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Uniform Data System
for Medical Rehabilitation

The Functional Assessment Specialists

The FIM System® Clinical Guide
Version 5.2.1

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The FIM System® Clinical Guide

Uniform Data System for Medical Rehabilitation, April 4, 2018

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Section I: Introduction

Uniform Data System for Medical Rehabilitation (UDSMR) is a not-for-profit organization affiliated with the Center for Functional Assessment Research, Department of Rehabilitation Medicine, at the University at Buffalo, School of Medicine and Biomedical Sciences. UDSMR offers subscribers a wide range of services and tools that enable them to document the severity of patient disability and the results of medical rehabilitation in a uniform way. Establishing a common language promotes communication about disability across disciplines and provides a basis for comparison of rehabilitation outcomes.

UDSMR provides a means of collecting rehabilitation data in a consistent manner so that clinicians can follow changes in the functional status of their patients from the start of rehabilitative care through discharge and follow-up. Clinicians can use this information to:

- Evaluate the outcomes of rehabilitation programs through feedback reports
- Demonstrate the effectiveness and efficiency of care
- Predict the burden of postdischarge care
- Enable administrators to manage resources
- Assist in the clinical management of patients
- Conduct clinical research

Development of the FIM® Instrument

Until the 1980s, rehabilitation clinicians lacked a universally accepted, consistent terminology with which to communicate about disability. Many had long recognized the need for such terminology, its potential value, and the difficulties of achieving uniformity. In 1984, the National Institute on Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education awarded a grant to the Department of Rehabilitation Medicine, School of Medicine and Biomedical Sciences, State University of New York at Buffalo, to develop a system to document—in a uniform fashion—both the severity of patient disability and the outcomes of medical rehabilitation. A task force was charged with developing a uniform data system for medical rehabilitation. The task force consisted of the codirectors of the project in Buffalo and representatives of the rehabilitation community nationwide, sponsored by the American Congress of Rehabilitation Medicine (ACRM) and the American Academy of Physical Medicine and Rehabilitation (AAPM&R).

The task force's goal was to create a minimum data set that would act as a concise, discipline-free measurement system useful to clinicians, administrators, and researchers alike. As part of this mission, the task force had to create a valid, reliable rating scale that could be administered quickly and uniformly. The FIM® instrument was intended to track patients from the initiation of hospital care through discharge and follow-up. Periodic reassessment would measure changes in patient performance over time while providing data to determine rehabilitation outcomes.

The task force created a seven-level scale for performance measurement and selected items that assessed self-care, sphincter control, transfers, locomotion, communication, and social cognition. In addition to the eighteen items, the data set includes patient demographic characteristics, diagnoses, impairment groups, lengths of inpatient rehabilitation stay, and rehabilitation charges. Since the 1984 pilot, trial and implementation studies have been conducted to improve the clinical and technical features of the data set, especially the FIM® instrument.

Today, the FIM® instrument includes a minimum number of items for assessment—that is, the smallest number of items that can be used without sacrificing key attributes. It is not intended to incorporate all activities that can possibly be measured or that might need to be measured for clinical purposes. Instead, it is meant to document a patient's functional abilities, and it can be administered by any trained clinician, regardless of discipline. As an indicator of the severity of disability, the FIM® instrument measures a patient's actual performance rather than the patient's capacity to perform certain activities under certain conditions.

Over the years, UDSMR has incorporated feedback from clinicians, educators, and researchers to improve the FIM® instrument and the clinical guide.

Validity of the FIM® Instrument

The FIM® instrument was intended to measure a patient's disability in terms of the need for assistance. In the initial development stages, the FIM® instrument was found to have high face and content validity as judged by both clinicians and a panel of experts.[1] There was near-unanimous agreement among clinicians that the instrument did not need additional items. Thus, the content validity of the FIM® instrument was judged more than adequate.

The construct validity of the FIM® instrument has been tested with Rasch models, which have shown that the FIM® instrument measures two unidimensional domains of motor and cognitive function. Perhaps the most important test of the validity of a measure is the extent to which it predicts outcomes in medical rehabilitation. This form of validity is often referred to as *predictive validity,* and it represents how well a scale predicts criterion scores. A wide variety of studies has shown the FIM® instrument to be predictive of a patient's need for assistance. The FIM® instrument was the best predictor of minutes of help needed per day for patients with multiple sclerosis,[2] stroke,[3] and traumatic brain injury.[4] These studies also showed that the FIM® instrument was highly correlated with other measures of disability in the patient groups studied, thus indicating that the FIM® instrument has good concurrent validity with other measures of disability.

Since the FIM® instrument's introduction, a sizeable amount of supporting research and study has been published related to its reliability and validity, including:

1. Beninato M, O'Kane KS, Sullivan PE. Relationship between motor FIM and muscle strength in lower cervical-level spinal cord injuries. *Spinal Cord.* 2004;42(9):533-540.
2. Corrigan JD, Smith-Knapp K, Granger CV. Validity of the functional independence measure for persons with traumatic brain injury. *Arch Phys Med Rehabil.* 1997;78(8):828-834.
3. Deutsch A, Braun S, Granger CV. The Functional Independence Measure and the Functional Independence Measure for Children: ten years of development. *Crit Rev Phys Med Rehabil.* 1996;8(4):267-281.
4. Jones CA, Feeny DH. Agreement between patient and proxy responses during recovery after hip fracture: evidence for the FIM® instrument. *Arch Phys Med Rehabil.* 2006;87(10):1382-1387.
5. Kidd D, Stewart G, Baldry J, et al. The Functional Independence Measure: a comparative validity and reliability study. *Disabil Rehabil.* 1995;17(1):10-14.
6. Linacre JM, Heinemann AW, Wright BD, Granger CV, Hamilton BB. The structure and stability of the Functional Independence Measure. *Arch Phys Med Rehabil.* 1994;75(2):127-132.

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[1] Granger CV, Hamilton BB, Keith RA, Zielezny M, Sherwin FS. Advances in functional assessment for medical rehabilitation. *Top Geriatr Rehabil.* 1986;1(3):59-74. http://journals.lww.com /topicsingeriatricrehabilitation/Abstract/1986/04000/Advances_in_functional_assessment_for_medical.7 .aspx. Accessed July 8, 2013.

[2] Granger CV, Cotter AC, Hamilton BB, Fiedler RC, Hens MM. Functional assessment scales: a study of persons with multiple sclerosis. *Arch Phys Med Rehabil.* 1990;71(11):870-875.

[3] Granger CV, Cotter AC, Hamilton BB, Fiedler RC. Functional assessment scales: a study of persons after stroke. *Arch Phys Med Rehabil.* 1993;74(2):133-138.

[4] Granger CV, Divan N, Fiedler RC. Functional assessment scales. A study of persons after traumatic brain injury. *Am J Phys Med Rehabil.* 1995;74(2):107-113.

7. Ottenbacher KJ, Hsu Y, Granger CV, Fiedler RC. The reliability of the functional independence measure: a quantitative review. *Arch Phys Med Rehabil.* 1996;77(12):1226-1232.
8. Stineman MG, Ross RN, Fiedler R, Granger CV, Maislin G. Functional independence staging: conceptual foundation, face validity, and empirical derivation. *Arch Phys Med Rehabil.* 2003;84(1):29-37.
9. Stineman MG, Shea JA, Jette A, et al. The Functional Independence Measure: tests of scaling assumptions, structure, and reliability across 20 diverse impairment categories. *Arch Phys Med Rehabil.* 1996;77(11):1101-1108.
10. Voll R, Krumm B, Schweisthal B. Functional independence measure (FIM) assessing outcome in medical rehabilitation of neurologically ill adolescents. *Int J Rehabil Res.* 2001;24(2):123-131.

Ongoing research and study continues to support the FIM® instrument's validity and reliability. For a comprehensive list of references, contact UDSMR.

Interrater Reliability of the FIM® Instrument

The interrater reliability of the FIM® instrument was determined by having two or more pairs of clinicians assess each of 1,018 patients undergoing inpatient medical rehabilitation at 89 hospitals that subscribed to UDSMR. The results demonstrated that the FIM® instrument was highly reliable across the rating clinicians. The total FIM® rating intraclass correlation coefficients were:

- Total FIM® rating: 0.96
- Self-care: 0.94
- Sphincter control: 0.90
- Transfers: 0.92
- Locomotion: 0.90
- Communication: 0.91
- Social cognition: 0.89

Individual FIM® items also showed high interrater agreement using kappa coefficients of reliability. Kappas ranged from 0.53 to 0.66 across the eighteen items of the FIM® instrument.[5]

The study concluded that the FIM® instrument demonstrated high interrater reliability among clinicians. In addition to the test of interrater reliability of the FIM® instrument, extensive studies using Rasch models have found the FIM® instrument to have high internal consistency (Cronbach's alpha > 0.95) for both the motor and cognitive domains. Ongoing efforts to further test and refine the FIM® instrument are being conducted across the country and at UDSMR. This further research on functional assessment will allow the FIM® instrument to become an even better predictor of clinical outcomes and resource needs.

[5] Hamilton BB, Laughlin JA, Fiedler RC, Granger CV. Interrater reliability of the seven-level Functional Independence Measure (FIM). *Scand J Rehab Med*. 1994;26(3):115-199.

More about UDSMR

From the very beginning, interest in the data set developed by UDSMR has been high. Since 1988, acute rehabilitation facilities have submitted patient records to UDSMR and received summary reports in return. Over the years, UDSMR has expanded its services across the postacute care continuum with products based on the principals of the FIM® instrument. Today, UDSMR provides medical rehabilitation outcomes for acute medical rehabilitation, subacute/SNF programs, long-term care hospitals, pediatric inpatient hospitals, pediatric outpatient rehabilitation programs, and community-based outpatient therapy programs.

All of these products enable subscribers to document the **severity of patient disability** and the **results of medical rehabilitation** in a *uniform* way. Establishing a common language promotes communication about disability across disciplines and provides a basis for comparison of rehabilitation outcomes. Data collected using the FIM® instrument may be used to:

- Evaluate the outcomes of rehabilitation programs
- Demonstrate the effectiveness and efficiency of care
- Assist in the clinical management of patients
- Conduct clinical research

Internationally recognized as a leader in functional assessment and research, UDSMR maintains the world's largest database for medical rehabilitation outcomes. The size and scope of this database allows hospitals to compare their performances regionally, nationally, and internationally with other healthcare organizations. Today, more than fifteen hundred facilities in the United States, Australia, Belgium, Canada, Chile, Denmark, Finland, Hong Kong, Iceland, Italy, Israel, Mexico, Norway, Saudi Arabia, Singapore, Spain, Sweden, and Switzerland subscribe to UDSMR, and the databases include more than thirteen million patient assessments. UDSMR has territorial agreements with Australia, Canada, Finland, and Sweden.

UDSMR® Services

UDSMR staff members are available to respond to inquiries weekdays between the hours of 8:00 a.m. and 5:00 p.m. Eastern. You can contact us using any of the methods listed here:

- **Phone:** If you have any questions about your FIM System® subscription, please call our client services department at 716-817-7872. If you have questions about this guide or related clinical questions, please contact our clinical support staff at clinicalsupport@udsmr.org or 716-817-7844. If you have questions about your software or need help with data entry, please contact our technical support department at techsupport@udsmr.org or 716-817-7834.
- **Fax:** Send faxes to 716-568-0037. Include a cover sheet that indicates the intended recipient of the fax.
- **E-mail:** Contact us at info@udsmr.org.
- **Mail:** Write to us at UDSMR, 270 Northpointe Parkway, Suite 300, Amherst, New York 14228-1897.

You can also visit our website at www.udsmr.org. The sections below describe the various services we offer.

Client Services

Our client services department provides information and support to our customers on the details of their subscriptions. The client services staff is a great starting point for any inquiry, and you can reach them at 716-817-7872.

Education and Training

Education and training are important components of developing a reliable and valid database. Rating accuracy is the key to dependable outcomes data.

You can familiarize yourself with the data set items, including the FIM® instrument, in various ways. You can study this guide, of course, or review decision trees and our *Helpful Hints* document. You can attend a UDSMR® training workshop, or simply examine one of your quarterly reports. Such familiarity helps ensure that your results are reliable. For more information, contact clinicalsupport@udsmr.org.

Credentialing

Accurate assessment and data collection are very important to us at UDSMR. To ensure that facilities are submitting reliable data, each participating facility goes through a two-phase credentialing process.

The first phase of the credentialing process is a credentialing exam with questions that test the rater's knowledge of FIM® instrument definitions and levels. This establishes that data is collected in a reliable manner. All clinicians collecting FIM® data are required to demonstrate their proficiency using the instrument by taking an online reliability examination after a practice period of approximately four weeks. Our Internet-based credentialing system allows clinicians to take their credentialing exams online and provides them with immediate results.

The second phase consists of a technical review of the facility's data to determine whether the data falls within internal guidelines for technical adequacy. Credentialing renewal is required every two years.

UDSMR credentials facilities, not individual clinicians. Consequently, individual results of the credentialing exam cannot be transferred from facility to facility.

Data Management Services

UDSMR's Data Management Services provide secure, cloud-based data collection and hosting options and reporting services. Aggregate reports with benchmarks can help programs compare themselves to national data sets. Custom reports can be developed at the patient or program level.

Consultation

UDSMR offers special analytic, reporting, and consultation services to help meet the unique needs of its individual subscribers. Fees for these special services are determined and agreed upon after (a) the subscribing facility has articulated its needs and (b) UDSMR and the subscribing facility reach an understanding about the deliverables. As a subscriber, you are encouraged to contact UDSMR to learn more about how UDSMR can help you meet the challenges facing your rehabilitation program. UDSMR also works with a variety of industry consulting companies that offer complementary products and services.

Research Services

UDSMR conducts a wide range of clinical and scientific research projects related to functional assessment in the field of medical rehabilitation. UDSMR also provides support to other researchers in this field. Credentialing is required for researchers who wish to use the FIM® instrument in their research. This demonstrates the test-taker's functional knowledge and keeps the UDSMR® data valid and reliable.

Section II: Item-by-Item Coding Instructions

This section provides instructions for coding the Case Coding Form used at admission and discharge and the Interim or Follow-Up Assessment Coding Form used for interim and follow-up assessments. Be sure to address each item on the coding form.

Coding the Case Coding Form

Completion of the following items is mandatory for the Case Coding Form:

- Item 1, Facility Code
- Item 2, Patient Code
- Item 3, Birth Date
- Item 21, Admission Date
- Item 22, Admission Class
- Item 23, Discharge Date
- Item 26, Impairment Group
- Items 42A to 42R (FIM® Instrument section, all admission and discharge ratings)

Completion of all other items on the Case Coding Form is voluntary. The following optional Case Coding Form fields are included in your reports:

- Item 14, Gender
- Item 15, Ethnicity
- Item 16, English Language
- Item 17, Marital Status
- Item 18, Payment Source
- Item 19, Gross Rehabilitation Charges
- Item 28, Date of Onset
- Item 33, Admit From
- Item 34, Prehospital Living Setting
- Item 35, Prehospital Living With
- Item 36, Prehospital Vocational Category
- Item 37, Prehospital Vocational Effort
- Item 38, Discharge to Living Setting
- Item 39, Discharge to Living With

No other optional Case Coding Form fields are included in your reports, but you can export all of your optional data for custom reporting.

A blank copy of the Case Coding Form is presented on page 124.

Patient Information

1. **Facility Code:** Enter the code assigned by UDSMR to your facility.

2. **Patient Code:** Enter the patient's code number. Use the patient's medical record number, social security number, or another unique number that remains consistent for each hospitalization. This field is limited to nine characters, whether digits, letters, or both.
3. **Birth Date:** Enter the patient's birth date. The date should take the form MM/DD/YYYY, where MM is a two-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).
4. **Social Security Number:** Enter the patient's social security number. Verify the number with the patient and/or business office.
5. **First Name:** Enter the patient's first name.
6. **MI:** Enter the patient's middle initial.
7. **Last Name:** Enter the patient's last name.
8. **Street:** Enter the street address of the patient's preadmission residence.
9. **City:** Enter the name of the city in which the patient lived most recently before admission.
10. **State or Province:** Enter the name or initials of the state or province in which the patient lived most recently before admission.
11. **Zip Code or Postal Code:** Enter the five-digit zip code or postal code of the patient's prehospital residence.
12. **Country:** Enter the name of the country in which the patient lived most recently before admission.
13. **Telephone:** Enter one or two phone numbers for the patient.
14. **Gender:** Enter the patient's gender.
    1 Male
    2 Female
15. **Ethnicity:** Enter the patient's ethnicity.
    1 White
    2 Black
    3 Asian
    4 Native American
    5 Other
    6 Hispanic
16. **English Language:** Indicate whether the patient understands and speaks English.
    1 Yes
    2 No
    3 Partial

Do not use this code to account for aphasia.

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

1 Never married

2 Married

3 Widowed

4 Separated

5 Divorced

Payer/Charge Information

18. Payment Source: Enter the source of payment for inpatient rehabilitation services. Enter the appropriate category for both item 18A, Primary Source, and item 18B, Secondary Source.

01 Blue Cross (fee-for-service)

02 Medicare non-MCO (non-managed care organization/fee-for-service)

03 Medicaid non-MCO (non-managed care organization/fee-for-service)

04 Commercial insurance

05 MCO HMO (managed care organizations, including health maintenance organizations and preferred provider organizations)

06 Workers' Compensation

07 Crippled Children's Services

08 Developmental Disabilities Services

09 State Vocational Rehabilitation

10 Private pay

11 Employee courtesy

12 Unreimbursed (use only for item 18A, Primary Source)

13 TRICARE

14 Other

15 None (use only for item 18B, Secondary Source)

16 No-fault auto insurance

51 Medicare MCO (managed care organizations, including Medicare+Choice)

52 Medicaid MCO (managed care organizations)

Do not use code 15, None, for item 18A, Primary Source.

19. Gross Rehabilitation Charges:

19A. Total Gross Rehabilitation Dollars: Enter the total gross charges accrued for hospital rehabilitation while the patient was on the rehabilitation unit. Charges should be consistent with the days spent on the rehabilitation unit, as recorded in item 21, Admission Date, and item 23, Discharge Date. If an interruption of the inpatient rehabilitation program occurs for thirty days or fewer, rehabilitation days and total

charges should reflect the total stay on the rehabilitation unit. Do not include acute hospital days and charges incurred during the program interruption. If the interruption lasts longer than thirty days, the patient's return to rehabilitation should be considered another (separate) admission and should be reported on a new (separate) case coding form. Record only the actual dollars charged to the nearest whole dollar.

19B. Physician Fee: Indicate whether the charges in item 19A include physician fees.

1 Included

2 Not included

Complete item 19B only if you completed item 19A, Total Gross Rehabilitation Dollars.

20. Net Rehabilitation Charges:

20A. Total Net Rehabilitation Dollars: Enter the total net charges or adjusted reimbursement for hospital rehabilitation. This is the amount reimbursed to the facility (contractual allowance) by third-party payers, or a reasonable estimate of the amount receivable, for the patient's rehabilitation hospitalization. Record the amount to the nearest whole dollar.

20B. Physician Fee: Indicate whether the charges in item 20A include physician fees.

1 Included

2 Not included

Complete item 20B only if you completed item 20A, Total Net Rehabilitation Dollars.

Case Information

21. Admission Date: Enter the date that the patient was admitted to the rehabilitation unit. The date should take the form MM/DD/YYYY, where MM is a two-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., 2017).

22. Admission Class: Enter the patient's admission classification.

1 Initial rehabilitation: This is the patient's first admission to any medical rehabilitation program for this impairment.

2 Short Stay Evaluation: This is a preplanned stay of fewer than ten days on the rehabilitation unit for evaluation **or** a rehabilitation stay that lasts fewer than ten days because of medical complications or a discharge against medical advice (AMA). Admission and discharge FIM® assessments are completed for a patient classified as a short stay evaluation. (Do not use this code for a rehabilitation stay that is completed in fewer than ten days without medical complications or a discharge AMA.)

3 Readmission: The patient was previously admitted to a medical rehabilitation unit/facility for this impairment but is not being admitted to the current rehabilitation program directly from another rehabilitation program.

4 Unplanned discharge: This is a stay that lasts less than three calendar days because of an unplanned discharge (e.g., due to a medical complication). An admission FIM® assessment is not completed for a patient classified as an unplanned discharge.

5 **Continuing rehabilitation:** The patient's rehabilitation stay began in another rehabilitation program from which the patient has been admitted directly.

23. Discharge Date: Enter the date on which the patient is discharged from the rehabilitation unit. The date should take the form MM/DD/YYYY, where MM is a two-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., 2017).

Discharge indicates that the patient has left the rehabilitation unit, not that the patient is no longer receiving therapy. If the patient transfers from the rehabilitation unit and later returns, record the last day spent on the rehabilitation unit as the discharge date. An interruption of thirty days or fewer should be considered the same rehabilitation hospitalization. An interruption of more than thirty days results in a new hospitalization and a classification of 3, Readmission, for item 22, Admission Class, in which case a new case coding form should be completed.

24. Program Interruptions: Indicate whether a program interruption occurred during the patient's rehabilitation stay. A *program interruption* occurs when a patient is transferred from the rehabilitation program for thirty days or fewer and returns for treatment of the same impairment. Use the following codes to indicate whether a program interruption occurred:

1 Yes, one or more program interruptions occurred.

2 No, a program interruption did not occur.

This item is appropriate for patients in rehabilitation units that are part of larger acute care medical facilities and for those in freestanding rehabilitation facilities that transfer patients to acute care hospitals. Figure 1 on page 15 illustrates whether and how to code program interruptions.

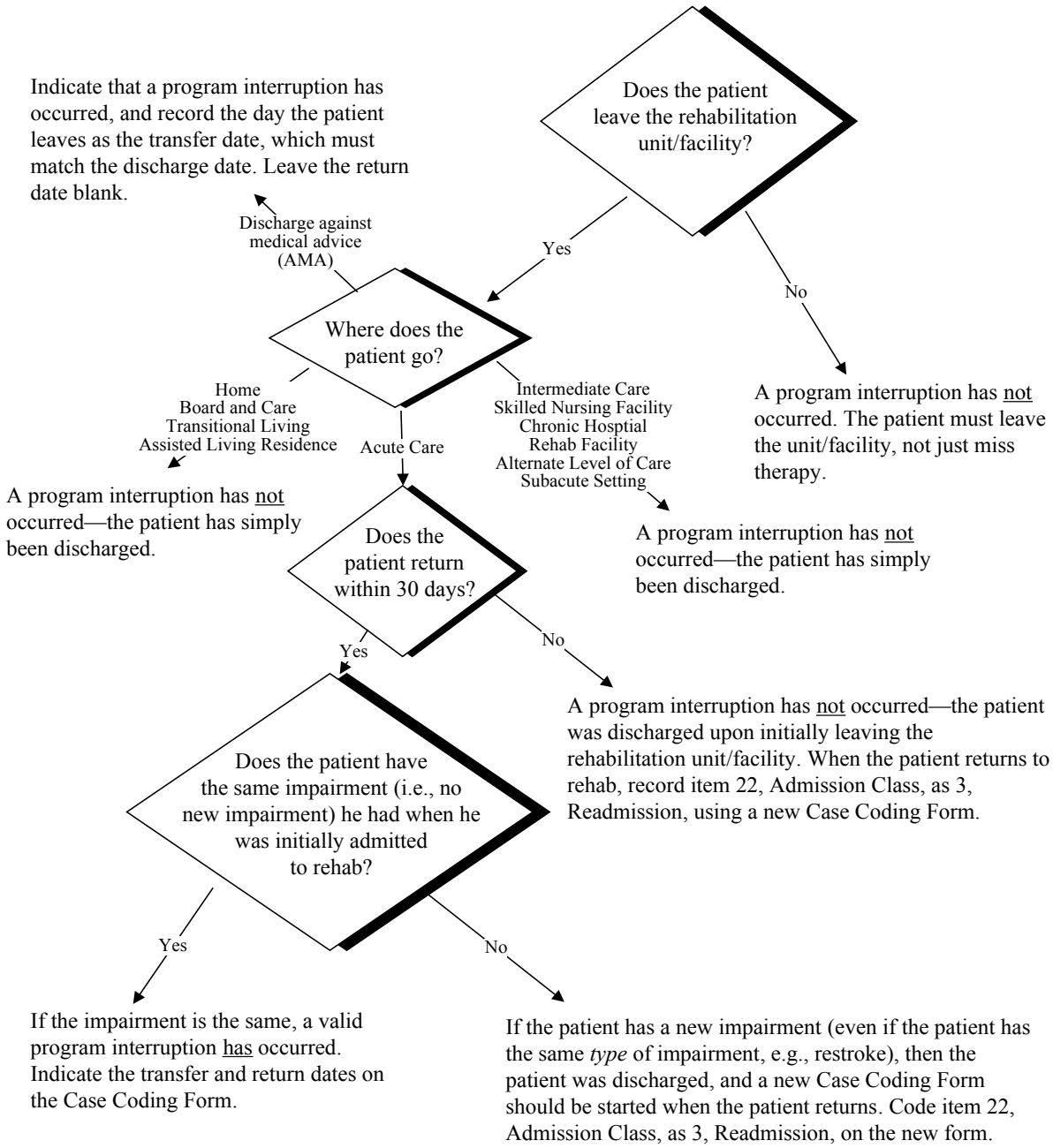


Figure 1. Decision tree for coding program interruptions

25. Program Interruption Dates: If one or more program interruptions occurred (i.e., if item 24 is coded 1, Yes), enter the interruption date and return date of each interruption. The *interruption date* is the day on which the interruption began (i.e., the day the patient left the rehabilitation facility); the *return date* is the day on which the interruption ended (i.e., the day the patient returned to the rehabilitation facility). As noted for item 24, a program interruption occurs when a patient is discharged from your rehabilitation facility and returns to your rehabilitation program within thirty consecutive calendar days. The dates should take the form MM/DD/YYYY, where MM is a two-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., 2017).

25A 1st Interruption Date

25B 1st Return Date

25C 2nd Interruption Date

25D 2nd Return Date

25E 3rd Interruption Date

25F 3rd Return Date

The Case Coding Form provides space for three interrupted stays. If more than three program interruptions occur during the patient's rehabilitation program, enter the transfer date of the third interruption in field 25E, determine the total number of days that the patient was off-service during the third interruption and any subsequent program interruptions, add the days together, and use this figure to determine the date of item 25F.

Example: The patient's third program interruption lasts from May 5, 2017, to May 10, 2017, for a total of five days, and a fourth interruption lasts from May 20, 2017, to May 24, 2017, for another four days (nine days total). Enter May 5, 2017, in field 25E, and enter May 14, 2017, in field 25F.

Medical Information

26. Impairment Group: For the admission assessment, enter the code that best describes the primary reason for the patient's admission to the rehabilitation program. Codes for this item are listed once following this explanation and again in appendix A on page 79. Each impairment group code (IGC) consists of a two-digit number, which indicates the major impairment group, followed by a decimal point and one to four additional digits that identify the subgroup. Exceptions to this general format are IGCs 09, 11, 13, 15, and 16, which have no subgroups (and therefore no decimal places). Be sure to code as specifically as possible.

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

List of IGCs for Item 21:

Stroke

01.1 Left body involvement, right brain
01.2 Right body involvement, left brain
01.3 Bilateral involvement
01.4 No paresis
01.9 Other stroke

Brain Dysfunction

02.1 Nontraumatic brain dysfunction
02.21 Traumatic brain dysfunction, open injury
02.22 Traumatic brain dysfunction, closed injury
02.9 Other brain dysfunction

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 conditions

Nontraumatic Spinal Cord Dysfunction

04.110 Paraplegia, unspecified
04.111 Paraplegia, incomplete
04.112 Paraplegia, complete
04.120 Quadriplegia, unspecified
04.1211 Quadriplegia, incomplete C1–C4
04.1212 Quadriplegia, incomplete C5–C8
04.1221 Quadriplegia, complete, C1–C4
04.1222 Quadriplegia, complete, C5–C8
04.130 Other nontraumatic spinal cord

Traumatic Spinal Cord Dysfunction

04.210 Paraplegia, unspecified
04.211 Paraplegia, incomplete
04.212 Paraplegia, complete
04.220 Quadriplegia, unspecified
04.2211 Quadriplegia, incomplete C1–C4
04.2212 Quadriplegia, incomplete C5–C8
04.2221 Quadriplegia, complete, C1–C4
04.2222 Quadriplegia, complete, C5–C8
04.230 Other traumatic spinal cord dysfunction

Amputation

05.1 Single upper extremity above the elbow (AE)
05.2 Single upper extremity below the elbow (BE)
05.3 Single lower extremity above the knee (AK)
05.4 Single lower extremity below the knee (BK)
05.5 Double lower extremity above the knee (AK/AK)
05.6 Double lower extremity above/below the knee (AK/BK)
05.7 Double lower extremity 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 Extremity pain
07.9 Other pain

Orthopaedic Disorders

08.11 Status post unilateral hip fracture
08.12 Status post bilateral hip fractures
08.2 Status post femur (shaft) fracture
08.3 Status post pelvic fracture
08.4 Status post major multiple fractures
08.51 Status post unilateral hip replacement
08.52 Status post bilateral hip replacements
08.61 Status post unilateral knee replacement
08.62 Status post bilateral knee replacements
08.71 Status post knee and hip replacements (same side)
08.72 Status post knee and hip replacements (different sides)
08.9 Other orthopaedic

Cardiac Disorders

09 Cardiac

Pulmonary Disorders

10.1 Chronic obstructive pulmonary disease
10.9 Other pulmonary

Burns

11 Burns

Congenital Deformities

12.1 Spina bifida
12.9 Other congenital

Other Disabling Impairments

13 Other disabling impairments

Major Multiple Trauma

14.1 Brain + spinal cord injury
14.2 Brain + multiple fracture/amputation
14.3 Spinal cord + multiple fracture/amputation
14.9 Other multiple trauma

Developmental Disabilities

15 Developmental disabilities

Debility

16 Debility (noncardiac, nonpulmonary)

Medically Complex Conditions

17.1 Infections
17.2 Neoplasms
17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition
17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition
17.4 Circulatory disorders
17.51 Respiratory disorders, ventilator-dependent
17.52 Respiratory disorders, non-ventilator-dependent
17.6 Terminal care
17.7 Skin disorders
17.8 Medical/surgical complications
17.9 Other medically complex conditions

27. ASIA Impairment Scale (modified Frankel scale): Enter the category that best describes the degree of motor and sensory involvement on admission to rehabilitation.

A Complete: No motor or sensory function is preserved in the sacral segments S4–S5.

B Sensory preserved: Sensory function, but not motor function, is preserved below the neurological level and extends through the sacral segments S4–S5.

C Motor nonfunctional: Motor function is preserved below the neurological level, and the majority of key muscles below the neurological level have a muscle grade less than 3.

D Motor functional: Motor function is preserved below the neurological level, and the majority of key muscles below the neurological level have a grade of 3 or greater.

E Normal: Motor and sensory functions are normal.

Complete item 27 only for patients with traumatic spinal cord injuries.

28. Date of Onset. Enter the onset date of the impairment coded in item 26, Impairment Group. The date should take the form MM/DD/YYYY, where MM is a two-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., 2017).

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

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

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

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

Although date of onset is an optional data element, it is an important rehabilitation outcome measure that is included in UDSMR® reports. The following list provides more specific instructions for capturing the most reflective onset date for major impairment groups:

- **Stroke:** Enter the date of admission to the acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke.[6]
- **Brain Dysfunction**
  - **Traumatic:** Enter the date of injury.
  - **Nontraumatic:** Enter the more recent date of (a) the date of surgery (e.g., for removal of brain tumor) or (b) the date of diagnosis.
  - **Other:** Enter the more recent date of (a) the date of surgery (e.g., for removal of brain tumor) or (b) the date of diagnosis.
- **Neurological Conditions**
  - **Multiple sclerosis:** Enter the date of exacerbation.
  - **All other neurological conditions:** Enter the date of diagnosis.
- **Spinal Cord Dysfunction**
  - **Traumatic:** Enter the date of injury.
  - **Nontraumatic:** Enter the more recent date of (a) the date of surgery (e.g., for tumor) or (b) the date of diagnosis.
- **Amputation:** Enter the date of the patient's most recent surgery.
- **Arthritis:** Enter the date of diagnosis. (For arthroplasty, see "Orthopaedic Conditions.")
- **Pain Syndromes:** Enter the date of onset related to the case of the pain (e.g., fall or injury).
- **Orthopaedic Conditions**
  - **Fractures:** Enter the date of fracture.
  - **Replacement:** Enter the date of surgery.
- **Cardiac Disorders:** Enter the more recent date of (a) the date of diagnosis (event) or (b) the date of surgery (e.g., bypass, transplant).
- **Pulmonary Disorders**
  - **COPD:** Enter the date of initial diagnosis (not exacerbation).
  - **Pulmonary transplant:** Enter the date of surgery.
  - **Other:** Enter the date of initial diagnosis.
- **Burns:** Enter the date of the burns.
- **Congenital Deformities:** Enter the date of the patient's birth.
- **Other Disabling Impairments:** Enter the date of diagnosis.
- **Major Multiple Trauma:** Enter the date of trauma.

[6] If the patient was not admitted to an acute hospital prior to admission to your rehabilitation facility, enter as the date of onset the date of diagnosis of the impairment that led to the patient's admission to your facility.

- **Developmental Disabilities:** Enter the patient's date of birth.
- **Debility:** Enter the date of admission to the acute hospital.[6]
- **Medically Complex Conditions:** Enter the date of admission to the acute hospital.

29. Etiologic Diagnosis: Enter the ICD code that indicates the etiological problem that led to the impairment for which the patient is receiving rehabilitation (i.e., for item 26, Impairment Group). Appendix B on page 84 contains a list of ICD codes associated with specific impairment groups. The most commonly used codes are listed, but the list is not exhaustive. If the necessary code is not listed, it may nevertheless be used with the appropriate impairment group. Consult your facility's health information management staff and current ICD coding books for exact codes.

30. Other Diagnoses: Most Significant: Enter the ICD codes that identify the most severe or significant diagnoses that are not already included in the impairment group code (e.g., H53.461, Homonymous bilateral field defects, right side; R13.1X, Dysphagia; R47.01, Aphasia; R15.9, Full incontinence of feces; N39.41, Urge incontinence; G81.01, Flaccid hemiplegia affecting right dominant side; G82.20, Paraplegia, unspecified; etc.).

31. Complications/Comorbidities: Enter the ICD codes that identify complications and/or comorbid conditions that delayed or compromised the effectiveness of the rehabilitation program or represented high medical risk disorders (e.g., previous cardiac arrest, pulmonary embolus, ruptured aneurysm, diabetes, etc.).

If the impairment is the result of an injury, enter the code that represents the external cause of morbidity in field 31C.

32. Diagnosis for Transfer or Death: Enter the ICD code for the diagnosis that caused the patient to be transferred from rehabilitation to acute care or the diagnosis that caused the patient's death (e.g., acute myocardial infarction, acute pulmonary embolus, sepsis, ruptured aneurysm, etc.).

Admission Information

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

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

02 Board and care: A community-based setting where individuals have private space (either a room or apartment), or a structured retirement facility. The facility may provide transportation, laundry, and meals, but it does not provide nursing care.

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

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

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

06 Acute unit of own facility: An acute medical/surgical care unit in the same facility as the rehabilitation unit.

07 Acute unit of another facility: An acute medical/surgical care facility separate from the rehabilitation unit.

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

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

10 Other: Used only if no other code is appropriate.

12 Alternate level of care (ALC) unit: A physically and fiscally distinct unit that provides care to individuals who no longer meet acute care criteria.

13 Subacute setting: Subacute care is goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalization to treat one or more specific active, complex medical conditions and overall situation. Generally, the condition of an individual receiving subacute care is such that the care does not depend heavily on high-technology monitoring or complex diagnostic procedures. Subacute care requires the coordinated services of an interdisciplinary team, including physicians, nurses, and other relevant professional disciplines who are knowledgeable and trained to assess and manage these specific conditions and to perform the necessary procedures. Subacute care is given as part of a specifically defined program, regardless of site. Subacute care is generally more intensive than traditional nursing home care but less intensive than acute inpatient care. It requires frequent (daily to weekly) patient assessment and review of the clinical course and treatment plan for a limited time (several days to several months), until a condition is stabilized or a predetermined course is completed.[7]

14 Assisted living residence: A community-based setting that combines housing, private quarters, freedom of entry and exit, supportive services, personalized assistance, and healthcare designed to respond to individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive services are available twenty-four 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.[8]

34. Prehospital Living Setting: Enter the setting where the patient was living prior to hospitalization. See item 33, Admit From, for code definitions.

01 Home

02 Board and care

[7] Source: The Joint Commission.
[8] Source: Assisted Living Facilities of America.

03 Transitional living

04 Intermediate care (nursing home)

05 Skilled nursing facility (nursing home)

06 Acute unit of your own facility

07 Acute unit of another facility

08 Chronic hospital

09 Rehabilitation facility

10 Other

12 Alternate level of care (ALC) unit

13 Subacute setting

14 Assisted living residence

35. Prehospital Living With: Complete this item only if you selected code 01, Home, for item 34, Prehospital Living Setting. Enter the relationship of any individuals who resided with the patient prior to the patient's hospitalization. If more than one person qualifies, enter the first appropriate category on the list.

1 Alone

2 Family/relatives

3 Friends

4 Attendant

5 Other

36. Prehospital Vocational Category: Indicate whether the patient was employed, a student, a homemaker, or retired prior to hospitalization for the current condition. If more than one category applies, enter the first appropriate code on the list.

Exception: If the patient is retired (usually at least sixty years old) and receiving retirement benefits, record code 6, Retired for Age.

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

2 Sheltered: The patient works for pay in a noncompetitive environment.

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

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

5 Not working: The patient is unemployed but is not retired and does not receive disability benefits.

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

7 Retired for disability: The patient is receiving disability benefits and is less than 60 years old.

37. Prehospital Vocational Effort: Complete this item only if item 36, Prehospital Vocational Category, is coded 1, 2, 3, or 4. Enter the patient's vocational effort prior to hospitalization for the current condition.

