

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.

*This statement applies to the 2015 release of the IRF-PAI (version 1.3) and not to any additional burden related to the addition of new data elements added for the purpose of informing CMS' newly adopted measures, which were finalized through the FY 2016 IRF PPS Final Rule, including those quality measures related to the IMPACT Act of 2014.

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*	Payer Information*																											
<p>1. Facility Information</p> <p>A. Facility Name _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5A. Patient Last Name _____</p> <p>5B. Patient Identification Number _____</p> <p>6. Birth Date _____/_____/_____ MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply)</p> <p style="padding-left: 40px;">American Indian or Alaska Native A. _____</p> <p style="padding-left: 100px;">Asian B. _____</p> <p style="padding-left: 40px;">Black or African American C. _____</p> <p style="padding-left: 80px;">Hispanic or Latino D. _____</p> <p style="padding-left: 40px;">Native Hawaiian or Other Pacific Islander E. _____</p> <p style="padding-left: 100px;">White F. _____</p> <p>10. Marital Status _____ (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)</p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p> <p>12. Admission Date _____/_____/_____ MM / DD / YYYY</p> <p>13. Assessment Reference Date _____/_____/_____ MM / DD / YYYY</p> <p>14. Admission Class _____ (1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</p> <p>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)</p> <p>16A. Pre-hospital Living Setting _____ Use codes from 15A. Admit From</p> <p>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)</p> <p>18. DELETED</p> <p>19. DELETED</p>	<p>20. Payment Source _____ (02 - Medicare Fee For Service; 51 - Medicare-Medicare Advantage; 99 - Not Listed)</p> <p>A. Primary Source _____</p> <p>B. Secondary Source _____</p>																											
	Medical Information*																											
	<p>21. Impairment Group _____</p> <p style="text-align: right;">Admission _____ Discharge _____</p> <p>Condition requiring admission to rehabilitation; code according to Appendix A.</p> <p>22. Etiologic Diagnosis _____ A. _____ (Use ICD codes to indicate the etiologic problem B. _____ that led to the condition for which the patient is receiving C. _____ rehabilitation)</p> <p>23. Date of Onset of Impairment _____/_____/_____ MM / DD / YYYY</p> <p>24. Comorbid Conditions _____ Use ICD codes to enter comorbid medical conditions</p> <table style="width: 100%; border: none;"> <tr> <td>A. _____</td> <td>J. _____</td> <td>S. _____</td> </tr> <tr> <td>B. _____</td> <td>K. _____</td> <td>T. _____</td> </tr> <tr> <td>C. _____</td> <td>L. _____</td> <td>U. _____</td> </tr> <tr> <td>D. _____</td> <td>M. _____</td> <td>V. _____</td> </tr> <tr> <td>E. _____</td> <td>N. _____</td> <td>W. _____</td> </tr> <tr> <td>F. _____</td> <td>O. _____</td> <td>X. _____</td> </tr> <tr> <td>G. _____</td> <td>P. _____</td> <td>Y. _____</td> </tr> <tr> <td>H. _____</td> <td>Q. _____</td> <td></td> </tr> <tr> <td>I. _____</td> <td>R. _____</td> <td></td> </tr> </table> <p>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)</p> <p>25. DELETED</p> <p>26. DELETED</p> <p>Height and Weight _____ (While measuring if the number is X.1-X.4 round down, X.5 or greater round up)</p> <p>25A. Height on admission (in inches) _____</p> <p>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.)</p> <p>27. Swallowing Status _____</p> <p style="text-align: right;">Admission _____ Discharge _____</p> <p>3- <u>Regular Food</u>: solids and liquids swallowed safely without supervision or modified food consistency</p> <p>2- <u>Modified Food Consistency/Supervision</u>: subject requires modified food consistency and/or needs supervision for safety</p> <p>1- <u>Tube/Parenteral Feeding</u>: tube/parenteral feeding used wholly or partially as a means of sustenance</p> <p>28. DELETED</p>	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. _____	
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Function Modifiers*			39. FIM™ Instrument*																																																																																																																																																			
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<p>FIM LEVELS</p> <p><i>No Helper</i></p> <p>7 Complete Independence (Timely, Safely)</p> <p>6 Modified Independence (Device)</p> <p><i>Helper - Modified Dependence</i></p> <p>5 Supervision (Subject = 100%)</p> <p>4 Minimal Assistance (Subject = 75% or more)</p> <p>3 Moderate Assistance (Subject = 50% or more)</p> <p><i>Helper - Complete Dependence</i></p> <p>2 Maximal Assistance (Subject = 25% or more)</p> <p>1 Total Assistance (Subject less than 25%)</p> <p>0 Activity does not occur; Use this code only at admission</p>																																																																																																																																																						

* 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.

