unspec	3					
016.31	TB urinary NEC-no exam	3					
016.32	TB urinary NEC-exam unkn	3					
016.33	TB urinary NEC-micro dx	3					
016.34	TB urinary NEC-cult dx	3					
016.35	TB urinary NEC-histo dx	3					
016.36	TB urinary NEC-oth test	3					
016.40	TB epididymis-unspec	3					
016.41	TB epididymis-no exam	3					
016.42	TB epididymis-exam unkn	3					
016.43	TB epididymis-micro dx	3					
016.44	TB epididymis-cult dx	3					
016.45	TB epididymis-histo dx	3					
016.46	TB epididymis-oth test	3					
016.50	TB male genit NEC-unspec	3					
016.51	TB male gen NEC-no exam	3					
016.52	TB male gen NEC-ex unkn	3					
016.53	TB male gen NEC-micro dx	3					
016.54	TB male gen NEC-cult dx	3					
016.55	TB male gen NEC-histo dx	3					
016.56	TB male gen NEC-oth test	3					
016.60	TB ovary & tube-unspec	3					
016.61	TB ovary & tube-no exam	3					
016.62	TB ovary/tube-exam unkn	3					
016.63	TB ovary & tube-micro dx	3					
016.64	TB ovary & tube-cult dx	3					
016.65	TB ovary & tube-histo dx	3					
016.66	TB ovary & tube-oth test	3					
016.70	TB female gen NEC-unspec	3					
016.71	TB fem gen NEC-no exam	3					
016.72	TB fem gen NEC-exam unkn	3					
016.73	TB fem gen NEC-micro dx	3					
016.74	TB fem gen NEC-cult dx	3					
016.75	TB fem gen NEC-histo dx	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
016.76	TB fem gen NEC-oth test	3					
016.90	Gu TB NOS-unspec	3					
016.91	Gu TB NOS-no exam	3					
016.92	Gu TB NOS-exam unkn	3					
016.93	Gu TB NOS-micro dx	3					
016.94	Gu TB NOS-cult dx	3					
016.95	Gu TB NOS-histo dx	3					
016.96	Gu TB NOS-oth test	3					
017.00	TB skin/subcutan-unspec	3					
017.01	TB skin/subcut-no exam	3					
017.02	TB skin/subcut-exam unkn	3					
017.03	TB skin/subcut-micro dx	3					
017.04	TB skin/subcut-cult dx	3					
017.05	TB skin/subcut-histo dx	3					
017.06	TB skin/subcut-oth test	3					
017.10	Erythema nodos tb-unspec	3					
017.11	Erythem nodos tb-no exam	3					
017.12	Erythem nod tb-exam unkn	3					
017.13	Erythem nod tb-micro dx	3					
017.14	Erythem nodos tb-cult dx	3					
017.15	Erythem nod tb-histo dx	3					
017.16	Erythem nod tb-oth test	3					
017.20	TB periph lymph-unspec	3					
017.21	TB periph lymph-no exam	3					
017.22	TB periph lymph-exam unk	3					
017.23	TB periph lymph-micro dx	3					
017.24	TB periph lymph-cult dx	3					
017.25	TB periph lymph-histo dx	3					
017.26	TB periph lymph-oth test	3					
017.30	TB of eye-unspec	3					
017.31	TB of eye-no exam	3					
017.32	TB of eye-exam unkn	3					
017.33	TB of eye-micro dx	3					
017.34	TB of eye-cult dx	3					
017.35	TB of eye-histo dx	3					
017.36	TB of eye-oth test	3					
017.40	TB of ear-unspec	3					
017.41	TB of ear-no exam	3					
017.42	TB of ear-exam unkn	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
017.43	TB of ear-micro dx	3					
017.44	TB of ear-cult dx	3					
017.45	TB of ear-histo dx	3					
017.46	TB of ear-oth test	3					
017.50	TB of thyroid-unspec	3					
017.51	TB of thyroid-no exam	3					
017.52	TB of thyroid-exam unkn	3					
017.53	TB of thyroid-micro dx	3					
017.54	TB of thyroid-cult dx	3					
017.55	TB of thyroid-histo dx	3					
017.56	TB of thyroid-oth test	3					
017.60	TB of adrenal-unspec	3					
017.61	TB of adrenal-no exam	3					
017.62	TB of adrenal-exam unkn	3					
017.63	TB of adrenal-micro dx	3					
017.64	TB of adrenal-cult dx	3					
017.65	TB of adrenal-histo dx	3					
017.70	TB of spleen-unspec	3					
017.71	TB of spleen-no exam	3					
017.72	TB of spleen-exam unkn	3					
017.73	TB of spleen-micro dx	3					
017.74	TB of spleen-cult dx	3					
017.75	TB of spleen-histo dx	3					
017.76	TB of spleen-oth test	3					
017.80	TB esophagus-unspec	3					
017.81	TB esophagus-no exam	3					
017.82	TB esophagus-exam unkn	3					
017.83	TB esophagus-micro dx	3					
017.84	TB esophagus-cult dx	3					
017.85	TB esophagus-histo dx	3					
017.86	TB esophagus-oth test	3					
017.90	TB of organ NEC-unspec	3					
017.91	TB of organ NEC-no exam	3					
017.92	TB organ NEC-exam unkn	3					
017.93	TB of organ NEC-micro dx	3					
017.94	TB of organ NEC-cult dx	3					
017.95	TB of organ NEC-histo dx	3					
017.96	TB of organ NEC-oth test	3					
018.00	Acute miliary tb-unspec	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
018.01	Acute miliary tb-no exam	3					
018.02	Ac miliary tb-exam unkn	3					
018.03	Ac miliary tb-micro dx	3					
018.04	Acute miliary tb-cult dx	3					
018.05	Ac miliary tb-histo dx	3					
018.06	Ac miliary tb-oth test	3					
018.80	Miliary TB NEC-unspec	3					
018.81	Miliary TB NEC-no exam	3					
018.82	Miliary TB NEC-exam unkn	3					
018.83	Miliary TB NEC-micro dx	3					
018.84	Miliary TB NEC-cult dx	3					
018.85	Miliary TB NEC-histo dx	3					
018.86	Miliary TB NEC-oth test	3					
018.90	Miliary TB NOS-unspec	3					
018.91	Miliary TB NOS-no exam	3					
018.92	Miliary TB NOS-exam unkn	3					
018.93	Miliary TB NOS-micro dx	3					
018.94	Miliary TB NOS-cult dx	3					
018.95	Miliary TB NOS-histo dx	3					
018.96	Miliary TB NOS-oth test	3					
027.0	Listeriosis	3					
027.1	Erysipelothrix infection	3					
027.2	Pasteurellosis	3					
027.8	Zoonotic bact dis NEC	3					
027.9	Zoonotic bact dis NOS	3					
036.0	Meningococcal meningitis	3	03,05				
036.2	Meningococcemia	3	03,05				
036.3	Meningococc adrenal synd	3	05				
036.40	Meningococc carditis NOS	3	14				
036.42	Meningococc endocarditis	3	14				
036.43	Meningococc myocarditis	3	14				
037.	Tetanus	3	06				
038.0	Streptococcal septicemia	3					
038.10	Staphylcocc septicem NOS	3					
038.11	Meth susc Staph aur sept	3					
038.12	MRSA septicemia	3					
038.19	Staphylcocc septicem NEC	3					
038.2	Pneumococcal septicemia	3					
038.3	Anaerobic septicemia	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
038.40	Gram-neg septicemia NOS	3					
038.41	H. influenae septicemia	3					
038.42	E coli septicemia	3					
038.43	Pseudomonas septicemia	3					
038.44	Serratia septicemia	3					
038.49	Gram-neg septicemia NEC	3					
038.8	Septicemia NEC	3					
038.9	Septicemia NOS	3					
042.	Human immuno virus dis	3					
047.8	Viral meningitis NEC	3	03,05				
047.9	Viral meningitis NOS	3	03,05				
048.	Oth enteroviral cns dis	3	03,05				
049.0	Lymphocytic choriomening	3	03,05				
049.9	Viral encephalitis NOS	3	03				
052.0	Postvaricella encephalit	3	03				
052.1	Varicella pneumonitis	3	15				
053.0	Herpes zoster meningitis	3	03,05				
053.13	Postherpes polyneuropath	3	06				
054.3	Herpetic encephalitis	3	03				
054.5	Herpetic septicemia	3	03				
054.72	H simplex meningitis	3	03,05				
054.74	Herpes simplex myelitis	3					
054.79	H simplex complicat NEC	3					
055.0	Postmeasles encephalitis	3	03				
055.1	Postmeasles pneumonia	3	15				
058.21	Human herpesvir 6 enceph	3	03				
058.29	Human herpesvr encph NEC	3	03				
070.20	Hpt B acte coma wo dlta	3	03				
070.21	Hpt B acte coma w dlta	3	03				
070.22	Hpt B chrn coma wo dlta	3	03				
070.23	Hpt B chrn coma w dlta	3	03				
070.41	Hpt C acute w hepat Coma	3	03				
070.42	Hpt dlt wo b w hpt coma	3	03				
070.43	Hpt E w hepat Coma	3	03				
070.44	Chrnc hpt C w hepat Coma	3	03				
070.49	Oth vrl hepat w hpt coma	3	03				
070.6	Viral hepat NOS w coma	3	03				
070.71	Hpt C w hepatic coma NOS	3	03				
072.1	Mumps meningitis	3	03,05				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
072.2	Mumps encephalitis	3	03				
072.3	Mumps pancreatitis	3					
079.50	Retrovirus, unspecified	3					
079.51	Htlv-1 infection oth dis	3	06				
079.52	Htlv-ii infectn oth dis	3	06				
079.53	Hiv-2 infection oth dis	3					
079.59	Oth specfied retrovirus	3					
090.42	Congen syph meningitis	3	03,05				
093.20	Syphil endocarditis NOS	3	14				
093.82	Syphilitic myocarditis	3	14				
094.2	Syphilitic meningitis	3	03,05				
094.87	Syph rupt cereb aneurysm	3	01,03				
098.89	Gonococcal inf site NEC	3					
112.4	Candidiasis of lung	3	15				
112.5	Disseminated candidiasis	3					
112.81	Candidal endocarditis	3	14				
112.83	Candidal meningitis	3	03,05				
112.84	Candidal esophagitis	3					
114.2	Coccidioidal meningitis	3	03,05				
115.00	Histoplasma capsulat NOS	3	15				
115.01	Histoplasm capsul mening	3	03,05				
115.02	Histoplasm capsul retina	3					
115.03	Histoplasm caps pericard	3	14				
115.04	Histoplasm caps endocard	3	14				
115.05	Histoplasm caps pneumon	3	15				
115.09	Histoplasma capsulat NEC	3	15				
115.10	Histoplasma duboisii NOS	3					
115.11	Histoplasm dubois mening	3	03,05				
115.12	Histoplasm dubois retina	3					
115.13	Histoplasm dub pericard	3	14				
115.14	Histoplasm dub endocard	3	14				
115.15	Histoplasm dub pneumonia	3	15				
115.19	Histoplasma duboisii NEC	3	15				
115.90	Histoplasmosis NOS	3	15				
115.91	Histoplasmosis meningit	3	03,05				
115.92	Histoplasmosis retinitis	3					
115.93	Histoplasmosis pericard	3	14				
115.94	Histoplasmosis endocard	3	14				
115.95	Histoplasmosis pneumonia	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
115.99	Histoplasmosis NEC	3	15				
130.0	Toxoplasm meningoenceph	3	03,05				
130.3	Toxoplasma myocarditis	3	14				
130.4	Toxoplasma pneumonitis	3	15				
136.3	Pneumocystosis	3	15				
139.0	Late eff viral encephal	3	03				
204.00	Ac lym leuk wo achv rmsn	3					
204.02	Act lymp leuk in relapse	3					
205.00	Ac myl leuk wo achv rmsn	3					
205.02	Act myel leuk in relapse	3					
206.00	Ac mono leu wo achv rmsn	3					
206.02	Act mono leuk in relapse	3					
207.00	Ac erth/erlk wo ach rmsn	3					
207.02	Ac erth/erylk in relapse	3					
208.00	Ac leu un cl wo ach rmsn	3					
208.02	Ac leuk uns cl relapse	3					
249.40	Sec DM renl nt st uncntr	3					
249.41	Sec DM renal uncontrld	3					
249.50	Sec DM ophth nt st uncn	3					
249.51	Sec DM ophth uncontrld	3					
249.60	Sec DM neuro nt st uncn	3					
249.61	Sec DM neuro uncontrld	3					
249.70	Sec DM circ nt st uncntr	3					
249.71	Sec DM circ uncontrld	3					
249.80	Sec DM oth nt st uncontr	3					
249.81	Sec DM other uncontrld	3					
249.91	Sec DM unsp uncontrold	3					
250.01	DMI wo cmp nt st uncntrl	3					
250.40	DMII renl nt st uncntrld	3					
250.41	DMI renl nt st uncntrld	3					
250.42	DMII renal uncntrld	3					
250.43	DMI renal uncntrld	3					
250.50	DMII ophth nt st uncntrl	3					
250.51	DMI ophth nt st uncntrld	3					
250.52	DMII ophth uncntrld	3					
250.53	DMI ophth uncntrld	3					
250.60	DMII neuro nt st uncntrl	3	06				
250.61	DMI neuro nt st uncntrld	3	06				
250.62	DMII neuro uncntrld	3	06				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
250.63	DMI neuro uncntrld	3	06				
250.70	DMII circ nt st uncntrld	3					
250.71	DMI circ nt st uncntrld	3					
250.72	DMII circ uncntrld	3					
250.73	DMI circ uncntrld	3					
250.80	DMII oth nt st uncntrld	3					
250.81	DMI oth nt st uncntrld	3					
250.82	DMII oth uncntrld	3					
250.83	DMI oth uncntrld	3					
250.91	DMI unspf nt st uncntrld	3					
250.92	DMII unspf uncntrld	3					
277.00	Cystic fibros w/o ileus	3	15				
277.01	Cystic fibrosis w ileus	3	15				
277.02	Cystic fibros w pul man	3	15				
277.03	Cystic fibrosis w GI man	3	15				
277.09	Cystic fibrosis NEC	3	15				
278.01	Morbid obesity	3					
282.60	Sickle cell disease NOS	3					
282.61	Hb-SS disease w/o crisis	3					
282.62	Hb-SS disease w crisis	3					
282.63	Hb-SS/hb-C dis w/o crsis	3					
282.64	Hb-S/Hb-C dis w crisis	3					
282.68	Hb-S dis w/o crisis NEC	3					
282.69	Hb-SS dis NEC w crisis	3					
284.01	Constitution RBC aplasia	3					
284.09	Const aplastc anemia NEC	3					