1 **Full-time:** The patient worked a full schedule (e.g., 37.5 or 40 hours per week, depending on the norm where the patient works).

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

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

Discharge Information

38. Discharge to Living Setting: Enter the setting to which the patient is discharged. See item 33, Admit From, for code definitions.

01 Home[9]

02 Board and care[9]

03 Transitional living[9]

04 Intermediate care (nursing home)[10]

05 Skilled nursing facility (nursing home)[10]

06 Acute unit of your own facility[11]

07 Acute unit of another facility[11]

08 Chronic hospital[10]

09 Rehabilitation facility

10 Other

11 Died (use if patient expired in the facility)

12 Alternate level of care (ALC) unit[10]

13 Subacute setting

14 Assisted living residence[9]

39. Discharge to Living With: Complete this item **only** if you recorded code 01, Home, for item 38, Discharge to Living Setting. Enter the relationship of any individuals who reside with the patient after the patient's discharge from rehabilitation. If more than one person qualifies, enter the first appropriate category on the list.

1 Alone

2 Family/relatives

3 Friends

4 Attendant

[9] Indicates a community-based discharge setting.
[10] Indicates a long-term care discharge setting.
[11] Indicates an acute care discharge setting.

5 Other

40. Therapy Date Range:

40A. Start of Therapy: Enter the date on which the patient first received therapy from a therapist (OT, PT, SLP, etc.). The date should take the form MM/DD/YYYY, where MM is a two-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., 2017). Complete this item only if the patient did not begin receiving therapy on the date of admission.

40B. End of Therapy: Enter the date on which the patient last received therapy from a therapist (OT, PT, SLP, etc.). The date should take the form MM/DD/YYYY, where MM is a two-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., 2017). Complete this item only if the patient did not receive therapy on the date of discharge.

41. Internal Program Name: Use this optional field to record custom facility-specific information that identifies case-level information (i.e., data associated with the admission-to-discharge episode). Examples include codes that indicate a new treatment or a special program, such as a wound care program.

FIM® Instrument

42. FIM® Instrument: Use FIM® levels 1–7 to rate items 42A–42R at both admission and discharge. For information on rating particular FIM® items, see page 30.

Recording 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 FIM® item (items 42A–42R). Completion of FIM® goals is voluntary.

Case Notes

43. Case Notes: Use this area to record any notes particular to the patient's case.

Coding the Interim or Follow-Up Assessment Coding Form

If you are completing the Interim or Follow-Up Assessment Coding Form for an **interim assessment,** the following fields are mandatory:

- Item 1, Facility Code
- Item 2, Patient Code
- Item 21, Admission Date
- Item 60, Assessment Type
- Item 61, Assessment Date

If you are completing the Interim or Follow-Up Assessment Coding Form for a **follow-up assessment**, the following fields are mandatory:

- Item 1, Facility Code
- Item 2, Patient Code
- Item 21, Admission Date
- Item 60, Assessment Type
- Item 61, Assessment Date
- Item 64, Follow-Up Living Setting
- Items 71A to 71R (FIM® Instrument section)

Completion of all other items on the Interim or Follow-Up Assessment Coding Form is voluntary.

A blank copy of the Interim or Follow-Up Assessment Coding Form is presented on page 126.
For more information about conducting follow-up assessments, see page 166.

Assessment Information

60. Assessment Type: Enter the appropriate code for the type of assessment being performed.

2 **Interim:** An assessment conducted any time between the admission assessment and the discharge assessment.

4 **Follow-Up:** An assessment conducted between 80 and 180 days after the patient's discharge from the rehabilitation program.

61. Assessment Date: Enter the date on which the assessment was performed. The date should take the form MM/DD/YYYY, where MM is a two-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., 2017).

Follow-Up Information

The items in this section should be used for follow-up assessments, not interim assessments.

62. Follow-Up Information Source: Enter the source of the follow-up information.

1 Patient

2 Family

3 Other

4 Unable to reach

If you are unable to reach the patient, the patient's family, or the patient's caretakers at follow-up, record the attempted follow-up method in item 63, Follow-Up Assessment Method, but do not complete additional follow-up items.

63. Follow-Up Assessment Method: Enter the method by which follow-up information was obtained by a rehabilitation professional who has been trained in the use of the FIM® instrument.

1 In person

2 Telephone

3 Mailed questionnaire

64. Follow-Up Living Setting: Enter the setting where the patient is living at the time of the follow-up assessment. See item 33, Admit from, for code definitions.

01 Home

02 Board and care

03 Transitional living

04 Intermediate care (nursing home)

05 Skilled nursing facility (nursing home)

06 Acute unit of your own facility

07 Acute unit of another facility

08 Chronic hospital

09 Rehabilitation facility

10 Other

11 Died

12 Alternate level of care (ALC) unit

13 Subacute setting

14 Assisted living residence

65. Follow-Up Living With: Complete this item only if you selected code 01, Home, for item 64, Follow-Up Living Setting. Enter the relationship of any individuals who reside with the patient at the time of the follow-up assessment. If more than one person qualifies, enter the first appropriate category on the list.

1 Alone

2 Family/relatives

3 Friends

4 Attendant

5 Other

66. Follow-Up Vocational Category: Indicate whether the patient is employed, a student, a homemaker, or retired at the time of the follow-up assessment. If more than one category applies, enter the first appropriate code on the list. See item 36, Prehospital Vocational Category, for code definitions.

Exception: If the patient is retired (usually at least sixty years old) and receiving retirement benefits, record code 6, Retired for Age.

1 Employed

2 Sheltered

3 Student

4 Homemaker

5 Not working

6 Retired for age

7 Retired for disability

67. Follow-Up Vocational Effort: Complete this item only if item 66, Follow-Up Vocational Category, is coded 1, 2, 3, or 4. Enter the patient's vocational effort at the time of the follow-up assessment. See item 37, Prehospital Vocational Effort, for code definitions.

1 Full-time

2 Part-time

3 Adjusted workload

68. Follow-Up Health Maintenance: Indicate the person or persons primarily responsible for performing routine personal care for the patient and managing the patient's personal environment at home or in an institution. Identify the helper who spends the most time helping the patient in item 68A, Primary Helper; identify the helper who spends the second-most time helping the patient in item 68B, Secondary Helper. If the patient requires only one helper, record the same code in both fields.

1 Own care

2 Unpaid person or family member

3 Paid attendant or aide

4 Paid, skilled professional

69. Follow-Up Therapy: Indicate the type of paid therapy the patient is currently receiving.

1 None

2 Outpatient therapy

3 Home-based, paid professional therapy (such as PT, OT, SLP, or nursing, i.e., not routine personal care or maintenance)

4 Outpatient and home-based paid professional therapy

5 Inpatient hospital

6 Long-term care facility

7 Other

8 Day treatment

70. Follow-Up Diagnoses: Enter the ICD codes that identify complications or diagnoses identified since the patient's discharge from the rehabilitation program.

FIM® Instrument

71. FIM® Instrument: Use FIM® levels 1–7 to rate items 71A–71R. For information on rating particular FIM® items, see page 30.

Interim or Follow-Up Notes

72. Interim or Follow-Up Notes: Use this area to record any notes particular to the patient's case.

Section III: 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 need to be measured, for clinical purposes. Rather, the FIM® instrument is a basic indicator of severity of disability that can be administered relatively 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 and energy that another person must expend to serve the dependent needs of the disabled patient so that the patient can achieve and maintain a certain quality of life.

The FIM® instrument is a measure of disability, not impairment. It is intended to measure what a patient with a disability actually does, whatever the diagnosis or impairment—not what the patient ought to be able to do or might be able to do under different circumstances. Experienced clinicians may be well aware that a patient with depression could do many things the patient is not currently doing; nevertheless, they should assess what the patient actually does. Note also that there is no provision to consider an item "not applicable." **All FIM® items (items 42A–42R) 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 have difficulty assessing certain activities. In such cases, a clinician with intimate knowledge of the patient's performance (such as a physical therapist who assists the patient with transfers) can help the team determine the most accurate rating for an item based on the patient's performance and the associated burden of care.

You must read the definitions of the items carefully before you begin using the FIM® instrument, committing to memory what each activity includes. Rate the patient only with respect to the specific item being considered. For example, when rating the patient for the items Bowel Management and Bladder Management, do not consider whether the patient can get to the toilet—that information is measured when assessing the items Locomotion: Walk, Wheelchair and Transfers: Toilet. Similarly, preparation for Grooming does not include getting to the washbasin.

Implicit in all of the definitions, and stated in many of them, is a concern that the patient perform these activities with reasonable safety. With respect to level 6, Modified Independence, ask yourself whether the patient is at risk of injury while performing the task. As with all human endeavors, your judgment should attempt to balance a patient's risk of participating in an activity and a corresponding, albeit different, risk if the patient does not.

FIM® ratings may be used to supplement information that has already been gathered by a facility. This information may include items such as performance of independent living skills, ability to take medications, use of community transportation, ability to direct care provided by an aide, writing ability, use of the telephone, and other characteristics, including outdoor mobility, impairments such as blindness and deafness, and premorbid status.

Do not modify the FIM® instrument itself.

Procedures for Rating the FIM® Instrument

Each of the eighteen items comprising the FIM® instrument has a maximum rating of 7, which indicates complete independence. The lowest possible rating is 1, which indicates total assistance. Only whole numbers are used for ratings. The following rules will help you administer the FIM® instrument.

1. Admission FIM® ratings must be collected during the first three calendar days of the patient's current rehabilitation stay. These ratings must be based on activities performed during the entire three-calendar-day admission period.
2. Discharge FIM® ratings must be collected during the last three calendar days of the patient's current rehabilitation stay. These ratings must be based on activities performed during the entire three-calendar-day discharge period.
3. Follow-up data, if collected, must be collected 80 to 180 days after discharge.
4. Record a **FIM® rating** that best describes the patient's level of function for **each** FIM® item (items 42A–42R). Do not leave any FIM® item blank or enter "N/A" for any FIM® item.
5. The patient's **FIM® ratings** should reflect the patient's actual performance of each activity—not what the patient should be able to do, not a simulation of the activity, and not what the patient is expected to do in a different environment (e.g., home).
6. If differences in function occur in different environments or at different times of the day, record the **lowest** (i.e., most dependent) rating. In such cases, the patient usually has not mastered the function across the twenty-four-hour period, is too tired, or is not motivated enough to perform the activity out of the therapy setting. Discussion among team members may be needed to identify the most dependent level.

   Note: The patient's ratings for measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, if a patient routinely ambulates more than 150 feet throughout the day with supervision (level 5 for Locomotion: Walk, Wheelchair), but the patient ambulates only 20 feet at night to use the toilet because the toilet is 20 feet from the patient's bed, rate the patient level 5 rather than a lower rating.
7. Base the patient's **FIM® ratings** on the best available information. Direct observation of the patient's performance is preferred, but credible reports of performance may be gathered from the medical record, the patient, other staff members, and the patient's family and friends. The medical record may provide additional information about bladder and bowel accidents and inappropriate behaviors.
8. Item 42G, Bladder Management, includes the complete and intentional control of the urinary bladder and the use of any equipment and medications (agents) necessary for bladder control. Consider each episode individually. If a patient does not have an accident, the level of assistance required will determine the rating, which will range from level 1, Total Assistance, to level 7, Complete Independence. If a patient has an accident or an incontinent episode, the rating will range from level 1, Total Assistance, to level 5, Supervision/Setup, based on the level of assistance needed to clean up after the accident or incontinent episode. Record the lower of the two variables in this item:

   a. The level of assistance required from a helper, an assistive device, or medication

   b. The level of success for the patient's bladder management program, as represented by the number of accidents that have occurred during the three-day assessment period

9. Item 42H, Bowel Management, includes the complete and intentional control of bowel movements and the use of any equipment and medications (agents) necessary for bowel control. Consider each episode individually. If a patient does not have an accident, the level of assistance will determine the rating, which will range from level 1, Total Assistance, to level 7, Complete Independence. If a patient has an accident or an incontinent episode, the rating will range from level 1, Total Assistance, to level 5, Supervision/Setup, based on the level of assistance needed to clean up after the accident or incontinent episode. Record the lower of the two variables in this item:
   a. The level of assistance required from a helper, an assistive device, or medication
   b. The level of success for the patient's bowel management program, as represented by the number of accidents that have occurred during the three-day assessment period
10. If a helper must lift a patient's limb so that the patient can complete an activity but the helper does not provide any other assistance, the rating will depend on the number of limbs lifted:
   a. One limb: Level 4, Minimal Assistance
   b. Two limbs: Level 3, Moderate Assistance
11. The data collection form provides boxes used to indicate the patient's more frequent mode for three FIM® items:
   - Item 42L, Locomotion: Walk, Wheelchair
   - Item 42N Comprehension
   - Item 42O, Expression

   Indicate the more frequent mode by placing the appropriate letter in each box.

   - **For item 42L, Locomotion: Walk, Wheelchair:**
     - W for walk
     - C for wheelchair
     - B for both
   - **For item 42N, Comprehension:**
     - A for auditory
     - V for visual
     - B for both
   - **For item 42O, Expression:**
     - V for vocal
     - N for nonvocal
     - B for both

   Do not place numbers in these boxes!

The mode of locomotion for item 42L, Locomotion: Walk, Wheelchair, must be the same on admission and discharge. Some patients may switch modes from admission to discharge, usually wheelchair to walking. In such cases, code the admission mode and rating based on the *more frequent mode of locomotion at discharge*. If, at discharge, the patient uses both modes (walk and wheelchair) equally, but the FIM® levels are different, use the rating that indicates the burden of care when the patient is walking.

Note: For items 42N, Comprehension, and 42O, Expression, the mode at admission does not have to match the mode at discharge.

12. Setup is uniformly rated at level 5 for all items. A patient who requires supervision is **not** independent.
13. If the patient would be put at risk for injury if tested, rate the patient level 1, Total Assistance.
14. If the patient does not perform an activity, rate the patient level 1, Total Assistance. For example, if a patient requires a bed bath, rate the patient level 1, Total Assistance, for Transfers: Tub, Shower.
15. If a patient requires assistance from two helpers to perform the tasks described in an item, rate the patient level 1, Total Assistance. The two helpers are not required to provide hands-on contact assistance. For example, rate the patient level 1, Total Assistance, if one helper assists the patient to walk and another helper follows the patient with a wheelchair.
16. If a helper is required to change a patient's diaper, pad, or brief, rate the patient level 1, Total Assistance, for the appropriate item (Bladder Management or Bowel Management) for that particular episode.

Description of the Levels of Function and Their Ratings

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

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

6 Modified Independence: The patient performs the activity, but the patient requires an assistive device or aid, the activity takes more than a reasonable amount of time, or the activity involves safety (risk) considerations for which the patient accepts responsibility.

DEPENDENT: The patient requires another person, whether for supervision or physical assistance, to perform the activity, or the activity is not performed (REQUIRES HELPER).

Modified Dependence: The patient expends half (50%) or more of the effort.

5 Supervision/Setup: The patient requires no more help than standby assistance, cueing, or coaxing, without physical contact; alternatively, a helper sets up needed items or applies orthoses or assistive/adaptive devices.

4 Minimal 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 the patient expends 50% to 74% of the effort.

Complete Dependence: The patient expends less than half (less than 50%) of the effort, requiring maximal or total assistance, or the patient does not perform the activity.

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

1 Total Assistance: The patient expends less than 25% of the effort, requires assistance from two helpers, or does not perform the activity.

Instructions for the Use of the FIM® Decision Trees

Many clinicians have found the FIM® decision trees useful tools to determine FIM® ratings as they observe patient behaviors. Answer the questions and follow the branches to the correct rating. Follow the YES path if you answer "yes" to any question; follow the NO path if you answer "no" to all questions. Behaviors and ratings above the dashed line indicate that no helper is needed; behaviors and ratings below the dashed line indicate that a helper is needed.

A separate decision tree for each item follows the description and rating guidelines for the item.

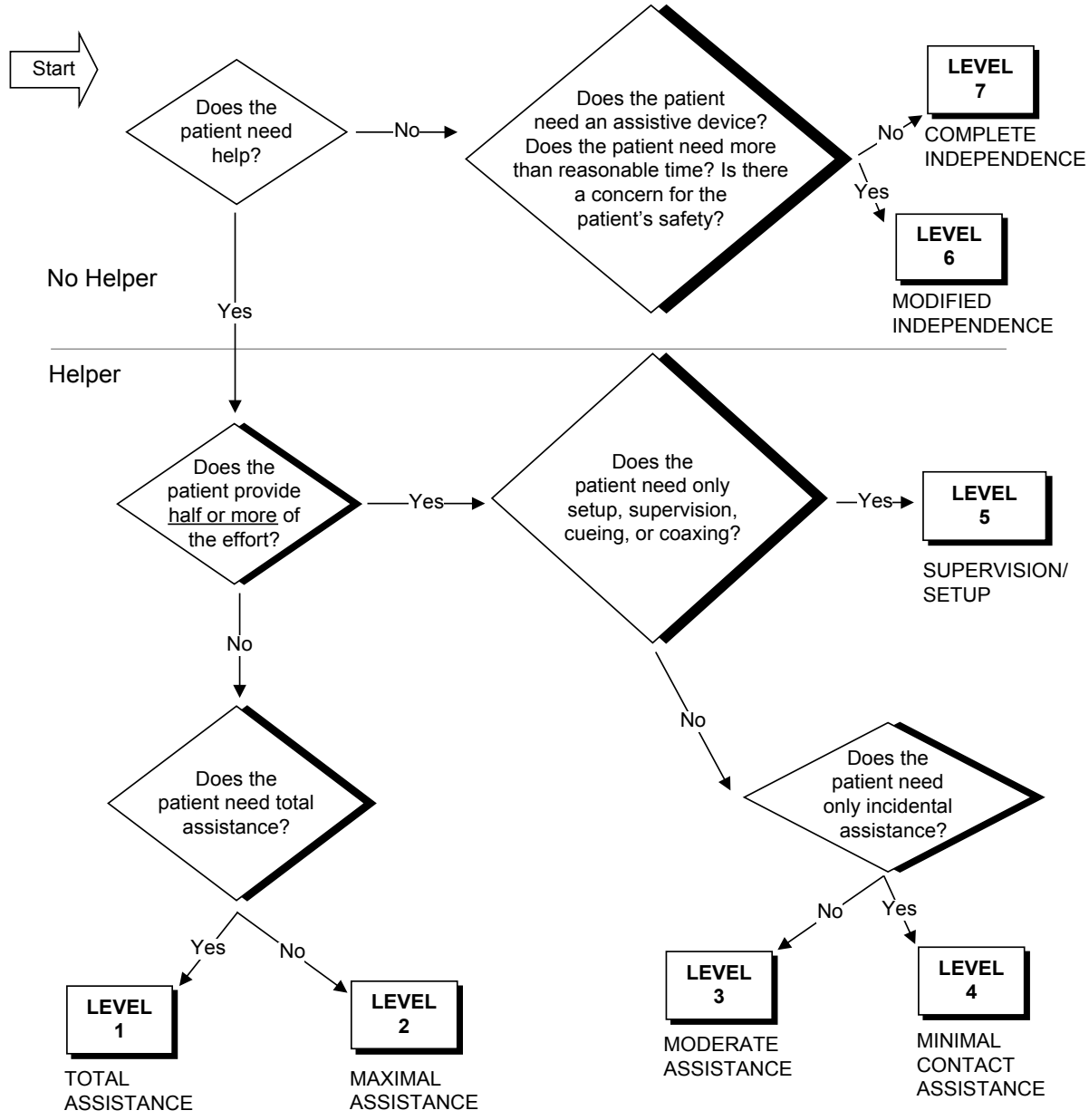


Figure 2. General FIM® decision tree

Eating

Eating includes using suitable utensils to bring food from a dish to the mouth, where the food is chewed and swallowed; using a cup or glass to bring liquid to the mouth, where it is swallowed; and managing a variety of food consistencies after a meal has been presented in the customary manner on a table or tray.

Rating guidelines:

- Presenting a meal in the customary manner includes delivering the meal tray and removing the cover of the tray.
- If the patient functions at different levels during the day (for example, level 5 in the morning and level 4 in the evening), record the lower rating.
- If the patient eats meals by mouth **and** receives nutrition through tube feedings, consider each time the patient eats and each tube feeding administration as a separate episode. If the patient's functional status varies by episode, record the lower rating.
- If the patient has a feeding tube that is **not** used for hydration or nutrition, and a helper flushes the tube to maintain patency, do **not** consider the feeding tube and the parenteral line when rating this item.

NO HELPER

7 Complete Independence: The patient safely performs all eating tasks without assistance from a helper, without a device, and in a reasonable amount of time.

6 Modified Independence: The patient performs all eating tasks without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, dentures, long straw, spork, or plate guard) to eat and applies the device without assistance from a helper.
- The patient takes extra time to eat.
- The patient requires modified food consistency, modified liquid consistency, or blenderized food, and the food arrives in a modified or blenderized consistency.
- The patient self-administers parenteral or gastrostomy feedings.
- There is a concern for the patient's safety when he eats.

HELPER

5 Supervision/Setup: The patient performs all eating tasks, and one or more of the following are true:

- The patient requires supervision (e.g., standing by, cueing, or coaxing) to eat.
- The patient requires setup assistance (including application of orthoses and assistive/adaptive devices necessary for eating) to eat.
- The patient requires a modified food consistency, and a helper modifies the food's consistency, applies Thick-It® powder, etc.
- The patient requires setup of the meal, such as opening containers, cutting meat, buttering bread, and pouring liquids.

4 Minimal Assistance: The patient performs 75% or more of the eating tasks.

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

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

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of the eating tasks.
- The patient does not eat or drink full meals by mouth, relying instead on other means of alimentation (for example, parenteral and gastrostomy feedings).
- The patient requires assistance from two helpers to eat.
- The patient requires an IV for fluids or hydration (or both) that is administered by a helper.

If the patient eats by mouth and receives nutrition through tube feedings, consider each time the patient eats and each tube feeding administration as a separate episode. If the patient's functional status varies by episode, record the lower rating. For example, if the patient eats meals with only setup assistance (e.g., opening containers), and a helper administers the feedings (i.e., the patient does not help with feedings), rate the patient level 1, Total Assistance, which is the lower of the ratings for the two statuses.

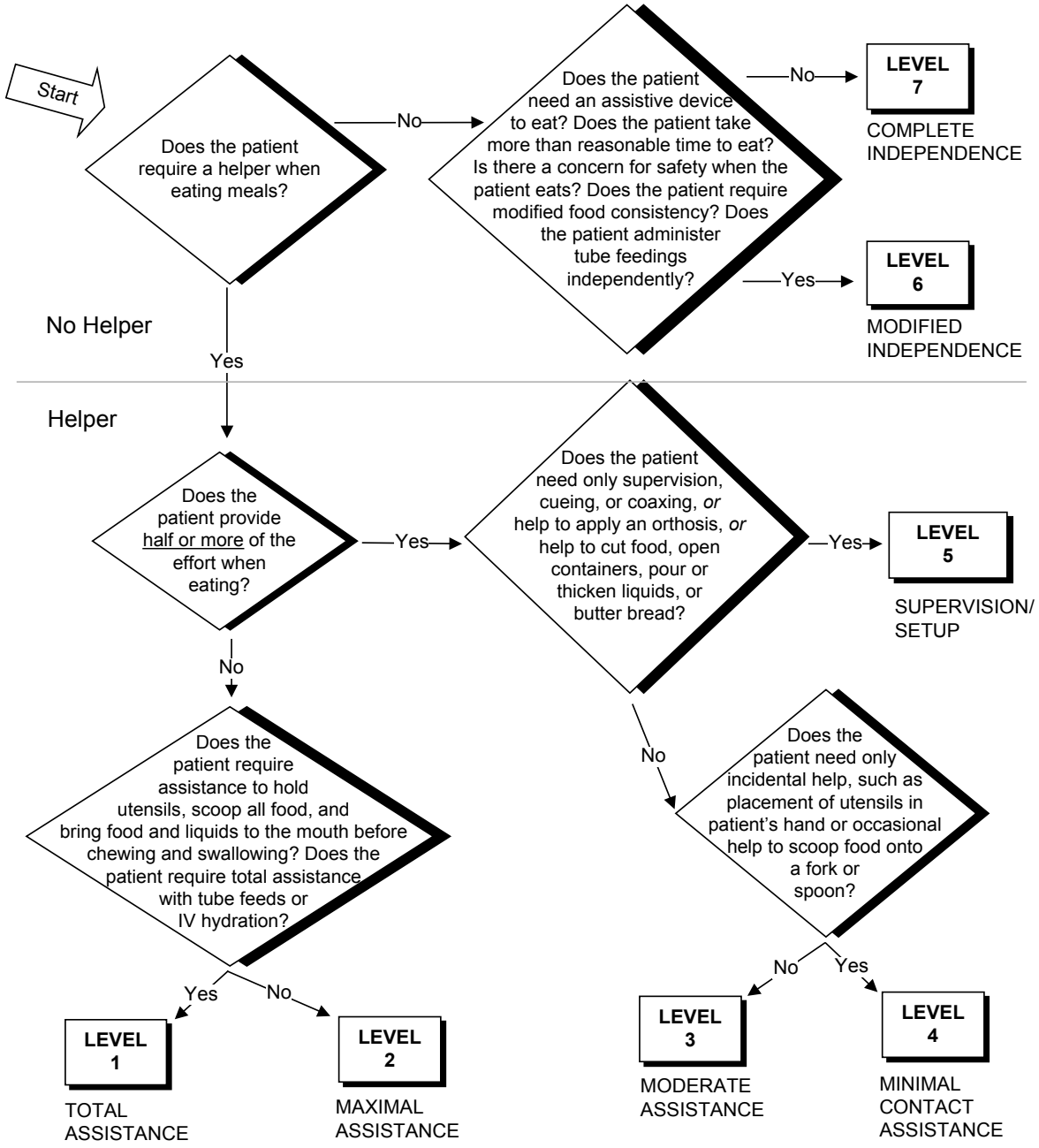


Figure 3. FIM® decision tree for item 42A, Eating

Grooming

Grooming includes oral care (brushing teeth); hair grooming (combing and brushing hair); washing, rinsing, and drying the hands; washing, rinsing, and drying the face; and shaving or applying makeup.

Rating guidelines:

- Grooming does not include flossing teeth, shampooing hair, or arranging hair in braids, ponytails, and other hairstyles.
- Grooming consists of four or five tasks. If the patient neither shaves nor applies makeup, grooming includes only the first four tasks, each of which should be rated as 25% of the total. If the patient does not have hair, do not assess hair grooming.
- Grooming includes obtaining articles necessary for grooming (for example, toothbrush, towels, combs, and brushes). It also includes initial setup (for example, applying toothpaste to a toothbrush).
- If the patient uses a wheelchair to complete grooming tasks, the wheelchair is **not** considered an assistive device.
- Base the rating on the number of tasks performed and the percentage of effort the patient contributes.

NO HELPER

7 **Complete Independence:** The patient safely performs all grooming tasks without assistance from a helper, without a device, and in a reasonable amount of time.

6 **Modified Independence:** The patient performs all grooming tasks without assistance from a helper, and one or more of the following are true:

- The patient requires an assistive/adaptive device (for example, orthosis, prosthesis, wash mitt, adapted toothbrush, adapted comb, and adapted brush), and the patient applies the device when applicable without assistance from a helper.
- The patient takes extra time to perform grooming tasks.
- There is a concern for the patient's safety when he performs grooming tasks.

HELPER

5 **Supervision/Setup:** The patient performs all grooming tasks but requires supervision (e.g., standing by, cueing, or coaxing) or setup (for example, applying an orthosis necessary for grooming, setting out grooming supplies, and assisting with initial preparation, such as applying toothpaste to toothbrush).

4 **Minimal Assistance:** The patient performs 75% or more of the grooming tasks.

3 **Moderate Assistance:** The patient performs 50% to 74% of the grooming tasks.

2 **Maximal Assistance:** The patient performs 25% to 49% of the grooming tasks.

1 **Total Assistance:** One or both of the following are true:

- The patient performs less than 25% of grooming tasks.
- The patient requires assistance from two helpers to perform grooming tasks.

Assess only the activities listed in the definition. Grooming does not include flossing teeth, shampooing or styling hair, applying deodorant, or shaving legs. If the patient is bald or chooses not to shave or apply makeup, do not assess those activities.

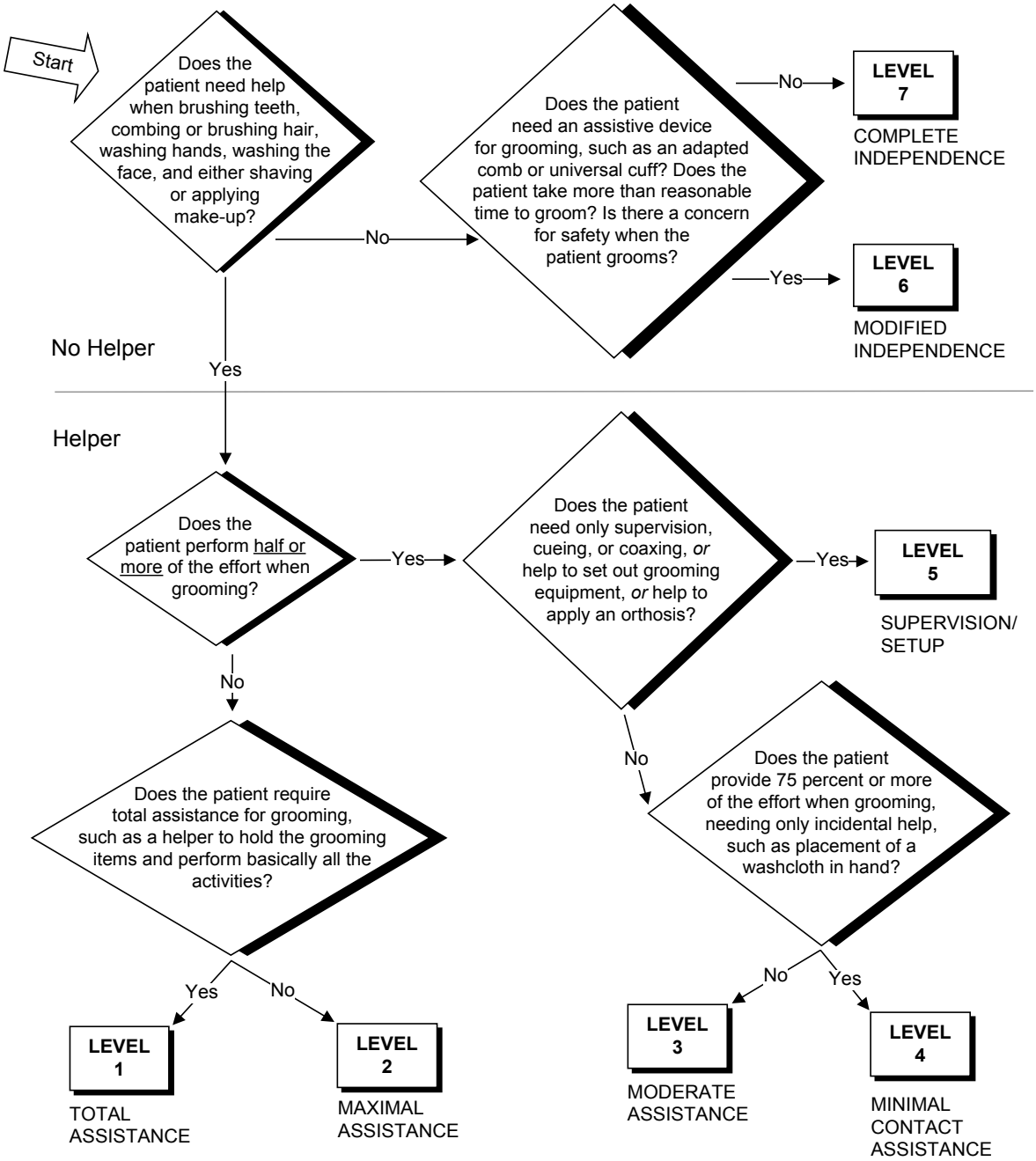


Figure 4. FIM® decision tree for item 42B, Grooming

Bathing

Bathing includes washing, rinsing, and drying the body from the neck down (excluding the neck and back) in 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 (such as a wash mitt or long-handled sponge) to bathe, the patient takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 **Supervision/Setup:** The patient requires supervision (e.g., standing by, cueing, 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 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:** One or more of the following are true:

- The patient performs less than 25% of bathing tasks.
- The patient requires assistance from two helpers.
- The activity does not occur. (The patient does not bathe himself, and a helper does not bathe him. This situation should be rare.)

When rating this item, divide the body into ten areas or body parts. If the patient requires physical assistance with washing, rinsing, and drying, count the number of areas the patient bathes from the following list:

1. Chest
2. Left arm
3. Right arm
4. Abdomen
5. Perineal area
6. Buttocks
7. Left upper leg
8. Right upper leg
9. Left lower leg (including foot)
10. Right lower leg (including foot)

Do not include the transfer to a tub bench or shower chair when assessing Bathing.

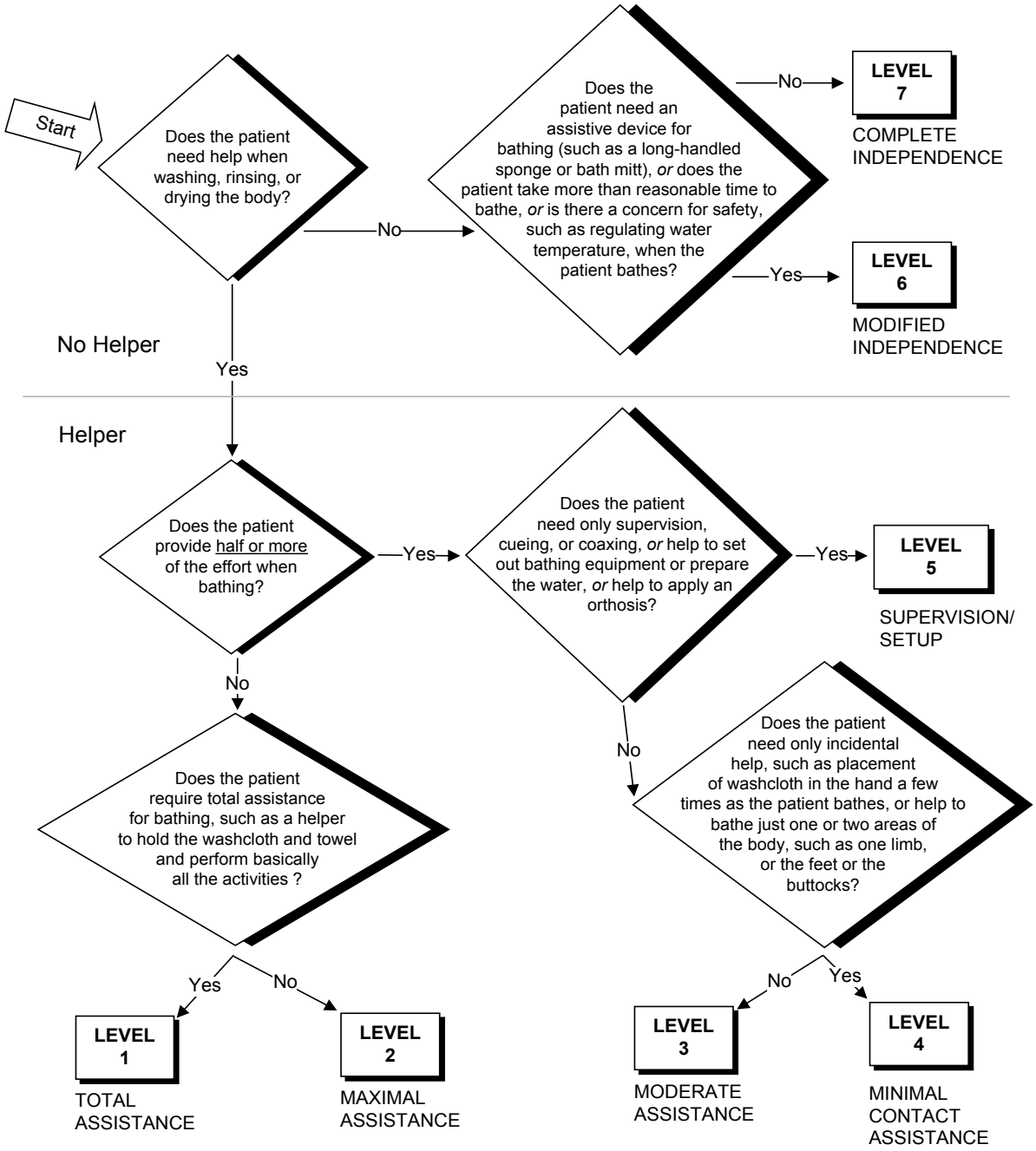


Figure 5. FIM® decision tree for item 42C, Bathing

Dressing: Upper Body

Dressing: Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or an orthosis when applicable. The patient performs the activity safely.

NO HELPER

7 **Complete Independence:** The patient dresses and undresses the upper body. 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. The patient performs this activity safely. If the patient uses a prosthesis or an orthosis, the patient applies it without assistance but does **not** require it as an assistive device in order to dress the upper body.

6 **Modified Independence:** The patient requires special adaptive closure, such as a Velcro® fastener, or an assistive device (including a prosthesis or an orthosis) to dress, or the patient takes more than a reasonable amount of time. If the patient uses a prosthesis or an orthosis as an assistive device to dress the upper body, the patient applies it himself.

HELPER

5 **Supervision/Setup:** The patient requires supervision (e.g., standing by, cueing, 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 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:** One or more of the following are true:

- The patient performs less than 25% of dressing tasks.
- The patient is completely dressed by a helper.
- The patient requires assistance from two helpers to complete the activity.
- The activity does not occur. (The patient does not dress himself, and a helper does not dress the patient.)

