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 **45 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.

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*

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

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

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

7. Social Security Number _____

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

9. Race/Ethnicity *(Check all that apply)*

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

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

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

Admission Information*

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

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

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

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

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

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

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

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

Paver Information*

20. Payment Source
    A. Primary Source _____

    B. Secondary Source _____

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

Medical Information*

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

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

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

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

    A. _____ B. _____

    C. _____ D. _____

    E. _____ F. _____

    G. _____ H. _____

    I. _____ J. _____

Medical Needs

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

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

27. Swallowing Status _____ _____
    Admission Discharge

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

28. Clinical signs of dehydration _____ _____
    Admission Discharge

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

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Function Modifiers*

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

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

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

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

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

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

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

	ADMISSION	DISCHARGE
33. Tub Transfer		
34. Shower Transfer		

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

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

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

	ADMISSION	DISCHARGE
37. Walk		
38. Wheelchair		

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

39. FIM™ Instrument*

	ADMISSION	DISCHARGE	GOAL
SELF-CARE			
A. Eating			
B. Grooming			
C. Bathing			
D. Dressing - Upper			
E. Dressing - Lower			
F. Toileting			
SPHINCTER CONTROL			
G. Bladder			
H. Bowel			
TRANSFERS			
I. Bed, Chair, 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			
SOCIAL COGNITION (V - Vocal; N - Nonvocal; B - Both)			
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

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Discharge Information*

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

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

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

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

A. 1st Interruption Date
MM/ DD /YYYY

B. 1st Return Date
MM / DD / YYYY

C. 2nd Interruption Date
MM / DD / YYYY

D. 2nd Return Date
MM / DD / YYYY

E. 3rd Interruption Date
MM / DD / YYYY

F. 3rd Return Date
MM / DD / YYYY

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

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

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

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

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

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

Quality Indicators

Pressure Ulcers

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

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

Number of Stage 2 pressure ulcers _____ _____
Admission Discharge

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

Number of Stage 3 pressure ulcers _____ _____
Admission Discharge

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

Number of Stage 4 pressure ulcers _____ _____
Admission Discharge

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

49A. Stage 2. Enter Number: _____

49B. Stage 3. Enter Number: _____

49C. Stage 4. Enter Number: _____

Healed Pressure Ulcers.

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

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

50B. Stage 2 Enter Number _____

50C. Stage 3 Enter Number _____

50D. Stage 4 Enter Number _____