Discharge Information*	Therapy Information
<p>40. Discharge Date ____/____/____ MM / DD / YYYY</p> <p>41. Patient discharged against medical advice? _____ (0 - No; 1 - Yes)</p> <p>42. Program Interruption(s) _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates (Code only if item 42 is 1 - Yes)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>A. 1st Interruption Date MM / DD / YYYY</p> <p>C. 2nd Interruption Date MM / DD / YYYY</p> <p>E. 3rd Interruption Date MM / DD / YYYY</p> </div> <div style="width: 45%;"> <p>B. 1st Return Date MM / DD / YYYY</p> <p>D. 2nd Return Date MM / DD / YYYY</p> <p>F. 3rd Return Date MM / DD / YYYY</p> </div> </div> <p>44C. Was the patient discharged alive? _____ (0 - No; 1 - Yes)</p> <p>44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46)</p> <p style="margin-left: 20px;"><i>(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)</i></p> <p>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)</p> <p>46. Diagnosis for Interruption or Death _____ (Code using ICD code)</p> <p>47. Complications during rehabilitation stay (Use ICD codes to specify up to six conditions that began with this rehabilitation stay)</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>A. _____</p> <p>C. _____</p> <p>E. _____</p> </div> <div style="width: 45%;"> <p>B. _____</p> <p>D. _____</p> <p>F. _____</p> </div> </div>	<p>O0401. Week 1: Total Number of Minutes Provided</p> <p>O0401A: Physical Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0401B: Occupational Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0401C: Speech-Language Pathology</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0402. Week 2: Total Number of Minutes Provided</p> <p>O0402A: Physical Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0402B: Occupational Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0402C: Speech-Language Pathology</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div>

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INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

QUALITY INDICATORS

ADMISSION

Section B Hearing, Speech, and Vision

BB0700. Expression of Ideas and Wants (3-day assessment period)

- | | |
|---|---|
| Enter Code
<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <p>Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)</p> <p>4. Expresses complex messages without difficulty and with speech that is clear and easy to understand</p> <p>3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear</p> <p>2. Frequently exhibits difficulty with expressing needs and ideas</p> <p>1. Rarely/Never expresses self or speech is very difficult to understand</p> |
|---|---|

BB0800. Understanding Verbal Content (3-day assessment period)

- | | |
|---|--|
| Enter Code
<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <p>Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)</p> <p>4. Understands: Clear comprehension without cues or repetitions</p> <p>3. Usually Understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand</p> <p>2. Sometimes Understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand</p> <p>1. Rarely/Never Understands</p> |
|---|--|

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be conducted? (3-day assessment period)

Attempt to conduct interview with all patients.

- | | |
|---|---|
| Enter Code
<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <p>0. No (patient is rarely/never understood) → <i>Skip to C0900. Memory/Recall Ability</i></p> <p>1. Yes → <i>Continue to C0200. Repetition of Three Words</i></p> |
|---|---|

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

- | | |
|---|--|
| Enter Code
<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <p>Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words."</p> <p>Number of words repeated by patient after first attempt:</p> <p>3. Three</p> <p>2. Two</p> <p>1. One</p> <p>0. None</p> <p>After the patient's first attempt say: "I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture." You may repeat the words up to two more times.</p> |
|---|--|

Patient _____

Identifier _____

Date _____

Section C**Cognitive Patterns****Brief Interview for Mental Status (BIMS) - Continued****C0300. Temporal Orientation: Year, Month, Day**

Enter Code <input type="text"/>	A. Ask patient: "Please tell me what year it is right now." Patient's answer is: 3. Correct 2. Missed by 1 year 1. Missed by 2 to 5 years 0. Missed by more than 5 years or no answer
Enter Code <input type="text"/>	B. Ask patient: "What month are we in right now?" Patient's answer is: 2. Accurate within 5 days 1. Missed by 6 days to 1 month 0. Missed by more than 1 month or no answer
Enter Code <input type="text"/>	C. Ask patient: "What day of the week is today?" Patient's answer is: 1. Correct 0. Incorrect or no answer