Comment: Do not assess dressing and undressing unless the patient wears clothing that is appropriate to wear in public. If the patient wears only hospital gowns or nightgowns/pajamas, rate the patient level 1, Total Assistance. Once the patient is admitted to the unit, and throughout the admission assessment period, staff must make every attempt to obtain clothing for the patient from any source. For example, if a patient is admitted wearing a hospital gown without any other items of clothing, and the patient does not possess these items on admission, then the staff should immediately request that the patient's family or friends bring suitable clothing for the patient to cover the upper body and lower body, including footwear. Once clothing is available during the admission assessment period, any previous ratings recorded during the admission assessment period should be updated to reflect the patient's performance of this task with clothing. Rate dressing tasks during the time of day in which the patient is usually awake and alert. The updated rating will better reflect the patient's actual functional performance; by contrast, level 1 in this instance indicates only that the activity did not occur during the admission assessment period or that a helper dressed the patient completely.

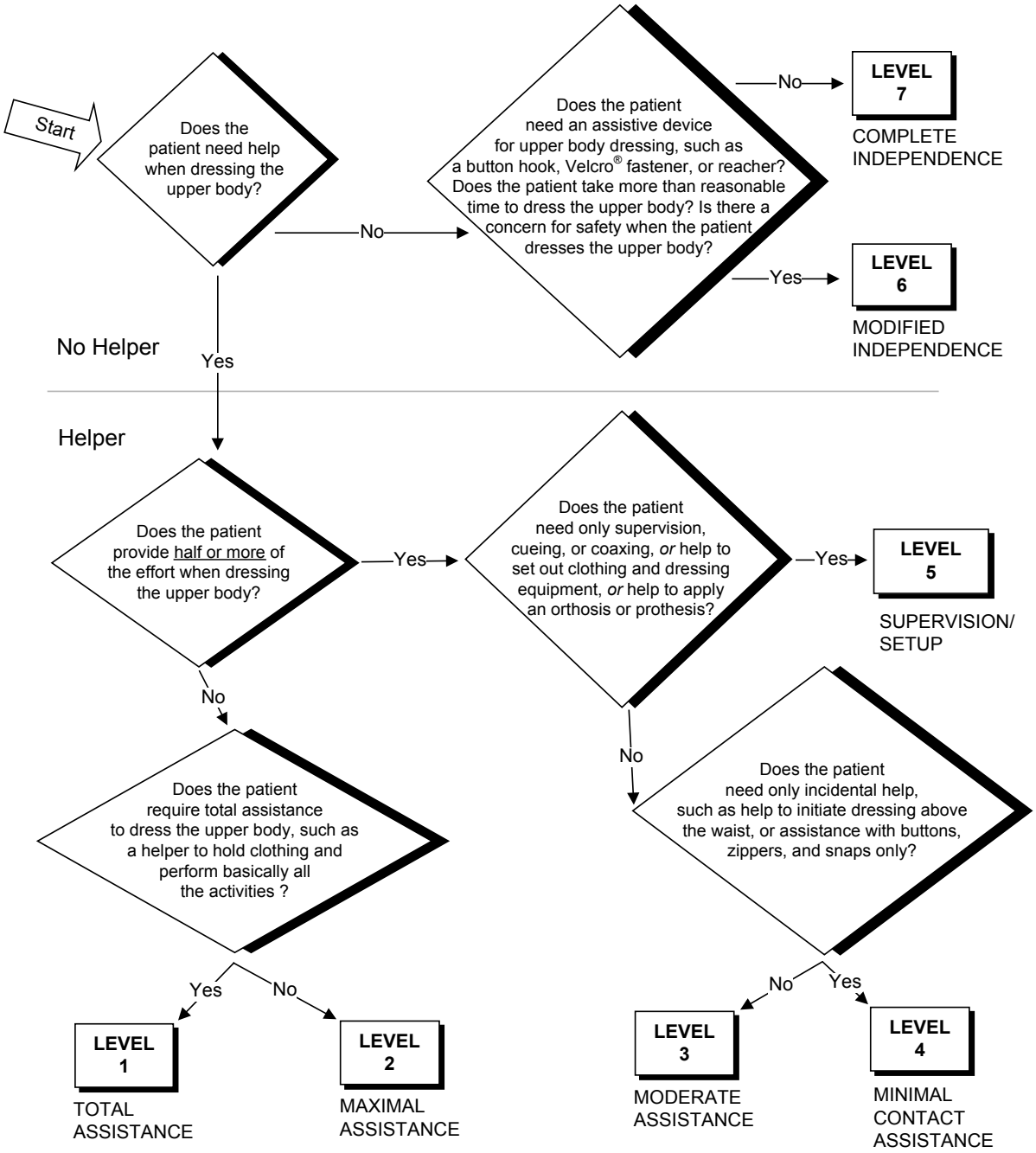


Figure 6. FIM® decision tree for item 42D, Dressing: Upper Body

Dressing: Lower Body

Dressing: Lower Body includes dressing and undressing from the waist down as well as applying and removing a prosthesis or an orthosis when applicable. The patient performs the activity safely.

NO HELPER

7 Complete Independence: The patient dresses and undresses the lower body. This includes obtaining clothes from their customary places (such as drawers and closets) and may include managing underpants, slacks, skirts, belts, stockings, shoes, zippers, buttons and snaps. The patient performs this activity safely. If the patient uses a prosthesis or an orthosis, the patient applies it himself but does **not** require it as an assistive device in order to dress the lower body.

6 Modified Independence: The patient requires special adaptive closure, such as a Velcro® fastener, or an assistive device (including a prosthesis or an orthosis) to dress, or the patient takes more than a reasonable amount of time. If the patient uses a prosthesis or an orthosis as an assistive device to dress the lower body, the patient applies it himself.

HELPER

5 Supervision/Setup: The patient requires supervision (e.g., standing by, cueing, 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 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: One or more of the following are true:

- The patient performs less than 25% of dressing tasks.
- The patient is completely dressed by a helper.
- The patient requires assistance from two helpers to complete the activity.
- The activity does not occur. (The patient does not dress himself, and a helper does not dress the patient.)

Comment: Do not assess dressing and undressing unless the patient wears clothing that is appropriate to wear in public. If the patient wears only hospital gowns or nightgowns/pajamas, rate the patient level 1, Total Assistance. Once the patient is admitted to the unit, and throughout the admission assessment period, staff must make every attempt to obtain clothing for the patient from any source. For example, if a patient is admitted wearing a hospital gown without any other items of clothing, and the patient does not possess these items on admission, then the staff should immediately request that the patient's family or friends bring suitable clothing for the patient to cover the upper body and lower body, including footwear. Once clothing is available during the admission assessment period, any previous ratings recorded during the admission assessment period should be updated to reflect the patient's performance of this task with clothing. Rate dressing tasks during the time of day in which the patient is usually awake and alert. The updated rating will better reflect the patient's actual functional performance; by contrast, level 1 in this

instance indicates only that the activity did not occur during the admission assessment period or that a helper dressed the patient completely.

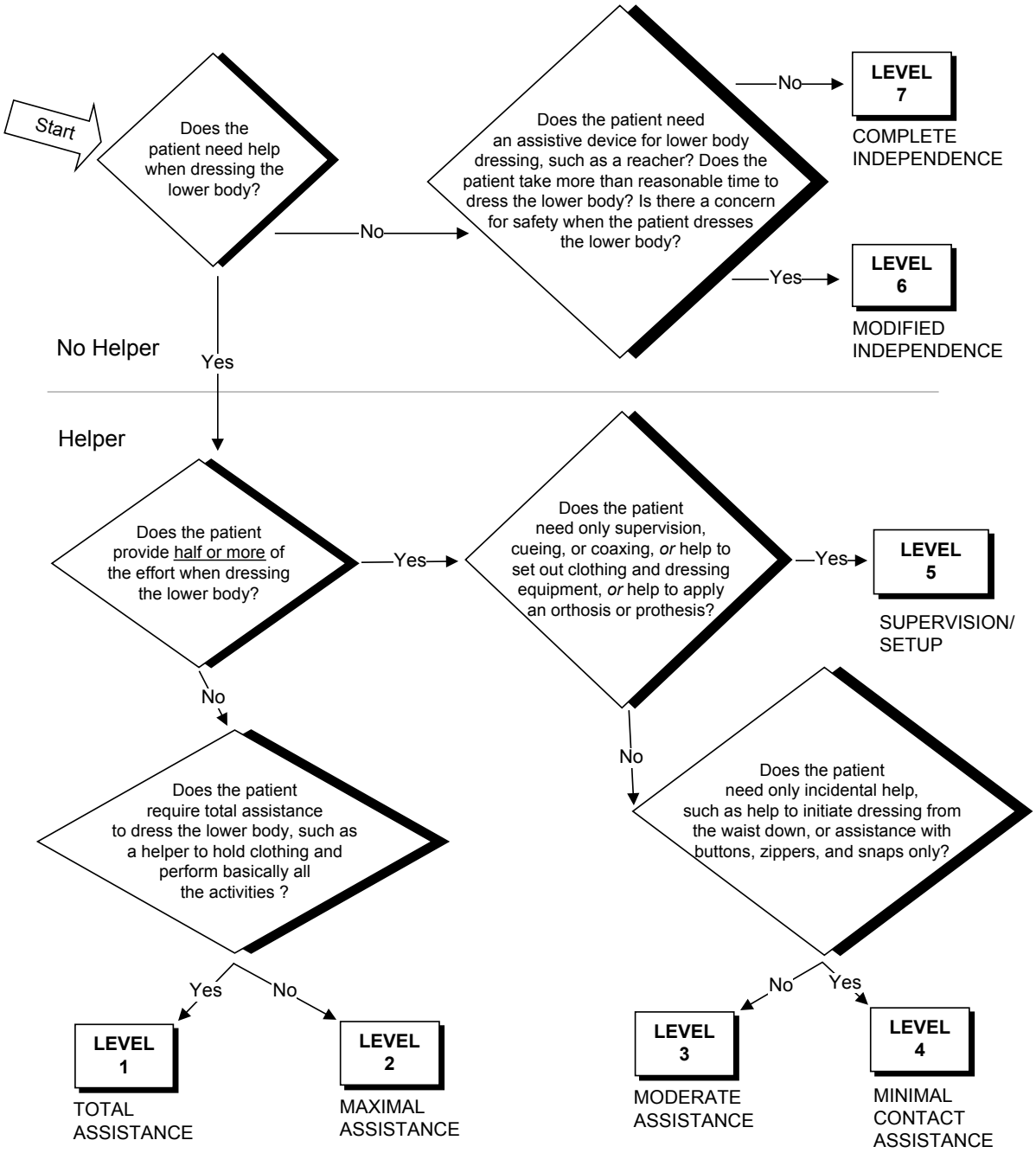


Figure 7. FIM® decision tree for item 42E, Dressing: Lower Body

Toileting

Toileting includes maintaining perineal hygiene and adjusting clothing before and after using toilet, commode, bedpan, or urinal after a continent episode. The patient performs the activity safely.

NO HELPER

7 **Complete Independence:** The patient safely cleanses self after voiding and bowel movements, safely puts on or inserts feminine hygiene products (sanitary napkins, tampons, etc.) if needed, and safely adjusts clothing before and after using a toilet, bedpan, commode, or urinal.

6 **Modified Independence:** The patient requires specialized equipment (such as an orthosis or prosthesis) during toileting, the patient takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 **Supervision/Setup:** The patient requires supervision (e.g., standing by, cueing, or coaxing), setup (application of adaptive devices or opening packages), or assistance with feminine hygiene products (sanitary napkins or tampons, usually three to five days per month).

4 **Minimal 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 or requires assistance from two helpers.

Comment: If the patient is incontinent of bowel **or** bladder, wait for a continent episode of bowel or bladder to rate this item. If the patient is always incontinent of **both** bowel and bladder throughout the entire assessment period, rate the patient level 1, Total Assistance.

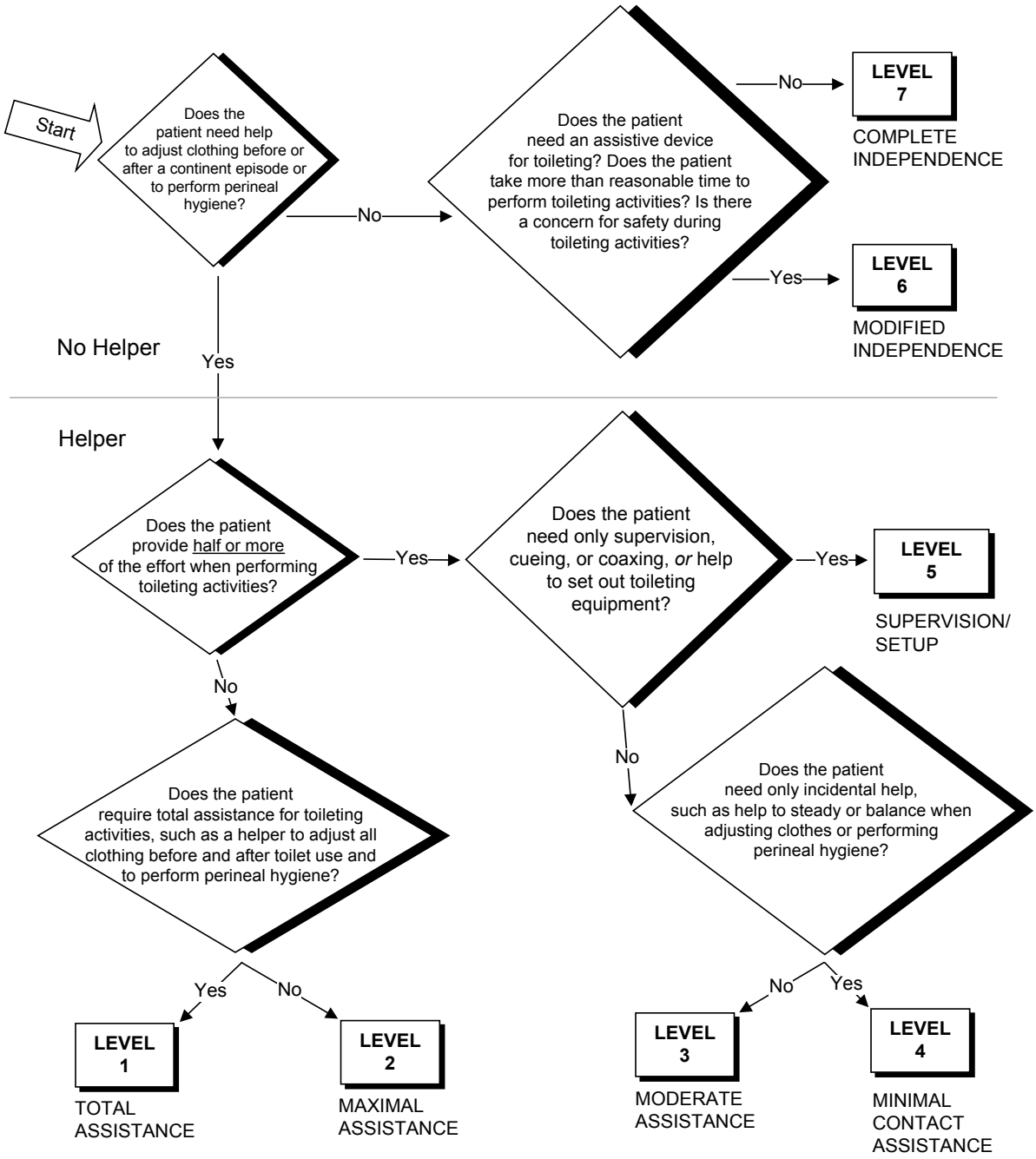


Figure 8. FIM® decision tree for item 42F, Toileting

Bladder Level of Assistance

Bladder Management includes complete and intentional control of urinary bladder and use of any equipment and medication (agents) necessary for bladder control. This item deals with the level of assistance required to complete bladder management tasks. A separate variable, Bladder Frequency of Accidents, deals with the success of the bladder program.

NO HELPER

7 Complete Independence: The patient controls the bladder completely and intentionally (no accidents) without assistance from a helper, without a device or medication, and in a reasonable amount of time; **or** the patient does not void (e.g., has renal failure and is on hemodialysis or peritoneal dialysis).

6 Modified Independence: The patient controls their bladder completely and intentionally (no accidents) **or** has an assistive device (such as a urostomy) that has not leaked (wetting linen or clothing), **and** one or more of the following are true:

- The patient requires an assistive device such as a bedpan, commode with a bucket, or urinal; retrieves the device if necessary; and empties it.
- The patient uses an absorbent pad or diaper and changes it without assistance.
- The patient requires catheterization, performs it independently (self-catheterization), and manages all aspects of preparation and cleanup.
- The patient requires medication (agents) for control.
- The patient maintains a urostomy without assistance, and there have not been any incidents of leakage onto linen or clothing.
- The patient takes extra time to perform bladder management tasks.
- There is a concern for the patient's safety when performing bladder management tasks.

HELPER

5 Supervision/Setup: One or more of the following are true:

- The patient requires supervision or setup of equipment necessary for the patient to maintain a satisfactory voiding pattern or to maintain a urostomy bag.
- A helper provides standby assistance, cueing, or coaxing as the patient uses a device (e.g., self-catheterization, urostomy care).
- A helper obtains a bedpan, urinal, or commode with a bucket for the patient; empties the device; or performs both tasks.
- The patient cleans himself up after an accident or incontinent episode.

4 Minimal Assistance: One or both of the following are true:

- The patient performs 75% or more of the bladder management tasks.
- The patient requires minimal assistance to maintain a satisfactory voiding pattern with the use of assistive devices.

3 Moderate Assistance: One or both of the following are true:

- The patient performs 50% to 74% of the bladder management tasks.
- The patient requires moderate assistance to maintain a satisfactory voiding pattern with the use of assistive devices.

2 Maximal Assistance: One or more of the following are true:

- The patient performs 25% to 49% of the bladder management tasks.
- The patient requires maximal assistance to maintain a satisfactory voiding pattern with the use of assistive devices.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of the bladder management tasks.
- A helper changes the patient's absorbent pad or diaper.
- The patient had an accident, and a helper changed the patient's linen or clothing.
- The patient requires assistance from two helpers to perform bladder management tasks.

Comment: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance for some patients.

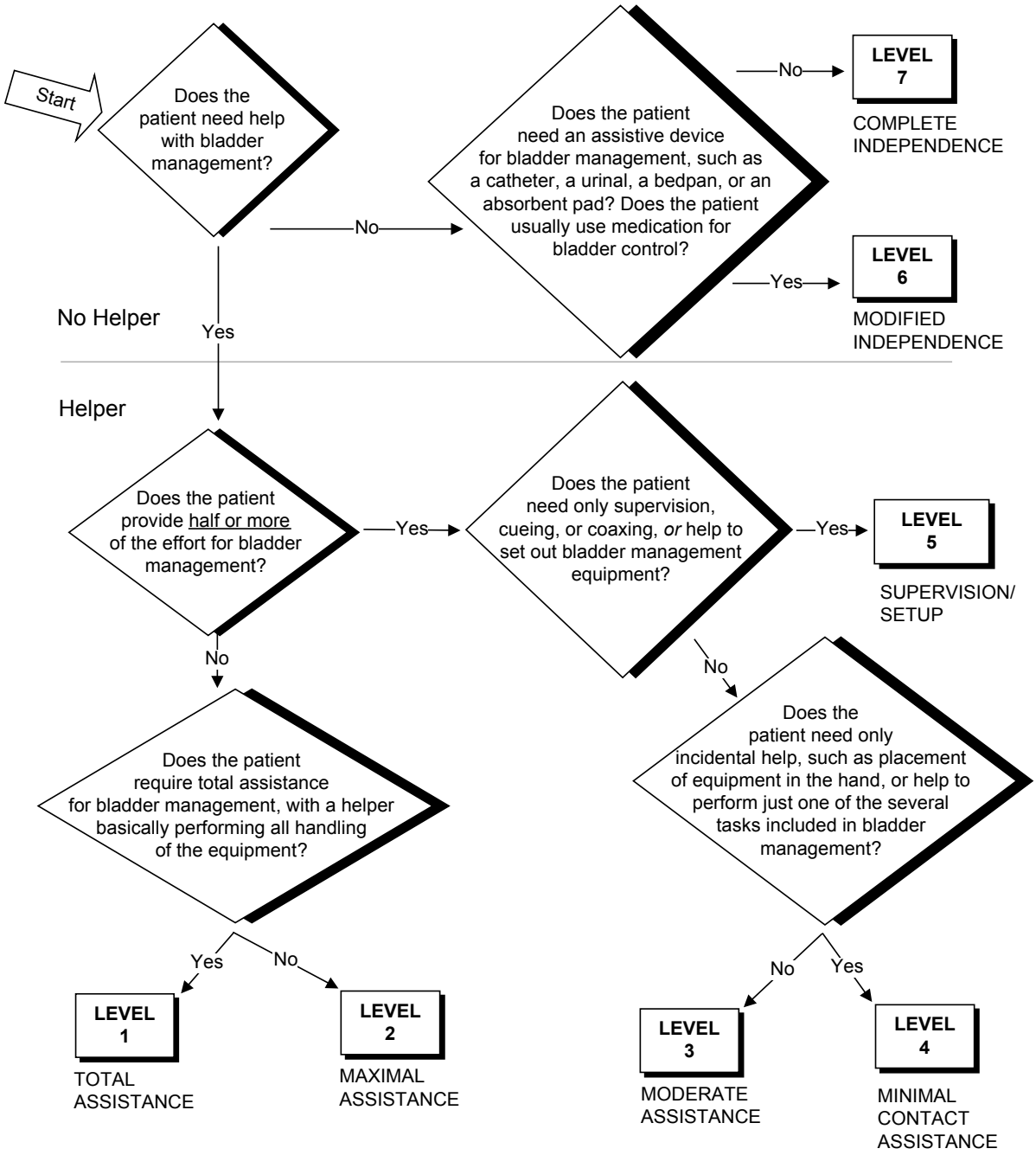


Figure 9. FIM® decision tree for Bladder Level of Assistance

Bladder Frequency of Accidents

Bladder Management includes complete and intentional control of urinary bladder and use of any equipment and medication (agents) necessary for bladder control. This item deals with the success of the bladder management program. A separate variable, Bladder Level of Assistance, deals with the level of assistance required to complete bowel management tasks.

Bladder Frequency of Accidents is determined by tallying the number of accidents (wetting of linen or clothing) that occur during the three-day assessment period.

For this item, a *bladder accident* is defined as the act of wetting linen or clothing with urine, including bedpan or urinal spills and urostomy leakage.

NO HELPER

7 **No accidents:** The patient controls his bladder completely and intentionally, is never incontinent, and thus has not had any accidents; **or** the patient does not void (e.g., has renal failure and is on hemodialysis or peritoneal dialysis).

6 **No accidents, uses a device such as a catheter:** The patient controls bladders completely and intentionally **(no accidents) or** has an assistive device (such as a urostomy or catheter) that has not leaked (wetting linen or clothing), **and** one or more of the following are true:

- The patient requires an assistive device such as a bedpan, commode with a bucket, or urinal; retrieves the device if necessary; and empties it.
- The patient uses an absorbent pad or diaper and changes it without assistance.
- The patient requires medication (agents) for control.
- The patient maintains a urostomy or catheter without assistance, and there have not been any incidents of wetting linen or clothing.
- The patient takes extra time to perform bladder management tasks.
- There is a concern for the patient's safety when he performs bladder management tasks.

5 The patient has had one (1) bladder accident, including bedpan or urinal spills or urostomy leakage, in the past three days.

4 The patient has had two (2) bladder accidents, including bedpan or urinal spills or urostomy leakage, in the past three days.

3 The patient has had three (3) bladder accidents, including bedpan or urinal spills or urostomy leakage, in the past three days.

2 The patient has had four (4) bladder accidents, including bedpan or urinal spills or urostomy leakage, in the past three days.

1 The patient has had five (5) or more accidents, including bedpan or urinal spills or urostomy leakage, in the past three days.

Comment: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance for some patients.

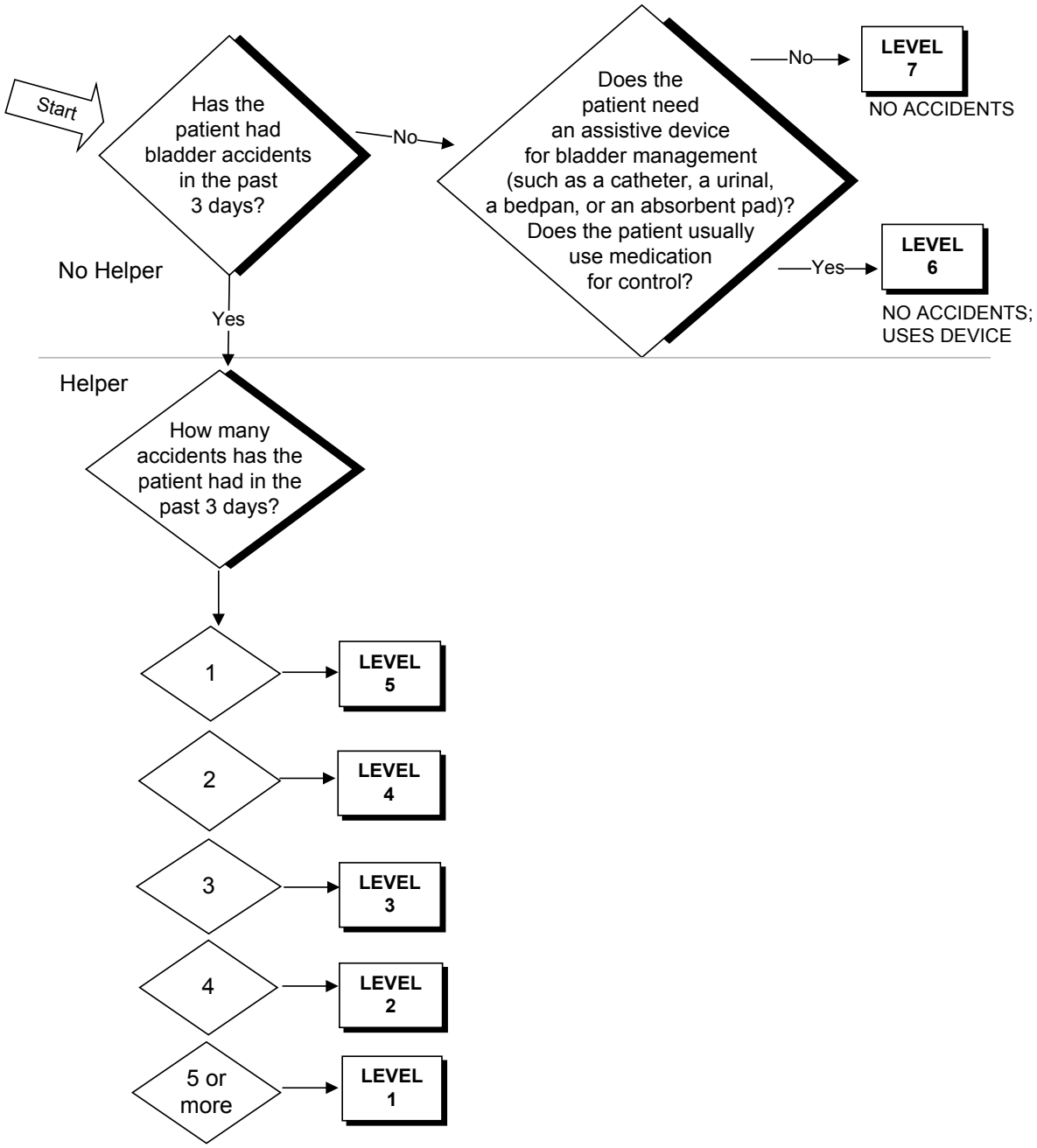


Figure 10. FIM® decision tree for Bladder Frequency of Accidents

Bowel Level of Assistance

Bowel Management includes complete intentional control of bowel movements and, if necessary, use of equipment or agents for bladder control. This item deals with the level of assistance required to complete bowel management tasks. A separate variable, Bowel Frequency of Accidents, deals with the success of the bowel management program.

NO HELPER

7 Complete Independence: The patient controls bowels completely and intentionally without assistance from a helper, without a device or medication, and in a reasonable amount of time.

6 Modified Independence: The patient controls bowels completely and intentionally **(no accidents) or** has an assistive device (such as a colostomy) that has not leaked (soiling linen or clothing), **and** one or more of the following are true:

- The patient requires an assistive device such as a bedpan or commode with a bucket, retrieves the device if necessary, and empties it.
- The patient uses an absorbent pad or diaper and changes it without assistance.
- The patient requires stool softeners, suppositories, or laxatives (other than natural laxatives such as prunes) and manages all aspects of administration, including preparation and cleanup.
- The patient requires medication (agents) for control.
- The patient maintains a colostomy without assistance, and there have not been any incidents of leakage onto linen or clothing.
- The patient takes extra time to perform bowel management tasks.
- There is a concern for the patient's safety when he performs bowel management tasks.

HELPER

5 Supervision/Setup: One or more of the following are true:

- The patient requires supervision or setup of equipment necessary for the patient to maintain a satisfactory excretory pattern or to maintain an ostomy device.
- A helper provides standby assistance, cueing, or coaxing as the patient uses a device (e.g., self-insertion of suppository, ostomy care).
- A helper obtains a bedpan or a commode with a bucket for the patient, empties it, or performs both tasks.
- The patient cleans himself up after an accident or incontinent episode.

4 Minimal Assistance: One or both of the following are true:

- The patient performs 75% or more of the bowel management tasks.
- The patient requires minimal assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

3 Moderate Assistance: One or both of the following are true:

- The patient performs 50% to 74% of the bowel management tasks.
- The patient requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

2 Maximal Assistance: One or both of the following are true:

- The patient performs 25% to 49% of the bowel management tasks.
- The patient requires maximal assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of the bowel management tasks.
- A helper changes the patient's absorbent pad or diaper.
- The patient had an accident, and a helper changed the patient's linen or clothing.
- The patient requires assistance from two helpers to perform bowel management tasks.

Comment: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance in some patients.

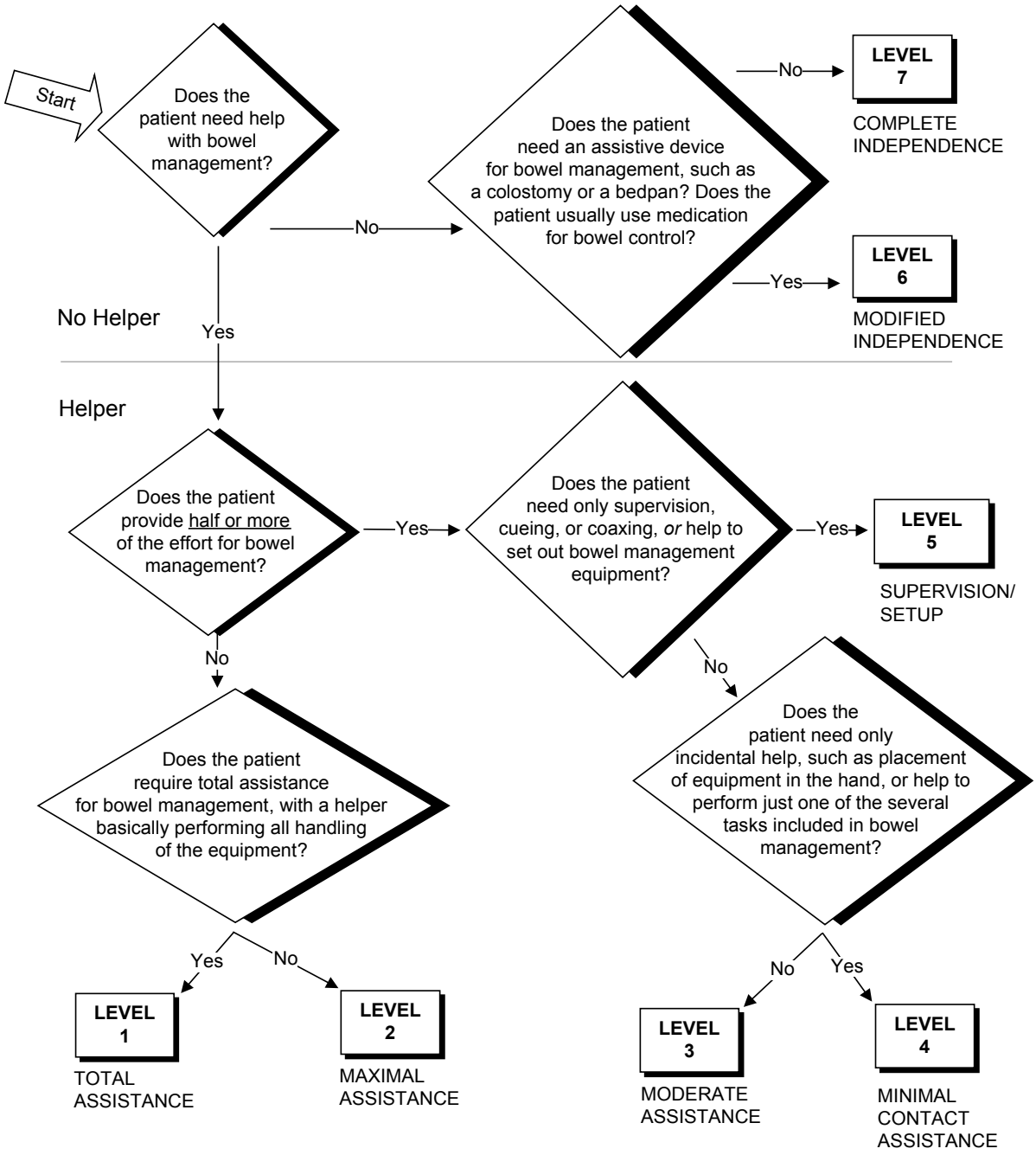


Figure 11. FIM® decision tree for Bowel Level of Assistance

Bowel Frequency of Accidents

Bowel Management includes complete and intentional control of bowel movements and use of any equipment and medication (agents) necessary for bowel control. This item deals with the success of the bowel management program. A separate variable, Bowel Level of Assistance, deals with the level of assistance required to complete bowel management tasks.

Bowel Frequency of Accidents is determined by tallying the number of accidents (wetting of linen or clothing) that occur during the three-day assessment period.

For this item, a *bowel accident* is defined as the act of soiling linen or clothing with stool, including bedpan spills and colostomy leakage.

NO HELPER

7 **No accidents:** The patient controls his bowels completely and intentionally, is never incontinent, and thus has not had any accidents.

6 **No accidents, uses a device such as an ostomy:** The patient controls bowels completely and intentionally **(no accidents) or** has an assistive device (such as a colostomy) that has not leaked (soiling linen or clothing), **and** one or more of the following are true:

- The patient requires an assistive device such as a bedpan or commode with a bucket, retrieves the device if necessary, and empties it.
- The patient uses an absorbent pad or diaper and changes it without assistance.
- The patient requires stool softeners, suppositories, or laxatives (other than natural laxatives such as prunes) and manages all aspects of administration, including preparation and cleanup.
- The patient requires medication (agents) for control.
- The patient maintains a colostomy without assistance, and there have not been any incidents of leakage onto linen or clothing.
- The patient takes extra time to perform bowel management tasks.
- There is a concern for the patient's safety when he performs bowel management tasks.

5 The patient has had one (1) bowel accident, including bedpan spills or colostomy leakage, in the past three days.

4 The patient has had two (2) bowel accidents, including bedpan spills or colostomy leakage, in the past three days.

3 The patient has had three (3) bowel accidents, including bedpan spills or colostomy leakage, in the past three days.

2 The patient has had four (4) bowel accidents, including bedpan pills or colostomy leakage, in the past three days.

1 The patient has had five (5) or more accidents, including bedpan spills or colostomy leakage, in the past three days.

Comment: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance in some patients.

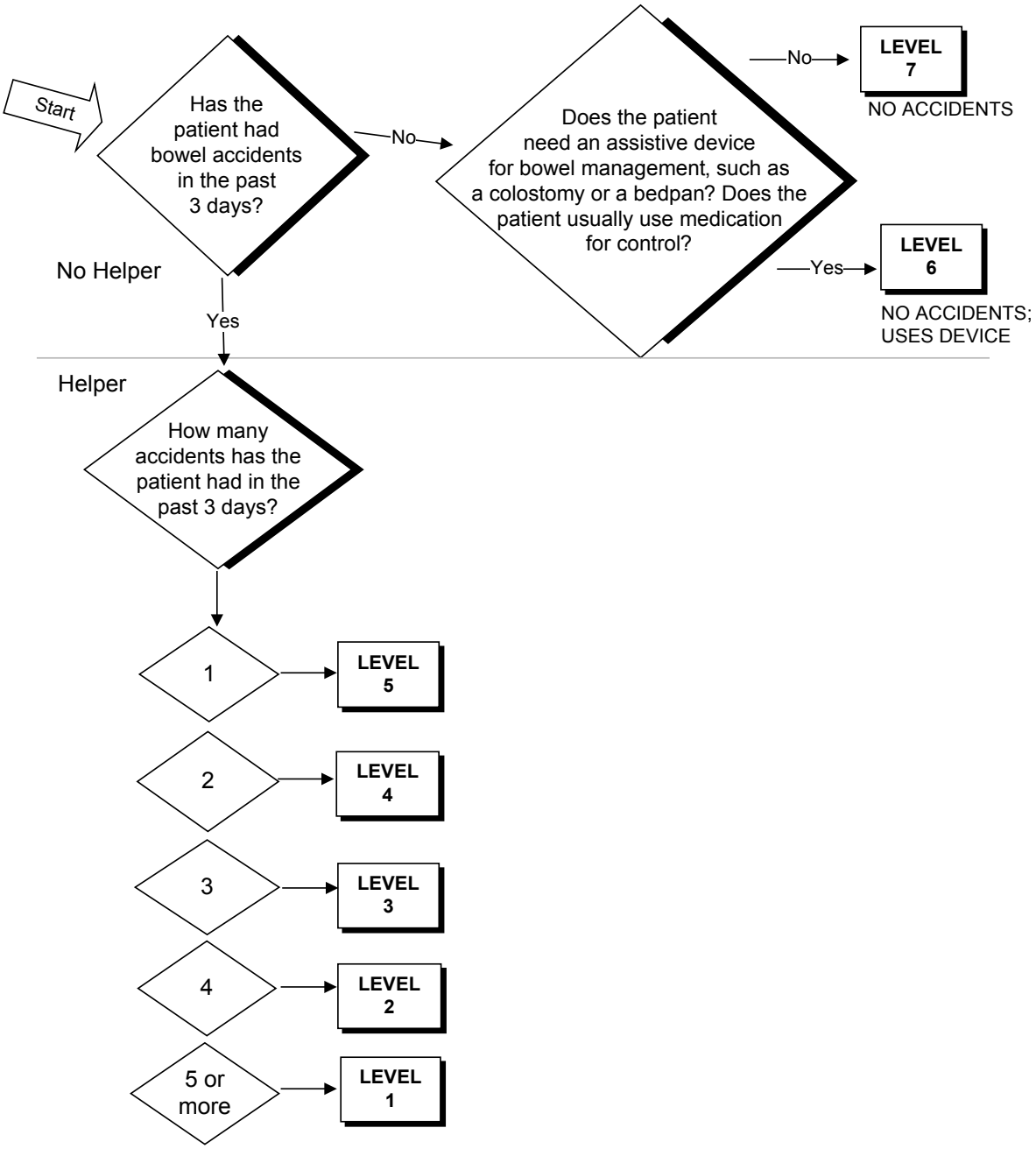


Figure 12. FIM® decision tree for Bowel Frequency of Accidents

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

If in a wheelchair, the patient 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. The patient performs this activity safely.