284.11	Antin chemo indcd pancyt	3					
284.12	Oth drg indcd pancytopna	3					
284.19	Other pancytopenia	3					
284.2	Myelophthisis	3					
284.81	Red cell aplasia	3					
284.89	Aplastic anemias NEC	3					
284.9	Aplastic anemia NOS	3					
285.3	Anemia d/t antineo chemo	3					
286.0	Cong factor viii diord	3					
286.1	Cong factor IX disorder	3					
286.6	Defibrination syndrome	3					
320.0	Hemophilus meningitis	3	03,05				
320.1	Pneumococcal meningitis	3	03,05				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
320.2	Streptococcal meningitis	3	03,05				
320.3	Staphylococc meningitis	3	03,05				
320.7	Mening in oth bact dis	3	03,05				
320.81	Anaerobic meningitis	3	03,05				
320.82	Mningts gram-neg bct NEC	3	03,05				
320.89	Meningitis oth spcf bact	3	03,05				
320.9	Bacterial meningitis NOS	3	03,05				
321.0	Cryptococcal meningitis	3	03,05				
321.1	Mening in oth fungal dis	3	03,05				
321.2	Mening in oth viral dis	3	03,05				
321.3	Trypanosomiasis meningit	3	03,05				
321.4	Meningit d/t sarcoidosis	3	03,05				
321.8	Mening in oth nonbac dis	3	03,05				
322.0	Nonpyogenic meningitis	3	03,05				
322.2	Chronic meningitis	3	03,05				
322.9	Meningitis NOS	3	03,05				
323.61	Inf ac dis encephalomyel	3	03				
323.62	Postinf encephalitis NEC	3	03				
323.63	Postinfectious myelitis	3	03				
323.81	Enceph & encephlalo NEC	3	03				
323.82	Myelitis cause NEC	3	03				
323.9	Encephalitis NOS	3	03				
324.0	Intracranial abscess	3	03				
324.1	Intraspinal abscess	3	03				
324.9	Cns abscess NOS	3	03				
341.20	Acute myelitis NOS	3	03				
341.21	Acute myelitis oth cond	3	03				
341.22	Idiopathc trans myelitis	3	03				
342.00	Flccd hmiplga unspf side	3	01				
342.01	Flccd hmiplga domnt side	3	01				
342.02	Flccd hmiplg nondmnt sde	3	01				
342.10	Spstc hmiplga unspf side	3	01				
342.11	Spstc hmiplga domnt side	3	01				
342.12	Spstc hmiplg nondmnt sde	3	01				
342.80	Ot sp hmiplga unspf side	3	01				
342.81	Ot sp hmiplga domnt side	3	01				
342.82	Ot sp hmiplg nondmnt sde	3	01				
342.90	Unsp hemiplga unspf side	3	01				
342.91	Unsp hemiplga domnt side	3	01				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
342.92	Unsp hmiplga nondmnt sde	3	01				
345.11	Gen cnv epil w intr epil	3	02,03				
345.3	Grand mal status	3	02,03				
348.1	Anoxic brain damage	3	02,03				
357.2	Neuropathy in diabetes	3	06				
376.01	Orbital cellulitis	3					
376.02	Orbital periostitis	3					
376.03	Orbital osteomyelitis	3					
398.0	Rheumatic myocarditis	3	14				
403.01	Mal hyp kid w cr kid V	3					
404.01	Mal hyp ht/kd I-IV w hf	3	14				
404.03	Mal hyp ht/kd stg V w hf	3	14				
415.11	Iatrogen pulm emb/infarc	3	15				
415.12	Septic pulmonary embolsm	3	15				
415.13	Saddle embol pulmon art	3	15				
415.19	Pulm embol/infarct NEC	3	15				
416.2	Chr pulmonary embolism	3	15				
421.0	Ac/subac bact endocard	3	14				
421.1	Ac endocardit in oth dis	3	14				
421.9	Ac/subac endocardit NOS	3	14				
422.0	Ac myocardit in oth dis	3	14				
422.90	Acute myocarditis NOS	3	14				
422.91	Idiopathic myocarditis	3	14				
422.92	Septic myocarditis	3	14				
422.93	Toxic myocarditis	3	14				
422.99	Acute myocarditis NEC	3	14				
427.41	Ventricular fibrillation	3	14				
427.5	Cardiac arrest	3	14				
428.1	Left heart failure	3	14				
428.20	Systolic hrt failure NOS	3	14				
428.21	Ac systolic hrt failure	3	14				
428.22	Chr systolic hrt failure	3	14				
428.23	Ac on chr syst hrt fail	3	14				
428.30	Diastolc hrt failure NOS	3	14				
428.31	Ac diastolic hrt failure	3	14				
428.32	Chr diastolic hrt fail	3	14				
428.33	Ac on chr diast hrt fail	3	14				
428.40	Syst/diast hrt fail NOS	3	14				
428.41	Ac syst/diastol hrt fail	3	14				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
428.42	Chr syst/diastl hrt fail	3	14				
428.43	Ac/chr syst/dia hrt fail	3	14				
430.	Subarachnoid hemorrhage	3	01,02,03				
431.	Intracerebral hemorrhage	3	01,02,03				
432.0	Nontraum extradural hem	3	01,02,03				
432.1	Subdural hemorrhage	3	01,02,03				
433.01	Ocl bslr art w infrct	3	01				
433.11	Ocl crtd art w infrct	3	01				
433.21	Ocl vrtb art w infrct	3	01				
433.31	Ocl mlt bi art w infrct	3	01				
433.81	Ocl spcf art w infrct	3	01				
433.91	Ocl art NOS w infrct	3	01				
434.01	Crbl thrmbs w infrct	3	01				
434.11	Crbl emblsm w infrct	3	01				
434.91	Crbl art ocl NOS w infrc	3	01				
436.	Cva	3	01				
440.23	Ath ext ntv art ulcrtion	3	10,11				
440.24	Ath ext ntv art gngrene	3	10,11				
440.4	Chr tot occl art extrem	3	10,11				
441.00	Dsct of aorta unsp site	3					
441.01	Dsct of thoracic aorta	3	05				
441.02	Dsct of abdominal aorta	3	05				
441.03	Dsct of thoracoabd aorta	3	05				
441.1	Ruptur thoracic aneurysm	3	05				
441.3	Rupt abd aortic aneurysm	3	05				
441.5	Rupt aortic aneurysm NOS	3	05				
441.6	Thoracoabd aneurysm rupt	3	05				
446.3	Lethal midline granuloma	3					
449.	Septic arterial embolism	3					
452.	Portal vein thrombosis	3					
453.0	Budd-chiari syndrome	3					
453.1	Thrombophlebitis migrans	3					
453.2	Oth inf vena cava thromb	3					
453.3	Renal vein thrombosis	3					
464.11	Ac tracheitis w obstruct	3	15				
464.21	Ac laryngotrach w obstr	3	15				
464.31	Ac epiglottitis w obstr	3	15				
466.11	Acu broncholitis d/t RSV	3	15				
466.19	Acu brnchlts d/t oth org	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
478.30	Vocal cord paralysis NOS	3	15				
480.0	Adenoviral pneumonia	3	15				
480.1	Resp syncyt viral pneum	3	15				
480.2	Parinfluenza viral pneum	3	15				
480.8	Viral pneumonia NEC	3	15				
480.9	Viral pneumonia NOS	3	15				
481.	Pneumococcal pneumonia	3	15				
482.0	K. pneumoniae pneumonia	3	15				
482.1	Pseudomonal pneumonia	3	15				
482.2	H.influenzae pneumonia	3	15				
482.30	Streptococcal pneumn NOS	3	15				
482.31	Pneumonia strptococcus a	3	15				
482.32	Pneumonia strptococcus b	3	15				
482.39	Pneumonia oth strep	3	15				
482.40	Staphylococcal pneu NOS	3	15				
482.41	Meth sus pneum d/t Staph	3	15				
482.42	Meth res pneu d/t Staph	3	15				
482.49	Staph pneumonia NEC	3	15				
482.81	Pneumonia anaerobes	3	15				
482.82	Pneumonia e coli	3	15				
482.83	Pneumo oth grm-neg bact	3	15				
482.84	Legionnaires' disease	3	15				
482.89	Pneumonia oth spcf bact	3	15				
482.9	Bacterial pneumonia NOS	3	15				
483.0	Pneu mycplsm pneumoniae	3	15				
483.1	Pneumonia d/t chlamydia	3	15				
483.8	Pneumon oth spec orgnsm	3	15				
484.1	Pneum w cytomeg incl dis	3	15				
484.3	Pneumonia in whoop cough	3	15				
484.5	Pneumonia in anthrax	3	15				
484.6	Pneum in aspergillosis	3	15				
484.7	Pneum in oth sys mycoses	3	15				
484.8	Pneum in infect dis NEC	3	15				
485.	Bronchopneumonia org NOS	3	15				
486.	Pneumonia, organism NOS	3	15				
487.0	Influenza with pneumonia	3	15				
488.01	Flu dt iden avian w pneu	3	15				
488.02	Flu dt avian w oth resp	3	15				
488.09	Flu dt avian manfest NEC	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
488.11	Flu dt 2009 H1N1 w pneu	3	15				
488.12	Flu-2009 H1N1 w oth resp	3	15				
488.19	Flu-2009 H1N1 w oth man	3	15				
488.81	Flu dt nvl A vrs w pneu	3	15				
506.0	Fum/vapor bronc/pneumon	3	15				
506.1	Fum/vapor ac pulm edema	3	15				
507.0	Food/vomit pneumonitis	3	15				
507.1	Oil/essence pneumonitis	3	15				
507.8	Solid/liq pneumonit NEC	3	15				
510.0	Empyema with fistula	3	15				
510.9	Empyema w/o fistula	3	15				
511.1	Bact pleur/effus not TB	3	15				
513.0	Abscess of lung	3	15				
513.1	Abscess of mediastinum	3	15				
514.	Pulm congest/hypostasis	3	15				
515.	Postinflam pulm fibrosis	3	15				
516.31	Idiopath pulmon fibrosis	3	15				
516.32	Idio non-spec inter pneu	3	15				
516.33	Acute interstitial pneum	3	15				
516.34	Resp brncio interst lung	3	15				
517.3	Acute chest syndrome	3					
518.3	Pulmonary eosinophilia	3	15				
518.51	Ac resp flr fol trma/srg	3	15				
518.52	Ot pul insuf fol trm/srg	3	15				
518.53	Ac/chr rsp flr fol tr/sg	3	15				
518.81	Acute respiratry failure	3	15				
519.2	Mediastinitis	3	15				
528.3	Cellulitis/abscess mouth	3					
530.4	Perforation of esophagus	3	15				
530.82	Esophageal hemorrhage	3					
531.00	Ac stomach ulcer w hem	3					
531.01	Ac stomac ulc w hem-obst	3					
531.10	Ac stomach ulcer w perf	3					
531.11	Ac stom ulc w perf-obst	3					
531.20	Ac stomac ulc w hem/perf	3					
531.21	Ac stom ulc hem/perf-obs	3					
531.40	Chr stomach ulc w hem	3					
531.41	Chr stom ulc w hem-obstr	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
531.50	Chr stomach ulcer w perf	3					
531.51	Chr stom ulc w perf-obst	3					
531.60	Chr stomach ulc hem/perf	3					
531.61	Chr stom ulc hem/perf-ob	3					
532.00	Ac duodenal ulcer w hem	3					
532.01	Ac duoden ulc w hem-obst	3					
532.10	Ac duodenal ulcer w perf	3					
532.11	Ac duoden ulc perf-obstr	3					
532.20	Ac duoden ulc w hem/perf	3					
532.21	Ac duod ulc hem/perf-obs	3					
532.40	Chr duoden ulcer w hem	3					
532.41	Chr duoden ulc hem-obstr	3					
532.50	Chr duoden ulcer w perf	3					
532.51	Chr duoden ulc perf-obst	3					
532.60	Chr duoden ulc hem/perf	3					
532.61	Chr duod ulc hem/perf-ob	3					
533.00	Ac peptic ulcer w hemorr	3					
533.01	Ac peptic ulc w hem-obst	3					
533.10	Ac peptic ulcer w perfor	3					
533.11	Ac peptic ulc w perf-obs	3					
533.20	Ac peptic ulc w hem/perf	3					
533.21	Ac pept ulc hem/perf-obs	3					
533.40	Chr peptic ulcer w hem	3					
533.41	Chr peptic ulc w hem-obs	3					
533.50	Chr peptic ulcer w perf	3					
533.51	Chr peptic ulc perf-obst	3					
533.60	Chr pept ulc w hem/perf	3					
533.61	Chr pept ulc hem/perf-ob	3					
534.00	Ac marginal ulcer w hem	3					
534.01	Ac margin ulc w hem-obst	3					
534.10	Ac marginal ulcer w perf	3					
534.11	Ac margin ulc w perf-obs	3					
534.20	Ac margin ulc w hem/perf	3					
534.21	Ac marg ulc hem/perf-obs	3					
534.40	Chr marginal ulcer w hem	3					
534.41	Chr margin ulc w hem-obs	3					
534.50	Chr marginal ulc w perf	3					
534.51	Chr margin ulc perf-obst	3					
534.60	Chr margin ulc hem/perf	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
534.61	Chr marg ulc hem/perf-ob	3					
535.01	Acute gastritis w hmrhg	3					
535.11	Atrph gastritis w hmrhg	3					
535.21	Gstr mcsl hyprt w hmrg	3					
535.31	Alchl gstritis w hmrhg	3					
535.41	Oth spf gastrt w hmrhg	3					
535.51	Gstr/ddnts NOS w hmrhg	3					
535.61	Duodenitis w hmrhg	3					
535.71	Eosinophilc gastrt w hem	3					
537.4	Gastric/duodenal fistula	3					
537.83	Angio stm/dudn w hmrhg	3					
537.84	Dieulafoy les,stom&duod	3					
540.0	Ac append w peritonitis	3					
557.0	Ac vasc insuff intestine	3					
562.02	Dvrtclo sml int w hmrhg	3					
562.03	Dvrtcli sml int w hmrhg	3					
562.12	Dvrtclo colon w hmrhg	3					
562.13	Dvrtcli colon w hmrhg	3					
567.0	Peritonitis in infec dis	3					
567.1	Pneumococcal peritonitis	3					
567.21	Peritonitis (acute) gen	3					
567.22	Peritoneal abscess	3					
567.23	Spontan bact peritonitis	3					
567.29	Suppurat peritonitis NEC	3					
567.38	Retroperiton abscess NEC	3					
567.39	Retroperiton infect NEC	3					
567.81	Choleperitonitis	3					
567.82	Sclerosing mesenteritis	3					
567.89	Peritonitis NEC	3					
567.9	Peritonitis NOS	3					
569.60	Colstomy/enter comp NOS	3					
569.61	Colosty/enterost infectn	3					
569.62	Colosty/enter comp-mech	3					
569.69	Colstmy/enteros comp NEC	3					
569.83	Perforation of intestine	3					
569.85	Angio intes w hmrhg	3					
570.	Acute necrosis of liver	3					
572.0	Abscess of liver	3					
572.4	Hepatorenal syndrome	3					