C0400. Recall

Enter Code <input type="text"/>	Ask patient: "Let's go back to the first question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word. A. Recalls "sock?" 2. Yes , no cue required 1. Yes , after cueing ("something to wear") 0. No , could not recall
Enter Code <input type="text"/>	B. Recalls "blue?" 2. Yes , no cue required 1. Yes , after cueing ("a color") 0. No , could not recall
Enter Code <input type="text"/>	C. Recalls "bed?" 2. Yes , no cue required 1. Yes , after cueing ("a piece of furniture") 0. No , could not recall

C0500. BIMS Summary Score

Enter Score <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview
-------------------------------------	--

C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?

Enter Code <input type="text"/>	0. No (patient was able to complete Brief Interview for Mental Status) → <i>Skip to GG0100. Prior Functioning: Everyday Activities</i> 1. Yes (patient was unable to complete Brief Interview for Mental Status) → <i>Continue to C0900. Memory/Recall Ability</i>
------------------------------------	---

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed.

C0900. Memory/Recall Ability

↓ Check all that the patient was normally able to recall	
<input type="checkbox"/>	A. Current season
<input type="checkbox"/>	B. Location of own room
<input type="checkbox"/>	C. Staff names and faces
<input type="checkbox"/>	E. That he or she is in a hospital/hospital unit
<input type="checkbox"/>	Z. None of the above were recalled

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals**

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Patient needed partial assistance from another person to complete activities. 1. Dependent - A helper completed the activities for the patient. 8. Unknown 9. Not Applicable	↓	Enter Codes in Boxes
	<input type="text"/>	A. Self-Care: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	<input type="text"/>	B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	<input type="text"/>	C. Stairs: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	<input type="text"/>	D. Functional Cognition: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓	Check all that apply
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals****GG0130. Self-Care** (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="text"/>	<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input type="text"/>	<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	<input type="text"/>	E. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
<input type="text"/>	<input type="text"/>	F. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
<input type="text"/>	<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		H1. Does the patient walk? 0. No , and walking goal is not clinically indicated → <i>Skip to GG0170Q1. Does the patient use a wheelchair/scooter?</i> 1. No , and walking goal is clinically indicated → <i>Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?</i> 2. Yes → <i>Continue to GG0170I. Walk 10 feet</i>
<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period) - Continued

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
<input type="text"/>	<input type="text"/>	M. 1 step (curb): The ability to step over a curb or up and down one step.
<input type="text"/>	<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="text"/>	<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		Q1. Does the patient use a wheelchair/scooter? 0. No → Skip to H0350. Bladder Continence 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Patient _____

Identifier _____

Date _____

Section H**Bladder and Bowel****H0350. Bladder Continence** (3-day assessment period)

Enter Code

Bladder continence - Select the one category that best describes the patient.

- 0. **Always continent** (no documented incontinence)
- 1. **Stress incontinence only**
- 2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
- 3. **Incontinent daily** (at least once a day)
- 4. **Always incontinent**
- 5. **No urine output** (e.g., renal failure)
- 9. **Not applicable** (e.g., indwelling catheter)

H0400. Bowel Continence (3-day assessment period)

Enter Code

Bowel continence - Select the one category that best describes the patient.

- 0. **Always continent**
- 1. **Occasionally incontinent** (one episode of bowel incontinence)
- 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
- 3. **Always incontinent** (no episodes of continent bowel movements)
- 9. **Not rated**, patient had an ostomy or did not have a bowel movement for the entire 3 days

Section I**Active Diagnoses****Comorbidities and Co-existing Conditions****Check all that apply**☐**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**☐**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)☐**I7900. None of the above****Section J****Health Conditions****J1750. History of Falls**

Enter Code

Has the patient had two or more falls in the past year or any fall with injury in the past year?

- 0. **No**
- 1. **Yes**
- 8. **Unknown**

J2000. Prior Surgery

Enter Code

Did the patient have major surgery during the 100 days prior to admission?

- 0. **No**
- 1. **Yes**
- 8. **Unknown**

Section K**Swallowing/Nutritional Status****K0110. Swallowing/Nutritional Status** (3-day assessment period) Indicate the patient's usual ability to swallow.**Check all that apply**☐**A. Regular food** - Solids and liquids swallowed safely without supervision or modified food or liquid consistency.☐**B. Modified food consistency/supervision** - Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.☐**C. Tube/parenteral feeding** - Tube/parenteral feeding used wholly or partially as a means of sustenance.