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

HELPER

5 Supervision/Setup: The patient requires supervision (e.g., standing by, cueing, or coaxing) or setup (positioning sliding board, moving footrests, etc.).

4 Minimal Assistance: One or more of the following are true:

- The patient performs 75% or more of transferring tasks.
- The patient requires only touching, guiding, or contact assistance to complete the transfer.
- The patient requires assistance to lift one extremity in and out of bed.

3 Moderate Assistance: One or more of the following are true:

- The patient performs 50% to 74% of transferring tasks.
- The patient approaches the chair or bed but requires lifting assistance to either sit down **or** stand up.
- The patient requires assistance to lift two extremities in and out of bed.

2 Maximal Assistance: One or both of the following are true:

- The patient performs 25% to 49% of transferring tasks.
- The patient approaches the chair or bed but requires lifting assistance to sit down **and** stand up.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of transferring tasks.
- The patient requires assistance from two helpers to transfer.
- The patient requires assistance to approach the chair or bed, sit down, **and** stand up.

- The activity does not occur.

Comment: During the bed-to-chair transfer, the patient begins in a supine position and ends in a sitting position; during the chair-to-bed transfer, the patient begins in a sitting position and ends in a supine position. If the patient uses a lift or a two-person transfer but does so because of facility policy rather than need, do not rate that transfer.

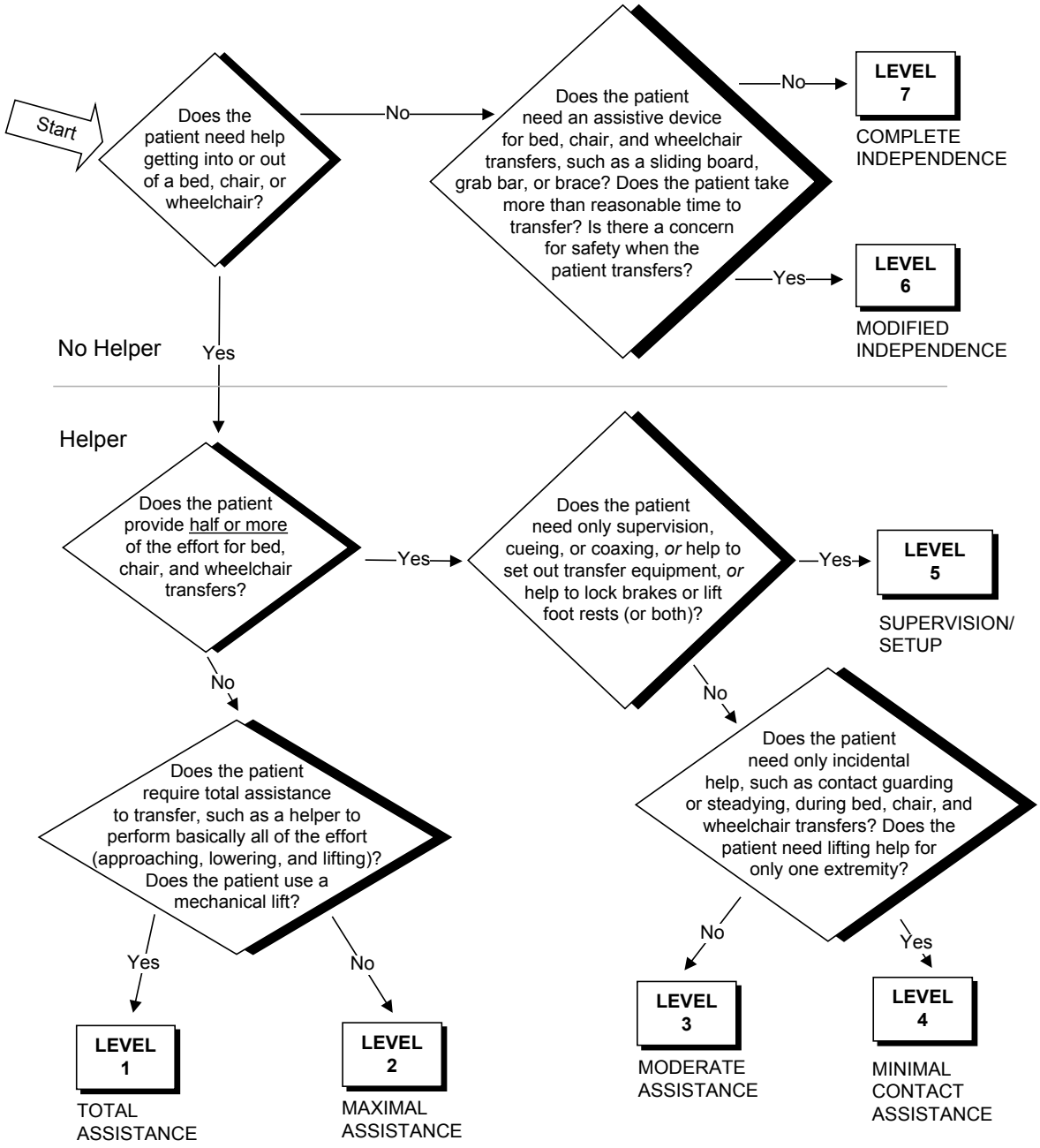


Figure 13. FIM® decision tree for item 42l, Transfers: Bed, Chair, Wheelchair

Transfers: Toilet

Transfers: Toilet includes all aspects of transferring on and off a toilet. This includes safely approaching, sitting down on, and getting up from the toilet.

Rating guidelines:

- When rating this item, assess the patient's transfers to and from a standard toilet.
- Prostheses and orthoses are considered assistive devices if required for a transfer.

NO HELPER

7 Complete Independence: The patient safely transfers to and from a toilet without assistance from a helper, without a device, and in a reasonable amount of time.

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

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

6 Modified Independence: The patient transfers to and from a toilet without assistance from a helper, and one or more of the following are true:

- The patient requires an adaptive/assistive device (for example, sliding board, grab bars, or special seat) to transfer.
- The patient takes extra time to transfer.
- There is a concern for the patient's safety when he transfers.

HELPER

5 Supervision/Setup: The patient transfers to and from a toilet but requires supervision (for example, standing by, cueing, or coaxing) or setup (for example, positioning a sliding board or moving an armrest).

4 Minimal Assistance: One or both of the following are true:

- The patient performs 75% or more of transferring tasks.
- The patient requires only touching, guiding, or contact assistance to complete the transfer.

3 Moderate Assistance: One or both of the following are true:

- The patient performs 50% to 74% of transferring tasks.
- The patient approaches the toilet or commode but requires lowering assistance to sit down **or** lifting assistance to stand up.

2 Maximal Assistance: One or both of the following are true:

- The patient performs 25% to 49% of transferring tasks.
- The patient approaches the toilet or commode with assistance but requires lifting assistance to sit down **and** stand up.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of transferring tasks.
- The patient requires assistance from two helpers to transfer.
- The patient requires assistance to approach the toilet or commode, lowering assistance to sit down, **and** lifting assistance to stand up.
- The activity does not occur.

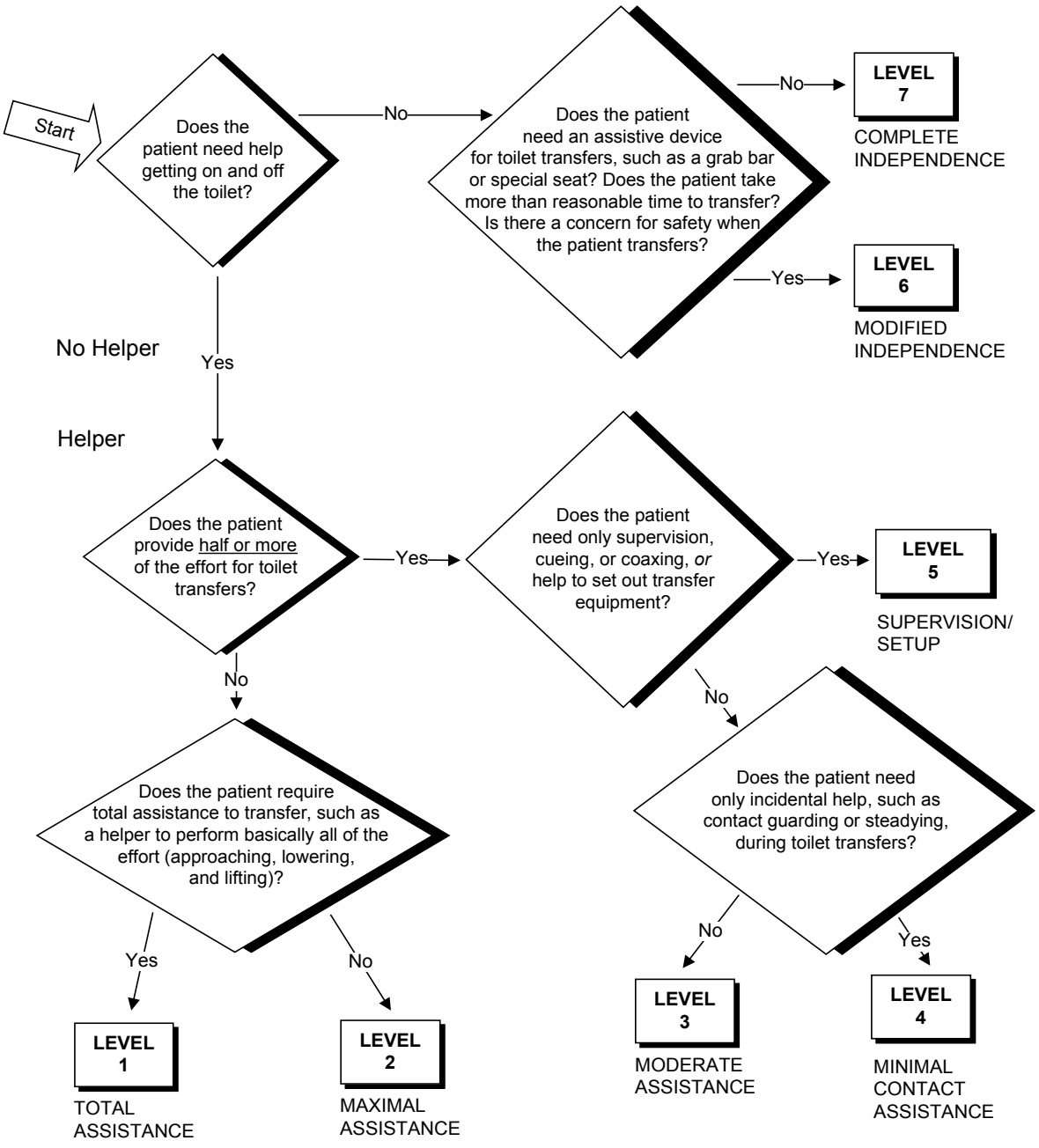


Figure 14. FIM® decision tree for item 42J, Transfers: Toilet

Transfers: Tub, Shower

Transfer: Tub, Shower includes getting into and out of a tub or shower. The patient performs the activity safely. Rate this item during an actual performance of the activity, not a simulation. If the patient performs both tub and shower transfers, base the patient's rating on the more frequent mode of transfer.

NO HELPER

7 Complete Independence:

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

If in a wheelchair, the patient approaches a 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. The patient performs the activity safely.

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

HELPER

5 Supervision/Setup: The patient requires supervision (e.g., standing by, cueing, or coaxing) or setup (positioning sliding board, moving footrests, etc.).

4 Minimal Assistance: One or more of the following are true:

- The patient performs 75% or more of transferring tasks.
- The patient requires only touching, guiding, or contact assistance to complete the transfer.
- The patient requires assistance to lift **one** extremity in and out of the tub or shower.

3 Moderate Assistance: One or more of the following are true:

- The patient performs 50% to 74% of transferring tasks.
- The patient approaches the tub or shower with assistance but also requires lifting assistance to transfer in **or** out of the tub or shower.
- The patient requires assistance to lift **two** extremities in and out of the tub or shower.

2 Maximal Assistance: One or both of the following are true:

- The patient performs 25% to 49% of transferring tasks.
- The patient approaches the tub or shower with assistance but requires lifting assistance to transfer in **and** out of the tub or shower.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of transferring tasks.
- The patient requires assistance from two helpers to transfer.

- The patient requires assistance to approach the tub or shower, transfer in, **and** transfer out.
- The activity does not occur.

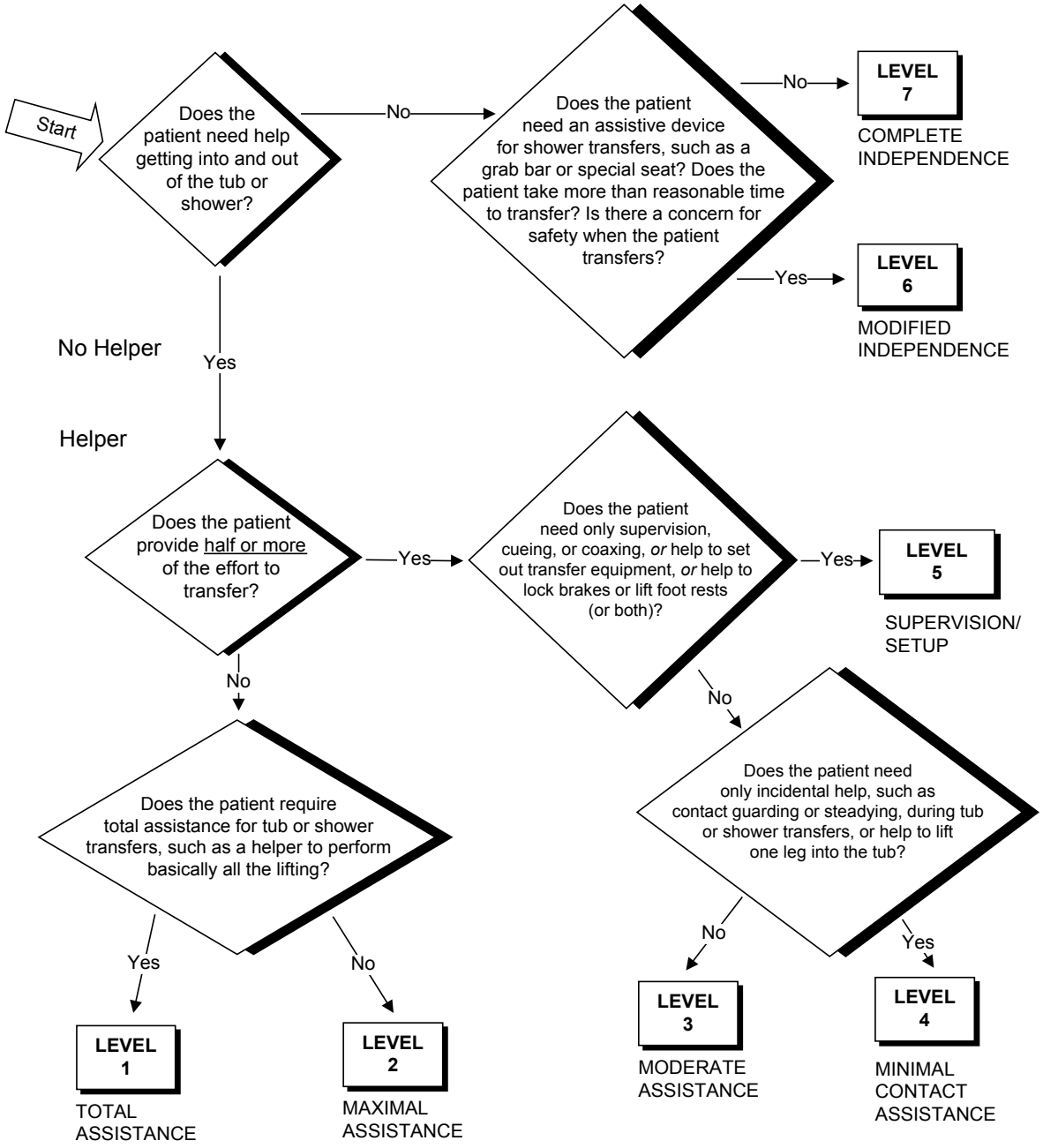


Figure 15. FIM® decision tree for item 42K, Transfers: Tub, Shower

Locomotion: Walk, Wheelchair

If the patient walks, *Locomotion: Walk, Wheelchair* includes walking on a level surface once in a standing position; if the patient uses a wheelchair, *Locomotion: Walk, Wheelchair* includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. Indicate the more frequent mode of locomotion ("W" for "walk" or "C" for "wheelchair"); if both are used about equally, code "B" for "both."

NO HELPER

7 Complete Independence: The patient walks a minimum of 150 feet (45 meters) without assistive devices. The patient performs the activity safely.

6 Modified Independence:

If walking, the patient walks a minimum of 150 feet, but one or more of the following are true: (a) the patient uses an assistive device of some kind, (b) the patient takes more than reasonable time, or (c) there are safety concerns when the patient performs the activity.

If using a wheelchair, the patient operates a manual or motorized wheelchair independently for a minimum of 150 feet (45 meters); turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; and maneuvers on rugs and over door sills.

5 Exception, Household Locomotion:

If walking, the patient walks only short distances (50–149 feet) **independently**, with or without a device.

If using a wheelchair, the patient operates a manual or motorized wheelchair **independently** for short distances only (50–149 feet).

HELPER

5 Supervision:

If walking, the patient requires standby supervision, cueing, or coaxing to walk a minimum of 150 feet (45 meters).

If in a wheelchair, the patient requires standby supervision, cueing, or coaxing to go a minimum of 150 feet (45 meters) in a wheelchair.

4 Minimal Assistance: The patient performs 75% or more of the effort to travel a minimum of 150 feet (45 meters).

3 Moderate Assistance: The patient performs 50% to 74% of the effort to travel a minimum of 150 feet (45 meters).

2 Maximal Assistance: The patient performs 25% to 49% of the effort to travel 50–149 feet and requires the assistance of one person only.

1 Total Assistance: One or more of the following are true:

- The patient performs less than 25% of the effort.
- The patient requires assistance from two helpers.
- The patient does not walk or wheel a minimum of 50 feet (15 meters).

- The activity does not occur.

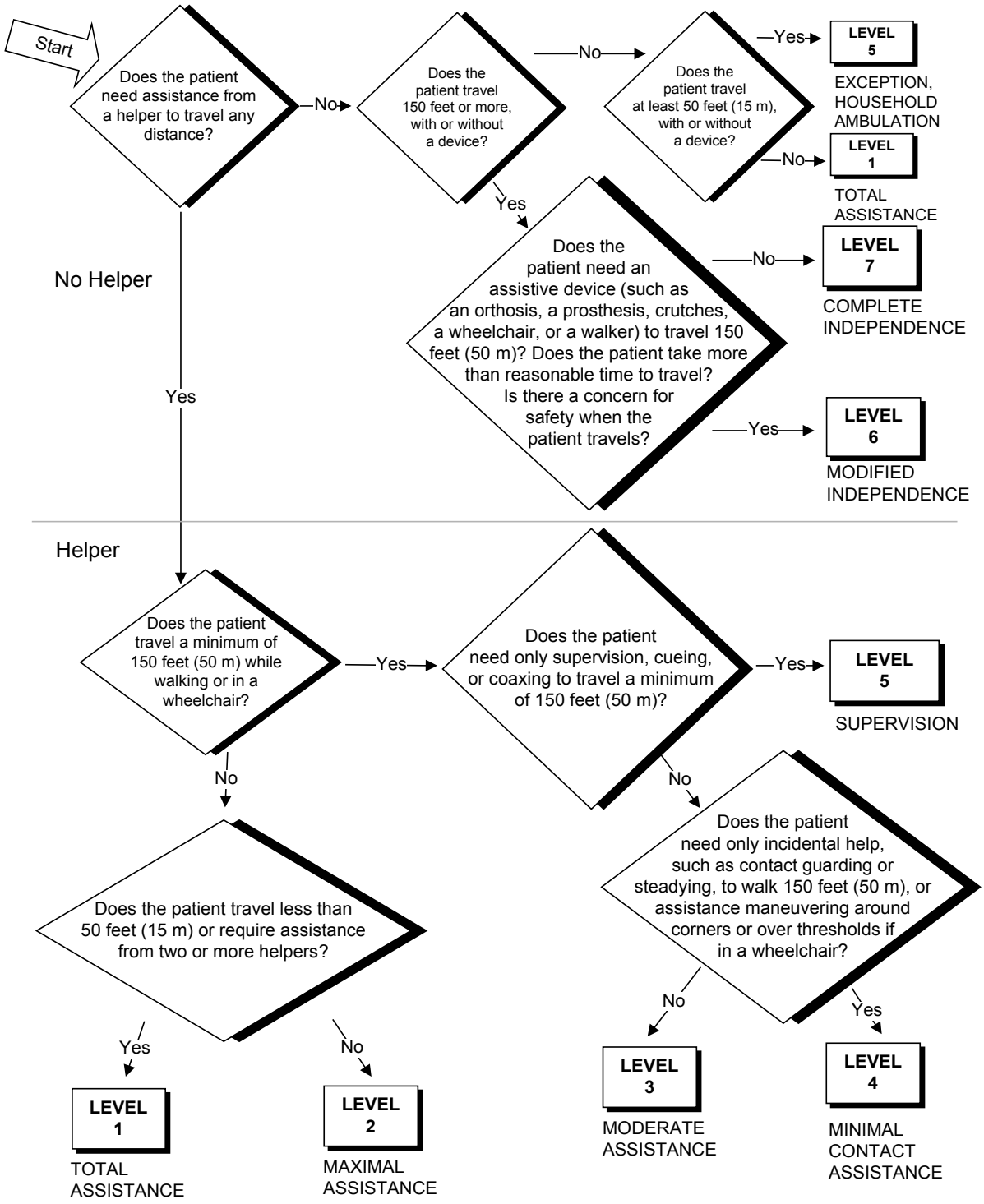


Figure 16. FIM® decision tree for item 42L, Locomotion: Walk, Wheelchair

Locomotion: Stairs

Locomotion: Stairs includes going up and down twelve to fourteen 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; 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 four to eleven stairs **independently**, with or without a device.

HELPER

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

4 **Minimal 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 four to eleven stairs.

1 **Total Assistance:** One or more of the following are true:

- The patient performs less than 25% of the effort.
- The patient requires assistance from two or more helpers.
- The patient goes up and down fewer than four stairs.
- The patient uses a mechanical lift operated entirely by a helper.
- The activity does not occur. (The patient does not go up or down stairs, **and** a helper does not carry the patient up or down stairs.)

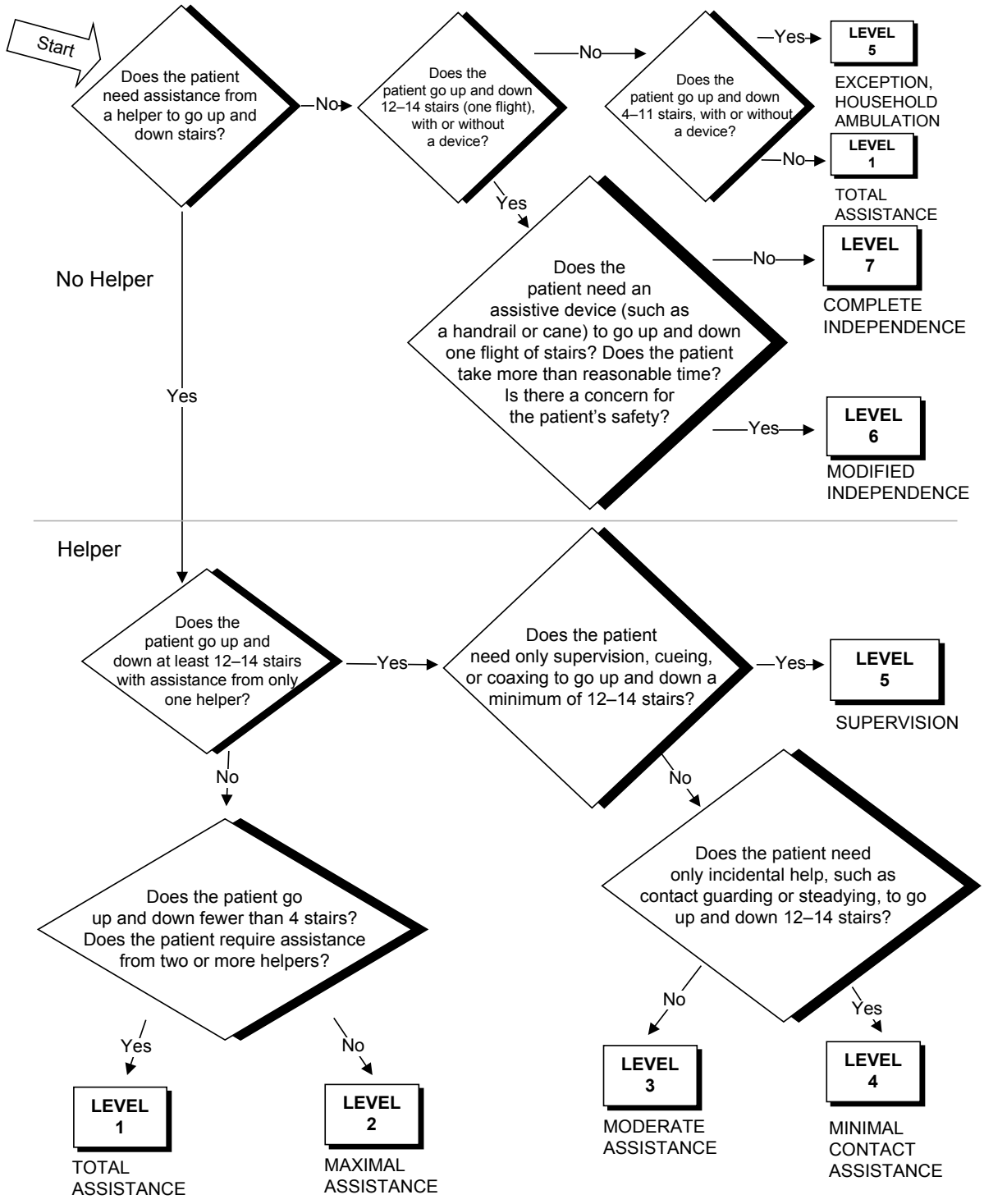


Figure 17. FIM® decision tree for item 42M, Locomotion: Stairs

Comprehension

Comprehension includes understanding of either auditory or visual communication (e.g., writing, sign language, and gestures). Evaluate and record the more usual mode of comprehension, whether "A" for "auditory" or "V" for "visual"; if both modes are used about equally, record "B" for "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 complex or abstract directions and conversation readily or with only mild difficulty. The patient does not require prompting but may require a hearing aid, a visual aid, another 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 (e.g., 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. The patient understands only simple, commonly used spoken expressions (e.g., "hello," "how are you?") or gestures (e.g., waving goodbye) and requires prompting more than half the time.

1 Total Assistance: One or more of the following are true:

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

Comment: Comprehension of complex or abstract information includes, but is not limited to, understanding current events appearing in television programs or newspaper articles and abstract information on such subjects as religion, humor, math, and 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, questions, and statements related to the patient's need for nutrition, fluids, elimination, hygiene, and sleep (i.e., physiological needs).

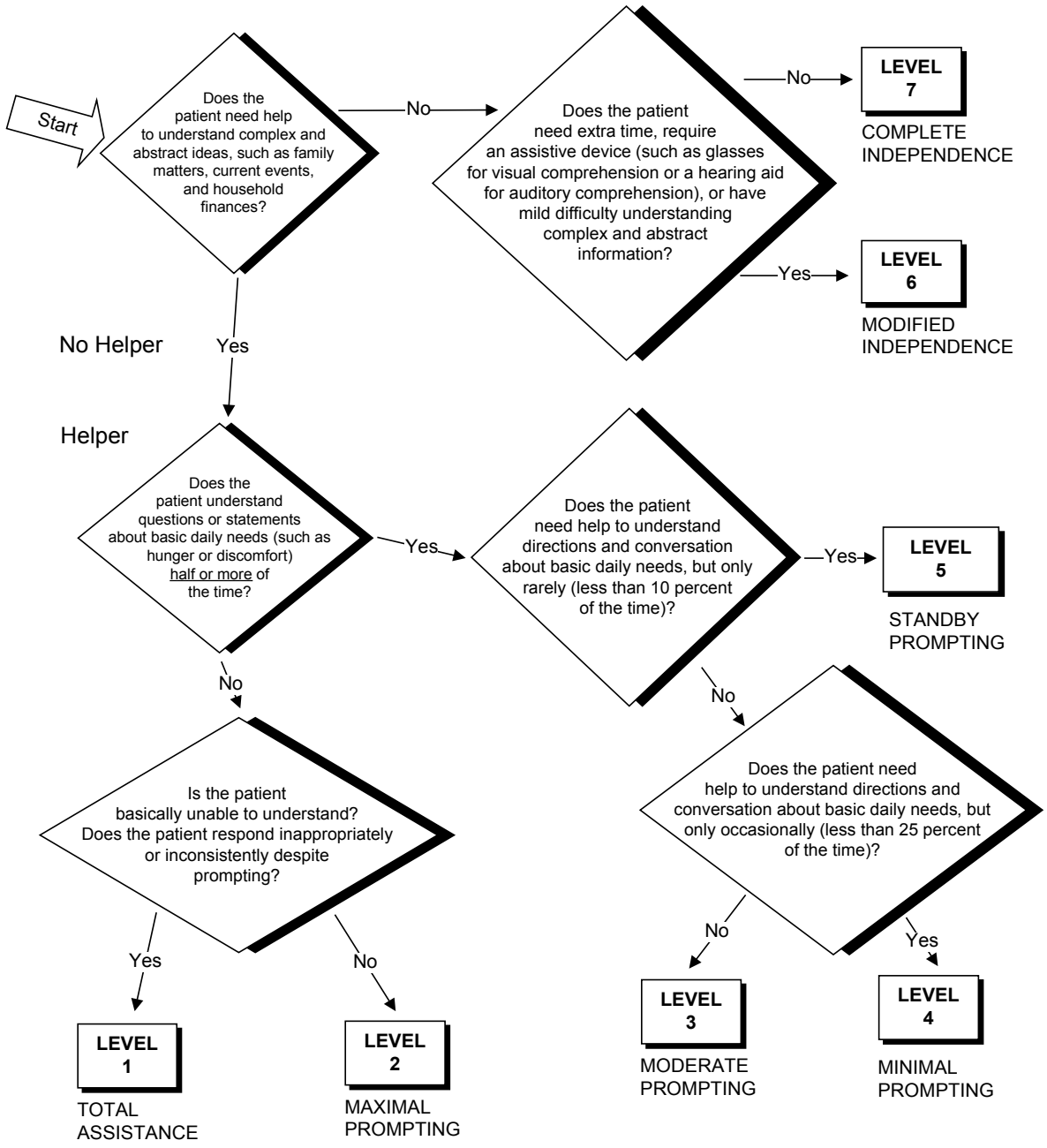


Figure 18. FIM® decision tree for item 42N, Comprehension

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 record the more usual mode of expression, whether "V" for "vocal" or "N" for nonvocal; if both modes are used about equally, record "B" for "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 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 and 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 requires 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.

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

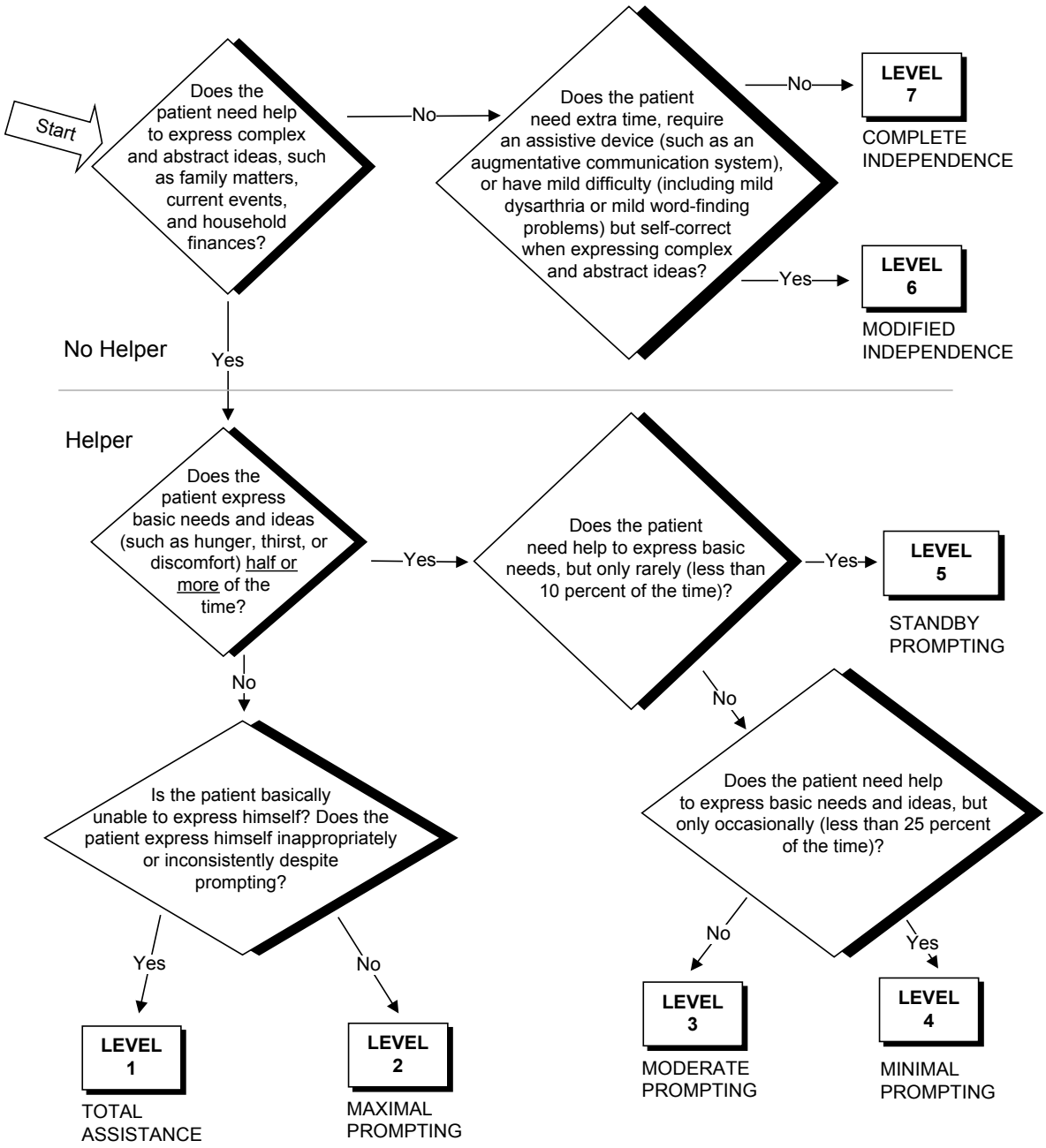


Figure 19. FIM® decision tree for item 42O, Expression

Social Interaction

Social Interaction includes skills related to getting along with others 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 the patient may require medication to control his mood or behavior.

HELPER

5 **Supervision:** The patient requires supervision (e.g., monitoring, verbal control, cueing, or coaxing) only under stressful or unfamiliar conditions, but the patient requires such supervision 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 and may need restraint due to socially inappropriate behaviors.

Comment: Socially inappropriate behaviors include temper tantrums; loud, foul, or abusive language; excessive laughing or crying; physical attack; and very withdrawn or noninteractive behavior.