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
573.4	Hepatic infarction	3					
575.4	Perforation gallbladder	3					
576.3	Perforation of bile duct	3					
577.2	Pancreat cyst/pseudocyst	3					
580.0	Ac proliferat nephritis	3					
580.4	Ac rapidly progr nephrit	3					
580.81	Ac nephritis in oth dis	3					
580.89	Acute nephritis NEC	3					
580.9	Acute nephritis NOS	3					
583.4	Rapidly prog nephrit NOS	3					
584.5	Ac kidny fail, tubr necr	3					
584.6	Ac kidny fail, cort necr	3					
584.7	Ac kidny fail, medu necr	3					
584.8	Acute kidney failure NEC	3					
584.9	Acute kidney failure NOS	3					
590.2	Renal/perirenal abscess	3					
596.6	Bladder rupt, nontraum	3					
659.30	Septicemia in labor-unsp	3					
659.31	Septicem in labor-deliv	3					
665.00	Prelabor rupt uter-unsp	3					
665.01	Prelabor rupt uterus-del	3					
665.03	Prelab rupt uter-antepar	3					
665.10	Rupture uterus NOS-unsp	3					
665.11	Rupture uterus NOS-deliv	3					
669.10	Obstetric shock-unspec	3	03				
669.11	Obstetric shock-deliver	3	03				
669.12	Obstet shock-deliv w p/p	3	03				
669.13	Obstetric shock-antepar	3	03				
669.14	Obstetric shock-postpart	3	03				
669.30	Ac kidny fail w del-unsp	3					
669.32	Ac kidney fail-del w p/p	3					
669.34	Ac kidney fail-postpart	3					
673.00	Ob air embolism-unspec	3	01				
673.01	Ob air embolism-deliver	3	01				
673.02	Ob air embol-deliv w p/p	3	01				
673.03	Ob air embolism-antepart	3	01				
673.04	Ob air embolism-postpart	3	01				
673.10	Amniotic embolism-unspec	3	01				
673.11	Amniotic embolism-deliv	3	01				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
673.12	Amniot embol-deliv w p/p	3	01				
673.13	Amniotic embol-antepart	3	01				
673.14	Amniotic embol-postpart	3	01				
673.20	Ob pulm embol NOS-unspec	3	15				
673.22	Pulm embol NOS-del w p/p	3	15				
673.23	Pulm embol NOS-antepart	3	15				
673.24	Pulm embol NOS-postpart	3	15				
673.30	Ob pyemic embol-unspec	3	03				
673.31	Ob pyemic embol-deliver	3	03				
673.32	Ob pyem embol-del w p/p	3	03				
673.33	Ob pyemic embol-antepart	3	03				
673.34	Ob pyemic embol-postpart	3	03				
673.80	Ob pulmon embol NEC-unsp	3	15				
673.81	Pulmon embol NEC-deliver	3	15				
673.82	Pulm embol NEC-del w p/p	3	15				
673.83	Pulmon embol NEC-antepar	3	15				
673.84	Pulmon embol NEC-postpar	3	15				
674.00	Puerp cerebvasc dis-unsp	3	01,03				
682.0	Cellulitis of face	3					
682.1	Cellulitis of neck	3					
682.2	Cellulitis of trunk	3					
682.3	Cellulitis of arm	3					
682.4	Cellulitis of hand	3					
682.5	Cellulitis of buttock	3					
682.6	Cellulitis of leg	3	10				
682.7	Cellulitis of foot	3	10				
682.8	Cellulitis, site NEC	3					
765.01	Extreme immatur <500g	3					
765.02	Extreme immatur 500-749g	3					
765.03	Extreme immatur 750-999g	3					
780.62	Postprocedural fever	3					
780.66	Feb nonhemo transf react	3					
781.7	Tetany	3	06				
785.4	Gangrene	3	10,11				
785.51	Cardiogenic shock	3	14				
785.52	Septic shock	3					
785.59	Shock w/o trauma NEC	3					
793.19	Ot nonsp ab fnd lung fld	3	15				
799.1	Respiratory arrest	3	15				