Patient _____

Identifier _____

Date _____

Section M**Skin Conditions**

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**
 0. **No** → Skip to 00100. Special Treatments, Procedures, and Programs
 1. **Yes** → Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number <input type="text"/>	A. 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 only it may appear with persistent blue or purple hues. Number of Stage 1 pressure ulcers
Enter Number <input type="text"/>	B. 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. 1. Number of Stage 2 pressure ulcers
Enter Number <input type="text"/>	C. 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. 1. Number of Stage 3 pressure ulcers
Enter Number <input type="text"/>	D. 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. 1. Number of Stage 4 pressure ulcers
Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device
Enter Number <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar
Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution

Section O**Special Treatments, Procedures, and Programs****00100. Special Treatments, Procedures, and Programs**

↓ Check if treatment applies at admission

☐ **N. Total Parenteral Nutrition**

Patient _____

Identifier _____

Date _____

DISCHARGE

Section GG

Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	E. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
<input type="text"/>	F. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="text"/>	H3. Does the patient walk? 0. No → Skip to GG0170Q3. Does the patient use a wheelchair/scooter? 2. Yes → Continue to GG0170I. Walk 10 feet
<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space
<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns
<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period) - Continued

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
<input type="text"/>	M. 1 step (curb): The ability to step over a curb or up and down one step.
<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	Q3. Does the patient use a wheelchair/scooter? 0. No → Skip to J1800. Any Falls Since Admission 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	RR3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	SS3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Patient _____

Identifier _____

Date _____

Section J**Health Conditions****J1800. Any Falls Since Admission**

Enter Code <input type="text"/>	Has the patient had any falls since admission ? 0. No → Skip to M0210. Unhealed Pressure Ulcer(s) 1. Yes → Continue to J1900. Number of Falls Since Admission
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J1900. Number of Falls Since Admission

CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	<input type="text"/>	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	<input type="text"/>	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<input type="text"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section M**Skin Conditions**

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code <input type="text"/>	Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to M0900A. Healed Pressure Ulcer(s) 1. Yes → Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage
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M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number <input type="text"/>	A. 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 only it may appear with persistent blue or purple hues. Number of Stage 1 pressure ulcers
Enter Number <input type="text"/>	B. 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. 1. Number of Stage 2 pressure ulcers <i>If 0 → Skip to M0300C. Stage 3</i>
Enter Number <input type="text"/>	2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/>	C. 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. 1. Number of Stage 3 pressure ulcers <i>If 0 → Skip to M0300D. Stage 4</i>
Enter Number <input type="text"/>	2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission

Patient _____

Identifier _____

Date _____

Section M**Skin Conditions****M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued**

Enter Number <input type="text"/>	D. 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. 1. Number of Stage 4 pressure ulcers <i>If 0 → Skip to M0300E. Unstageable - Non-removable dressing</i> 2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device <i>If 0 → Skip to M0300F. Unstageable - Slough and/or eschar</i> 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar <i>If 0 → Skip to M0300G. Unstageable - Deep tissue injury</i> 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution <i>If 0 → Skip to M0800. Worsening in Pressure Ulcer Status Since Admission</i> 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission

M0800. Worsening in Pressure Ulcer Status Since Admission

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission.
 If no current pressure ulcer at a given stage, enter 0.

Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4
Enter Number <input type="text"/>	D. Unstageable - Non-removable dressing
Enter Number <input type="text"/>	E. Unstageable - Slough and/or eschar
Enter Number <input type="text"/>	F. Unstageable - Deep tissue injury

Patient _____

Identifier _____

Date _____

Section M**Skin Conditions****M0900. Healed Pressure Ulcer(s)**

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

A. Stage 1

Enter Number

B. Stage 2

Enter Number

C. Stage 3

Enter Number

D. Stage 4**Section O****Special Treatments, Procedures, and Programs****O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.**

Enter Code

A. 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 reason1. **Yes** → Continue to O0250B. Date influenza vaccine received**B. Date influenza vaccine received** → Complete date and skip to Z0400A. Signature of Persons Completing the Assessment

M M D D Y Y Y Y

Enter Code

C. 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.			