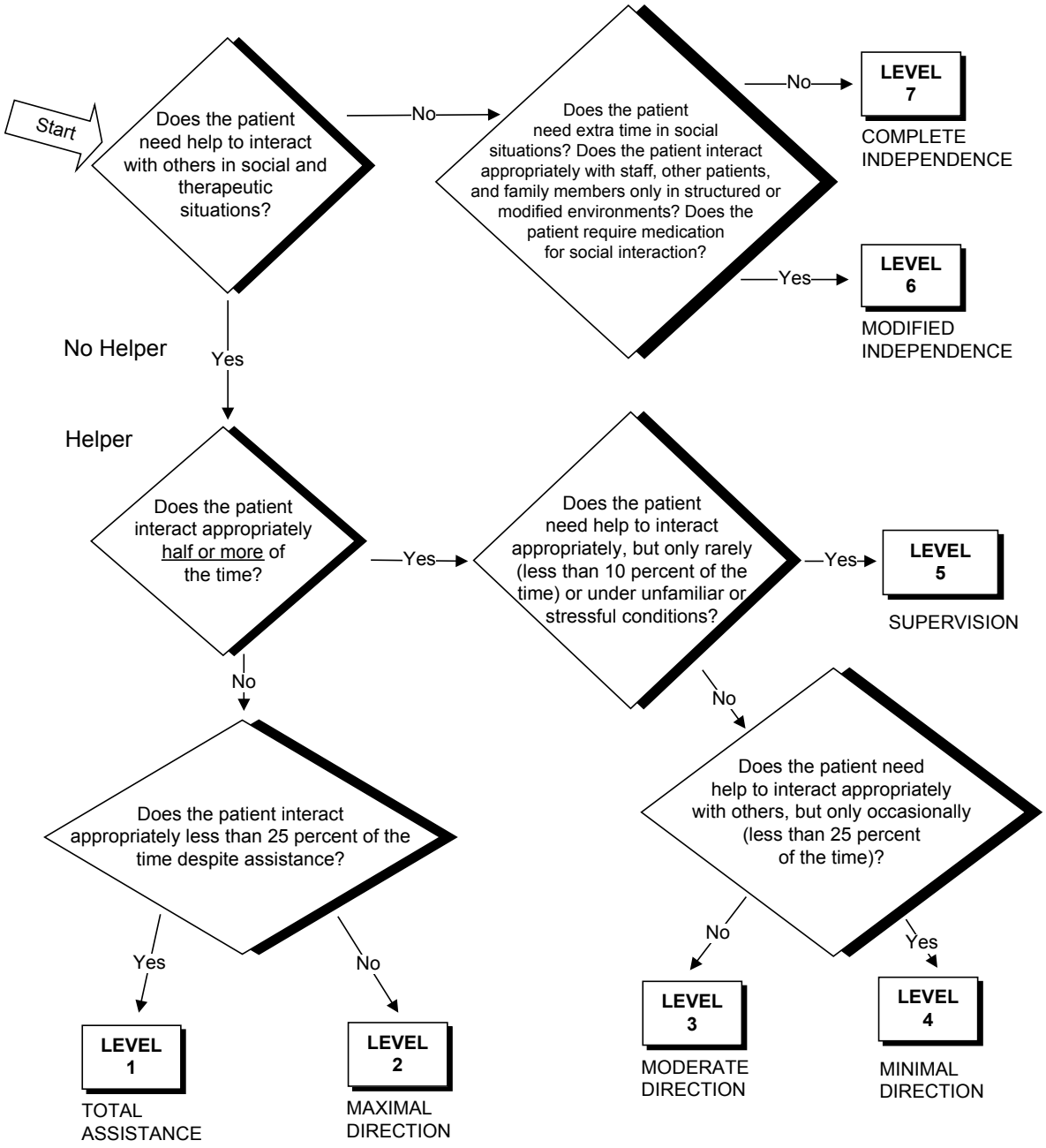


Figure 20. FIM® decision tree for item 42P, Social Interaction

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 initiating, sequencing, and self-correcting 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 and initiates and carries out a sequence of steps to solve complex problems; or the patient requires more than a reasonable amount of time to make appropriate decisions or solve complex problems.

HELPER

5 **Supervision:** The patient requires supervision (e.g., cueing or coaxing) to solve routine problems only under stressful or unfamiliar conditions, but the patient requires such supervision less 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 the patient does not effectively solve problems. The patient may require constant one-to-one direction to complete simple daily activities and may need a restraint for safety.

Comment: Complex problems include managing a checking account, participating in discharge plans, self-administering medications, confronting interpersonal problems, and making employment decisions. Routine problems include successfully completing daily tasks and dealing with unplanned events and hazards that occur during daily activities. Specific examples of routine problems include asking for assistance appropriately during a 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.

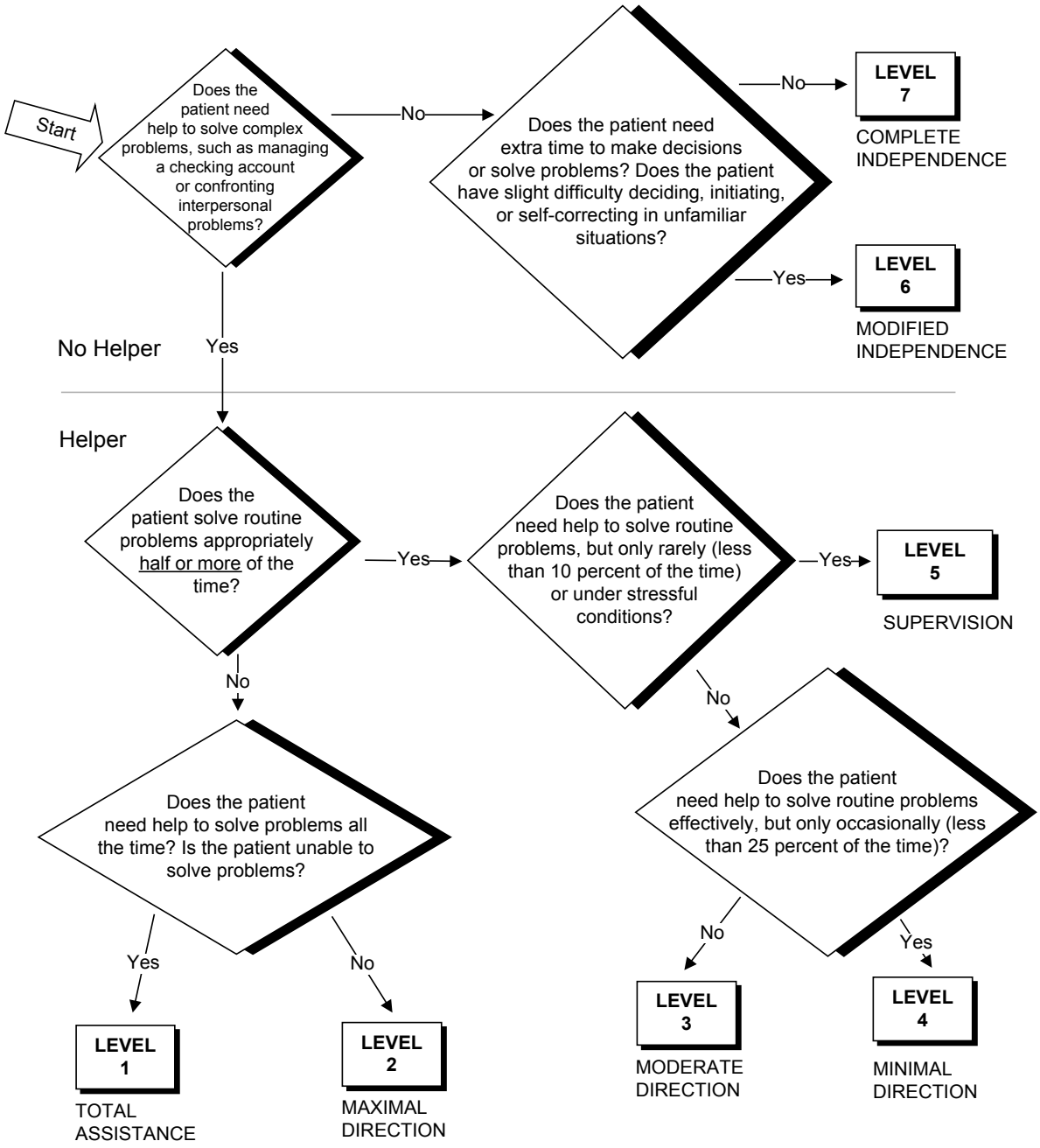


Figure 21. FIM® decision tree for item 42Q, Problem Solving

Memory

Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. In this context, memory 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 the 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 **Standby Prompting:** The patient requires prompting (e.g., cueing, repetition, reminders) only under stressful or unfamiliar conditions, but the patient requires such prompting less 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 the patient does not effectively recognize and remember.

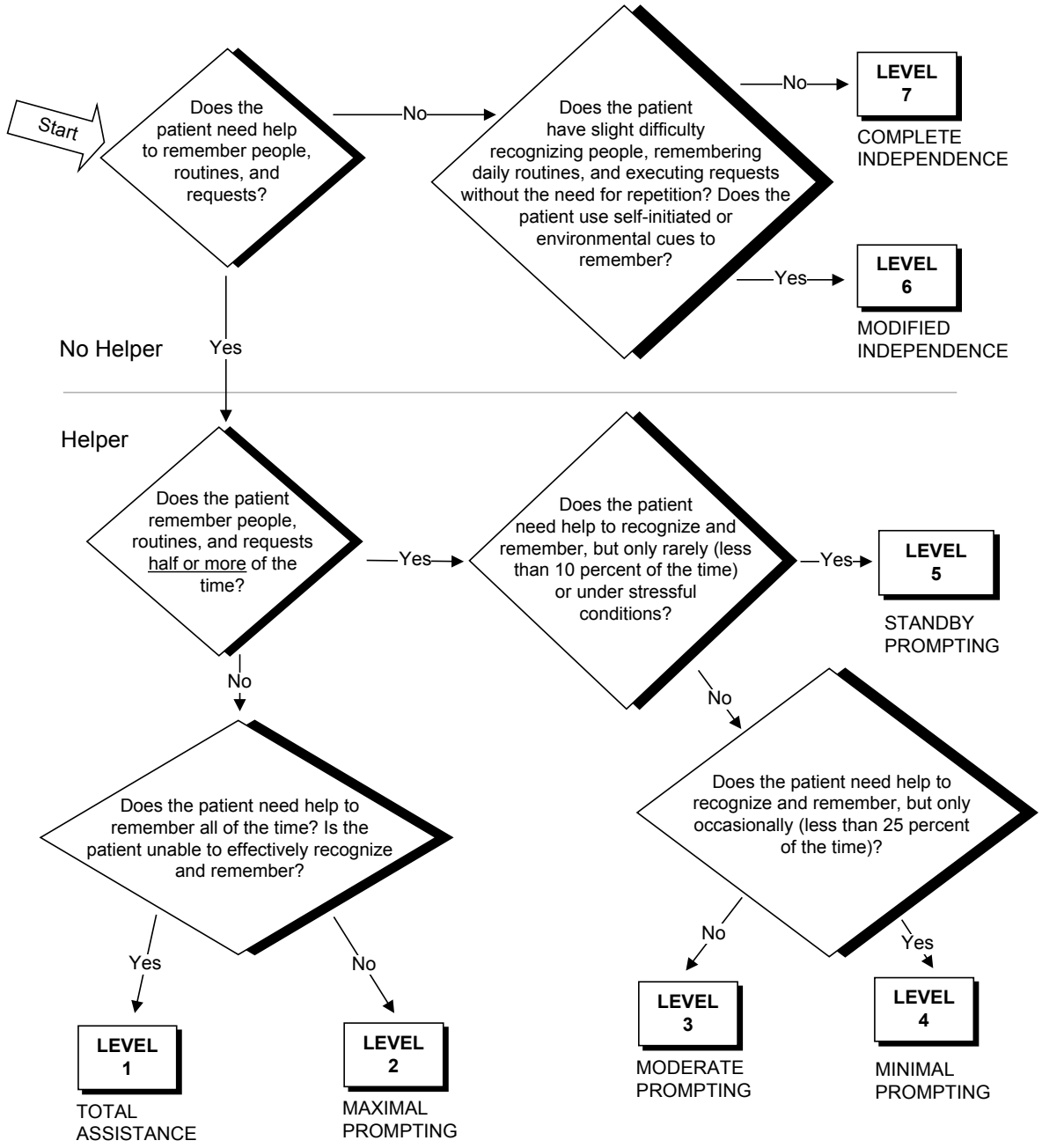


Figure 22. FIM® decision tree for item 42R, Memory

Appendix A: 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	Nontraumatic brain dysfunction
	02.21	Traumatic brain dysfunction, open injury
	02.22	Traumatic brain dysfunction, closed injury
	02.9	Other brain dysfunction
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 conditions
Spinal Cord Dysfunction		
Nontraumatic	04.110	Paraplegia, unspecified
	04.111	Paraplegia, incomplete
	04.112	Paraplegia, complete
	04.120	Quadriplegia, unspecified
	04.1211	Quadriplegia, incomplete C1–C4
	04.1212	Quadriplegia, incomplete C5–C8
	04.1221	Quadriplegia, complete C1–C4
	04.1222	Quadriplegia, complete C5–C8
	04.130	Other nontraumatic 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–C4
	04.2212	Quadriplegia, incomplete C5–C8
	04.2221	Quadriplegia, complete C1–C4
	04.2222	Quadriplegia, complete C5–C8
	04.230	Other traumatic spinal cord dysfunction

Impairment Group	Code	Description
Amputation	05.1	Single upper extremity above the elbow (AE)
	05.2	Single upper extremity below the elbow (BE)
	05.3	Single lower extremity above the knee (AK)
	05.4	Single lower extremity below the knee (BK)
	05.5	Double lower extremity above the knee (AK/AK)
	05.6	Double lower extremity above/below the knee (AK/BK)
	05.7	Double lower extremity 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	Extremity 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
Congenital Deformities	12.1	Spina bifida
	12.9	Other congenital
Other Disabling Impairments	13	Other disabling impairments
Major Multiple Trauma	14.1	Brain + spinal cord injury
	14.2	Brain + multiple fracture/amputation
	14.3	Spinal cord + multiple fracture/amputation
	14.9	Other multiple trauma
Developmental Disabilities	15	Developmental disabilities
Debility	16	Debility (noncardiac, nonpulmonary)

Impairment Group	Code	Description
Medically Complex Conditions	17.1	Infections
	17.2	Neoplasms
	17.31	Nutrition (endocrine/metabolic) with intubation/parenteral nutrition
	17.32	Nutrition (endocrine/metabolic) without intubation/parenteral nutrition
	17.4	Circulatory disorders
	17.51	Respiratory disorders, ventilator-dependent
	17.52	Respiratory disorders, non-ventilator-dependent
	17.6	Terminal care
	17.7	Skin disorders
	17.8	Medical/surgical complications
	17.9	Other medically complex conditions

Appendix B: UDSMR® ICD Coding Policy and Suggested Codes

ICD coding is important for understanding specific medical impairments that affect a patient's health and ability to function. In order to provide reliable data to UDSMR, a uniform approach to coding impairment groups and ICD diagnoses is necessary. Future analysis related to ICD diagnoses is facilitated by standardizing code entry.

There must be an informative link between item 26, Impairment Group, and item 29, Etiologic Diagnosis. Because UDSMR is developing methods for analyzing the ICD diagnostic codes in the UDSMR® database in meaningful ways, identification of the following is important:

1. The medical cause underlying the impairment condition for which the patient was admitted to rehabilitation
2. The most severe or significant impairment associated with the impairment condition
3. The medical complications that may have delayed discharge or otherwise compromised the effectiveness or efficiency of the rehabilitation outcome
4. Comorbid conditions that pose a medical risk during rehabilitation
5. Other medical conditions associated with interruption of rehabilitative care and causing the patient's transfer to acute care or the patient's death

The following conventions apply to recording ICD diagnostic codes on the Case Coding Form:

6. **Item 29, Etiologic Diagnosis:** Record the ICD diagnostic code that best characterizes the pathophysiological process underlying the impairment condition for which the patient is admitted for rehabilitation. For example, for IGC 01.x, Stroke, the etiologic diagnosis must be circulatory or vascular in nature, such as ICD code I61.X, Nontraumatic intracerebral hemorrhage, or ICD code I63.0X, Cerebral infarction due to thrombosis.
7. **Item 30, Other Diagnoses, Most Significant Impairments Related to Impairment Group:** Use fields A, B, and C to record the ICD diagnostic codes for the most severe or significant impairments associated with the impairment condition. Examples include:
    - H54.X, Blindness and low vision
    - R47.0X, Dysphasia and aphasia
    - R13.1X, Dysphagia
    - R32, Unspecified urinary incontinence
    - R15.X, Fecal incontinence
    - G81.XX, Hemiplegia and hemiparesis
    - G82.2X, Paraplegia
    - G82.5X, Quadriplegia
8. **Item 31, Other Diagnoses, Complications/Comorbidities/Z Codes:** Use fields A, B, and C to record the ICD diagnostic codes for complications that may have delayed discharge or otherwise compromised the effectiveness or efficiency of the rehabilitation outcome, such as depression, or comorbid conditions that placed the patient at medical risk, such as diabetes

mellitus, chronic obstructive pulmonary disease, or cardiac arrest prior to rehabilitation admission. If the impairment is a result of an injury, record the code specifying the external cause of morbidity that is associated with the rehabilitation admission in field C.

9. **Item 32, Diagnosis for Transfer or Death:** Enter the ICD diagnostic code for the condition associated with the patient's transfer to acute care or the patient's death.
10. **Z codes:** Although Z codes are generally less specific than required, a few exceptions exist. Use Z codes for conditions that are being managed during the rehabilitation stay, not conditions that have resolved.

If you are using the Interim or Follow-Up Assessment Coding Form, follow the conventions provided for item 30, above, when coding item 70, Follow-Up Diagnoses.

The information on the following pages is intended to facilitate coding the proper linkage between the following items:

- Item 26, Impairment Group
- Item 29, Etiologic Diagnosis
- Item 30, Other Diagnoses, Most Significant Impairments Related to Impairment Group
- Item 31, Other Diagnoses, Complications/Comorbidities/E Codes
- Item 32, Diagnosis for Transfer or Death

The information consists of an abstracted, simplified version of ICD diagnostic codes to facilitate the use of diagnostic coding for the subpopulation common to medical rehabilitation facilities. The codes in the simplified version are intended only as guidelines. Consult an official ICD codebook for exact codes.

These guidelines are solely for internal data collection and analysis using the FIM® instrument.

ICD Codes Related to Specific Impairment Groups

This section provides ICD codes associated with each of the seventeen impairment group categories.

Unless otherwise specified, all ICD codes within a code grouping with a single seventh-character extension include only those codes with the same seventh character. For example, the range *S02.0XXS–S02.92XS* includes only codes with a seventh character of S. By contrast, a range that includes multiple seventh-character extensions includes all codes within the range. For example, the range *S82.90XA–S82.90XC* consists of codes S82.90XA, S82.90XB, and S82.90XC.

Stroke (01)

Category 01, Stroke, includes patients with a diagnosis of cerebral ischemia due to vascular thrombosis, embolism, or hemorrhage.

Cases with brain dysfunction secondary to nonvascular causes (e.g., trauma, inflammation, tumor, degenerative changes) are part of **category 02, Brain dysfunction**.

01.1 Left body (right brain)
01.2 Right body (left brain)
01.3 Bilateral
01.4 No paresis
01.9 Other stroke

Table 1. ICD codes and etiologic diagnoses for IGCs 01.1–01.9

ICD Code (Item 29)	Etiologic Diagnosis
I60.00–I60.9	Nontraumatic subarachnoid hemorrhage, including ruptured cerebral aneurysm
I62.00–I62.9	Other and unspecified nontraumatic intracranial hemorrhage
I63.00, I63.011–I63.019, I63.02, I63.031–I63.039, I63.09, I63.10, I63.111–I63.119, I63.12, I63.131–I63.139, I63.19, I63.20, I63.211–I63.219, I63.22, I63.231–I63.239, I63.29	Occlusion and stenosis of precerebral arteries, with cerebral infarction
I69.00–I69.998	Sequelae of cerebrovascular disease[12]

Do **not** use codes G45.0–G45.2, G45.8, G45.9, G46.0–G46.2, or I67.841–I67.848 for transient cerebral ischemia (TIA).

[12] Use one of these codes only when the patient has completed an inpatient rehabilitation program for the same injury prior to the current stay.

Brain Dysfunction (02)

Codes 02.1, Nontraumatic brain dysfunction, and 02.9, Other brain, include cases with such etiologies as encephalitis, inflammation, anoxia, metabolic toxicity, degenerative processes, and neoplasm (including metastases).

02.1 Nontraumatic brain dysfunction
02.9 Other brain

Do **not** use these IGCs for cases with hemorrhagic stroke; use codes from **category 01, Stroke**, instead.

Table 2. ICD codes and etiologic diagnoses for IGCs 02.1 and 02.9

ICD Code (Item 29)	Etiologic Diagnosis
A39.0	Meningococcal meningitis
A39.81	Meningococcal encephalitis
A85.0, A85.1, A85.8, A86, A87.1, A87.2, A88.8, A89	Viral encephalitis, meningitis, other specified viral infections
C70.0, C70.9	Malignant neoplasm of cerebral meninges
C71.0–C71.9	Malignant neoplasm of brain
C79.31	Secondary malignant neoplasm of brain
D32.0, D32.9	Benign neoplasm of cerebral meninges
D33.0–D33.2	Benign neoplasm of brain
D33.3	Benign neoplasm of cranial nerves
D42.0, D42.9	Neoplasm of uncertain behavior of cerebral meninges
D43.0–D43.2	Neoplasm of uncertain behavior of brain
D49.6	Neoplasm of unspecified behavior of brain
G04.00–G04.02, G04.30–G04.39, G04.81–G04.91, G05.3, G05.4, G37.4, G92	Encephalitis (except bacterial), myelitis, and encephalomyelitis
G06.0	Intracranial abscess and granuloma
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G31.1	Senile degeneration of brain, not elsewhere classified
G91.0	Communicating hydrocephalus
G93.1	Anoxic brain damage, not elsewhere classified

Code 02.21, Traumatic brain dysfunction, open injury, and **code 02.22, Traumatic brain dysfunction, closed injury**, include cases with motor or cognitive disorders secondary to brain trauma.

02.21 Open injury
02.22 Closed injury

Table 3. ICD codes and etiologic diagnoses for IGC 02.21, Traumatic brain dysfunction, open injury

ICD Code (Item 29)	Etiologic Diagnosis
Combination codes: S01.90XA + one of S06.330A–S06.339A, S06.370A–S06.389A	Cerebral laceration and contusion with open intracranial wound
Combination codes: S01.90XA + one of S06.360A–S06.369A	Traumatic other and unspecified intracranial hemorrhage
Combination codes: S01.90XA + one of S06.890A–S06.899A	Intracranial injury of other and unspecified nature
Combination codes: S02.0XXB + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Skull fracture (vault)
S02.0XXS–S02.92XS	Sequelae of fracture of skull and face bones[12]
Combination codes: S02.10XB + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Skull fracture (base)
Combination codes: S02.91XB + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Other and unqualified skull fractures
S06.0X0S–S06.9X9S	Sequelae of intracranial injury without mention of skull fracture[12]
S06.6X0A **Combination codes:** S01.90XA + one of S06.4X0A–S06.6X9A	Traumatic subarachnoid, subdural, and extradural hemorrhage

Table 4. ICD codes and etiologic diagnoses for IGC 02.22, Traumatic brain dysfunction, closed injury

ICD Code (Item 29)	Etiologic Diagnosis
Combination codes: S02.0XXA + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Skull fracture (vault)
S02.0XXS–S02.92XS	Sequelae of fracture of skull and face bones[12]

ICD Code (Item 29)	Etiologic Diagnosis
Combination codes: S02.10XA + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Skull fracture (base)
Combination codes: S02.91XA + one of S06.330A–S06.339A, S06.360A–S06.369A, S06.4X0A–S06.6X9A, or S06.890A–S06.9X9A	Other and unqualified skull fractures
S06.0X0A–S06.0X9A	Concussion
S06.0X0S–S06.9X9S	Sequelae of intracranial injury without mention of skull fracture[12]
S06.1X0A–S06.309A, S06.810A–S06.9X9A **Combination code:** S06.090A + S06.0X0A	Intracranial injury of other and unspecified nature
S06.310A–S06.339A, S06.370A–S06.389A	Cerebral laceration and contusion
S06.340A–S06.369A	Traumatic other and unspecified intracranial hemorrhage
S06.4X0A–S06.4X9A, S06.5X0A–S06.5X9A, S06.6X0A–S06.6X9A	Traumatic subarachnoid, subdural, and extradural hemorrhage

Neurologic Conditions (03)

Category 03, Neurologic conditions, includes patients 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

Table 5. ICD codes and etiologic diagnoses for IGC 03.1, Multiple sclerosis

ICD Code (Item 29)	Etiologic Diagnosis
G35	Multiple sclerosis

Table 6. ICD codes and etiologic diagnoses for IGC 03.2, Parkinsonism

ICD Code (Item 29)	Etiologic Diagnosis
G20, G21.11–G21.9	Parkinsonism

Table 7. ICD codes and etiologic diagnoses for IGC 03.3, Polyneuropathy

ICD Code (Item 29)	Etiologic Diagnosis
G60.0–G60.8	Hereditary and idiopathic neuropathy
G61.81–G61.89, G62.0–G62.2, G62.81–G62.89, G64	Inflammatory polyneuropathy, other and unspecified polyneuropathies, other disorders of peripheral nervous system

Table 8. ICD codes and etiologic diagnoses for IGC 03.4, Guillain-Barré syndrome

ICD Code (Item 29)	Etiologic Diagnosis
G61.0	Acute infective polyneuritis (Guillain-Barré syndrome)

Table 9. ICD codes and etiologic diagnoses for IGC 03.5, Cerebral palsy

ICD Code (Item 29)	Etiologic Diagnosis
G80.0–G80.2, G80.4–G80.8	Cerebral palsy

Table 10. ICD codes and etiologic diagnoses for IGC 03.8, Neuromuscular disorders

ICD Code (Item 29)	Etiologic Diagnosis
B91, G14	Sequelae of poliomyelitis; postpolio syndrome
G12.20–G12.9	Motor neuron disease
G70.00, G70.01	Myasthenia gravis
G71.0–G71.2, G72.0–G72.3	Muscular dystrophies and other myopathies

Table 11. ICD codes and etiologic diagnoses for IGC 03.9, Other neurologic conditions

ICD Code (Item 29)	Etiologic Diagnosis
G10, G21.0, G23.0–G26, G80.3, G90.3	Other extrapyramidal disease and abnormal movement disorders
G11.0–G11.8	Hereditary ataxia
G36.0–G36.8, G37.0–G37.8	Other demyelinating diseases of central nervous system
G90.09, G90.2, G90.4, G90.50–G90.9	Disorders of the autonomic nervous system

Spinal Cord Dysfunction (04)

Category 04, Spinal cord dysfunction, includes patients with various forms of quadriplegia/paresis and paraplegia/paresis, regardless of the etiology, whether medical, postoperative, or traumatic.

If the impairment requiring rehabilitation can be definitively linked to a prior spinal cord dysfunction, code the case as spinal cord dysfunction.

Subcategory 04.1, Nontraumatic spinal cord dysfunction, includes patients with paraplegia or quadriplegia secondary to nontraumatic causes, including postoperative change.

04.110 Paraplegia, unspecified
04.111 Paraplegia, incomplete
04.112 Paraplegia, complete
04.120 Quadriplegia, unspecified
04.1211 Quadriplegia, incomplete, C1–C4
04.1212 Quadriplegia, incomplete, C5–C8
04.1221 Quadriplegia, complete, C1–C4
04.1222 Quadriplegia, complete, C5–C8
04.130 Other nontraumatic spinal cord dysfunction

Table 12. ICD codes and etiologic diagnoses for IGCs 04.110–04.130, Nontraumatic spinal cord dysfunction

ICD Code (Item 29)	Etiologic Diagnosis
A18.01	Tuberculosis of spine
C41.2	Malignant neoplasm of vertebral column
C70.1, C72.0, C72.1	Malignant neoplasm of spinal cord, spinal meninges
C79.40, C79.49	Secondary malignant neoplasm of other and unspecified parts of nervous system
D32.1, D33.4	Benign neoplasm of spinal cord, spinal meninges
D42.1, D42.9	Neoplasm of uncertain behavior of spinal
D43.4	Neoplasm of uncertain behavior of spinal cord
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
G04.90, G04.91	Encephalitis, myelitis, and encephalomyelitis, unspecified
G06.1	Intraspinal abscess and granuloma
G37.3, G37.4	Transverse myelitis, subacute necrotizing myelitis
I71.00–I71.03	Dissection of aorta
I71.1, I71.3, I71.5, I71.8	Aortic aneurysm, ruptured
M47.011–M47.029, M47.10–M47.16	Spondylosis with myelopathy
M48.00, M48.04–M48.08, M99.22, M99.23, M99.24–M99.29, M99.32, M99.33, M99.34–M99.39, M99.42, M99.43, M99.44–M99.49, M99.52, M99.53, M99.54–M99.59, M99.62, M99.63, M99.64–M99.69, M99.72, M99.73, M99.74–M99.79	Spinal stenosis, other than cervical (if deficits include weakness)
M48.01–M48.03, M99.20, M99.21, M99.30, M99.31, M99.40, M40.41, M99.50, M99.51, M99.60, M99.61, M99.70, M99.71	Spinal stenosis in cervical region (if deficits include weakness)

ICD Code (Item 29)	Etiologic Diagnosis
M50.00–M50.03, M51.04–M51.06	Intervertebral disc disorder with myelopathy

Subcategory 04.2, Traumatic spinal cord dysfunction, includes patients with paraplegia or quadriplegia secondary to traumatic causes.

04.210 Paraplegia, unspecified
04.211 Paraplegia, incomplete
04.212 Paraplegia, complete
04.220 Quadriplegia, unspecified
04.2211 Quadriplegia, incomplete, C1–C4
04.2212 Quadriplegia, incomplete, C5–C8
04.2221 Quadriplegia, complete, C1–C4
04.2222 Quadriplegia, complete, C5–C8
04.230 Other traumatic spinal cord dysfunction

Table 13. ICD codes and etiologic diagnoses for IGCs 04.210–04.230, Traumatic spinal cord dysfunction

ICD Code (Item 29)	Etiologic Diagnosis
Combination codes: S12.000A with one of S14.101A, S14.111A, S14.121A, S14.131A, or S14.151A S12.000B with one of S14.101A, S14.111A, S14.121A, S14.131A, or S14.151A S12.001A with one of S14.101A, S14.111A, S14.121A, S14.131A, or S14.151A S12.001B with one of S14.101A, S14.111A, S14.121A, S14.131A, or S14.151A S12.100A with one of S14.102A, S14.112A, S14.122A, S14.132A, or S14.152A S12.100B with one of S14.102A, S14.112A, S14.122A, S14.132A, or S14.152A S12.101A with one of S14.102A, S14.112A, S14.122A, S14.132A, or S14.152A S12.101B with one of S14.102A, S14.112A, S14.122A, S14.132A, or S14.152A S12.200A with one of S14.103A, S14.113A, S14.123A, S14.133A, or S14.153A S12.200B with one of S14.103A, S14.113A, S14.123A, S14.133A, or S14.153A S12.201A with one of S14.103A, S14.113A, S14.123A, S14.133A, or S14.153A S12.201B with one of S14.103A, S14.113A, S14.123A, S14.133A, or S14.153A S12.300A with one of S14.104A, S14.114A, S14.124A, S14.134A,	Fracture of vertebral column with spinal cord injury

ICD Code (Item 29)	Etiologic Diagnosis
or S14.154A	
S12.300B with one of S14.104A, S14.114A, S14.124A, S14.134A, or S14.154A	
S12.301A with one of S14.104A, S14.114A, S14.124A, S14.134A, or S14.154A	
S12.301B with one of S14.104A, S14.114A, S14.124A, S14.134A, or S14.154A	
S12.400A with one of S14.105A, S14.115A, S14.125A, S14.135A, or S14.155A	
S12.400B with one of S14.105A, S14.115A, S14.125A, S14.135A, or S14.155A	
S12.401A with one of S14.105A, S14.115A, S14.125A, S14.135A, or S14.155A	
S12.401B with one of S14.105A, S14.115A, S14.125A, S14.135A, or S14.155A	
S12.500A with one of S14.106A, S14.116A, S14.126A, S14.136A, or S14.156A	
S12.500B with one of S14.106A, S14.116A, S14.126A, S14.136A, or S14.156A	
S12.501A with one of S14.106A, S14.116A, S14.126A, S14.136A, or S14.156A	
S12.501B with one of S14.106A, S14.116A, S14.126A, S14.136A, or S14.156A	
S12.600A with one of S14.107A, S14.117A, S14.127A, S14.137A, or S14.157A	
S12.600B with one of S14.107A, S14.117A, S14.127A, S14.137A, or S14.157A	
S12.601A with one of S14.107A, S14.117A, S14.127A, S14.137A, or S14.157A	
S12.601B with one of S14.107A, S14.117A, S14.127A, S14.137A, or S14.157A	
S12.9XXA + S14.109A	
S22.009A + S24.109A	
S22.009B + S24.109A	
S22.019A + one of S24.101A, S24.111A, S24.131A, or S24.151A	
S22.019B + one of S24.101A, S24.111A, S24.131A, or S24.151A	
S22.029A + one of S24.102A, S24.112A, S24.132A, or S24.152A	
S22.029B + one of S24.102A, S24.112A, S24.132A, or S24.152A	
S22.039A + one of S24.102A, S24.112A, S24.132A, or S24.152A	
S22.039B + one of S24.102A, S24.112A, S24.132A, or S24.152A	
S22.049A + one of S24.102A, S24.112A, S24.132A, or S24.152A	

ICD Code (Item 29)	Etiologic Diagnosis
S22.049B + one of S24.102A, S24.112A, S24.132A, or S24.152A S22.059A + one of S24.102A, S24.112A, S24.132A, or S24.152A S22.059B + one of S24.102A, S24.112A, S24.132A, or S24.152A S22.069A + one of S24.103A, S24.113A, S24.133A, or S24.153A S22.069B + one of S24.103A, S24.113A, S24.133A, or S24.153A S22.079A + one of S24.103A, S24.113A, S24.133A, or S24.153A S22.079B + one of S24.103A, S24.113A, S24.133A, or S24.153A S22.089A + one of S24.104A, S24.114A, S24.134A, or S24.154A S22.089B + one of S24.104A, S24.114A, S24.134A, or S24.154A S32.009A + one of S34.109A, S34.119A, or S34.129A S32.009B + one of S34.109A, S34.119A, or S34.129A S32.019A + one of S34.101A, S34.111A, or S34.121A S32.019B + one of S34.101A, S34.111A, or S34.121A S32.029A + one of S34.102A, S34.112A, or S34.122A S32.029B + one of S34.102A, S34.112A, or S34.122A S32.039A + one of S34.103A, S34.113A, or S34.123A S32.039B + one of S34.103A, S34.113A, or S34.123A S32.049A + one of S34.104A, S34.114A, or S34.124A S32.049B + one of S34.104A, S34.114A, or S34.124A S32.059A + one of S34.105A, S34.115A, or S34.125A S32.059B + one of S34.105A, S34.115A, or S34.125A S32.10XA + one of S34.131A, S34.132A, S34.139A, or S34.3XXA S32.10XB + one of S34.131A, S34.132A, S34.139A, or S34.3XXA S32.2XXA + one of S34.131A, S34.132A, S34.139A, or S34.3XXA S32.2XXB + one of S34.131A, S34.132A, or S34.3XXA	
S14.0XXA–S14.108A, S14.111A–S14.118A, S14.121A–S14.128A, S14.131A–S14.138A, S14.141A–S14.148A, S14.151A–S14.158A, S24.0XXA–S24.104A, S24.111A–S24.114A, S24.131A–S24.134A, S24.141A–S24.144A, S24.151A–S24.154A, S34.01XA–S34.139A, S34.3XXA	Spinal cord injury without evidence of spinal bone injury
S14.0XXS–S14.159S, S24.0XXS–S24.159S, S34.01XS–S34.139S	Sequelae of spinal cord injury[12]
S14.2XXA, S14.3XXA, S24.2XXA, S34.21XA–S34.22XA, S34.4XXA	Injury to nerve roots and spinal plexus

Amputation of Limb (05)

Category 05, Amputation of limb, includes patients whose major deficit is the partial or complete absence of one or more limbs.

05.1 Single upper extremity above the elbow (AE)
05.2 Single upper extremity below the elbow (BE)

05.3 Single lower extremity above the knee (AK)
05.4 Single lower extremity below the knee (BK)
05.5 Double lower extremity above the knee (AK/AK)
05.6 Double lower extremity above/below the knee (AK/BK)
05.7 Double lower extremity below the knee (BK/BK)
05.9 Other amputation

Table 14. ICD codes and etiologic diagnoses for IGCs 05.1, Single upper extremity above the elbow (AE), and 05.2, Single upper extremity below the elbow (BE)

ICD Code (Item 29)	Etiologic Diagnosis
C40.00–C40.02, C40.10–C40.12	Malignant neoplasm of bones of upper limb
C47.10–C47.12, C49.10–C49.12	Malignant neoplasm of connective and other soft tissue of upper limb
C79.51, C79.52	Secondary malignant neoplasm of bone
E08.51, E08.52, E09.51, E09.52, E10.51, E10.52, E11.51, E11.52, E13.51, E13.52, I79.1–I79.8	Peripheral angiopathy in diseases classified elsewhere[13]
E08.52, E09.52, E10.52, E11.52, E13.52, I70.361–I70.369, I70.461–I70.469, I70.561–I70.569, I70.661–I70.669, I70.761–I70.769, I73.01, I96	Gangrene[13]
I70.201–I70.299	Atherosclerosis of native arteries of the extremities
I73.9	Peripheral vascular disease, unspecified
I74.2	Arterial embolism and thrombosis of upper extremities
I77.0–I77.3, I77.5, I77.6, I77.810–I77.89, M31.8, M31.9	Other disorders of arteries and arterioles
I87.001–I87.8, I99.8, R58	Other disorders of circulatory system
M21.20–M21.279, M21.70–M21.739, M21.80–M21.829, M21.921–M21.929, M21.951–M21.969	Acquired deformity of other parts of limbs, not elsewhere classified
M86.00–M86.9, M46.20–M46.28	Osteomyelitis[13]
M87.00–M87.046, M87.061–M87.146, M87.161–M87.179, M87.188–M87.250, M87.261–M87.346, M87.361–M87.849, M87.861–M87.9, M90.50–M90.549, M90.561–M90.59	Aseptic necrosis of bone[13]
Q27.31	Upper limb vessel anomaly
Q71.00–Q71.53	Reduction deformities of upper limb

[13] Use an additional code to identify the underlying disease as a comorbid condition.