SECTION 7: COMORBID CONDITIONS AND COMORBIDITY TIER CODE LOOKUP TABLE

ICD9	ICD9CM Label	Tier	RIC Exclusion	Added	Tier Change	Exclusion Change	Label Change
958.0	Air embolism	3	02,03				
958.1	Fat embolism	3	02,03				
958.5	Traumatic anuria	3					
995.90	SIRS, NOS	3					
995.91	Sepsis	3					
995.92	Severe sepsis	3					
995.93	SIRS-noninf w/o ac or ds	3					
995.94	SIRS-noninf w ac org dys	3					
996.02	Malfunc prosth hrt valve	3	14				
996.61	React-cardiac dev/graft	3	14				
996.62	React-oth vasc dev/graft	3					
996.63	React-nerv sys dev/graft	3					
996.66	React-inter joint prost	3	08				
996.67	React-oth int ortho dev	3	09				
996.68	React-periton dialy cath	3	09				
996.69	React-int pros devic NEC	3	09				
997.62	Infection amputat stump	3	09,10,11				
998.00	Postoperative shock, NOS	3					
998.01	Postop shock,cardiogenic	3					
998.02	Postop shock, septic	3					
998.09	Postop shock, other	3					
998.30	Wound disruption NOS	3					
998.31	Disrup internal op wound	3					
998.32	Disrup-external op wound	3					
998.33	Disrpt trauma wound repr	3					
998.51	Infected postop seroma	3					
998.59	Other postop infection	3					
998.6	Persist postop fistula	3					
999.1	Air embol comp med care	3	03				
999.31	Oth/uns inf-cen ven cath	3					
999.32	Blood inf dt cen ven cth	3					
999.33	Lcl inf dt cen ven cth	3					

SECTION 8: IRF-PAI CODING FORM

This section of the manual contains the final version of the IRF-PAI from the IRF PPS FY 2014 final rule. While we have not included the FY 2015 final rule IRF-PAI updates in this iteration of the training manual, we intend to finalize another iteration of this training manual prior to the October 1, 2015 effective date of the IRF-PAI.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0842.** The time required to complete this information collection is estimated to average **54.5 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 _____

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)

15A. Admit From
(01- Home (private home/apt., board/care, assisted living, group home, transitional living); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)

16A. Pre-hospital Living Setting _____
Use codes from 15A. Admit From

17. Pre-hospital Living With _____
(Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)

18. DELETED

19. DELETED

Payer Information*

20. Payment Source
(02 - Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99 - Not Listed)

   A. Primary Source _____

   B. Secondary Source _____

Medical Information*

21. Impairment Group _____ _____
Admission Discharge

Condition requiring admission to rehabilitation; code according to Appendix A.

22. Etiologic Diagnosis A. _____
(*Use ICD codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation*) B. _____ C. _____

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

24. Comorbid Conditions

Use ICD codes to enter comorbid medical conditions

A. _____	J. _____	S. _____
B. _____	K. _____	T. _____
C. _____	L. _____	U. _____
D. _____	M. _____	V. _____
E. _____	N. _____	W. _____
F. _____	O. _____	X. _____
G. _____	P. _____	Y. _____
H. _____	Q. _____	
I. _____	R. _____	

24A. Are there any arthritis conditions recorded in items #21, #22, or #24 that meet all of the regulatory requirements for IRF classification (in 42 CFR 412.29(b)(2)(x), (xi), and (xii))? _____ _____
(0 - No; 1 - Yes)

25. DELETED

26. DELETED

Height and Weight

(While measuring if the number is X.1-X.4 round down, X.5 or greater round up)

25A. Height on admission (in inches) _____

26A. Weight on admission (in pounds) _____
Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)

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. DELETED

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 a 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 31and 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, Wheelchair	☐	☐	☐
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

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

44C. Was the patient discharged alive? _____
(0 - No; 1 - Yes)

44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46)

_____

(01- Home (private home/apt., board/care, assisted living, group home, transitional living); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)

45. Discharge to Living With _____
(Code only if item 44C is 1 - Yes and 44D 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 code)

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

A. _____ B. _____
C. _____ D. _____
E. _____ F. _____

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. © 1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

Therapy Information

O0401. Week 1: Total Number of Minutes Provided

O0401A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402. Week 2: Total Number of Minutes Provided

O0402A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

Quality Indicators- Admission Assessment		Quality Indicators- Discharge Assessment	
	Unhealed Pressure Ulcer(s)- Admission		**Unhealed Pressure Ulcer(s)- Discharge**
Enter Code ☐	**M0210.** Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at Admission? **0. No →** skip to question **I0900 on Admission Assessment** **1. Yes →** continue to question **M0300A on Admission Assessment**	Enter Code ☐	**M0210.** Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge? **0. No→** skip to question **M0900A on Discharge Assessment** **1. Yes →** continue to question **M0300A on Discharge Assessment**
	M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission		**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Discharge**
Enter Number ☐	**M0300A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones it may appear with persistent blue or purple hues. **M0300A1. Number of Stage 1 pressure ulcers:** enter how many were noted at the time of admission	Enter Number ☐	**M0300A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones it may appear with persistent blue or purple hues. **M0300A1.** Enter **total** number of pressure ulcers currently at **Stage 1**. **If patient has no Stage 1 pressure ulcers at discharge, skip to Item M0300B1.**
		Enter Number ☐	**M0300A2.** Of **<u>these</u> Stage 1** pressure ulcers present at discharge, enter number that were: (a) present on admission as a Stage 1 **and** (b) remained at Stage 1 at discharge.
		Enter Number ☐	**M0300A3.** Of **<u>these</u> Stage 1** pressure ulcers, enter the number that were **not present on admission.** (i.e. – New stage 1 pressure ulcers that have developed during the IRF stay)
Enter Number ☐	**M0300B. 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. **M0300B1. Number of Stage 2 pressure ulcers:** enter how many were noted at the time of admission	Enter Number ☐	**M0300B. 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. **M0300B1.** Enter **total** number of pressure ulcers currently at **Stage 2. (If patient has no Stage 2 pressure ulcers at discharge, skip to Item M0300C1.)**
		Enter Number ☐	**M0300B2.** Of **<u>these</u> Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 2 at discharge.
		Enter Number ☐	**M0300B3.** Of **<u>these</u> Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer** due to the presence of a **non-removable device and** (b) when it became stageable, the pressure ulcer was staged as a Stage 2, **and** (c) it remained at Stage 2 at the time of discharge.
		Enter Number ☐	**M0300B4. Of <u>these</u> Stage 2** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay

Quality Indicators- Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
	M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission, Continued		**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage-Discharge, Continued**
	M0300C. 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.		**M0300C. 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.
Enter Number ☐	**M0300C1. Number of Stage 3 pressure ulcers:** enter how many were noted at the time of admission	Enter Number ☐	**M0300C1.** Enter **total** number of pressure ulcers currently at **Stage 3. (If patient has no Stage 3 pressure ulcers at discharge, skip to Item M0300D1.**
		Enter Number ☐	**M0300C2.** Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 3 at discharge.
		Enter Number ☐	**M0300C3.** Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer**, **and** (b) when it became stageable, it was staged as a **Stage 3**; **and** (c) it remained at **Stage 3** at the time of discharge.
		Enter Number ☐	**M0300C4.** Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay; **or** (c) were unstageable due to a non-removeable device at admission, initially became stageable at a lesser stage, , but then progressed to a Stage 3 by the time of discharge.
	M0300D. 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.		**M0300D. 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.
Enter Number ☐	**M0300D1. Number of Stage 4 pressure ulcers:** enter how many were noted at the time of admission	Enter Number ☐	**M0300D1.** Enter **total** number of pressure ulcers currently at **Stage 4. (If patient has no Stage 4 pressure ulcers at discharge, skip to Item M0300E1.)**
		Enter Number ☐	**M0300D2. Of these Stage 4** pressure ulcers present at discharge, enter number that were: (a) present on admission at Stage 4 , **and** (b) remained at Stage 4 at discharge.
		Enter Number ☐	**M0300D3. Of these Stage 4** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer**, **and** (b) when it became stageable, it was staged as a **Stage 4**, **and** (c) it remained at **Stage 4** at the time of discharge.
		Enter Number ☐	**M0300D4. Of these Stage 4** pressure ulcers present at discharge, enter the number that were: (a) not present on admission); **or** (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge; **or** (c) were unstageable on admission, initially became stageable at a lesser stage, and then progressed to a Stage 4 by the time of discharge.

Quality Indicators-Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
	M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device: Known but not stageable due to the presence of a non-removable dressing/device.		**M0300E. Unstageable Pressure Ulcers due to a non-removable dressing or device:** pressure ulcers that are known but not stageable due to the presence of a non-removable dressing or device.
Enter Number ☐	**M0300E1. Number of unstageable pressure ulcers due to non-removable dressing/device**: enter how many were noted at the time of admission	Enter Number ☐	**M0300E1.** Enter **total** number of pressure ulcers currently **Unstageable** due to a **Non-removable dressing or device. (If patient has no pressure ulcers Unstageable due to Non-Removable Device at discharge, skip to Item M0300F1.)**
		Enter Number ☐	**M0300E2.** Of **<u>these</u> Unstageable** pressure ulcers due to a **non-removable dressing or device** present at discharge**,** enter number that were:(a) present on admission as an unstageable pressure ulcer due to **non-removable dressing or device; and** (b) remained unstageable due to **non-removable dressing or device** until discharge.
		Enter Number ☐	**M0300E3. Of <u>these</u> Unstageable** pressure ulcers due to **non-removable dressing or device** present at discharge**,** enter number that were (a) present on admission as a stageable pressure ulcer **and** became **unstageable due to non-removable dressing or device** during the IRF stay; and (b) remained unstageable due to a **non-removable dressing or device** until discharge.
	M0300F. Unstageable Pressure Ulcers due to slough and/or eschar: pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar.		**M0300F. Unstageable Pressure Ulcers due to slough or eschar:** pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar.
Enter Number ☐	**M0300F1. Number of unstageable pressure ulcers due to slough and/ or eschar**: enter how many were noted at the time of admission	Enter Number ☐	**M0300F1.** Enter **total** number of pressure ulcers currently **Unstageable** due to a **Slough and/or Eschar. (If patient has no pressure ulcers Unstageable due to Slough and/or Eschar at discharge, skip to Item M0300G1.)**
		Enter Number ☐	**M0300F2. Of <u>these</u> Unstageable** pressure ulcers due to **slough and/or eschar** present at discharge, enter number that were: (a) present on admission as an unstageable pressure ulcer due to **slough and/or eschar**; **and** (b) remained unstageable due to **slough and/or eschar** until discharge.
		Enter Number ☐	**M0300F3. Of <u>these</u> Unstageable** pressure ulcers due to **slough or eschar** present at discharge**,** enter number that were: (a) present on admission as a stageable pressure ulcer **and** became unstageable due to **slough and/or eschar,** during the IRF stay; **and** (b) remained unstageable due to **slough and/or eschar** until discharge.
	M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution: suspected deep tissue injury in evolution.		**M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution:** suspected deep tissue injury in evolution.
Enter Number ☐	**M0300G1. Number of unstageable pressure ulcers with Suspected Deep Tissue Injury in evolution:** enter how many were noted at the time of admission	Enter Number ☐	**M0300G1.** Enter **total** number of **unstageable pressure ulcers with Suspected Deep Tissue Injury**. (**If patient has no Unstageable pressure ulcers with Suspected Deep Tissue Injury at discharge, skip to Item M0900A.)**
		Enter Number ☐	**M0300G2. Of <u>these</u> unstageable pressure ulcers with Suspected DTI** present at discharge**,** enter number that were:(a) present on admission as an unstageable pressure ulcer due to a **suspected deep tissue injury**; **and** (b) remained unstageable due to a **suspected DTI** until discharge.

Quality Indicators- Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
	I0900. Pressure Ulcer Risk Conditions- Admission		**M0900. Healed Pressure Ulcers- Discharge**
	Indicate below if the patient has any of the following pressure ulcer risk conditions: (**NOTE:** You must also document the appropriate ICD codes for any pressure ulcer risk conditions documented below in Item 24 "Comorbid Conditions" above.)		Indicate the number of pressure ulcers that were: (a) present on **Admission**; **and** (b) have completely closed (resurfaced with epithelium) upon **Discharge.** If there are no healed pressure ulcers noted at a given stage, enter 0.
Enter Number ☐	**I0900A**. Peripheral Vascular Disease (PVD) 0. No 1. Yes	Enter Number ☐	**M0900A.** Stage 1
Enter Number ☐	**I0900B.** Peripheral Arterial Disease(PAD) 0. No 1. Yes	Enter Number ☐	**M0900B.** Stage 2
Enter Number ☐	**I2900A.** Diabetes Mellitus (DM) ***If I2900A = 0, skip I2900B-D*** 0. No 1. Yes	Enter Number ☐	**M0900C.** Stage 3
Enter Number ☐	**I2900B.** Diabetic Retinopathy 0. No 1. Yes	Enter Number ☐	**M0900D.** Stage 4
Enter Number ☐	**I2900C.** Diabetic Nephropathy 0. No 1. Yes		
Enter Number ☐	**I2900D.** Diabetic Neuropathy 0. No 1. Yes		
			O0250. Influenza Vaccine – Discharge - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.
		Enter Code ☐	**O0250A.** Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza *vaccination* season? **0. No →** Skip to O0250C, If influenza vaccine not received, state reason **1. Yes →** Continue to O0250B, Date influenza vaccine received
			O0250B. Date influenza vaccine received → Complete date and skip to Z0400A, Signature of Persons Completing the Assessment ☐☐ ☐☐ ☐☐☐☐ **MM DD YYYY**
		Enter Code ☐	**O0250C. If influenza vaccine not received, state reason:** **1. Patient not in this facility** during this year's influenza vaccination season **2. Received outside of this facility** **3. Not eligible -** medical contraindication **4. Offered and declined** **5. Not offered** **6. Inability to obtain influenza vaccine** due to a declared shortage. **9. None of the above**

Item Z0400A. Signature of Persons Completing the Assessment*			
I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.			
Signature	**Title**	**Date Information is Provided**	**Time**
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

This section of the manual includes two tables that will allow providers to easily identify what items on the IRF-PAI are voluntary and what items are mandatory. Table 1 specifically identifies what **non-quality reporting** IRF-PAI items are voluntary and what items are mandatory. Table 2 illustrates what **quality reporting** IRF-PAI items are voluntary and what items are mandatory. We have italicized the voluntary items on both tables to assist providers in being able to differentiate between the IRF-PAI items more easily.

For questions or concerns regarding the **non-quality** related IRF-PAI items please contact: IRFCoverage@cms.hhs.gov

For questions or concerns regarding the **quality** related IRF-PAI items please contact: IRF.Questions@cms.hhs.gov

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

Table 1. Non-Quality Reporting Items on the IRF-PAI

Note: *Non-Quality voluntary IRF-PAI items are italicized*

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
1A. Facility Name	Mandatory	Required for Payment
1B. Facility Medicare Provider Number	Mandatory	Required for Payment
2. Patient Medicare Number	Mandatory	Required for Payment
3. Patient Medicaid Number	Mandatory	Required for Payment
4. Patient First Name	Mandatory	Required for Payment
5A. Patient Last Name	Mandatory	Required for Payment
6. Birth Date	Mandatory	Required for Payment
7. Social Security Number	Mandatory	Required for Payment
8. Gender	Mandatory	Required for Payment
9. Race/Ethnicity	Mandatory	Required for Payment
10. Marital Status	Mandatory	Required for Payment
11. Zip Code of Patient's Pre-Hospital Residence	Mandatory	Required for Payment
12. Admission Date	Mandatory	Required for Payment
13. Assessment Reference Date	Mandatory	Required for Payment
14. Admission Class	Mandatory	Required for Payment
15A. Admit From	Mandatory	Required for Payment
16A. Pre-Hospital Living Setting	Mandatory	Required for Payment
17. Pre-Hospital Living With	Mandatory	Required for Payment
18. DELETED	DELETED	DELETED
19. DELETED	DELETED	DELETED

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IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
20. Payment Source	Mandatory	Required for Payment
21. Impairment Group	Mandatory	Required for Payment
22. Etiologic Diagnosis	Mandatory	Required for Payment
23. Date of Onset of Impairment	Mandatory	Required for Payment
24. Comorbid Conditions	Mandatory	Required for Payment
25. DELETED	DELETED	DELETED
26. DELETED	DELETED	DELETED
25A. Height on Admission	Mandatory	Required for Payment. Also required in order to calculate the New or Worsened Pressure Ulcer quality measure.
26A. Weight on Admission	Mandatory	Required for Payment. Also required in order to calculate the New or Worsened Pressure Ulcer quality measure.
27. Swallowing Status	*Voluntary*	
28. DELETED	DELETED	DELETED
29. Bladder Level of Assistance (Admission and Discharge)	Mandatory	Required for Payment
30. Bladder Frequency of Accidents (Admission and Discharge)	Mandatory	Required for Payment
31. Bowel Level of Assistance (Admission and Discharge)	Mandatory	Required for Payment
32. Bowel Frequency of Accidents (Admission and Discharge)	Mandatory	Required for Payment
33. Tub Transfer (Admission and Discharge)	Mandatory	Required for Payment
34. Shower Transfer (Admission and Discharge)	Mandatory	Required for Payment

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
35. Distance Walked (Admission and Discharge)	Mandatory	Required for Payment
36. Distance Traveled in Wheelchair (Admission and Discharge)	Mandatory	Required for Payment
37. Walk (Admission and Discharge)	Mandatory	Required for Payment
38. Wheelchair (Admission and Discharge)	Mandatory	Required for Payment
39. Self-Care, Sphincter Control, Transfers, Locomotion, Communication, Social Cognition (Admission and Discharge)	Mandatory	Required for Payment
39. Self-Care, Sphincter Control, Transfers, Locomotion, Communication, Social Cognition (Goals)	*Voluntary*	
40. Discharge Date	Mandatory	Required for Payment
41. Patient Discharged Against Medical Advice	Mandatory	Required for Payment
42. Program Interruption(s)	Mandatory	Required for Payment
43. Program Interruption Dates	Mandatory	Required for Payment
44C. Was the Patient Discharged Alive	Mandatory	Required for Payment
44D. Patient's Discharge Destination/Living Setting	Mandatory	Required for Payment
45. Discharge to Living With	Mandatory	Required for Payment
46. Diagnosis for Interruption or Death	Mandatory	Required for Payment