ICD Code (Item 29)	Etiologic Diagnosis
S48.011A–S48.929A, S58.011A–S58.929A, S68.411A–S68.429A, S68.711A–S68.729A **Combination codes:** S48.911A + S48.912A S48.911A + S48.922A S48.912A + S48.921A S48.921A + S48.922A	Traumatic amputation of arm and hand (complete) (partial)
T87.30–T87.9	Amputation stump complication

Table 15. ICD codes and etiologic diagnoses for IGCs 05.3–05.7

ICD Code (Item 29)	Etiologic Diagnosis
A52.15, E08.40, E08.42, E09.40, E09.42, E10.40, E10.42, E11.40, E11.42 E13.40, E13.42, G13.0–G13.1, G61.0–G65.2, M05.50–M05.59	Inflammatory and toxic neuropathy[13]
C40.20–C40.32	Malignant neoplasm of bones of lower limb
C47.20–C47.22, C49.20–C49.22	Malignant neoplasm of connective and soft tissue of lower limb
C79.51–C79.52	Secondary malignant neoplasm of bone
E08.51–E08.52, E09.51–E09.52, E10.51–E10.52, E11.51–E11.52, E13.51–E13.52, I79.1–I79.8	Peripheral angiopathy in diseases classified elsewhere[13]
E08.52, E09.52, E10.52, E11.52, E13.52, I70.361–I70.369, I70.461–I70.469, I70.561–I70.569, I70.661–I70.669, I70.761–I70.769, I73.01, I96	Gangrene[13]
G60.0–G60.9	Hereditary and idiopathic peripheral neuropathy
I70.201–I70.299	Atherosclerosis of native arteries of the extremities
I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.749, L97.101–L97.929	Ulcer of lower limbs, except decubitus
I74.3–I74.4	Arterial embolism and thrombosis, extremities
I77.0–I77.3, I77.5–I77.6, I77.810–I77.89, M31.8–M31.9	Other disorders of arteries and arterioles
I87.001–I87.8, I99.8, R58	Other disorders of circulatory system
L02.611–L02.619, L03.031–L03.049	Toe cellulitis and abscess
M21.20–M21.279, M21.70–M21.739, M21.80–M21.829, M21.921–M21.929, M21.951–M21.969	Acquired deformity of other parts of limbs, other
M86.051–M86.09, M86.151–M86.19, M86.251–M86.9	Osteomyelitis[13]

ICD Code (Item 29)	Etiologic Diagnosis
M87.00, M87.10, M87.20, M87.30, M87.80, M87.9, M90.50, M87.031–M87.119, M87.131–M87.179, M87.188–M87.19, M87.211–M87.219, M87.231–M87.29, M87.311–M87.319, M87.331–M87.39, M87.811–M87.819, M87.831–M87.89, M90.50–M90.59	Aseptic necrosis of bone[13]
Q27.32	Lower limb vessel anomaly
Q72.00–Q72.73, Q72.90–Q72.93	Reduction deformities of lower limb
S78.011A–S78.929A, S88.011A–S88.929A **Combination code:** S88.911A + S88.912A	Traumatic amputation of leg
S98.011A–S98.029A, S98.311A–S98.929A **Combination codes:** S98.911A + S98.912A S98.911A + S98.922A S98.912A + S98.921A S98.921A + S98.922A	Traumatic amputation of foot (complete) (partial)
T87.30–T87.9	Amputation stump complication

Table 16. ICD codes and etiologic diagnoses for IGC 05.9, Other amputation

ICD Code (Item 29)	Etiologic Diagnosis
C40.00–C40.02, C40.10–C40.12	Malignant neoplasm of bones of upper limb
C47.10–C47.12, C49.10–C49.12	Malignant neoplasm of connective and other soft tissue of upper limb
C79.51–C79.52	Secondary malignant neoplasm of bone
E08.51–E08.52, E09.51–E09.52, E10.51–E10.52, E11.51–E11.52, E13.51–E13.52, I79.1–I79.8	Peripheral angiopathy in diseases classified elsewhere[13]
E08.52, E09.52, E10.52, E11.52, E13.52, I70.361–I70.369, I70.461–I70.469, I70.561–I70.569, I70.661–I70.669, I70.761–I70.769, I73.01, I96	Gangrene[13]
I70.201–I70.299	Atherosclerosis of native arteries of the extremities
I73.9	Peripheral vascular disease, unspecified
I74.2	Arterial embolism and thrombosis of upper extremities
I77.0–I77.3, I77.5–I77.6, I77.810–I77.89, M31.8–M31.9	Other disorders of arteries and arterioles
I87.001–I87.8, I99.8, R58	Other disorders of circulatory system
M21.20–M21.279, M21.70–M21.739, M21.80–M21.829, M21.921–M21.929, M21.951–M21.969	Acquired deformity of other parts of limbs, not elsewhere classified

ICD Code (Item 29)	Etiologic Diagnosis
M86.00–M86.9, M46.20–M46.28	Osteomyelitis[13]
M87.00–M87.046, M87.061–M87.146, M87.161–M87.179, M87.188–M87.250, M87.261–M87.346, M87.361–M87.849, M87.861–M87.9, M90.50–M90.549, M90.561–M90.59	Aseptic necrosis of bone[13]
Q27.31	Upper limb vessel anomaly
Q71.00–Q71.53	Reduction deformities of upper limb
S48.011A–S48.929A, S58.011A–S58.929A, S68.411A–S68.429A, S68.711A–S68.729A **Combination codes:** S48.911A + S48.912A S48.911A + S48.922A S48.912A + S48.921A S48.921A + S48.922A	Traumatic amputation of arm and hand (complete) (partial)
S78.011A–S78.929A, S88.011A–S88.929A **Combination code:** S88.911A + S88.912A	Traumatic amputation of leg
S98.011A–S98.029A, S98.311A–S98.929A **Combination codes:** S98.911A + S98.912A S98.911A + S98.922A S98.912A + S98.921A S98.921A + S98.922A	Traumatic amputation of foot (complete) (partial)
T87.30–T87.9	Amputation stump complication

Arthritis (06)

Category 06, Arthritis, includes patients whose major disorder is arthritis of all etiologies.

06.1 Rheumatoid arthritis
06.2 Osteoarthritis
06.9 Other arthritis

Do **not** use these IGCs for patients entering rehabilitation immediately after joint replacement, even if the procedure was performed secondary to arthritis. Instead, record one of the joint replacement IGCs (08.51–08.72) in item 26, Impairment Group, and record the arthritis ICD code in item 29, Etiologic Diagnosis.

Table 17. ICD codes and etiologic diagnoses for IGC 06.1, Rheumatoid arthritis

ICD Code (Item 29)	Etiologic Diagnosis
M05.00–M05.09, M05.20–M06.9	Rheumatoid arthritis
M08.00–M08.99	Juvenile chronic polyarthritis
M12.00–M12.09	Chronic postrheumatic arthropathy

Table 18. ICD codes and etiologic diagnoses for IGC 06.2, Osteoarthritis

ICD Code (Item 29)	Etiologic Diagnosis
M15.0–M19.93	Osteoarthritis and allied disorders

Table 19. ICD codes and etiologic diagnoses for IGC 06.9, Other arthritis

ICD Code (Item 29)	Etiologic Diagnosis
E08.618, E09.618, E10.618, E11.618, E13.618, M07.60–M07.69, M12.10–M12.19, M12.50–M13.89	Other and unspecified arthropathies
L40.50–L40.59	Psoriatic arthropathy
M00.00–M00.9	Pyogenic arthritis[14]
M08.1, M45.0–M45.9, M48.8X1–M48.8X8	Ankylosing spondylitis
M32.0–M32.9	Systemic lupus erythematosus
M33.00–M33.19, M33.90–M33.99	Dermatomyositis
M33.20–M33.29	Polymyositis
M34.0–M34.9	Systemic sclerosis (includes generalized scleroderma)

Pain Syndromes (07)

Category 07, Pain syndromes, includes patients whose major disorder is pain of various etiologies, unaccompanied by a neurologic deficit.

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

If a patient is receiving rehabilitation for a neurologic deficit, use an IGC from **category 03, Neurologic conditions**, or **category 04, Spinal cord dysfunction**, instead.

Table 20. ICD codes and etiologic diagnoses for IGCs 07.1, 07.2, and 07.9

ICD Code (Item 29)	Etiologic Diagnosis
M25.78, M47.011–M47.9, M48.10–M48.38, M48.9	Spondylosis and allied disorders
M35.6, M54.10, M54.18, M60.80, M60.9, M72.9, M79.0–M79.4, M79.601–M79.7	Other disorders of soft tissues
M43.20–M43.28, M43.8X9, M48.00, M48.04–M48.08, M51.14–M51.17, M53.2X7, M53.2X8, M53.3, M53.80, M53.84–M53.9, M54.03–M54.09, M54.30–M54.6, M54.89, M54.9, M62.830, M99.22–M99.79	Other and unspecified disorders of back
M43.6, M48.01–M48.03, M53.0, M53.1, M53.81–M53.83, M54.00–M54.02, M54.11–M54.13, M54.2, M99.20, M99.21, M99.30, M99.31, M99.40, M99.41, M99.50, M99.51, M99.60, M99.61, M99.70, M99.71	Other disorders of cervical region
M46.40–M46.49, M50.00–M51.06, M51.24–M51.9, M96.1	Intervertebral disc disorder

[14] Use an additional code to identify the underlying organism as a comorbid condition.

ICD Code (Item 29)	Etiologic Diagnosis
S13.4XXA, S13.8XXA, S16.1XXA, S23.3XXA, S23.8XXA, S33.5XXA, S33.8XXA	Sprains and strains of other and unspecified parts of back
S33.6XXA, S33.8XXA, S33.9XXA	Sprains and strains of sacroiliac region

Orthopaedic Disorders (08)

Category 08, Orthopaedic disorders, includes patients whose major disorder is post fracture of bone or post arthroplasty (joint replacement).

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

If the patient's hip replacement is secondary to hip fracture, record a hip fracture IGC (08.11 or 08.12). If the patient's hip replacement is secondary to arthritis or the patient is admitted following revision of an implant, record a hip replacement IGC (08.51, 08.52, 08.71, or 08.72).

Table 21. ICD codes and etiologic diagnoses for IGCs 08.11 and 08.12

ICD Code (Item 29)	Etiologic Diagnosis
S72.001A–S72.26XA, S79.001A–S79.099A	Fracture of neck of femur

Table 22. ICD codes and etiologic diagnoses for IGC 08.2, Status post femur (shaft) fracture

ICD Code (Item 29)	Etiologic Diagnosis
S72.301A–S72.399A, S72.8X1A–S72.92XA, S72.8X1B–S72.92XB, S72.8X1C–S72.92XC	Fracture of shaft or unspecified part of femur
S72.401A–S72.446A, S72.401B–S72.466B, S72.401C–S72.466C, S72.451A–S72.499A, S72.491B–S72.499B, S72.491C–S72.499C, S79.101A–S79.199A	Fracture of lower end of femur

Table 23. ICD codes and etiologic diagnoses for IGC 08.3, Pelvic fracture

ICD Code (Item 29)	Etiologic Diagnosis
S32.301A–S32.399A, S32.301B–S32.399B, S32.401A–S32.499A, S32.401B–S32.499B, S32.501A–S32.599A, S32.501B–S32.599B, S32.601A–S32.699A, S32.601B–S32.699B, S32.810A–S32.9XXA, S32.810B–S32.9XXB	Fracture of pelvis

Table 24. ICD codes and etiologic diagnoses for IGC 08.4, Major multiple fractures

ICD Code (Item 29)	Etiologic Diagnosis
Combination codes: S82.101A + S82.831A S82.101B + S82.831B S82.102A + S82.832A S82.102B + S82.832B S82.161A + S82.811A S82.162A + S82.812A S82.201A + S82.401A S82.201B + one of S82.202B, S82.401B, or S82.402B S82.202A + S82.402A S82.202B + one of S82.401B or S82.402B S82.311A + S82.821A S82.312A + S82.822A S82.401B + S82.402B	Fractures of tibia and fibula
S82.90XA–S82.90XC, S82.91XA–S82.91XC, S82.92XA–S82.92XC	Fracture of multiple bones of same lower limb

Table 25. ICD codes and etiologic diagnoses for IGCs 08.51–08.72

ICD Code (Item 29)	Etiologic Diagnosis
E08.618, E09.618, E10.618, E11.618, E13.618, M07.60–M07.69, M12.10–M12.19, M12.50–M13.89	Other and unspecified arthropathies
L40.50–L40.59	Psoriatic arthropathy
M00.00–M00.9	Pyogenic arthritis
M05.00–M05.09, M05.20–M06.9	Rheumatoid arthritis
M08.00–M08.99	Juvenile chronic polyarthritis
M08.1, M45.0–M45.9, M48.8X1–M48.8X8	Ankylosing spondylitis
M12.00–M12.09	Chronic postrheumatic arthropathy
M15.0–M19.93	Osteoarthrosis and allied disorders
T84.010A–T84.498A, M96.0, M96.621–M96.69	Mechanical complication of internal orthopedic devices, implants and grafts
T84.50XA–T84.7XXA	Infection and inflammatory reaction due to internal orthopedic devices, implants and grafts
T84.81XA–T84.9XXA, T85.81XA–T85.89XA, T86.848, T86.849	Other complications due to internal orthopedic or prosthetic devices, implants and grafts

Table 26. ICD codes and etiologic diagnoses for IGCs 08.9, Other orthopaedic

ICD Code (Item 29)	Etiologic Diagnosis
C40.00–C40.32, C41.2–C41.4	Malignant neoplasm of bone and articular cartilage
C79.51, C79.52	Secondary malignant neoplasm of bone
M12.20–M12.49, M25.00–M25.18, M25.40–M25.676, M25.80–M25.879, M79.646, R26.2, R29.4, R29.898	Other and unspecified disorders of joint
M48.50XA–M48.58XA, M80.011A–M80.08XA, M80.811A–M80.88XA, M84.411A–M84.48XA, M84.511A–M84.58XA, M84.611A–M84.68XA	Pathologic fracture
Q67.5, Q76.3, Q76.425–Q76.429	Congenital postural lordosis or scoliosis
S82.101A–S82.199A, S82.201A–S82.299A, S82.201B–S82.299B, S82.201C–S82.299C, S82.301A–S82.319A, S82.401A–S82.499A, S82.401B–S82.499B, S82.401C–S82.499C, S82.811A–S82.839A, S82.861A–S82.866A, S82.861B–S82.866B, S82.861C–S82.866C, S89.001A–S89.099A, S89.201A–S89.299A **Combination codes:** S82.101A + S82.831A S82.101B + S82.831B S82.102A + S82.832A S82.102B + S82.832B S82.161A + S82.811A S82.162A + S82.812A S82.201A + S82.401A S82.202A + S82.402A S82.201B + S82.202B S82.201B + S82.402B S82.202B + S82.401B S82.311A + S82.821A S82.312A + S82.822A S82.401B + S82.402B	Fracture of tibia or fibula

Cardiac (09)

Code 09, Cardiac disorders, includes patients whose major disorder is either poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to a cardiac disorder.

09 Cardiac disorders

Table 27. ICD codes and etiologic diagnoses for IGC 09, Cardiac disorder

ICD Code (Item 29)	Etiologic Diagnosis
I20.0, I24.0–I24.9, I25.110, I25.700, I25.710, I25.720, I25.730, I25.750, I25.760, I25.790	Other acute and subacute forms of ischemic heart disease
I21.01–I22.9	Acute myocardial infarction, within 4 weeks (28 days)
I25.10–I25.119, I25.700–I25.812	Coronary atherosclerosis
I25.3–I25.6, I25.82, I25.83, I25.89, I25.9	Other forms of chronic ischemic heart disease
I46.2–I49.9, R00.1	Cardiac dysrhythmias
I50.1–I50.9	Heart failure

Pulmonary Disorders (10)

Category 10, Pulmonary disorders, includes patients whose major disorder is poor activity tolerance secondary to pulmonary insufficiency.

10.1 Chronic obstructive pulmonary disease
10.9 Other pulmonary disorders

Table 28. ICD codes and etiologic diagnoses for IGCs 10.1, COPD, and 10.9, Other pulmonary disorders

ICD Code (Item 29)	Etiologic Diagnosis
J41.0–J41.8, J44.0–J44.9	Chronic bronchitis
J43.0–J43.9	Emphysema
J44.0–J45.998	Asthma
J44.9	Chronic obstructive pulmonary disease, not elsewhere classified
J47.0–J47.9	Bronchiectasis

Burns (11)

Code 11, Burns, includes patients whose major disorder is thermal injury to major areas of the skin, underlying tissue, or both.

11 Burns

Table 29. ICD codes and etiologic diagnoses for IGC 11, Burns

ICD Code (Item 29)	Etiologic Diagnosis
T20.00XA–T20.79XA, T26.40XA–T26.42XA	Burns of face, head, and neck
T21.00XA–T21.79XA	Burns of trunk
T22.00XA–T22.799A	Burns of upper limb, except wrist and hand
T23.00XA–T23.799A	Burns of wrist(s) and hand(s)

ICD Code (Item 29)	Etiologic Diagnosis
T24.001A–T25.799A	Burns of lower limb(s)
T30.0–T30.4	Burns of multiple specified sites

Congenital Deformities (12)

Category 12, Congenital deformities, includes patients whose 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

Table 30. ICD codes and etiologic diagnoses for IGC 12.1, Spina bifida

ICD Code (Item 29)	Etiologic Diagnosis
Q05.0–Q05.9, Q07.00–Q07.03	Spina bifida

Table 31. ICD codes and etiologic diagnoses for IGC 12.9, Other congenital deformities

ICD Code (Item 29)	Etiologic Diagnosis
G90.1, Q01.0–Q04.8, Q06.0–Q06.9, Q07.8	Other congenital anomalies of nervous system
M62.3, M62.89	Arthrogryposis
Q65.00–Q65.6, Q66.0–Q66.9, Q67.6–Q68.5, Q74.3, Q76.3, Q76.425–Q76.429 **Combination codes:** Q65.01 + Q65.32 Q65.02 + Q65.31	Certain congenital musculoskeletal deformities
Q65.81–Q65.9, Q66.89, Q68.2, Q68.8–Q74.2, Q74.8, Q74.9	Other congenital deformities of limb
Q68.8, Q75.0–Q76.2, Q76.4–Q79.9, Q87.0	Other congenital musculoskeletal anomalies

Other Disabling Impairments (13)

Code 13, Other disabling impairments, is used **only** for cases that **cannot be classified into any of the other impairment groups**. Use of this code should be **rare**.

13 Other disabling impairments

As noted above, this category is used only for cases that cannot be classified into any other impairment group. Etiologic diagnoses for patients with IGC 13 include conversion disorder, transmetatarsal amputation, and transient ischemic attack (TIA).

Major Multiple Trauma (14)

Category 14, Major multiple trauma, includes trauma cases that require more complex management due to the involvement of **multiple systems or sites**. Record the ICD code for the *primary* trauma in item 29, Etiologic Diagnosis, and the ICD codes for *secondary* traumas in item 30, Other Diagnoses: Most Significant. If there are more than three secondary trauma codes, record the additional ICD codes in item 31, Comorbidities/Complications.

14.1 Brain + spinal cord injury
14.2 Brain + multiple fractures/amputation

14.3 Spinal cord + multiple fractures/amputation
14.9 Other multiple trauma

If the patient has major multiple trauma with brain injury, spinal cord injury, or both, record code 14.1, 14.2, or 14.3 as the IGC and then record two or more ICD codes appropriate for the traumatic impairment code as the etiologic diagnosis. The following combinations are valid:

- Traumatic brain dysfunction + traumatic spinal cord dysfunction
- Traumatic brain dysfunction + multiple fractures/amputation
- Traumatic spinal cord dysfunction + multiple fractures/amputation

If the patient has other multiple trauma, record code 14.9 as the IGC and then record two or more ICD codes for trauma to multiple systems or sites, but not brain dysfunction or spinal cord dysfunction.

If the patient has only multiple fractures, record IGC 08.4, Major multiple fractures, instead.

Developmental Disability (15)

Code 15, Developmental disability, includes patients whose major disorder is impaired cognitive and/or motor function resulting in developmental delay.

15 Developmental disability

Table 32. ICD codes and etiologic diagnoses for IGC 15, Developmental disability

ICD Code (Item 29)	Etiologic Diagnosis
F70–F79	Intellectual disabilities

Debility (16)

Code 16, Debility, includes patients with generalized deconditioning not attributable to another impairment group code.

16 Debility

Do **not** use this code for cases with debility secondary to cardiac or pulmonary conditions. For cardiac conditions, use **IGC 09, Cardiac disorders**; for pulmonary conditions, use a code from **category 10, Pulmonary disorders**, instead.

When recording the etiologic diagnosis for a patient with IGC 16, code the specific medical condition that is primarily responsible for the patient's debility.

Medically Complex Conditions (17)

Category 17, Medically complex conditions, includes patients with multiple medical and functional problems and complications prolonging the recuperation period. Medically complex patients require medical management of a principal condition and monitoring of comorbidities and potential complications. **The rehabilitation treatments of such patients are secondary to the management of their medical conditions.** The codes in this category group patients by the **focus of the program or treatment** rather than the etiology.

Code 17.1, Infections, includes patients admitted primarily for medical management of infections.

17.1 Infections

Do **not** use IGC 17.1 for respiratory infections, meningitis, encephalitis, or post-op infections. For respiratory infections, use IGC 17.51 or 17.52. For meningitis or encephalitis, use IGC 02.1, Nontraumatic brain dysfunction. For post-op infections, use IGC 17.8, Medical/surgical complications.

Table 33. ICD codes and etiologic diagnoses for IGC 17.1, Infections

ICD Code (Item 29)	Etiologic Diagnosis
A17.0, A17.1, A17.9, A17.81–A17.89	Tuberculosis of meninges and central nervous system
A40.0–A41.9, A42.7	Septicemia
A49.01–A49.02, B95.61–B95.8, M00.00–M00.09	Staphylococcus infection
A49.1, B95.0–B95.5, J20.2, M00.20–M00.29	Streptococcus infection
A49.3–A49.8, B96.0, B96.6–B96.89, J20.0, M00.80–M00.89	Other and unspecified bacterial infection
B20	Human immunodeficiency virus (HIV) disease[15]

Code 17.2, Neoplasms, includes patients who require continuing care after surgery, chemotherapy, radiation, immunotherapy, or hormone therapy because of a neoplasm. Care may include management of complications from the illness or the treatment.

17.2 Neoplasms

Do **not** use IGC 17.2 for patients in a hospice/terminal care program or patients with neoplasms of the brain, spinal cord, or skeletal system. For patients in a hospice or terminal-care program, use IGC 17.8, Terminal care. For patients with neoplasms of the brain, use IGC 02.1, Nontraumatic brain dysfunction. For patients with neoplasms of the spinal cord, use a code from category 04.1, Nontraumatic spinal cord dysfunction. For patients with neoplasms of the skeletal system, use a code from category 05, Amputation of limb, or code 08.9, Other orthopaedic.

Table 34. ICD codes and etiologic diagnoses for IGC 17.2, Neoplasms

ICD Code (Item 29)	Etiologic Diagnosis
C00.0–C00.9	Malignant neoplasm of lip, oral cavity, and pharynx

[15] Record this diagnosis only if your state permits the release of this information.

ICD Code (Item 29)	Etiologic Diagnosis
C15.3–C15.9	Malignant neoplasm of digestive organs and peritoneum
C30.0–C39.9, C45.0, C45.2	Malignant neoplasm of respiratory and intrathoracic organs
C40.00–C41.9	Malignant neoplasm of bone and articular cartilage
C43.0–C43.9, D03.0–D03.9	Malignant melanoma of skin
C44.00–C44.99	Other malignant neoplasm of skin
C46.0–C46.9	Kaposi's sarcoma
C47.0–C47.9, C49.0–C49.9	Malignant neoplasm of connective and other soft tissue
C50.011–C50.019, C50.111–C50.119, C50.211–C50.219, C50.311–C50.319, C50.411–C50.419, C50.511–C50.519, C50.611–C50.619, C50.811–C50.819, C50.911–C50.919	Malignant neoplasm of female breast
C50.021–C50.029, C50.121–C50.129, C50.221–C50.229, C50.321–C50.329, C50.421–C50.429, C50.521–C50.529, C50.621–C50.629, C50.821–C50.829, C50.921–C50.929	Malignant neoplasm of male breast
C51.0–C68.9	Malignant neoplasm of genitourinary tract
C81.00–C81.99	Hodgkin's disease
C82.00–C82.99, C84.00–C84.49, C84.A0–C86.4, C91.40–C91.42, C96.0–C96.4, C96.A–C96.9	Other malignant neoplasms of lymphoid and histiocytic tissue
C83.00–C83.99, C84.60–C84.79, C85.20–C85.29, C86.5–C86.6, C88.4	Lymphosarcoma and reticulosarcoma
C88.2, C88.3, C88.8, C88.9, C90.00–C90.21, C90.30, C90.31	Multiple myeloma and immunoproliferative neoplasms
C91.00–C91.32, C91.50–C91.91	Lymphoid leukemia
C92.00–C92.91	Myeloid leukemia
C93.00–C93.92	Monocytic leukemia
C94.00–C94.32, C94.80–C95.92	Other and unspecified leukemia

Subcategory 17.3, Nutrition, includes patients 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

Table 35. ICD codes and etiologic diagnoses for IGCs 17.31 and 17.32

ICD Code (Item 29)	Etiologic Diagnosis
E10.10–E13.9 **Combination codes:** E10.65 + one of E10.10, E10.11, E10.21, E10.311, E10.319, E10.36, E10.39, E10.40, E10.51, E10.69, or E10.8 E11.65 + one of E11.00, E11.01, E11.21, E11.311, E11.319, E11.36, E11.39, E11.40, E11.51, E11.69, E11.8, or E13.10	Diabetes mellitus
E86.0–E87.8	Disorders of fluid, electrolyte, and acid-base balance

Code 17.4, Circulatory disorders, includes patients who have complications of the circulatory system (heart, blood vessels) or need continuing management after surgery or treatment for circulatory conditions. This IGC may include acute myocardial infarction and cerebrovascular disease (stroke) if the time since the onset of the circulatory disorder is more than two months.

17.4 Circulatory disorders

Do **not** use IGC 17.4 for patients admitted for cardiac rehabilitation (post myocardial infarction, coronary artery bypass graft, etc.) if the time since onset is two months or less; use IGC 09, Cardiac disorders, instead.

Table 36. ICD codes and etiologic diagnoses for IGC 17.4, Circulatory disorders

ICD Code (Item 29)	Etiologic Diagnosis
E08.51, E08.52, E09.51, E09.52, E10.51, E10.52, E11.51, E11.52, E13.51, E13.52, I67.0, I73.01–I73.9, I77.71–I77.79, I79.1–I79.8	Other peripheral vascular disease
I12.0, I12.9	Hypertensive renal disease
I13.0–I13.2	Hypertensive heart and renal disease
I25.10–I25.119, I25.700–I25.812	Coronary atherosclerosis
I50.1–I50.9	Heart failure
I82.0–I82.4Z9, I82.601–I82.C29, I82.890–I82.91	Other venous embolism and thrombosis

Code 17.51, Respiratory disorders, ventilator-dependent, includes respiratory patients 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

Code 17.52, Respiratory disorders, non-ventilator-dependent, includes respiratory patients who are **not** dependent on a ventilator.

17.52 Respiratory disorders, non-ventilator-dependent

Table 37. ICD codes and etiologic diagnoses for IGCs 17.51 and 17.52

ICD Code (Item 29)	Etiologic Diagnosis
A22.1, A37.01, A37.11, A37.81, A37.91, A48.1, B25.0, B44.0, B77.81, J13–J18.1, J18.8, J18.9	Pneumonia due to bacteria or other or unspecified organism
B44.81, J80–J81.0, J82, J95.1–J95.3, J95.821, J95.822, J95.84, J96.00–J96.92, J98.11–J98.4	Other diseases of lung, including pulmonary collapse, pulmonary insufficiency and respiratory failure
J12.0–J12.9	Viral pneumonia
J69.0–J69.8	Pneumonitis due to solids and liquids

Code 17.6, Terminal care, includes patients 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 patient.

17.6 Terminal care

As noted above, this code is used for patients whose care typically focuses on comfort measures and pain relief as desired by the patient. Etiologic diagnoses for patients with IGC 17.6 are typically end-stage conditions for cancer, Alzheimer's disease, renal failure, congestive heart failure, stroke, acquired immunodeficiency syndrome (AIDS), Parkinsonism, and emphysema.

Code 17.7, Skin disorders, includes patients with open wounds; pressure-related, circulatory, and decubitus ulcers; and poorly healing wounds due to surgery, cancer, or immune disorders.

17.7 Skin disorders

Table 38. ICD codes and etiologic diagnoses for IGC 17.7, Skin disorders

ICD Code (Item 29)	Etiologic Diagnosis
I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, L97.101–L97.929, L98.411–L98.429	Chronic ulcer of lower limbs, except decubitus
K12.2, L02.11, L02.211–L02.219, L02.31, L02.411–L02.419, L02.511–L02.519, L02.611–L02.619, L03.111–L03.898	Other cellulitis and abscess
L02.611–L02.619, L03.031–L03.049	Cellulitis and abscess of toe
L89.000–L89.95	Decubitus ulcer

ICD Code (Item 29)	Etiologic Diagnosis
S01.00XA–S01.95XA, S02.5XXA, S02.5XXB, S03.2XXA, S05.20XA–S05.92XA, S08.0XXA–S08.89XA, S09.12XA, S09.20XA–S09.91XA, S09.93XA, S11.011A–S11.95XA, S16.2XXA, S21.001A–S21.259A, S21.90XA–S21.95XA, S28.1XXA, S28.211A–S28.229A, S29.029A, S31.000A, S31.010A, S31.020A, S31.030A, S31.040A, S31.050A, S31.100A–S31.552A, S31.801A–S31.839A, S38.211A–S38.221A, S38.3XXA, S39.023A **Combination codes:** S11.012A + S11.022A S11.014A + S11.024A S11.019A + S11.029A	Open wound of head, neck, and trunk
S71.021A–S71.159A, S76.021A–S76.029A, S76.121A–S76.129A, S76.221A–S76.229A, S76.321A–S76.329A, S76.821A–S76.829A, S76.921A–S76.929A, S81.001A–S81.859A, S86.021A–S86.029A, S86.121A–S86.129A, S86.221A–S86.229A, S86.321A–S86.329A, S86.821A–S86.829A, S86.921A–S86.929A, S91.001A–S91.359A, S96.021A–S96.029A, S96.121A–S96.129A, S96.221A–S96.229A, S96.821A–S96.829A **Combination codes:** S96.929A + one of S91.109A, S91.209A, S91.309A, or S96.921A	Open wound of lower limb (except traumatic amputation)

Code 17.8, Medical/surgical complications, includes patients with complications of medical and surgical care.

17.8 Medical/surgical complications

Table 39. ICD codes and etiologic diagnoses for IGC 17.8, Medical/surgical complications

ICD Code (Item 29)	Etiologic Diagnosis
D78.01–D78.22, E36.01–E36.8, G97.31–G97.32, G97.48–G97.52, H59.021–H59.029, H59.111–H59.329, H95.21–H95.42, I97.410–I97.62, J95.61–J95.72, J95.830, J95.831, K68.11, K91.61–K91.72, K91.840–K91.841, L76.01–L76.82, M96.810–M96.831, N99.61–N99.821, T810.10XA–T81.69XA, T81.83XA–T81.9XXA, T88.8XXA	Other complications of procedures, not elsewhere classified
D78.81–D78.89, E89.810–E89.89, G03.8, G97.0, G97.2–G97.32, G97.81–G97.82, H59.011–H59.019, H59.031–H59.099, H59.811–H59.89, H95.811–H95.89, I97.110–I97.191, I97.3, I97.710–I97.89, J95.4, J95.5, J95.851–J95.89, K91.3, K91.81–K91.83, K91.86–K91.89, M96.89, N98.1–N99.0, N99.520–N99.538, N99.81, N99.89, T81.710–T81.72XA, T87.30–T87.9	Complications affecting specified body systems, not elsewhere classified

ICD Code (Item 29)	Etiologic Diagnosis
T82.817A–T82.9XXA, T83.81XA–T83.9XXA, T84.81XA–T84.9XXA, T85.81XA–T85.9XXA, T86.848, T86.849	Complications of internal device, implant and graft
T86.00–T86.819, T86.830–T86.839, T86.850–T86.99	Complications of transplanted organ
T87.0X1–T87.2	Complications of reattached extremity or body part

Code 17.9, Other medical complex conditions, includes medically complex patients who cannot be classified elsewhere.

17.9 Other medically complex conditions

ICD Code (Item 29)	Etiologic Diagnosis
A56.01, N30.00–N30.81	Cystitis
N17.0–N17.9	Acute renal failure
N18.1–N18.9	Chronic kidney disease
N34.0–N34.3	Urethritis, not sexually transmitted, and urethral syndrome

Appendix C: Sample Case Studies

This appendix presents admission and discharge information for two cases. They can be used as self-tests, part of training sessions, etc. Answers and rationales are presented after each case study.

Practice Case Study #1

Mr. G. is a seventy-two-year-old white male. He is married and lives with his wife. Mr. G. speaks English. He fell down a flight of stairs and was admitted to General Hospital on November 20, 2017, with confused sensorium and incomplete motor and sensory tetraplegia due to a fracture dislocation at C6–C7. The majority of his key muscles had grades of 3 or 4. Mr. G. did not lose consciousness. Cervical traction was applied. An emergency room CT scan of the head showed a right parietal subdural hematoma. A burr hole evacuation of the subdural hematoma was performed under local anesthesia. Two days later, Mr. G.'s cervical spine was reduced and fused posteriorly.

Mr. G. was transferred to the rehabilitation unit on November 30, 2017. His functional assessment during the first three days of his rehabilitation stay at General Hospital was as follows:

Eating

Mr. G. eats a regular diet for each meal after a helper applies a universal cuff and occasionally scoops the 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 and drinks from a glass without assistance.

Grooming

Each morning, 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. A helper washes Mr. G.'s right hand and shaves him.

Bathing

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

Dressing: Upper Body

Mr. G. typically wears a pullover sweatshirt. A helper places the shirt over Mr. G.'s head and threads both his arms through the sleeves. Mr. G. then leans forward so the helper can pull the shirt down over his trunk.

Dressing: Lower Body

Mr. G. usually wears sweatpants with an elastic waist, anti-embolism stockings, socks, and slip-on shoes. A helper applies Mr. G.'s anti-embolism 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 a 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 bladder accidents.

Bowel Management

Mr. G. is not on a bowel program, but he has had episodes of incontinence, after which a helper cleaned him and changed his clothing. Mr. G. has had one bowel accident during the past three 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 transfer into a bath or shower stall. He bathes in bed each morning.

Locomotion: Walk, Wheelchair

Mr. G. does not walk. A helper pushes Mr. G. in his wheelchair. The therapist expects Mr. G. to walk by discharge.

Locomotion: Stairs

Mr. G. has not attempted to climb stairs because of the risk of injury.

Comprehension

Mr. G. consistently understands questions that the staff asks him about routine, everyday matters, such as meals and his 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 he 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. cooperates 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, and transportation arrangements.

Memory

Mr. G. recognizes the rehabilitation staff members 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, Mr. G.'s functional assessment was as follows:

Eating

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

Grooming

Mr. G. combs his hair and brushes his teeth without assistance. He uses a wash mitt to wash his hands and face, doing so without difficulty. He begins shaving by himself but needs assistance to shave under his chin.

Bathing

Mr. G. uses a tub bench and handheld shower to wash in the tub. A helper adjusts the water temperature and pressure and helps wash both lower legs, including the feet.

Dressing: Upper Body

A helper sets out Mr. G.'s clothing. Mr. G. typically wears a sweatshirt on his upper body. He threads both arms and then pulls the sweatshirt over his head and down over his trunk.

Dressing: Lower Body

Mr. G. threads both legs and pulls up both sides of his underwear and pants over his hips. A helper then puts on both of Mr. G.'s socks and both of his slip-on shoes. Mr. G. no longer wears anti-embolism stockings.

Toileting

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

Bladder Management

Although Mr. G. no longer requires intermittent catheterizations at discharge, he requires medication to prevent urinary retention. Mr. G. uses a toilet during the day, but at night he prefers to use a urinal, which the nursing staff empties. Mr. G. has had one accident in the past three days, requiring assistance from nursing to change linen and clothing.

Bowel Management

By using a suppository every other day, Mr. G. has developed better control of his bowel function. He positions himself in bed and inserts the suppository. After breakfast, he ambulates to the bathroom and uses the toilet. Mr. G. has not had an episode of bowel incontinence (soiling linen or clothing) in the past three 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, Mr. G. uses a grab bar to transfer to the toilet. He no longer requires supervision during this transfer.

Transfers: Tub, Shower

Mr. G. transfers onto the tub bench by himself but requests supervision to get out of the tub because of the wet surfaces.

Locomotion: Walk, Wheelchair

Mr. G. uses Lofstrand crutches to walk over 150 feet (over 45 meters) in a safe and timely manner.

Locomotion: Stairs

Mr. G. goes up and down four stairs with touching assistance from 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 his social worker without difficulty when she discusses insurance coverage for his hospitalization.

Expression

Mr. G. speaks with friends about common interests of all kinds and has begun discussing his 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 and 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 five minutes before his therapy sessions, without any reminders from the hospital staff. Mr. G. remembers three-step unrelated commands without repetition.