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
47. Complications During Rehabilitation Stay	Mandatory	Required for Payment

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

Table 2. Quality Reporting Items on the IRF-PAI -Admission Items

Note: *Quality voluntary IRF-PAI items are italicized*

IRF-PAI Item (Admission)	Mandatory or Voluntary[1]	Rationale for Mandatory Status
25A. Height on admission (in inches)	Mandatory	Required in order to risk adjust the New or Worsened Pressure Ulcer quality measure.
26A. Weight on admission (in pounds)	Mandatory	Required in order to risk adjust the New or Worsened Pressure Ulcer quality measure.
M0210. **Unhealed Pressure Ulcer(s) - Admission** Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at **Admission**?	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
*M0300A1. **Number of Stage 1 pressure ulcers***	*Voluntary*	
M0300B1. **Number of Stage 2 pressure ulcers**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
M0300C1. **Number of Stage 3 pressure ulcers**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
M0300D1. **Number of Stage 4 Pressure Ulcers**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
*M0300E1. **Number of unstageable pressure ulcers due to non-removable dressing/device***	*Voluntary*	
*M0300F1. **Number of unstagable pressure ulcers due to slough and/or eschar***	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

M0300G1. ***Number of unstageable pressure ulcers with suspected Deep Tissue Injury (DTI) in evolution***	*Voluntary*	
I0900A. Peripheral Vascular Disease (PVD)	Mandatory	Required in order to risk adjust the New or Worsened Pressure Ulcer quality measure.
I0900B. Peripheral Arterial Disease (PAD)	Mandatory	Required in order to risk adjust the New or Worsened Pressure Ulcer quality measure.
I2900A. Diabetes Mellitus (DM)	Mandatory	Required in order to risk adjust the New or Worsened Pressure Ulcer quality measure.
I2900B. Diabetic Retinopathy	*Voluntary*	
I2900C. Diabetic Nephropathy	*Voluntary*	
I2900D. Diabetes Neuropathy	*Voluntary*	
M0210. **Unhealed Pressure Ulcer(s) - Discharge** Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge?	Mandatory	Required in order to calculate the New or Worsened Pressure Ulcer quality measure.

[1] If the facility does not wish to submit information for a voluntary item, a value of an equal sign "=" can be submitted

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
M0210. **Unhealed Pressure Ulcer(s) - Discharge** Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge?	Mandatory	Required in order to calculate the New or Worsened Pressure Ulcer quality measure.
*M0300A1. Enter **total** number of pressure ulcers currently at Stage 1.*	*Voluntary*	
*M0300A2. Of **these** **Stage 1** pressure ulcers present at discharge, enter number that were: (a) present on admission as a Stage 1 **and** (b) remained at Stage 1 at discharge.*	*Voluntary*	
*M0300A3. Of **these** **Stage 1** pressure ulcers, enter the number that were **not present on admission.** (i.e. – New stage 1 pressure ulcers that have developed during the IRF stay)*	*Voluntary*	
M0300B1. Enter **total** number of pressure ulcers currently at **Stage 2.**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
*M0300B2. Of **these** **Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 2 at discharge.*	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300B3. Of **these** **Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer** due to the presence of a **non-removable device and** (b) when it became stageable, the pressure ulcer was staged as a Stage 2, **and** (c) it remained at Stage 2 at the time of discharge.*	*Voluntary*	
M0300B4**. Of these Stage 2** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay	Mandatory	Required in order to calculate the New or Worsened Pressure Ulcer quality measure.
M0300C1**.** Enter **total** number of pressure ulcers currently at **Stage 3.**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
*M0300C2. Of **these** **Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 3 at discharge.*	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300C3. **Of <u>these</u> Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer**, **and** (b) when it became stageable, it was staged as a **Stage 3**; **and** (c) it remained at **Stage 3** at the time of discharge.*	*Voluntary*	
M0300C4. **Of <u>these</u> Stage 3** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay; **or** (c) were unstageable due to a non-removable device at admission, initially became stageable at a lesser stage, but then progressed to a Stage 3 by the time of discharge.	Mandatory	Required in order to calculate the New or Worsened Pressure Ulcer quality measure.
M0300D1. Enter **total** number of pressure ulcers currently at **Stage 4.**	Mandatory	Required in order to validate the New or Worsened Pressure Ulcer quality measure.
*M0300D2. **Of <u>these</u> Stage 4** pressure ulcers present at discharge, enter number that were: (a) present on admission at Stage 4, **and** (b) remained at Stage 4 at discharge.*	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300D3. **Of <u>these</u> Stage 4** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an unstageable pressure ulcer, **and** (b) when it became stageable, it was staged as a **Stage 4**, **and** (c) it remained at **Stage 4** at the time of discharge.*	*Voluntary*	
M0300D4. **Of <u>these</u> Stage 4** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge; **or** (c) were unstageable on admission, initially became stageable at a lesser stage, and then progressed to a Stage 4 by the time of discharge.	Mandatory	Required in order to calculate the New or Worsened Pressure Ulcer quality measure.
*M0300E1. Enter **total** number of pressure ulcers currently **Unstageable** due to a **Non-removable dressing or device.***	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300E2. Of **these** **Unstageable** pressure ulcers due to a **non-removable dressing or device** present at discharge, enter number that were:(a) present on admission as an unstageable pressure ulcer due to **non-removable dressing or device; and** (b) remained unstageable due to **non-removable dressing or device** until discharge.*	*Voluntary*	
*M0300E3. **Of these** **Unstageable** pressure ulcers due to **non-removable dressing or device** present at discharge, enter number that were (a) present on admission as a stageable pressure ulcer **and** became unstageable due to **non-removable dressing or device** during the IRF stay; **and** (b) remained unstageable due to a **non-removable dressing or device** until discharge.*	*Voluntary*	
*M0300F1. Enter **total** number of pressure ulcers currently **Unstageable** due to a **Slough and/or Eschar***	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300F2**. Of <u>these</u> Unstageable** *pressure ulcers due to **slough and/or eschar** present at discharge, enter number that were: (a) present on admission as an unstageable pressure ulcer due to **slough and/or eschar**; **and** (b) remained unstageable due to **slough and/or eschar** until discharge.*	*Voluntary*	
*M0300F3. **Of <u>these</u> Unstageable** pressure ulcers due to **slough or eschar** present at discharge**,** enter number that were: (a) present on admission as a stageable pressure ulcer; **and** became unstageable due to **slough and/or eschar** during the IRF stay; **and** (b) remained unstageable due to **slough and/or eschar** until discharge.*	*Voluntary*	
*M0300G1. Enter **total** number of **unstageable pressure ulcers with Suspected Deep Tissue Injury (DTI) in evolution**.*	*Voluntary*	

SECTION 9: VOLUNTARY/MANDATORY IRF-PAI ITEMS

IRF-PAI Item	Mandatory or Voluntary	Rationale for Mandatory Status
*M0300G2**. Of <u>these</u> unstageable pressure ulcers with suspected DTI** present at discharge**,** enter number that were:**(a)** present on admission as an unstageable pressure ulcer due to a **suspected deep tissue injury**; **and** (b) remained unstageable due to a **suspected DTI** until discharge.*	*Voluntary*	
*M0900A-D. Indicate the number of pressure ulcers that were: (a) present on **Admission**: **and** (b) have completely closed (resurfaced with epithelium) upon **Discharge.** If there are no healed pressure ulcers noted at a given stage, enter 0.*	*Voluntary*	
O0250A. Did the **patient receive the influenza vaccine** *in this facility* for this year's influenza *vaccination* season?	Mandatory	Required in order to calculate the Patient Influenza Vaccination quality measure.
O0250B. **Date influenza vaccine received**	Mandatory	Required in order to validate the Patient Influenza Vaccination quality measure.
O0250C. **If influenza vaccine not received, state reason**: 1- 9	Mandatory	Required in order to calculate the Patient Influenza Vaccination quality measure.

SECTION 10: 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.

ON ADMISSION, the functional assessment 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.

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 total 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.

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 total assistance from nursing for changing of linen and clothing.

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.

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.

SECTION 10: SAMPLE CASE STUDIES

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.
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.

SECTION 10: SAMPLE CASE STUDIES

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.
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.

SECTION 10: SAMPLE CASE STUDIES

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.

ON ADMISSION, the functional assessment 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.

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. Mr. H relies totally on nursing staff to change after each accident.

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.

AT DISCHARGE, the functional assessment is as follows:

Eating

SECTION 10: SAMPLE CASE STUDIES

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. Mr. H relies totally on nursing staff to change after each accident.

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.

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

SECTION 10: SAMPLE CASE STUDIES

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.

SECTION 10: SAMPLE CASE STUDIES

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.

SECTION 10: SAMPLE CASE STUDIES

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.

SECTION 11: CLARIFICATION OF TERMINOLOGY

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 ICF).

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.

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.

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

SECTION 11: CLARIFICATION OF TERMINOLOGY

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 back); may be performed in a tub, shower, or sponge/bed bath.

Benchmarking - Measuring products and services for comparison.

Bladder Accidents – the act of the patient 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 the patient 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.

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.

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), board and care, assisted living, group home, or transitional living.

Comorbidity - A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF. The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' treatment for their primary diagnosis.

Complete Dependence - Reflected in the flow chart and explanations per each activity.

Complete Independence - Reflected in the flow chart and explanations per each activity.

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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).

Contact Guard - Placing one hand on the patient to ensure the patient's safety.

Cueing - A gesture, facial expression, verbal instruction, or reminder provided to the patient just before or during the performance of an activity.

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.

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.

Etiologic Diagnosis: Enter the ICD code to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Section 6 of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive.

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Consult with health information management staff and current ICD coding books for exact codes.

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.

Falls - Unintentionally coming to rest on the ground, floor, or other surface.

Far/Distant Supervision - The patient 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 patient neither shaves nor applies make-up, Grooming includes only the first four tasks.

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 patient that is discharged from the IRF and returns to the same IRF within 3 consecutive calendar days. Since Medicare treats this situation as one combined IRF stay, the IRF would not need to repeat all of the required documentation when the patient returns to the IRF after the interruption. However, we would expect the IRF to update the information in the patient's medical record to make sure that it is current (i.e., update the patient's condition, comorbidities, rehabilitation goals, plan of care, etc.). Of course, the patient must continue to meet the criteria for admission to an IRF, and all of the elements required during the patient's stay (such as the 3 physician visits per week,

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the weekly interdisciplinary team meetings, etc.) must all continue to take place. If the patient returns to the IRF in 4 or more consecutive days (that is, it is not considered an interrupted stay), then all of the required documentation must be completed as with any "new" IRF patient.

Length of Stay (LOS) - The number of days a patient spends in the rehabilitation program. The day of discharge is not counted in the length of stay calculation

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 - Reflected in the flow chart and explanations per each activity.

Medicaid - A joint Federal and State program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare - Medicare is the Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

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 - Reflected in the flow chart and explanations per each activity.

Moderate Assistance - Reflected in the flow chart and explanations per each activity.

Modified Dependence - Reflected in the flow chart and explanations per each activity.

Modified Independence - Reflected in the flow chart and explanations per each activity.

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*;

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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.

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 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 ICF).

Patient Assessment Instrument - A document that contains clinical, demographic, and other information on a patient.

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 and effectiveness 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.

Readmission - A patient's readmission to any rehabilitation program.

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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, defined as the FIM™ items Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, and Toileting.

Setup - Assistance with preparation before the patient performs an activity (prior preparation), or removal and disposal of equipment/materials after the patient 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. talking while sitting) 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 patient.

Supervision or **Setup** - Reflected in the flow chart and explanations per each activity.

Toileting - Includes the safe and timely maintainence of perineal hygiene and adjusting clothing before and after toilet, commode, bedpan or urinal use.

Total Assistance - Reflected in the flow chart and explanations per each activity.

Transfer (In the case of a short stay transfer policy) - The release of a Medicare inpatient from one inpatient rehabilitation facility to another inpatient rehabilitation facility, an

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acute care hospital, a long-term care hospital, a skilled nursing facility or a nursing facility that qualifies to receive Medicare or Medicaid payments.

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.

Transfers: Toilet - Includes getting on and off a toilet.

Transfers: Tub or Shower - Includes getting in and out of a tub or shower stall.

Typical Case- Patients who stay more than 3 days, receive a full course of inpatient rehabilitation care and are discharged to the community.

Validity- The degree to which a measurement instrument measures what it is intended to measure.

Visual Cue- Any visible gesture, posture, signage or facial expression used to aid in the performance of a task.

Weak cough and difficulty clearing airway secretions – The patient reports 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.

Week- A week is a 7 consecutive calendar day period starting with the day of admission.

CODING THE CMS PATIENT DATA SYSTEM

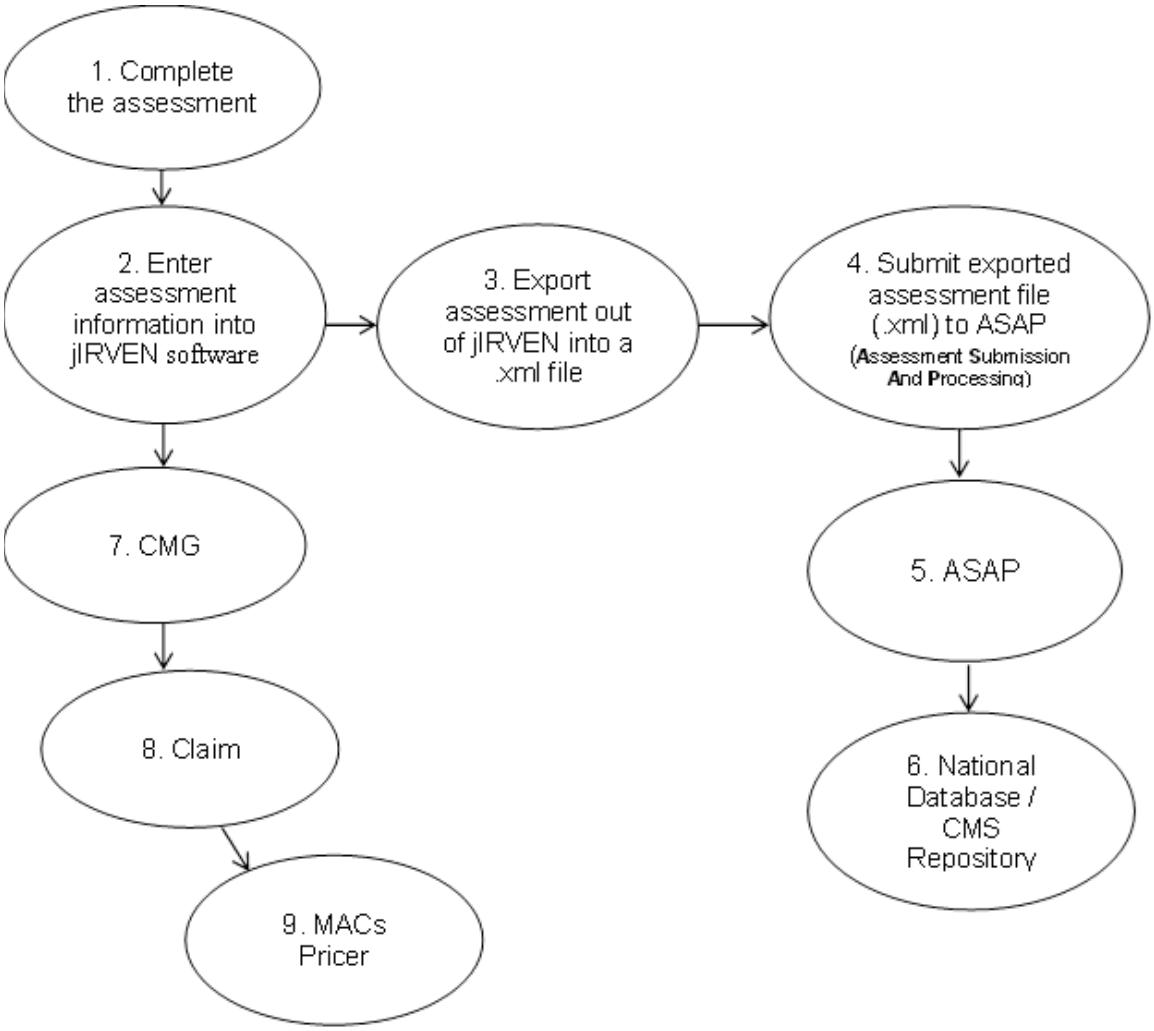
CODING FORMS

The input software for payment, jIRVEN, uses the IRF-PAI instrument on a question by question basis. Therefore, it is critical to complete the questions on the IRF-PAI carefully and accurately. All questions must be answered, except those that are specifically identified as voluntary (see Section 9 of this manual for reference). As shown in the jIRVEN data flow diagram on the next page, patient data are collected within the facility and entered into the software. These data are used for payment purposes and quality reporting. In addition, the data will be used to develop an analytical database for monitoring and assessing implementation of the IRF prospective payment system.

CMS PATIENT DATA SYSTEM FLOW

jIRVEN software is a computer program available to all IRFs and can be downloaded free of charge from the CMS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html. The diagram on the next page illustrates the role of jIRVEN software in the flow of data within an IRF.

CMS PATIENT DATA SYSTEM FLOW



The above diagram depicts the following steps:

1. Complete the assessment.

2. Enter assessment information into the jIRVEN software.

3. Export the assessment out of jIRVEN into a .xml file.

4. Submit the exported assessment file from step 3 to the Assessment Submission And Processing system (ASAP).

5 and 6. Once accepted by ASAP, the data will reside in the National Database/CMS Repository.

7. After entering in the (discharge) assessment information into the jIRVEN software (step 2), you can obtain the CMG value.

8. The IRF submits a Medicare claim.

9. The MAC processes the claim through it's software system that includes pricing programming called the "Pricer" software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data to adjust the IRF's prospective payment.

SECTION 13: PATIENT PRIVACY AND PRIVACY RIGHTS UNDER THE IRF PPS

Included in this section of the manual are the following documents:

- Privacy Act Statement- Health Care Records (**English**)
- Data Collection Information Summary for Patients in IRFs (**English**)
- Privacy Act Statement- Health Care Records (**Spanish**)
- Data Collection Information Summary for Patients in IRFs (**Spanish**)

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 (IRF) 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 IRF must use the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-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.

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 (MAC)) 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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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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DECLARACIÓN DE LA LEY DE PRIVACIDAD – EXPEDIENTES MÉDICOS
Esta declaración es una notificación sobre la recolección de información requerida por la sección 552a(e)(3) de la Ley de Privacidad de 1974.
Esta declaración no es una autorización. No se utilizará para divulgar o para usar su información médica.

I. La sección 1886(j)(2)(D) de la Ley del Seguro Social autoriza a la Secretaría a recopilar la información necesaria para establecer y administrar el Sistema de Pago (PPS en inglés) de los Centros de Rehabilitación para Pacientes Internos (IRF en inglés).

Los centros de rehabilitación para pacientes internos que participan en Medicare deben hacer una evaluación completa que refleje con precisión su condición clínica actual e incluir información que pueda usarse para demostrar su progreso hacia las metas de rehabilitación. El centro de rehabilitación para pacientes internos debe usar el Instrumento de Evaluación del Paciente en Centros de Rehabilitación para Pacientes Internos - (IRF-PAI en inglés), cuando se evalúa su condición clínica. El IRF-PAI debe usarse para evaluar a cada paciente internado bajo la Parte A (pago por servicio), la Parte C (Medicare Advantage) y podría usarse para evaluar a otros tipos de pacientes internados. Esta información se presentará a los Centros de Servicios de Medicare y Medicaid (CMS en inglés) para garantizar que se les pague correctamente a los IRF por los servicios que le proveyeron y para ayudar a determinar si los centros cumplen los estándares de calidad y ofrecen a sus pacientes el cuidado apropiado.

CMS guardará los datos de IRF-PAI en el sistema de expedientes. El sistema limita el acceso a las personas autorizadas y controladores que vigilan el uso no autorizado de la información o la divulgación de la misma. El sistema se ajusta a las leyes federales aplicables y reglamentaciones, así como a las disposiciones y estándares del gobierno federal, del Departamento de Salud y Servicios Humanos (HHS) y de CMS relacionadas con la seguridad y confidencialidad de la información. Las leyes y reglamentaciones aplicables incluyen, pero no se limitan a: la Ley de Privacidad de 1974; La Ley Federal de Control de la Seguridad de la Información de 2002; la Ley de Fraude y Abuso por Computadora de 1986; de la Ley de Transferencia y Responsabilidad del Seguro Médico de 1996; la Ley de Servicios Gubernamentales Electrónicos (*E- Government*) de 2002; la Ley Clinger-Cohen de 1996; la Ley de Modernización de Medicare de 2003; y las reglamentaciones para aplicarlas.