Answers and Rationales: Admission FIM® Ratings

Item	Rationale
Eating	**Level 4, Minimal Assistance:** The helper occasionally scoops the food. Mr. G. brings the food to his mouth, chews it, and swallows it.
Grooming	**Level 3, Moderate Assistance:** Mr. G. completes three and a half of the five tasks independently (70%) and needs help with the other one and a half tasks.
Bathing	**Level 1, Total Assistance:** Mr. G. washes and dries his chest and left arm only. Overall, he expends less than 25% of the effort.
Dressing: Upper Body	**Level 1, Total Assistance:** Mr. G. only leans forward as the helper dresses him. He performs less than 25% of the effort.
Dressing: Lower Body	**Level 1, Total Assistance:** Mr. G. only shifts from side to side as the helper dresses him. He performs less than 25% of the effort.
Toileting	**Level 2, Maximal Assistance:** Mr. G. only shifts from side to side as the helper adjusts Mr. G.'s pants. Mr. G. performs perineal hygiene without assistance.
Bladder Management	**Level 1, Total Assistance:** The staff performs intermittent catheterizations. Mr. G. requires assistance from nursing.
Bowel Management	**Level 1, Total Assistance:** Mr. G. has had one accident over the past three days, requiring cleanup by nursing.
Transfers: Bed, Chair, Wheelchair	**Level 1, Total Assistance:** Mr. G. needs assistance from two staff members to get into and out of bed.
Transfers: Toilet	**Level 1, Total Assistance:** Mr. G. needs help from two staff members to get on and off the toilet.
Transfers: Tub, Shower	**Level 1, Total Assistance:** Mr. G. does not transfer into a tub or shower.
Locomotion: Walk, Wheelchair	**Level 1, Total Assistance:** The rating for walking is used because Mr. G. is expected to walk at discharge.
Locomotion: Stairs	**Level 1, Total Assistance:** Mr. G. does not climb stairs.
Comprehension	**Level 5, Standby Prompting:** Mr. G. understands conversation about daily activities consistently but does not understand complex/abstract information.
Expression	**Level 5, Standby Prompting:** Mr. G. expresses routine needs clearly but does not express complex/abstract information.
Social Interaction	**Level 7, Complete Independence:** Mr. G. cooperates with staff and does not need redirection. He interacts appropriately.
Problem Solving	**Level 5, Supervision:** Mr. G. recognizes and solves routine problems consistently but cannot handle complex problems.
Memory	**Level 5, Standby Prompting:** Mr. G. recognizes therapists, lists his daily activities, follows two thoughts or activities, and needs prompting in stressful or unfamiliar circumstances less than 10% of the time.

Answers and Rationales: Discharge FIM® Ratings

Item	Rationale
Eating	**Level 5, Setup/Supervision:** The helper provides only setup assistance (cutting up meat and opening containers), after which Mr. G. eats by himself.
Grooming	**Level 4, Minimal Assistance:** Mr. G. performs four of five grooming activities independently; the helper only shaves under Mr. G.'s chin.
Bathing	**Level 4, Minimal Assistance:** The helper washes Mr. G.'s lower legs only.
Dressing: Upper Body	**Level 5, Supervision/Setup:** The helper provides only setup assistance (setting out clothes).
Dressing: Lower Body	**Level 3, Moderate Assistance:** Mr. G. puts on his underwear and pants independently. He needs help to put on both socks and both shoes.
Toileting	**Level 6, Modified Independence:** Mr. G. uses a device (the grab bar) during toileting tasks.
Bladder Management	**Level 1, Total Assistance:** Staff empties Mr. G.'s urinal at night (level 5). Mr. G. is on medication (level 6). He has had one accident in the past three days (level 5), requiring cleanup by nursing (level 1).
Bowel Management	**Level 6, Modified Independence:** Mr. G. inserts his own suppository after positioning himself (level 6). He has not had an incontinent episode.
Transfers: Bed, Chair, Wheelchair	**Level 5, Setup/Supervision:** The helper supervises Mr. G.'s transfers into and out of bed.
Transfers: Toilet	**Level 6, Modified Independence:** Mr. G. uses a grab bar for independent toilet transfers.
Transfers: Tub, Shower	**Level 5, Supervision/Setup:** The helper supervises Mr. G.'s transfer out of the tub due to the wet surface.
Locomotion: Walk, Wheelchair	**Level 6, Modified Independence:** Mr. G. uses an assistive device (the Lofstrand crutches) to walk over 150 feet (45 meters).
Locomotion: Stairs	**Level 2, Maximal Assistance:** Mr. G. walks up and down four stairs with touching assistance from one person.
Comprehension	**Level 7, Complete Independence:** Mr. G. understands routine and complex information without difficulty.
Expression	**Level 7, Complete Independence:** Mr. G. expresses routine and complex information without difficulty.
Social Interaction	**Level 7, Complete Independence:** Mr. G. is cooperative with staff. He has not had an episode of inappropriate behavior.
Problem Solving	**Level 7, Complete Independence:** Mr. G. solves routine and complex problems independently.
Memory	**Level 7, Complete Independence:** Mr. G. remembers the staff and his daily routine and executes requests without repetition.

Practice Case Study #2

Mr. H., a seventy-seven-year-old white male, was admitted to General Hospital at 11:00 a.m. on January 30, 2017. Mr. H. is a retired accountant who has been widowed for approximately five years. He lives alone in a second-story apartment. He has had adult-onset diabetes for ten 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. Because Mr. H.'s blood glucose was 220, insulin reaction was ruled out as the cause of his admitting condition. Mr. H.'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 an ability to respond to questions with eye movements but an 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 February 4, 2017. His functional assessment during the first three days of his rehabilitation stay at General Hospital was as follows:

Eating

Mr. H. is NPO. Staff members administer continuous nasogastric feeds.

Grooming

After a helper hands Mr. H. a washcloth, Mr. H. washes his face, but staff members wash his hands, comb his hair, shave him, and provide oral care (brush his teeth).

Bathing

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

Dressing: Upper Body

Mr. H. typically wears a sweatshirt. A helper threads both of Mr. H.'s arms through the sleeves of the shirt, after which Mr. H. pulls the shirt over his head. The helper pulls the shirt down Mr. H.'s trunk and adjusts it.

Dressing: Lower Body

Mr. H. wears anti-embolism stockings, underwear, pants, and slip-on shoes. The helper threads both legs into the underwear and pants. Mr. H. turns side to side as a helper pulls his pants and underwear up. The helper applies Mr. H.'s anti-embolism stockings and slip-on shoes.

Toileting

Mr. H. depends on staff to pull his pants up and down and to provide perineal hygiene.

Bladder Management

Mr. H. has an indwelling catheter, which the nursing staff manages.

Bowel Management

Mr. H. has been on a bowel program and has had two bowel accidents (soiling linen and clothing) in the past three days. The nursing staff changes Mr. H. after each incontinent episode.

Transfers: Bed, Chair, Wheelchair

Mr. H. transfers out of bed to a chair via mechanical lift and assistance from two helpers.

Transfers: Toilet

Mr. H. does not transfer to a toilet.

Transfers: Tub, Shower

Mr. H. does not transfer to a tub or shower.

Locomotion: Walk, Wheelchair

Mr. H. does not ambulate. He propels a wheelchair for thirty feet (nine meters). Mr. H.'s therapist expects him to walk at discharge.

Locomotion: Stairs

Mr. H. has not attempted to climb stairs because of the risk of injury.

Comprehension

When asked such questions as whether he wants another pillow, whether he is comfortable, and whether he wants to go back to bed, Mr. H. signifies a positive response by nodding his head. When asked simple questions such as whether it's 2018 or whether he is in a hospital, he gives correct responses. Mr. H. 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. cooperates 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

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

At discharge, Mr. H.'s functional assessment was as follows:

Eating

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

Grooming

Mr. H. washes his hands and face after a helper places a towel and washcloth in front of him. He removes his dentures and places them in his denture cup. The helper opens the packet of denture cleanser, after which Mr. H. puts the cleansing tablet into the denture cup. Mr. H. shaves himself with an electric razor. The helper plugs in the shaver and places it within Mr. H.'s reach. Because Mr. H.'s range of motion is limited, the helper combs Mr. H.'s hair. Mr. H. cleans his dentures and inserts them without assistance.

Bathing

Mr. H. bathes in a tub on most days. He uses a hand-held shower and a tub bench. A helper adjusts the water temperature before Mr. H. gets into the tub. Mr. H. 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. Mr. H. typically wears an undershirt and a front-buttoning shirt. He puts on his undershirt and shirt by himself but needs assistance to button his shirt.

Dressing: Lower Body

A helper begins the process of putting 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, after which the helper zips up Mr. H.'s pants. The helper puts on both socks and Mr. H.'s left shoe; Mr. H. puts on his right shoe.

Toileting

Mr. H. pulls down his pants before he uses the toilet. After Mr. H. voids, a helper provides perineal hygiene. Mr. H. then pulls up his pants; the helper provides assistance only to zipper the pants.

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 one accident in the past three days, requiring nursing to clean up and change linen and clothing.

Bowel Management

Mr. H. uses a stool softener to establish a satisfactory bowel program. He has had no bowel accidents.

Transfers: Bed, Chair, Wheelchair

Mr. H.'s transfers in and out of bed are supervised by a helper.

Transfers: Toilet

Mr. H. uses a grab bar as he transfers to the toilet. A nurse always supervises his transfers.

Transfers: Tub, Shower

A helper supervises Mr. H.'s transfer into the tub. Once Mr. H. completes bathing, he puts on his call light, after which he transfers out of the tub as the helper provides steadying assistance.

Locomotion: Walk, Wheelchair

Mr. H. walks over 150 feet (45 meters) with a walker and supervision from a helper.

Locomotion: Stairs

Mr. H. goes up and down a full flight of twelve stairs while holding on to a handrail; a helper provides steadying assistance during the climb.

Comprehension

Mr. H. understands information discussed in a group. He understands information about activities of daily living, discharge plans, and financial affairs without difficulty.

Expression

Mr. H. uses brief phrases to express his basic needs. He becomes very frustrated when he understands complex information about his discharge plans and his financial status but cannot express complex information because of his inability to speak fluently or clearly. Mr. H. expresses his basic needs over 90% of the time.

Social Interaction

Mr. H. is actively involved in therapy sessions, appears to enjoy recreation (e.g., cards, bingo, "exercise to music," and other 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 an unrelated three-step command without difficulty. He does not have any difficulty with his memory.

Answers and Rationales: Admission FIM® Ratings

Item	Rationale
Eating	**Level 1, Total Assistance:** The staff administers the NG feedings.
Grooming	**Level 1, Total Assistance:** Mr. H. performs one of the five tasks (20%).
Bathing	**Level 2, Maximal Assistance:** Mr. H. bathes three of ten body parts (30%).
Dressing: Upper Body	**Level 2, Maximal Assistance:** Mr. H. is dependent on a helper and only pulls his shirt over his head.
Dressing: Lower Body	**Level 1, Total Assistance:** Mr. H. is dependent on a helper and performs less than 25% of the effort.
Toileting	**Level 1, Total Assistance:** Mr. H. is dependent on a helper.
Bladder Management	**Level 1, Total Assistance:** The staff manages the indwelling catheter.
Bowel Management	**Level 1, Total Assistance:** Mr. H. is incontinent of stool. He has soiled linen and clothing twice in the past three days. In both cases, staff changed Mr. H.'s linen and clothing.
Transfers: Bed, Chair, Wheelchair	**Level 1, Total Assistance:** Mr. H. needs two staff members to get into and out of bed.
Transfers: Toilet	**Level 1, Total Assistance:** Mr. H. does not transfer to a toilet.
Transfers: Tub, Shower	**Level 1, Total Assistance:** Mr. H. does not transfer into a tub or shower.
Locomotion: Walk, Wheelchair	**Level 1, Total Assistance:** Mr. H. propels his wheelchair only thirty feet (level 1, Total Assistance). Walking is his expected mode of locomotion at discharge, but ambulation did not occur (level 1).
Locomotion: Stairs	**Level 1, Total Assistance:** Mr. H. does not climb stairs.
Comprehension	**Level 5, Standby Prompting:** Mr. H. understands conversations about daily activities but does not understand complex/abstract information.
Expression	**Level 2, Maximal Prompting:** Mr. H. says only single words.
Social Interaction	**Level 7, Complete Independence:** Mr. H. acts appropriately and participates in therapy.
Problem Solving	**Level 5, Supervision:** Mr. H. solves simple problems but cannot solve complex problems.
Memory	**Level 3, Moderate Assistance:** Mr. H. recognizes therapists most of the time. He remembers his therapy routines just over half of the time.

Answers and Rationales: Discharge FIM® Ratings

Item	Rationale
Eating	**Level 5, Supervision/Setup:** The helper provides only setup assistance (cutting up meat and opening containers), after which Mr. H. eats by himself.
Grooming	**Level 4, Minimal Assistance:** Mr. H. performs four of the five grooming tasks independently after the helper provides setup assistance. Mr. H. needs help to comb his hair.
Bathing	**Level 4, Minimal Assistance:** Mr. H. bathes all body parts himself except for his feet (80%).
Dressing: Upper Body	**Level 4, Minimal Assistance:** Mr. H. put on his own undershirt and shirt. The helper assists with buttoning the shirt only.
Dressing: Lower Body	**Level 2, Maximal Assistance:** The helper threads Mr. H.'s underwear and pants, which Mr. H. pulls up. The helper puts on Mr. H.'s socks and left shoe; Mr. H. puts on his right shoe.
Toileting	**Level 3, Moderate Assistance:** Mr. H. depends on staff for perineal hygiene and zipping up his pants. He pulls his pants up and down.
Bladder Management	**Level 1, Total Assistance:** Mr. H. uses a urinal after setup (level 5). He has had one accident in the past three days (level 5), requiring assistance from nursing to change linen and clothing (level 1).
Bowel Management	**Level 6, Modified Independence:** Mr. H. uses a stool softener for bowel management (level 6). He is not incontinent of stool (level 6).
Transfers: Bed, Chair, Wheelchair	**Level 5, Setup/Supervision:** The helper supervises Mr. H.'s bed-to-chair transfers.
Transfers: Toilet	**Level 5, Supervision/Setup:** The helper supervises the transfers.
Transfers: Tub, Shower	**Level 4, Minimal Assistance:** The helper provides steadying assistance as Mr. H. transfers out of the tub.
Locomotion: Walk, Wheelchair	**Level 5, Supervision/Setup:** Mr. H. walks 150 feet (45 meters) with an assistive device (a walker) and supervision from a helper.
Locomotion: Stairs	**Level 4, Minimal Assistance:** Mr. H. walks up and down a full flight of stairs with steadying assistance from the helper.
Comprehension	**Level 7, Complete Independence:** Mr. H. understands complex/abstract information.
Expression	**Level 5, Standby Prompting:** Mr. H. expresses basic information over 90% of the time, but not complex/abstract information.
Social Interaction	**Level 7, Complete Independence:** Mr. H. cooperates with staff. He has not had an episode of inappropriate behavior.
Problem Solving	**Level 7, Complete Independence:** Mr. H. solves routine/complex problems without difficulty.
Memory	**Level 7, Complete Independence:** Mr. H. remembers the staff and his daily routine and executes requests without repetition.

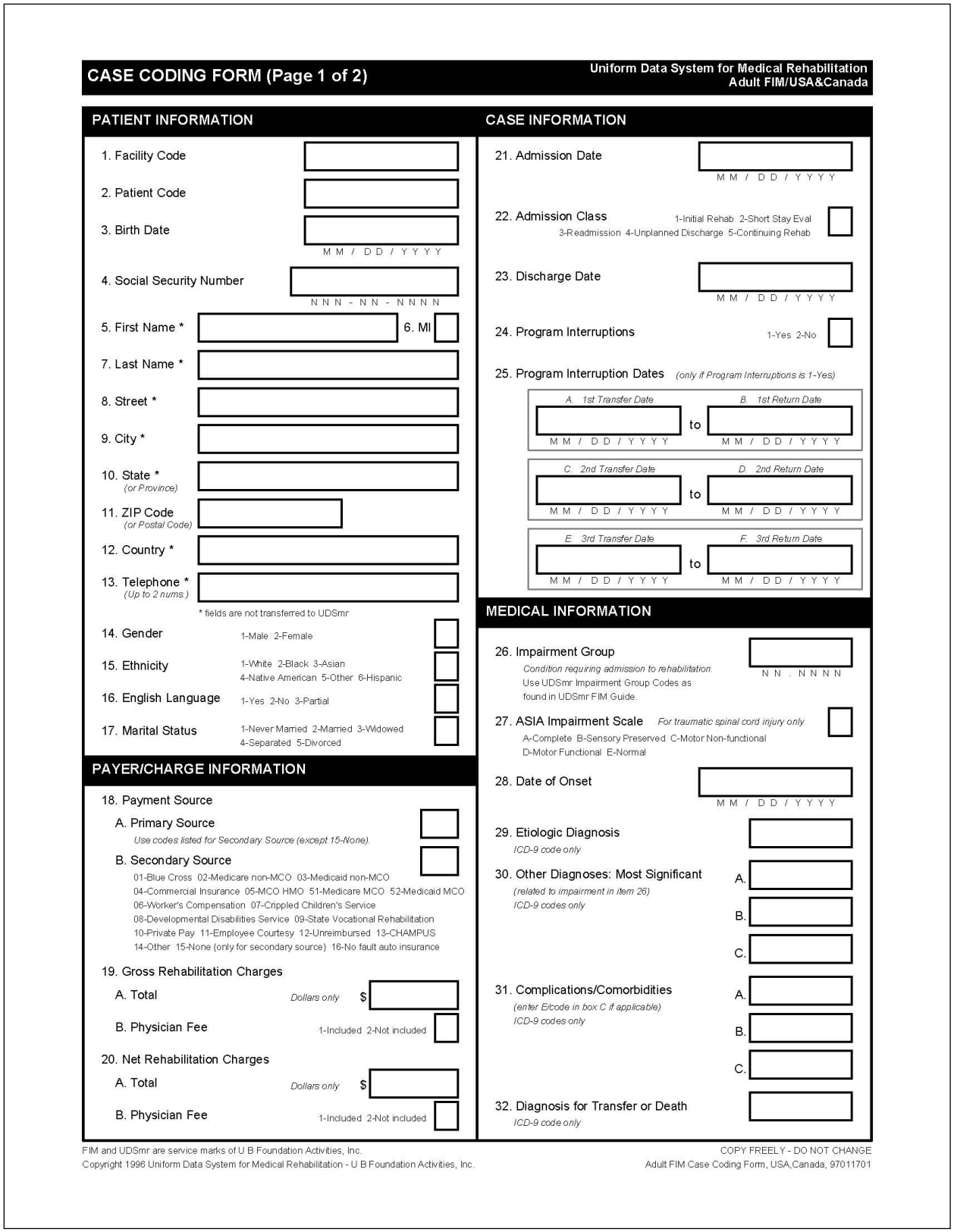
Appendix D: FIM® Coding Forms

This appendix contains two coding forms:

- Case Coding Form (used for case information, the admission assessment, and the discharge assessment)
- Interim or Follow-Up Assessment Form (used for interim assessments and follow-up assessments)

Each form is presented in as a blank form usable for data collection. For information about coding the Case Coding Form, see page 10. For information about coding the Interim or Follow-Up Assessment Form, see page 26.

Case Coding Form



CASE CODING FORM (Page 1 of 2)

Uniform Data System for Medical Rehabilitation
Adult FIM/USA&Canada

PATIENT INFORMATION

1. Facility Code
2. Patient Code
3. Birth Date — M M / D D / Y Y Y Y
4. Social Security Number — N N N - N N - N N N N
5. First Name * — 6. MI
7. Last Name *
8. Street *
9. City *
10. State * *(or Province)*
11. ZIP Code *(or Postal Code)*
12. Country *
13. Telephone * *(Up to 2 nums.)*

* fields are not transferred to UDSmr

14. Gender — 1-Male 2-Female
15. Ethnicity — 1-White 2-Black 3-Asian 4-Native American 5-Other 6-Hispanic
16. English Language — 1-Yes 2-No 3-Partial
17. Marital Status — 1-Never Married 2-Married 3-Widowed 4-Separated 5-Divorced

PAYER/CHARGE INFORMATION

18. Payment Source
    - A. Primary Source — *Use codes listed for Secondary Source (except 15-None).*
    - B. Secondary Source

    01-Blue Cross 02-Medicare non-MCO 03-Medicaid non-MCO
    04-Commercial Insurance 05-MCO HMO 51-Medicare MCO 52-Medicaid MCO
    06-Worker's Compensation 07-Crippled Children's Service
    08-Developmental Disabilities Service 09-State Vocational Rehabilitation
    10-Private Pay 11-Employee Courtesy 12-Unreimbursed 13-CHAMPUS
    14-Other 15-None (only for secondary source) 16-No fault auto insurance
19. Gross Rehabilitation Charges
    - A. Total — *Dollars only* $
    - B. Physician Fee — 1-Included 2-Not included
20. Net Rehabilitation Charges
    - A. Total — *Dollars only* $
    - B. Physician Fee — 1-Included 2-Not included

CASE INFORMATION

21. Admission Date — M M / D D / Y Y Y Y
22. Admission Class — 1-Initial Rehab 2-Short Stay Eval 3-Readmission 4-Unplanned Discharge 5-Continuing Rehab
23. Discharge Date — M M / D D / Y Y Y Y
24. Program Interruptions — 1-Yes 2-No
25. Program Interruption Dates *(only if Program Interruptions is 1-Yes)*
    - A. *1st Transfer Date* — M M / D D / Y Y Y Y to B. *1st Return Date* — M M / D D / Y Y Y Y
    - C. *2nd Transfer Date* — M M / D D / Y Y Y Y to D. *2nd Return Date* — M M / D D / Y Y Y Y
    - E. *3rd Transfer Date* — M M / D D / Y Y Y Y to F. *3rd Return Date* — M M / D D / Y Y Y Y

MEDICAL INFORMATION

26. Impairment Group — *Condition requiring admission to rehabilitation.* Use UDSmr Impairment Group Codes as found in UDSmr FIM Guide. — N N . N N N N
27. ASIA Impairment Scale — *For traumatic spinal cord injury only* — A-Complete B-Sensory Preserved C-Motor Non-functional D-Motor Functional E-Normal
28. Date of Onset — M M / D D / Y Y Y Y
29. Etiologic Diagnosis — *ICD-9 code only*
30. Other Diagnoses: Most Significant — *(related to impairment in item 26)* *ICD-9 codes only* — A. B. C.
31. Complications/Comorbidities — *(enter E/code in box C if applicable)* *ICD-9 codes only* — A. B. C.
32. Diagnosis for Transfer or Death — *ICD-9 code only*

Case Coding Form

CASE CODING FORM (Page 2 of 2) — Uniform Data System for Medical Rehabilitation, Adult FIM/USA&Canada

PATIENT/CASE IDENTIFICATION

1. Facility Code
2. Patient Code
21. Admission Date (M M / D D / Y Y Y Y)

ADMISSION INFORMATION

33. Admit From
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 12-Alternate Level of Care Unit
13-Subacute setting 14-Assisted Living Residence

34. Prehospital Living Setting
Use codes listed for Admit From.

35. Prehospital Living With
(code only if Prehospital Living Setting is 1-Home)
1-Alone 2-Family/Relatives 3-Friends 4-Attendant 5-Other

36. Prehospital Vocational Category
1-Employed 2-Sheltered 3-Student 4-Homemaker
5-Not Working 6-Retired for Age 7-Retired for Disability

37. Prehospital Vocational Effort
(code only if Prehospital Vocational Category is 1 to 4)
1-Full-time 2-Part-time 3-Adjusted Workload

DISCHARGE INFORMATION

38. 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

39. Discharge To Living With
(code only if discharge living setting is 1-Home)
1-Alone 2-Family/Relatives 3-Friends 4-Attendant 5-Other

PROGRAM INFORMATION

40. Therapy Date Range
(code only if different from admission and discharge dates)
A. Start of Therapy (M M / D D / Y Y Y Y) to *B. End of Therapy* (M M / D D / Y Y Y Y)

41. Internal Program Name

42. FUNCTIONAL INDEPENDENCE MEASURE (FIM)

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

** Leave no blanks. Enter 1 if not testable due to risk.*

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 or not testable (Subject less than 25%)

43. CASE NOTES

Interim or Follow-Up Assessment Coding Form

INTERIM OR FOLLOW-UP ASSESSMENT CODING FORM — Uniform Data System for Medical Rehabilitation, Adult FIM/USA&Canada

PATIENT/CASE IDENTIFICATION

1. Facility Code
2. Patient Code
21. Admission Date — M M / D D / Y Y Y Y

ASSESSMENT INFORMATION

60. Assessment Type — **2-Interim OR 4-Follow-up**
61. Assessment Date — *Enter date assessment was performed.* M M / D D / Y Y Y Y

FOLLOW-UP INFORMATION ONLY

62. Follow-up Information Source
1-Patient 2-Family 3-Other 4-Unable to reach
63. Follow-up Assessment Method
1-In person 2-Telephone 3-Mailed questionnaire
64. Follow-up 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
65. Follow-up Living With
(only if living setting above is 1-Home)
1-Alone 2-Family/Relatives 3-Friends 4-Attendant 5-Other
66. Follow-up Vocational Category
1-Employed 2-Sheltered 3-Student 4-Homemaker
5-Not Working 6-Retired for Age 7-Retired for Disability
67. Follow-up Vocational Effort
(only if vocational category above is 1 to 4)
1-Full-time 2-Part-time 3-Adjusted Workload
68. Follow-up Health Maintenance
A. Primary
1-Own care 2-Unpaid person or family
3- Paid attendant or aide 4-Paid, skilled professional
B. Secondary
Use codes listed for primary follow-up health maintenance.
69. Follow-up Therapy
1-None 2-Outpatient therapy 3-Home-based paid professional therapy
4-Outpatient and home-based paid professional therapy
5-Inpatient Hospital 6-Long Term Care Facility 7-Other 8-Day Treatment
70. Follow-up Diagnoses — *ICD-9 codes only*
A. B. C. D. E. F. G.

71. FUNCTIONAL INDEPENDENCE MEASURE (FIM)

*INTERIM OR FOLLOW-UP **

SELF-CARE
A. Eating
B. Grooming
C. Bathing
D. Dressing - Upper
E. Dressing - Lower
F. Toileting

SPHINCTER CONTROL
G. Bladder
H. Bowel

TRANSFERS
I. Bed, Chair, Whlchair
J. Toilet
K. Tub, Shower

LOCOMOTION
L. Walk/Wheelchair — W-Walk C-wheelChair B-Both
M. Stairs

COMMUNICATION
N. Comprehension — A-Auditory V-Visual B-Both
O. Expression — V-Vocal N-Nonvocal B-Both

SOCIAL COGNITION
P. Social Interaction
Q. Problem Solving
R. Memory

** Leave no blanks. Enter 1 if not testable due to risk.*

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 or not testable (Subject less than 25%)

72. INTERIM OR FOLLOW-UP NOTES

Appendix E: Glossary

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

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

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

Adaptive device: An item used during the performance of an everyday activity that improves function and compensates for physical, sensory, or cognitive limitations.

Admission FIM® rating: The baseline functional assessment collected with the FIM® instrument at the time of the patient's admission to the rehabilitation program. The FIM® instrument should be administered during the first three days of admission.

Assisted living residence: A community-based setting that combines housing, private quarters, freedom of entry and exit, supportive services, personalized assistance, and healthcare designed to respond to the individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive services are available twenty-four 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.

Bathing (FIM® item): Includes bathing (washing, rinsing, and drying) the body from the neck down (excluding the neck and back). Bathing tasks may be performed in a tub, shower, or sponge/bed bath.

Benchmarking: Measuring products and services for comparison.

Bladder accident: Includes complete and intentional control of the urinary bladder and use of any equipment and medication (agents) necessary for bladder control.

Bladder Management (FIM® item): Includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. This item deals with two variables: (1) the level of assistance required by a helper, use of an assistive device, or medication; and (2) the level of bladder management success, reflected in the number of accidents that have occurred during the three-day assessment period.

Bowel accident: The act of soiling linen or clothing with stool, including bedpan spills.

Bowel Management (FIM® item): Includes complete and intentional control of bowel movements and use of any equipment and medication (agents) necessary for bowel control. This item deals with two variables: (1) the level of assistance required by a helper, use of an assistive device, or medication; and (2) the level of bowel management success, reflected in the number of accidents that have occurred during the three-day assessment period.

CARF (Commission on Accreditation of Rehabilitation Facilities): A private, not-for-profit agency, founded in 1966, that establishes standards of quality for rehabilitation services to persons with disabilities.

Clinical indicator: A variable used to monitor and evaluate care to ensure desirable outcomes (or prevent undesirable ones).

CMS: The Centers for Medicare and Medicaid Services. Formerly known as Healthcare Finance Administration (HCFA).

Cognitive subscale: The last five items of the FIM® instrument:

1. Comprehension
2. Expression
3. Social Interaction
4. Problem Solving
5. Memory

Community discharge: The number or percent of patients discharged to a community-based setting, including a home (of the patient, relative, or another person), transitional living setting, board and care setting, or assisted living residence.

Complete Dependence: The patient expends less than half (less than 50%) of the effort. Maximal or total assistance is required, or the activity is not performed. This includes level 1 and level 2.

Complete Independence (FIM® level 7): All of the tasks described as making up an activity for a FIM® item are typically performed safely without modification, assistive devices, or aids, and within a reasonable amount of time.

Comprehension (FIM® item): Includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures).

Contact guard assistance: Placing one hand on the patient to ensure the patient's safety.

Continuing rehabilitation: Part of a rehabilitation stay that began in another rehabilitation unit/facility. The patient was admitted directly from a rehabilitation program, either subacute or inpatient medical rehabilitation.

Cueing: Providing a gesture, facial expression, verbal instruction, or reminder to a patient just before or during the performance of an activity.

Discharge date: The date of discharge from a rehabilitation unit. *Discharge* indicates that the patient has left the rehabilitation service, not that the patient is no longer receiving therapy.

Discharge FIM® rating: The assessment of the patient's functional status, collected with the FIM® instrument at discharge. The FIM® instrument should be administered within three days of the patient's discharge from the rehabilitation program.

Dressing: Lower Body (FIM® item): Includes dressing and undressing below the waist, as well as putting on and removing a lower-body or lower-limb prosthesis or orthosis (when applicable).

Dressing: Upper Body (FIM® item): Includes dressing and undressing above the waist, as well as putting on and removing an upper-body or upper-limb prosthesis or orthosis (when applicable).

Eating (FIM® item): 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 results achieved in relation to the effort expended in terms of resources, time, and money.

Expression (FIM® item): Includes clear vocal and nonvocal expression of language. This item includes clear intelligible speech or clear expression of language using writing or a communication device.

FIM® instrument: The functional assessment instrument included in the Uniform Data Set for Medical Rehabilitation. It comprises eighteen items, each of which is rated on a seven-level scale that represents gradations in function from independence (level 7) to complete dependence (level 1).

Grooming (FIM® item): Includes oral care, hair grooming (combing or brushing hair), washing the hands, washing the face, and either shaving or applying makeup. If the patient neither shaves nor applies makeup, Grooming includes only the first four tasks.

Handicap: A disadvantage for a given individual resulting from an impairment or a disability that limits or prevents fulfillment of a role that is normal (depending on age, gender, and social and cultural factors) for that individual.

ICIDH-2: International Classification of Impairment, Disability, and Handicap, now referred to as *International Classification of Functioning, Disability, and Health*.

Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Impairment group code (IGC): A code that describes the primary reason for which the patient is being admitted to the rehabilitation program. The IGC 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 a particular impairment.

Inpatient rehabilitation facility (IRF): An acute medical rehabilitation inpatient program with patient care provided by an interdisciplinary team led by a medical director providing a minimum of three hours of rehabilitation per day.

International Classification of Diseases, 9th Edition, Clinical Management: A listing of diagnoses and identifying codes used to report diagnoses for individuals.

The Joint Commission (TJC): A private, not-for-profit organization that evaluates and accredits hospitals and other healthcare organizations that provide home care, mental healthcare, ambulatory care, and long-term care services.

Length of stay (LOS): The number of days spent in the rehabilitation program. In the UDSMR® reports, mean length of stay is calculated at the individual patient level by dividing FIM® gain by LOS for each patient and then aggregating across all patients for any given impairment or group of impairments.

Locomotion: Stairs (FIM® item): Going up and down twelve to fourteen stairs (one flight) indoors.

Locomotion: Walk, Wheelchair (FIM® item): 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.

Managed care: A system of healthcare delivery and financing structured to encourage preventive and primary care through review of payment methodologies that make care providers responsible for the health of their patients and for the utilization of healthcare services.

Maximal Assistance (FIM® level 2): The patient expends 25% to 49% of the effort to perform an activity assessed by the FIM® instrument, resulting in a rating of level 2 for that activity.

Medicaid: A federally funded, state-administered program of medical assistance for people with low incomes.

Medicaid Managed Care: A federally funded, state-administered program of medical assistance for people with low incomes in which medical care is coordinated by a managed care organization.

Medicare: A federal government program serving persons over sixty-five years of age and persons who are disabled and eligible for social security disability payments.

Medicare Managed Care: A national health payment program for persons over sixty-five years of age and persons who are disabled in which medical care is coordinated by a managed care organization.

Memory (FIM® item): Includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. In this context, memory includes the ability to store and retrieve information (particularly verbal and visual information). The functional evidence of memory includes the following:

1. Recognizing people frequently encountered
2. Remembering daily routines
3. Executing requests without being reminded

A deficit in memory impairs learning as well as performance of tasks.

Minimal Assistance (FIM® level 4): The patient requires no more help than touching and expends 75% or more of the effort to perform an activity assessed by the FIM® instrument, resulting in a rating of level 4 for that activity.

Moderate Assistance (FIM® level 3): The patient requires more help than touching or expends half (50%) or more (but less than 75%) of the effort to perform an activity assessed by the FIM® instrument, resulting in a rating of level 3 for that activity.

Modified Dependence: The patient expends half (50%) or more of the effort to perform an activity assessed by the FIM® instrument. Modified Dependence comprises levels 3, 4, and 5.

Modified Independence (FIM® level 6): The patient performs all tasks that make up a FIM® item, and one or more of the following are true:

1. The patient requires an assistive device to perform the activity.
2. The patient takes more than a reasonable amount of time to perform the activity.
3. There are safety (risk) considerations when the patient performs the activity.

Motor subscale: The first thirteen items of the FIM® instrument:

1. Eating
2. Grooming
3. Bathing
4. Dressing: Upper Body
5. Dressing: Lower Body
6. Toileting
7. Bladder Management
8. Bowel Management
9. Transfers: Bed, Chair, Wheelchair
10. Transfers: Toilet
11. Transfers: Tub, Shower
12. Locomotion: Walk, Wheelchair
13. Locomotion: Stairs

National data: Aggregate data from all subscribing credentialed facilities of the same classification (e.g., U.S. inpatient rehabilitation facilities, U.S. long-term care hospitals).

Onset days: In the UDSMR® reports, the number of days from acute onset of the impairment to admission to the rehabilitation program. Values for onset days that exceed 365 days are not included in the calculation of mean onset days.

Orthosis: A 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-embolism stockings, other stockings, abdominal binders, and Ace® wraps are examples of orthoses.

Outlier: An observation outside a certain range that differs widely from the rest of the data.

Outcome: The result or endpoint achieved by a defined point following delivery of services.

Pain: Any type of physical pain or discomfort in any part of the body.

Participation: An individual's involvement in life situations in relation to health conditions, body functions, and structures, activities and contextual factors (definition from the World Health Organization's ICIDH-2). Formerly known as *handicap*.

Performance index: The sum of weighted ratios of the facility values for five program objectives to regional or national values. A score greater than 100 means that a facility has a higher performance compared with the region or national group. The rank ordering of facilities by the performance indices developed for each impairment group gives an indication of where a given facility stands compared to all others.

Problem Solving (FIM® item): Includes skills related to solving problems of daily living. Problem Solving involves making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, as well as initiation, sequencing, and self-correction of tasks and activities required to solve problems.

Program evaluation: A recognized method of determining quality, effectiveness, and efficiency of services. Program evaluation allows an organization to identify the results of services and the effects of the program on the persons served.

Program interruption: A patient's transfer to another unit or facility (usually an acute care unit) and return to the rehabilitation program within thirty days, provided the patient does not have a new rehabilitation impairment.

Prosthesis: A device that replaces a body part.

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

Self-care activities: Basic activities necessary for daily personal care, including the FIM® items Eating, Grooming, Bathing, Dressing: Upper Body, Dressing: Lower Body, and Toileting.

Setup: Assistance with preparation provided before a patient performs an activity (prior preparation), or removal and disposal of equipment/materials after a patient performs an activity.

Social Interaction (FIM® item): 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.

Standby supervision: A situation in which, for safety reasons, a caregiver stays within one arm's reach of the patient.

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

Supervision/Setup (FIM® level 5): For safety reasons, a caregiver monitors a patient. In regard to assessing activities with the FIM® instrument, this level refers to help such as standby or distant supervision, cueing or coaxing without physical contact, setup of needed items, or application of orthoses. Performance of an activity at this level is rated level 5.

Toileting (FIM® item): Includes the safe and timely maintainence of perineal hygiene and adjusting clothing before and after use of a toilet or bedpan.

Technical review: An analysis of data submitted to UDSMR to ensure that it falls within guidelines of technical adequacy. Also called Phase II of credentialing.

Total Assistance (FIM® level 1): The patient expends less than 25% of the effort to perform an activity assessed by the FIM® instrument, resulting in a rating of level 1.

Touching assistance: A caregiver provides touching to prompt the patient to perform the desired physical movement.

Transfers: Bed, Chair, Wheelchair (FIM® item): 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 (FIM® item): Includes getting on and off a toilet.

Transfers: Tub, Shower (FIM® item): Includes getting in and out of a tub or shower stall.

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

Visual cue: Any visible gesture, posture, or facial expression used to aid in the performance of a task.

Appendix F: General Questions about the FIM® Instrument

Q: What is the conceptual basis for the FIM® instrument?

A: The FIM® instrument measures the severity of patient disability in terms of the need for assistance (burden of care). The need for assistance translates into the time/energy that another person must expend to serve the dependent needs of the individual with a disability to achieve and maintain a certain quality of life, or extra time the disabled individual spends to complete activities of daily living.

Q: Why does the FIM® instrument address only eighteen areas of function?