Si lo desea, usted puede negarse a proveerle al IRF la información para la evaluación. Sin embargo, la misma es importante para garantizar que los IRF reciban el pago correcto por los servicios que le brindaron, que cumplan con los estándares de calidad y le brinden la atención médica que usted necesita. Esperamos que coopere con el IRF brindándole la información solicitada. Tal y como lo explicamos abajo, cualquier información que le provea al gobierno federal a través de esta evaluación, estará protegida por la Ley de Privacidad de 1974 según lo indicado por el Aviso del Sistema de Expedientes IRF-PAI. Además, usted tiene el derecho de ver, copiar, revisar y solicitar la corrección de su información médica personal incorrecta o incompleta en el Sistema de Expedientes IRF-PAI.

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II. PROPÓSITO PRINCIPAL PARA EL CUAL SE USARÁ SU INFORMACIÓN

La información recopilada se entrará en el Sistema IRF-PAI Número 09-70-0521. La información se usará principalmente para respaldar el sistema de pagos IRF PPS por los servicio de la Parte A de Medicare brindados por el IRF a los beneficiarios de Medicare. La información también puede usarse o divulgarse para otros asuntos relacionados con el propósito principal para el cual se solicitó la información. A estos usos adicionales se les conoce como "usos de rutina" y se los analizará en detalle a continuación.

III. USOS DE RUTINA

Estos "usos de rutina" especifican las circunstancias en las que los Centros de Servicios de Medicare y Medicaid podrían divulgar su información del Sistema de Expedientes IRF-PAI sin su consentimiento. Antes de recibir su información para estos "usos de rutina", cada destinatario potencial debe garantizar por escrito la continuación de la confidencialidad y la seguridad de su información. La divulgación de la información de salud protegida autorizada para estos usos de rutina podrían hacerse sólo si, y como lo permitan o lo requieran los 'Estándares de Privacidad para la Información de Salud Identificable Individualmente' (45CFR Partes 160 y 164 a la que se le conoce como "Norma de Privacidad de HIPAA"). La divulgación de la información podría ser para:

1. Brindar apoyo a los contratistas, consultores o donatarios utilizados por la agencia para proveer algún servicio relacionado con el Sistema de Expedientes y que para realizar dicha actividad, deben tener acceso a la información.

2. Para ayudar a las Organizaciones para Mejoras de la Calidad (QIO en inglés) en la revisión de las reclamaciones, o actividades relacionadas con estudios u otras revisiones de la Parte B, estipuladas en el Título XI de la Ley, y actividades para establecer y mantener la elegibilidad de las personas para los beneficios de Medicare o de los planes médicos.

3. Para asistir a otra agencia federal y/o estatal, una agencia de un gobierno estatal, una agencia establecida por una ley estatal o su agente fiscal a:

    a. Contribuir al pago correcto de CMS de los beneficios de Medicare;
    b. Permitir que dicha agencia o agente administre el programa federal de beneficios de salud o, cuando sea necesario, para permitir que esta agencia cumpla con un requisito de un estatuto o reglamentación federal que implementa un programa de beneficios de salud subvencionado en forma parcial o total con fondos federales, o
    c. Mejorar el proceso de encuesta estatal para la investigación de quejas relacionadas con la salud, seguridad o calidad de los servicios y para implementar una encuesta de opinión orientada a los resultados y un programa de certificación.

4. A una persona u organización para una investigación, evaluación o proyectos epidemiológicos relacionados a la prevención de enfermedades o discapacidades, el restablecimiento o el mantenimiento de la salud o para comprender y mejorar los proyectos de pagos.

5. Para apoyar al Departamento de Justicia (DOJ en inglés), tribunal o cuerpo judicial cuando:

   a. La agencia o cualquiera de sus componentes; o
   b. Cualquier empleado de la agencia en su capacidad oficial; o
   c. Cualquier empleado de la agencia en su capacidad individual donde el empleado sea representado por DOJ; o
   d. El Gobierno de los Estados Unidos; es una de las partes del litigio o tiene un interés en este litigio y mediante una revisión cuidadosa, CMS determina que los expedientes son relevantes y necesarios al litigio y el uso de estos expedientes por el DOJ, el tribunal o el cuerpo judicial es compatible con el propósito para el cual la agencia recopiló los expedientes.

6. Para ayudar a un contratista de CMS (incluyendo, pero no necesariamente limitado a los intermediarios fiscales y agencias de seguros) que asiste en la administración de un programa de beneficios de salud administrado por CMS o a un beneficiario o a un programa de beneficiarios administrado por CMS, cuando la divulgación se considera razonablemente necesaria por CMS para prevenir, impedir, descubrir, detectar, investigar, examinar, enjuiciar, demandar con respecto a, defender contra, corregir, remediar, o combatir el fraude y el abuso en estos programas.

7. Apoyar a otra agencia federal o a una agencia de cualquier jurisdicción gubernamental dentro o bajo el control de los Estados Unidos (entre ellas, cualquier agencia gubernamental estatal o local) que administre, o que tenga la autoridad para investigar el posible fraude o abuso total o parcial a los fondos federales, cuando la divulgación se considera razonablemente necesaria por CMS para prevenir, impedir, descubrir, detectar, investigar, examinar, enjuiciar, demandar con respecto a, defender contra, corregir, remediar, o combatir el fraude y el abuso en estos programas.

8. Asistir a una organización nacional acreditada que ha sido aprobada como la autoridad para considerar los requisitos de Medicare para servicios de rehabilitación para pacientes internos (éstas son, la Comisión Conjunta para la Acreditación de Organizaciones al Cuidado de la Salud, la Asociación Americana de Osteopatía y la Comisión para la Acreditación de Instalaciones de Rehabilitación).
   La información se divulgará a estas organizaciones sólo para aquellos centros que participen en Medicare por estar acreditados y aún así, solamente si cumplen los requisitos siguientes:

a. Proporcionen información identificable para los IRF acreditados por la organización que lo requiera.
b. Presenten un expediente que identifique a los pacientes/beneficiarios que reciban servicios de IRF;
c. Protejan la confidencialidad de la información y eviten el acceso no autorizado; y
d. Hayan firmado un acuerdo de intercambio o acuerdo de utilización de la información de CMS.

9. Para ayudar a las compañías de seguros, administradores de terceros (TPA en inglés), empleadores, compañías de seguros por cuenta propia, compañías de seguros no coordinadoras, fideicomisos de empleadores múltiples, planes de salud grupales (por ejemplo, Organizaciones para el Mantenimiento de la Salud (HMO en inglés) o un Plan Médico Competitivo (CMP en inglés) que tenga un contrato con Medicare, o un plan médico prepagado aprobado por Medicare (HCPP en inglés), directamente o a través de un contratista, y otros grupos que proveen protección a los miembros del plan. La información divulgada se limita exclusivamente a aquella autorizada por Medicare. Para recibirla, deben:

   a. Certificar que la persona sobre la cual se provee información es uno de sus asegurados o empleados, y que está asegurada y/o empleada por otra entidad para la cual ellos rinden servicio como un administrador de terceros;
   b. Utilizar la información sólo para propósitos de procesar las reclamaciones de seguros del individuo; y
   c. Proteger la confidencialidad de la información y prevenir el acceso no autorizado.

10. A las agencias federales apropiadas, funcionarios de Ministerios y sus contratistas y a los contratistas de CMS para responder a la sospecha o confirmación de una violación a la seguridad o confidencialidad de la información del Sistema de Expedientes.

IV. LAS CONSECUENCIAS SI DECIDE NO PROVEER LA INFORMACIÓN

El IRF necesita la información del Sistema IRF-PAI para cumplir las normas de Medicare. Su centro para la rehabilitación para pacientes internos también usará el IRF-PAI para brindarle cuidado de calidad. Es importante que la información esté correcta para evitar errores en los pagos. La información incorrecta también podría hacer más difícil la evaluación de la calidad de los servicios provistos por el centro. Si bien esta información es importante, no hay una ley federal en la que pueda ampararse su IRF para negarle servicios si usted decide no proporcionar la información solicitada.

INFORMACIÓN DE CONTACTO

Si desea que CMS vea, revise, copie o corrija la información incorrecta o incompleta sobre su salud que consta en el Sistema de Expedientes IRF-PAI: Llame gratis al 1-800-MEDICARE si necesita ayuda para comunicarse con el Gerente de Sistema de Expedientes IRF-PAI. Los usuarios de TTY deben llamar al 1-800-820-1202.

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Resumen de Información de Recopilación de Datos para Pacientes en Centros de Rehabilitación para Pacientes Internos

Este aviso es un resumen en lenguaje simplificado de la información que aparece en el documento adjunto "Declaración de la Ley de Privacidad-Informes de Cuidado de la Salud"

Como paciente interno de rehabilitación en un hospital, usted tienen los siguientes derechos de privacidad:

- **Usted tiene el derecho de saber por qué necesitamos hacer preguntas.**

  - Se nos requiere por ley federal recopilar información de salud para asegurarnos que:
    1) usted obtiene cuidado de salud de calidad, y
    2) el pago para los pacientes de Medicare esté correcto.

- **Usted tiene el derecho de mantener la información del cuidado personal de su salud en confidencialidad y seguridad.**

  - Le pediremos información sobre usted para poder proveerle los servicios apropiados y completos.
  - Mantendremos la información que nos brinda en confidencialidad y seguridad. Esto significa que sólo podrán verla aquellos que tienen permiso legal para usar u obtener la información recopilada durante esta evaluación.

- **Usted tiene el derecho de negarse a responder a las preguntas.**

  - Usted no tiene que responder a ninguna pregunta para obtener servicios.

- **Usted tiene el derecho de ver su información de salud personal.**

  - Sabemos cuán importante es que la información que recopilemos sobre usted esté correcta.
  - Podría pedir revisar la información que usted proveyó. Si considera que hemos cometido un error, puede pedirnos una corrección.

Además, podría pedir a los Centros de Servicios de Medicare y Medicaid ver, revisar, copiar o solicitar correciones de información de salud personal perdida o incorrecta que esta agencia federal mantiene en su Sistema de Informes IRF-PAI. Para INFORMACIÓN DE CONTACTO o una descripción detallada de sus derechos de privacidad, refiérase a la DECLARACIÓN DE LA LEY DE PRIVACIDAD- INFORMES DE CUIDADO DE LA SALUD adjuntos.
Nota: Los derechos en la lista anterior están de acuerdo con los derechos en la lista de las condiciones de participación del hospital y los derechos establecidos según la Norma Federal de Privacidad.

This is a Medicare & Medicaid Approved Notice.

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