A: The FIM® instrument was designed to measure a minimum number of items. It is not intended to include all the activities that would be possible to measure, 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.

Q: How do you rate a patient who refuses to perform a functional activity you know the patient can perform? For example, what is the correct rating for a patient who can transfer to a tub but prefers a sponge bath and will not even attempt a tub transfer? Also, how do you rate a patient with a HALO who can perform a shower transfer but actually gets a bed bath every day?

A: The FIM® instrument is intended to measure what the patient actually does, whatever the patient's diagnosis or impairment is—it does not measure what the patient ought to be able to do or what the patient might be able to do if certain circumstance were different. If the patient does not perform a tub or shower transfer, rate the patient level 1, Total Assistance, for item 42K, Transfers: Tub, Shower, because the activity did not occur.

Q: What are the guidelines for "more than a reasonable amount of time?"

A: "More than a reasonable amount of time" is a clinical judgment made by an experienced clinician who observes a recognizable difference in the time required for an activity to be performed by a patient—usually, this equals three times the normal time required to complete an activity. If a patient performs an activity independently but takes more than a reasonable amount of time, rate the patient level 6, Modified Independence.

Q: For some patients, the quality of the patient's performance of an activity improves, or the patient's endurance improves for a particular activity, but this doesn't always result in a higher FIM® rating. Why doesn't the FIM® instrument address these aspects of a patient's performance?

A: The FIM® instrument measures disability in terms of a patient's need for assistance, regardless of impairment or limitations. If a helper assists the patient, care is being provided, and the patient's FIM® rating will reflect the need for assistance within a particular range for each rating level. A patient's performance can improve within the range without an increase in the rating—for example, a patient will be rated level 5 even if his performance improves from 75% of a task to 85%. (This is why narrative documentation is still important.)

Q: For high-level quadriplegic or tetraplegic patients with injuries at C1–C5 and low-level traumatic brain injury patients, FIM® ratings may not change from admission to discharge. For these patients, therapy is geared toward family education and training. Is there a way to rate the family's involvement for certain patients (for example, a family who has progressed from dependent transfers to independent transfers)?

A: The progress notes and team conference notes in the medical record document the patient and family's learning. The FIM® ratings reflect the need for assistance, and these patients require assistance to complete activities of daily living.

Q: What is the difference between a safety concern at level 6, Modified Independence, and level 5, Supervision/Setup?

A: In most circumstances in rehabilitation, the patient who is at risk (i.e., has a safety concern) for injury will be supervised and will be rated level 5, Supervision/Setup. Level 6, Modified Independence, is for patients who are at risk for injury but typically unaccompanied by a helper for some reason. An example of such a patient is a follow-up tub transfer assessment performed on a patient who lives alone. If a safety concern exists, but a helper does not supervise the patient, rate the patient level 6, Modified Independence, for item 42K, Transfers: Tub, Shower. In other words, level 5 indicates that a helper assumes the risk, and level 6 indicates that the patient assumes the risk alone. This rating should be assigned only if a patient has high cognitive ratings for the items Comprehension, Problem Solving, and Memory.

Q: What rating should I record for a patient whose nurse reports bed-to-wheelchair transfers that require moderate assistance and whose therapist reports bed-to-wheelchair transfers that require only supervision?

A: If the patient functions differently in different settings, or at different times of the day, record the lower rating. Because the lower rating represents a higher need for assistance, it more realistically reflects the patient's actual performance rather than the patient's peak performance.

If clinicians are accurately reporting the patient's functional status, then the patient is functioning differently on the nursing unit than in the therapy setting. It is not uncommon for a nurse to report a lower level of independence in self-care and transfer activities than the physical or occupational therapist for the following reasons:

- The therapist is working with the patient just after breakfast, when the patient is still fresh, but the nurse sees the patient after the patient has been working intensively in therapy.
- The nurse and the therapist are using different transfer techniques or equipment, or the environment of the patient's room is crowded with furniture, making it less safe for the patient to function more independently.
- The patient believes that he is supposed to "work" in therapy but expects the nurses to help him after a strenuous therapy session.

Q: Why doesn't the FIM® instrument address neglect or spatial problems?

A: These deficits are captured in the patient's performance of each of the activities included in the items. The question is, "What help is needed as a result of these problems?" For example, a patient who has left-sided neglect may need help to bathe or groom that side of the body and will receive a lower rating on those items due to the physical assistance required.

Q: Why don't the cognitive FIM® items address the severity of the patient's cognitive problems?

A: The FIM® instrument measures the amount of assistance required, not the severity of the patient's problems. The patient's rating represents how often the patient needs help because of cognitive deficits. This approach to estimating the severity of disability is based on what a helper must do to help the patient to accomplish certain key daily activities over a twenty-four-hour period.

Q: How do you rate a patient who refuses treatment?

A: If a patient or the patient's family refuses a course of recommended therapy, base the patient's rating on the actual performance of the activities that do occur on the care unit. Document that the patient refused treatment in the medical record. If an activity, such as stair climbing or tub transfer, does not occur on admission, rate the patient level 1, Total Assistance.

Q: How do treatments provided by speech-language pathologists fit into the rating of the FIM® instrument?

A: If the patient is mildly difficult to understand (dysarthric), rate the patient level 6, Modified Independence, for Expression. Dysphonia and facial paresis may also be captured as part of the Expression rating if the patient is difficult to understand. The patient's Expression rating reflects the amount of assistance (i.e., prompting) the patient requires to express himself.

Problems with swallowing are assessed as part of the Eating item. For example:

- If the patient requires modified food consistency, rate the patient level 6, Modified Independence.
- If the patient requires supervision for speed of eating or thickening of liquids by a helper, rate the patient level 5, Supervision/Setup.
- If the patient requires self-administered tube feedings, rate the patient level 6, Modified Independence.
- If the patient requires staff-administered tube feedings, rate the patient level 1, Total Assistance.

Q: Why isn't bed mobility included as a FIM® item?

A: The FIM® instrument is a minimum data set consisting of only eighteen items. Many daily activities are not included; bed mobility is one of them. However, bed mobility is captured, in part, in the Transfers: Bed, Chair, Wheelchair item. Patients must begin and end in the supine position when they transfer to and from a bed, and the assistance they require for this aspect of the transfer affects the rating.

Eating

Q: How should I rate a patient who eats a pureed diet?

A: If the patient eats a pureed diet independently, rate the patient level 6, Modified Independence. The definition of level 7, Complete Independence, specifies that the patient manage all consistencies of food. At level 6, Modified Independence, the patient requires modified food consistency or blenderized food.

Q: Can you explain setup for Eating?

A: Setup for Eating may include any of the following:

- Applying an orthosis or prosthesis
- Opening containers
- Cutting up meat
- Buttering bread
- Pouring liquids
- Thickening liquid

Setup for Eating differs from setup for other items setup because the assessment begins after the meal has been presented to the patient in the customary manner on a table or tray. Therefore, placing the tray in front of the patient does not affect the rating.

Q: The definition for Eating includes chewing and swallowing. How should I rate a patient who has a swallowing problem?

A: In order to remain consistent with the concepts of need for assistance (burden of care) and the disablement model, consider what a helper must do because of the patient's restricted ability to eat. Here are some examples:

- If a helper supervises, or provides verbal cues during the meal, for speed of eating or portion size, rate the patient level 5, Supervision/Setup.
- If a helper inserts a finger into the patient's mouth to check for pocketed food, rate the patient level 4, Minimal Assistance.
- If the patient receives tube feedings, and a helper administers the tube feeding entirely, rate the patient level 1, Total Assistance.

Q: How should I rate a patient who requires a helper to cut up food?

A: Rate the patient level 5, Supervision/Setup.

Q: How should I rate a patient who requires a helper to pour sauce or dressing on food?

A: Rate the patient level 5, Supervision/Setup.

Q: When assessing Eating, should I rate the left and right hands separately and pencil in the ratings until the final discharge assessment?

A: The patient's Eating rating should reflect what the patient actually does, whether with his left hand, his right hand, or both. The FIM® instrument measures disability, not impairment.

Q: Are dentures considered assistive devices for Eating?

A: Dentures are considered assistive devices for Eating only if the patient requires the dentures to eat. If the patient eats independently but requires the dentures to eat, rate the patient level 6, Modified Independence. If a staff member inserts the dentures, rate the patient level 5, Supervision/Setup.

Q: How do I rate a patient who receives nutrition through tube feedings?

A: The rating for a patient who receives all nutrition through tube feedings can range from level 6, Modified Independence, to level 1, Total Assistance. Here are some examples:

- **Level 6, Modified Independence:** The patient self-administers the tube feedings.
- **Level 5, Supervision/Setup:** A helper provides prior preparation, such as opening feeding cans and gathering equipment for the patient.
- **Level 4, Modified Assistance:** A helper flushes the tube with water to get started, the patient administers the feeding, and the patient flushes the tube with water after the feeding.
- **Level 1, Total Assistance:** A helper administers the feedings and flushes the tube with water.

If the patient functions at different levels during the day (e.g., level 5 in the morning and level 6 in the evening), record the lower rating.

If the patient eats meals by mouth and receives nutrition through tube feedings, consider each time the patient eats and each tube feeding administration as a separate episode. If the patient's functional status varies by episode, record the lower rating. For example, if the patient eats meals with only setup assistance (e.g., opening containers), and a helper administers the feedings (i.e., the patient does not help with feedings), rate the patient level 1, Total Assistance.

Grooming

Q: The Grooming item includes shaving and applying makeup. How should I rate the patient who chooses not to shave or apply makeup?

A: Simply ignore the tasks of shaving or applying makeup when assessing the patient. In this case, Grooming will be an assessment of four activities: washing the hands, washing the face, brushing hair, and providing oral care for teeth or dentures. If the patient decides to perform only three tasks before going to bed (e.g., oral care, washing the face, and washing the hands), each task would be 33% of the rating.

Q: If a nurse brings the patient a towel and washcloth, is that considered setup for Grooming?

A: Passing out linen is part of the regular hospital routine; the patient is not expected to get linen from the cart. If the linen is placed in the patient's lap for grooming at bedside or a sink, however, rate the patient level 5, Supervision/Setup.

Q: How should I rate a patient with a head injury who needs constant cueing when grooming?

A: If the patient requires cueing, coaxing, or supervision but does **not** require touching assistance, rate the patient level 5, Supervision/Setup. If the patient does not initiate the task, and the helper must begin any of the grooming activities, rate the patient level 4, Minimal Assistance.

Q: How should I rate a patient who needs help to shampoo the hair or apply deodorant?

A: Do not assess shampooing hair or applying deodorant when rating this item.

Q: What are some examples of setup for Grooming?

A: Examples of setup (level 5) for Grooming include a helper's performance of one or more of the following tasks:

- Gathering equipment, and placing equipment within the patient's reach
- Applying an orthosis or adaptive/assistive device
- Providing initial preparation, such as applying toothpaste to a toothbrush, opening makeup containers, opening a denture cleanser packet, adjusting water temperature or volume, or plugging in shaver

Patients are not expected to gather clean towels from a linen closet or linen cart, but they are expected to take towels placed at the bedside into the bathroom.

Bathing

Q: Can I divide the body into parts or areas to rate Bathing?

A: When assessing a patient, most clinicians find it helpful to determine the rating by dividing the body into ten areas:

1. Left arm
2. Chest
3. Right arm
4. Abdomen
5. Front perineal area
6. Buttocks
7. Left upper leg
8. Right upper leg
9. Left lower leg, including the foot
10. Right lower leg, including the foot

Each "area" represents about one-tenth, or 10%, of the total bathing area. These "areas" will help the clinician rate a patient who needs more than supervision/setup assistance. Calculate the percent of effort by determining the percent of the body the patient bathes. For example, if the patient bathes (washes, rinses, and dries) the chest, left arm, left upper leg, and abdomen, the patient washes four areas, or approximately 40% of the body, and a helper bathes the remaining areas; rate the patient level 2, Maximal Assistance.

Q: Why is the back excluded when rating this item?

A: Remember that the FIM® instrument measures disability. If the back were included in the definition for this item, persons who are not disabled might be rated lower than level 7, Complete Independence, because they do not wash their backs every day or may use an assistive device (e.g., a long-handled sponge) to wash their backs. Omitting the back provides a clearer picture of the patient's level of disability.

Q: How should I rate a patient who needs someone to wring his washcloth for him?

A: If this assistance is given with initial preparation, rate the patient level 5, Supervision/Setup. If a helper wrings the washcloth and hands it to the patient many times during the bathing episode, rate the patient level 4, Minimal Assistance.

Q: What is the correct rating if a patient decides to wash only four body parts and no helper washes the remaining parts?

A: Determine what assistance, if any, the patient needs to complete this activity, and then rate this episode accordingly.

Dressing: Upper Body and Dressing: Lower Body

Q: Often, in the hospital, getting clothes out of the closet or drawers is not part of the patient's routine; someone else does it. How should I rate this patient if he otherwise dresses independently?

A: Rate the patient level 5, Supervision/Setup, for both Dressing: Upper Body and Dressing: Lower Body. These ratings capture the patient's actual performance, not what he could do if circumstances were different.

Q: How should I rate a patient who is independent with dressing (she safely and timely completes dressing tasks) but uses a walker while ambulating to get her clothes: level 6, Modified Independence, or level 7, Complete Independence?

A: Rate this patient level 7, Complete Independence, for both Dressing: Upper Body and Dressing: Lower Body. Opening closets and drawers is included when rating this item, but getting to and from the closet or drawer is rated as part of Locomotion: Walk, Wheelchair.

Q: How should I rate a patient who is unable to get to the closet because of the hospital setup? A wheelchair would not fit in the small area between the bed and the closet at our hospital. The nurses always have to get the clothes for the patients, and even they have difficulty getting to the closet.

A: This assistance counts as setup. Rate the patient level 5, Supervision/Setup, for both Dressing: Upper Body and Dressing: Lower Body.

Q: How should I rate a patient with burns if a helper applies pressure garments?

A: If the helper applies pressure garments on the patient, rate the patient level 5, Supervision/Setup, for both Dressing: Upper Body and Dressing: Lower Body.

Q: Why are upper-body dressing and lower-body dressing rated separately?

A: Because these tasks require different skills, the levels of assistance are often different. Lower-body dressing is usually more difficult.

Q: Do patients have to obtain their own clothes for these items?

A: For both items, the patient must obtain clothes from a closet or drawer, dress, and undress. It does not matter whether the patient uses a wheelchair, cane, or walker to get to the closet or drawer, or whether the patient needs help to walk to the closet; these aspects are rated as part of Locomotion: Walk, Wheelchair. Also, it does not matter whether the patient gathers the clothing on the prior evening or in the morning. If a helper gathers the patient's clothing, however, do not rate the patient higher than level 5, Supervision/Setup.

Q: How should I rate a patient who dresses in bed?

A: If a patient gathers his own clothing (either on the prior evening or in the morning) and puts on the clothing without help or the use of devices, rate the patient level 7, Complete Independence, for both items. If a helper gathers the patient's clothing, and the patient dresses himself without further assistance, rate the patient level 5, Supervision/Setup.

Dressing: Upper Body

Q: How should I rate a patient who needs assistance with buttoning a blouse or shirt only?

A: Rate the patient level 4, Minimal Assistance.

Q: How should I rate a patient who wears only a sweatshirt on his upper body? Do I need to rate all other aspects of upper-body dressing included in the definition?

A: You do not need to test every aspect included in the definition. If the patient wears only a pullover sweatshirt each day, assess the amount of assistance needed with that item of clothing only. If the patient wears a sweatshirt during the week and a button-down shirt on weekends, rate each episode individually.

Q: How should I rate a patient who needs help applying a thoracolumbosacral orthosis (TLSO) or back brace?

A: Supervision/setup includes the need for supervision (e.g., standby assistance, cueing, or coaxing) or setup (e.g., applying orthosis, setting out clothes). If the patient needs assistance from one helper to apply a TLSO or back brace, rate the patient level 5, Supervision/Setup. If the patient needs assistance from two helpers, rate the patient level 1, Total Assistance.

Q: How should I rate a patient who has an upper-body or upper-limb prosthesis?

A: If a helper applies the upper-body or upper-limb prosthesis but the patient receives no other assistance with upper-body dressing, rate the patient level 5, Supervision/Setup.

If the patient applies the prosthesis and dresses the upper body without a device (including the prosthesis) or other help, rate the patient level 7, Complete Independence.

If the patient applies the prosthesis and uses it to dress the upper body, rate the patient level 6, Modified Independence.

Q: What do you mean by "count the steps for the articles of clothing for Dressing: Upper Body"?

A: Do not rate the level of assistance for each step of the activity; instead, rate the number of steps the patient completes and determine how much help the patient needs overall. For clothing that is typically worn, use these steps for each article of clothing:

1. Bra: Three or more steps, depending on how it is put on
2. Pullover garment (shirt or sweatshirt): Four steps (five if tucked in)
3. Front-opening garment (shirt, sweater, or jacket): Four steps (five if tucked in)

Dressing: Lower Body

Q: How should I rate a patient who needs assistance tying shoelaces only?

A: Rate the patient level 4, Minimal Assistance.

Q: Are sneakers with Velcro® closures considered an adaptive device?

A: If the sneakers are obtained commercially at no additional cost, they are **not** considered an adaptive device. If they were adapted by a therapist, however, they **are** considered an adaptive device.

Q: How should I rate a patient who needs help applying anti-embolism stockings?

A: Anti-embolism stockings are considered orthoses for this item. If the patient requires help applying any type of specialty stockings and completes all other lower-body dressing tasks himself, rate the patient level 5, Supervision/Setup.

For example, consider a patient who wears anti-embolism stockings, pants, socks, and shoes. The patient needs help with the anti-embolism stockings but then threads the left and right sides of his pants and pulls up his pants over both hips. A helper applies both socks and both shoes. The fact that the patient needs help with the specialty stockings lowers his rating to level 5, Supervision/Setup. The assistance with anti-embolism stockings is not a rating concern, however, in this example: the patient performs half of the effort and would thus be rated level 3, Moderate Assistance. Count the number of steps performed by the patient, and divide that number by the total number of steps in the entire task. Refer to the *Motor FIM® Step Table* on the Subscriber Support website.

When determining how much effort (the percent of effort) the patient expends for this item, do not consider the stockings. Level 5, Supervision/Setup, already accounts for the patient's need for help.

Q: Can you provide an example of level 1, Total Assistance, for Dressing: Lower Body?

A: Here are some examples:

- One helper supervises a patient while another helper provides hands-on assistance.
- A patient requires the assistance of two helpers to get his pants over his hips.
- A patient does not help dress his lower body (i.e., a helper dresses the patient).
- A patient performs less than 25% of the effort (e.g., the patient rolls from side to side while a helper dresses him).

Q: How should I rate a patient who dresses his lower body while still in bed? His ability to dress in bed is very different from his ability to dress while standing.

A: Base the rating on the patient's performance of the activity. If the patient dresses himself in bed and only needs a helper to bring his clothes, rate the patient level 5, Supervision/Setup. If the patient typically dresses his lower body while standing and requires a helper to provide steadying assistance, rate the patient level 4, Minimal Assistance. The FIM® instrument measures the need for assistance (the burden of care) required to complete activities. In this case, the patient needs more assistance while standing.

Q: How should I rate a patient with a lower-limb prosthesis?

A: Base the patient's rating on the burden of care required to apply the lower-limb prosthesis and whether the patient uses the prosthesis as a device to complete lower-body dressing, as follows:

- If the patient applies the lower-limb prosthesis but does not use it as a device and does not require additional assistance, rate the patient level 7, Complete Independence.
- If the patient applies the lower-limb prosthesis and uses it as a device but does not require additional assistance, rate the patient level 6, Modified Independence.
- If a helper applies the prosthesis but the patient does not require additional assistance, rate the patient level 5, Supervision/Setup.

If the patient uses the prosthesis as a device to transfer to a toilet, transfer from a bed to a chair and back, walk, or climb stairs, do not rate the patient higher than level 6 for the relevant FIM® items.

Q: How do I rate a patient who uses a shoehorn and wears Velcro® closure sneakers? Is the use of Velcro® fasteners on clothing rated level 6 or level 7?

A: If the patient dresses himself in commercially available clothing, rate the patient level 7, Complete Independence. Velcro® closure sneakers are available commercially, so use level 7 to rate the patient in this example.

By contrast, a Velcro® closure bra is not available commercially. If a patient dresses her upper body independently but wears a Velcro® closure bra, rate the patient level 6, Modified Independence. The rating reflects the added cost of adapting clothing or ordering specialized clothing for a patient. If a patient dresses the lower body independently but wears sweatpants with a Velcro® closure added by a therapist, nurse, or helper, rate the patient level 6, Modified Independence.

Q: How should I rate a patient who starts dressing his lower body on his own but requires two helpers to complete lower-body dressing—for example, a patient who is so unsteady that one helper must steady him while another pulls up his pants?

A: Because there is a significant need for assistance (burden of care) when two helpers are required to help one person with one activity, rate the patient level 1, Total Assistance. Any time two helpers are required to help a patient with a single activity, rate the patient level 1, Total Assistance.

Q: What do you mean by "count the steps for the articles of clothing for Dressing: Lower Body"?

A: Do not rate the level of assistance for each step of the activity; instead, rate the number of steps the patient completes and determine how much help the patient needs overall. For clothing that is typically worn, use these steps for each article of clothing.

1. Underpants: Three or four steps
2. Pants/shorts/skirt:

   Elastic waist: Three or four steps

   With fasteners: Four or five steps
3. Socks: One step each

4. Shoes:

   Slip-on: One step each

   With ties: Two steps each

5. Belt: Two steps (threading and buckling)

Toileting

Q: How should I rate a patient if the amount of assistance required for voiding differs from the amount of assistance required for bowel movements?

A: Record the lower rating.

Q: How should I rate a patient who pulls her pants down, cleanses herself at the toilet, and requires steadying assistance from a helper while she pulls her pants up?

A: If a patient requires steadying or contact guard assistance during one or all of the toileting tasks, rate the patient level 4, Minimal Assistance. The helper is providing minimal assistance for the activities to occur. If a patient requires an assistive device (e.g., a grab bar) but no helper while she stands to pull up her pants, rate the patient level 6, Modified Independence.

Q: How should I rate a patient who needs help to perform perineal hygiene and adjust clothing after toilet use?

A: Toileting includes three activities:

1. Adjusting clothing before toilet use
2. Performing perineal hygiene
3. Adjusting clothing after toilet use

   In this case, the patient performs one of the three activities (one-third of the total effort). Because the patient performs less than half of the toileting effort, rate the patient level 2, Maximal Assistance.

Q: Should I rate Toileting if a patient uses a bedpan rather than a toilet?

A: Yes. Toileting includes performing perineal hygiene and adjusting clothing before and after toilet or bedpan use. Use of the bedpan itself is addressed as part of the FIM® items Bladder Management and Bowel Management.

Bladder Management

Q: How should I rate a patient who goes to the toilet six times during the day at level 6, Modified Independence, but needs assistance to use a urinal twice during the night with no accidents?

A: If a helper sets up the urinal (i.e., hands it to the patient and empties it after use), rate the patient level 5, Supervision/Setup; if the helper places the patient's penis in the urinal, rate the patient level 4, Minimal Assistance.

Q: How should I rate a patient who uses a urinal?

A: If the patient uses the urinal independently (i.e., retrieves it and empties it), rate the patient level 6, Modified Independence, for item 42G, Bladder Management. If a helper sets up the urinal, empties it, or performs both tasks, rate the patient level 5, Supervision/Setup.

Q: How should I rate a patient who is incontinent of urine once in the first three days?

A: If the patient wets linen or clothing, rate the patient level 5, One accident in the past three days, for Bladder Frequency of Accidents. Rate the level of assistance needed before assigning the rating for Bladder Management.

If the patient wears absorptive pads and does not wet linen or clothing with urine, rate the patient level 6, No accidents, device used, for Bladder Frequency of Accidents. If a helper changes the patient's absorptive pad, rate the patient level 1, Total Assistance, for Bladder Level of Assistance. Use the lower rating—level 1 in this example—to rate item 42G, Bladder Management.

Q: How should I rate a patient who is on renal dialysis and does not void?

A: Rate the patient level 7, Complete Independence. The patient does not have bladder accidents and does not need assistance to void. The need for renal dialysis stems from an impairment of the kidney, not the bladder. As a result, there is no disability related to the Bladder Management item.

Q: How should I rate a patient who is independent when putting on and taking off absorptive pads?

A: Rate the patient level 6, Modified Independence, for item 42G, Bladder Management.

Q: Our facility undertakes an intensive, timed-void bladder-training program as part of its rehabilitation process. This program provides for scheduled bathroom visits every two hours, and these visits are coordinated by nursing staff. The FIM® instrument does not recognize the amount of nursing effort required to maintain a patient's continence through this program. Essentially, patients may be continent, but only because of the effectiveness of this program. How should I rate Bladder Management for these patients?

A: When assessing bladder function, the management effort (level of assistance) and the level of success (frequency of accidents) are assessed separately, and the lower rating is recorded as the FIM® rating for Bladder Management. If a patient is on a timed voiding program and is completely dependent on nursing staff to implement the program, rate the patient level 1, Total Assistance.

To rate item 42G, Bladder Management, the nurses should outline the tasks required for each individual's bladder program and determine what portion of the activity a helper performs

and what portion the patient performs. This process will allow them to determine the level of assistance rating. If the patient keeps himself on the program and needs reminding only twice throughout the twenty-four-hour period, the rating for level of assistance would be level 4, Minimal Assistance.

Q: A patient with a stroke has benign prostatic hypertrophy and no devices. This patient, however, receives medication at night for sleep and has bladder accidents each night. During the day, he does not need a device and is continent of urine. How should I rate the patient?

A: If the patient wets his linen or clothing with urine each night during the assessment period, rate the patient level 3, Three accidents during the past three days, for Bladder Frequency of Accidents. If a nurse cleans him after his nightly bladder accident, rate the patient level 1, Total Assistance, for Bladder Level of Assistance. Record the lower rating—level 1 in this example—as the patient's Bladder Management rating in item 42G.

Q: How should I rate a patient who performs intermittent straight catheterization for his bladder program? What about a patient with an indwelling catheter? Both patients are continent of urine.

A: If a patient performs intermittent catheterizations independently, including gathering equipment and emptying the urine, rate the patient level 6, Modified Independence, for Bladder Level of Assistance. The patient uses a device in this case, but he performs the tasks independently and is performing at a level of modified independence. If a nurse (or any helper) performs the intermittent catheterization, rate the patient level 1, Total Assistance, for Bladder Level of Assistance. As the patient learns to perform the catheterization himself, his rating will increase, reflecting his learning.

If a patient has an indwelling catheter, inserts the catheter, and empties the leg bag or drainage bag, rate the patient level 6, Modified Independence, for item 42G, Bladder Management. If a helper inserts the indwelling catheter and empties the urine bags, rate the patient level 1, Total Assistance, for item 42G.

Q: How should I rate a patient who uses absorptive pads and is completely independent?

A: If the patient's clothing and bedding remain dry, rate the patient level 6, Modified Independence.

Q: How should I rate a patient who puts on an absorptive pad during the night, does not have any accidents (i.e., does not wet linen or clothing), and requires no assistance except for putting on the absorbent pad?

A: Rate the patient level 1, Total Assistance, for Bladder Level of Assistance because the helper donned the absorbent pad. Rate the patient level 6, No accidents, uses device such as a catheter, for Bladder Frequency of Accidents. Record the lower rating—level 1 in this example—as the patient's rating for item 42G, Bladder Management.

Q: Can you address the issues of continence and independent toileting programs?

A: When assessing bladder function, the level of assistance and the level of success (frequency of accidents) are assessed separately, and the lower rating is recorded as the FIM® rating for item 42G, Bladder Management.

For example, if a patient is on a timed voiding program and is completely dependent on nursing staff to implement the program, rate the patient level 1, Total Assistance, for Bladder Level of Assistance. If, however, the patient manages his bladder program during the day but

has had two accidents in the past three days, rate the patient level 4, Two accidents during the past three days, for Bladder Frequency of Accidents.

Outline the tasks required for each individual's bladder program, and then determine what portion of the activity is performed by the helper and what portion is performed by the patient. Next, determine the level of success (frequency of accidents). Record the lower of the two ratings as the patient's FIM® rating.

Q: How should I rate a patient who is incontinent of urine?

A: When rating Bladder Management, you must recognize the difference between bladder incontinence and a bladder accident. *Bladder incontinence* refers to the loss of control of the passage of urine from the bladder. A *bladder accident* has occurred when clothing or linen is wet from urine. If a patient is incontinent, but the urine is contained within an absorbent pad or other device (e.g., external catheter or indwelling catheter), the patient has not had an accident.

Rate the frequency of bladder accidents in Bladder Frequency of Accidents. Do not record the number of incontinent episodes when determining the rating for item 42G, Bladder Management.

If the patient uses an absorbent pad to contain urine and does not wet linen or clothing, rate the patient level 6, No accidents, uses device such as a catheter, for Bladder Frequency of Accidents. If the patient changes his own absorbent pad, rate the patient level 6, Modified Independence, for Bladder Level of Assistance. In this example, rate the patient level 6, Modified Independence, for item 42G, Bladder Management.

Q: Has a patient had an accident if he is continent but spills his urine on his clothing?

A: Yes, spilling a urinal that results in wetting linen or clothing with urine qualifies as an accident. Record the number of times the patient wets his linen or clothing with urine during the three-day observation period.

Q: Can you provide an example that would result in a lower rating for frequency of accidents?

A: The rating recorded on the FIM® assessment in most situations will be determined by the level of assistance required for the most dependent episode over the three-day assessment period. In some instances, however—usually upon discharge—a patient may learn to clean himself after an accident or incontinent episode; as a result, tallying the number of accidents during the assessment period may result in a lower rating for frequency of accidents, which will determine the accurate rating.

Bowel Management

Q: How should I rate Bowel Level of Assistance for a patient who has a colostomy?

A: The rating for a patient who has a colostomy can range from level 1, Total Assistance, to level 6, Modified Independence. At level 1, a nurse or another helper takes care of the colostomy completely; at level 6, the patient is independent in all tasks related to bowel management (changing the bag, changing the wafer, emptying the bag into the toilet, etc.).

Q: How should I rate a patient who asks for a laxative, needs no other assistance, and does not have accidents?

A: If the patient uses bowel medication, rate the patient level 6, Modified Independence, for Bowel Level of Assistance, and level 6, No accidents, uses device such as an ostomy, for Bowel Frequency of Accidents. It does not matter whether the patient asks for the medication. Record the lower rating—level 6 in this example—in item 42H, Bowel Management.

Q: How should I rate a patient who is independent with his own bowel program but uses bowel medication, such as a stool softener or laxative, on a daily basis?

A: Rate the patient level 6, Modified Independence, for Bowel Level of Assistance, and level 6, No accidents, uses device such as an ostomy, for Bowel Frequency of Accidents.

Q: How should I rate a patient who uses medication two times during the admission assessment period?

A: Base the rating on the burden of care during each individual episode. If the patient has not had any accidents during the admission assessment period, but has used medication, rate the patient level 6, Modified Independence, for Bowel Level of Assistance. If the patient did not have any accidents, rate the patient level 6, No accidents, uses device such as an ostomy, for Bowel Frequency of Accidents, to indicate that the patient has received medication for sphincter control during the admission assessment period.

Q: How should I rate a patient who takes a stool softener that he doesn't administer himself? Some facilities have self-medication programs, but others do not.

A: Administering medication is a typical hospital routine. If a patient receives medication from a nurse, rate the patient level 6, Modified Independence, for Bowel Level of Assistance, and level 6, No accidents, uses device such as an ostomy, for Bowel Frequency of Accidents.

Q: How should I rate a patient whose bowel management program involves using a suppository every other day?

A: The patient's rating will depend on the amount of assistance needed.

- If the patient completes the program independently, rate the patient level 6, Modified Independence, for Bowel Management because of the use of medication.
- If the patient needs only setup of supplies (incontinence pads) each time, supervision, or both, rate the patient level 5, Supervision/Setup.
- If the patient only needs the helper to lubricate and insert the suppository, rate the patient level 4, Minimal Assistance.

- If the patient needs a helper for positioning, placement of an absorbent pad, lubrication and insertion of the suppository, and help to evacuate the bowel (digital stimulation), rate the patient level 1, Total Assistance.

Q: How should I rate a patient who has a colostomy and empties into a bedpan at bedside for Bowel Management?

A: If the nurse only brings the bedpan to the patient and empties it, rate the patient level 5, Supervision/Setup.

Transfers: Bed, Chair, Wheelchair

Q: Can I rate a patient level 7 if the patient uses a wheelchair?

A: Yes. Wheelchair use is rated as part of Locomotion: Walk, Wheelchair. However, if the patient uses the wheelchair in such a way that the wheelchair itself facilitates the transfer, such as the use of an armrest, rate the patient level 6, Modified Independence.

Q: How can I determine whether a patient has expended 50% of the effort to transfer?

A: Most clinicians find it helpful to think about touching help versus lifting help when rating this item.

- If the patient transfers in a safe and timely manner and without a device, rate the patient level 7, Complete Independence.
- If the patient takes more than a reasonable amount of time, there is a concern for safety when the patient transfers, or the patient uses a device to transfer, rate the patient level 6, Modified Independence.
- If the patient needs a helper to lock wheels, position the chair, or supervise, rate the patient level 5, Supervision/Setup.
- If the patient requires steadying (touching) assistance, help to scoot forward in the chair only, or assistance to lift one limb, rate the patient level 4, Minimal Assistance.
- If a helper helps lift the patient's body, rate the patient level 3, Moderate Assistance.
- If the patient requires lifting assistance **and** lowering assistance during a transfer, rate the patient level 2, Maximal Assistance.
- If the patient is unable to bear weight or does not help with the transfer at all, rate the patient level 1, Total Assistance.
- If the activity does not occur on admission or discharge (or both), rate the patient level 1, Total Assistance.

Q: It is often more difficult to transfer to a hospital bed than a standard bed. How should I rate a patient who needs more assistance transferring to a hospital bed than to a standard bed in therapy?

A: Rate the patient's transfer into and out of the bed that is used every day (that is, the hospital bed).

Q: How should I rate a patient who is nearly independent when transferring from a wheelchair?

A: If the patient requires supervision or cueing only, rate the patient level 5, Supervision/Setup. If the patient requires touching assistance (i.e., steadying or contact assistance), rate the patient level 4, Minimal Assistance.

Q: How do I rate a patient who requires minimal assistance to transfer **from** a bed to a chair and moderate assistance to transfer **back** to the bed from the chair?

A: If a patient has different levels of ability transferring onto and off these surfaces, record the lower rating—level 3, Moderate Assistance, in this example.

Transfers: Toilet

Q: How should I rate a patient for Transfers: Toilet, given that all our toilet seats are elevated in the patients' rooms? Does the elevation mean that no patient's rating will be higher than level 6, Modified Independence?

A: The definition for level 6, Modified Independence, states that the patient requires an adaptive or assistive device. If the patient does not need help and the therapist has practiced this standard toilet transfer with the patient several times in another area of the facility, rate the patient level 7, Complete Independence, unless the patient requires an elevated toilet seat.

Q: Is a bedside commode transfer the same as a toilet transfer?

A: You can use the patient's transfer to and from the commode to rate this item. The bedside commode frame is an assistive device, so a patient who transfers on and off a bedside commode by himself cannot be rated higher than level 6, Modified Independence, for Transfers: Toilet.

Q: In transferring to a toilet, a patient must adjust clothing (e.g., pants) as he sits down or stands up from the toilet, but the patient's management of pants is not considered when rating Transfers: Toilet; just the physical act of sitting down and getting up is evaluated. How should I rate a patient who can transfer independently but can't manage his pants at the same time?

A: The tasks you describe are actually rated as part of two separate items:

1. Toileting
2. Transfers: Toilet

   Toileting assesses the patient's ability to maintain perineal hygiene and adjust clothing before and after toilet or bedpan use; Transfers: Toilet examines the patient's ability to get on and off the toilet.

   The patient in this example transfers onto and off the toilet independently. If the patient transfers safely, in a timely manner, and without the use of assistive devices, rate the patient level 7, Complete Independence, for Transfers: Toilet. If the patient pulls down his pants and performs his own perineal hygiene, but a helper pulls up the patient's pants, rate the patient level 3, Moderate Assistance, for Toileting.

Transfers: Tub, Shower

Q: If a patient is going home and will use a tub at home, should I evaluate the patient's tub transfers even if the patient uses a shower during his hospital stay?

A: Rate the patient's actual performance for Transfers: Tub, Shower. If a patient takes a shower each day in the hospital, rate the patient's shower transfer and record the rating in item 42K, Transfers: Tub, Shower. The patient's tub transfer ability has not been assessed; shower transfer is the actual activity performed every day. Ideally, if you know that the patient will perform tub transfers at home, the patient should practice that activity in the hospital every day as a therapeutic intervention.

Q: During a tub transfer, a patient requires moderate assistance to get onto a tub bench but needs maximum assistance to move her leg into the tub. Should I base the patient's rating on the aspect of the tub transfer that requires the most assistance?

A: Rate item 42K, Transfers: Tub, Shower, based on the patient's overall ability to get into and out of the tub. This activity includes getting onto the tub bench and getting the legs over the threshold of the tub or shower. In this example, rate the patient level 3, Moderate Assistance, if she needs lifting assistance to start the transfer and assistance to lift one leg into the tub.

Q: On admission, a patient transfers to a bench in the shower with just contact guard assistance. During the stay, the patient progresses to transferring to a shower seat in the shower, which is a more difficult task, but requires minimal assistance to complete the transfer. Under these circumstances, the patient appears to have dropped in rating when actually performing a more difficult task. Why doesn't the FIM® rating distinguish between these differences in performance?

A: The patient who receives touching or contact guard assistance during a tub transfer should be rated level 4, Minimal Assistance. This patient's rating was level 4 in both cases. A patient's rating may go down if he requires a greater amount of physical assistance, even as he no longer requires the use of assistive devices like tub benches. Levels 1–4 include a percentage range. Even though contact guard assistance is less assistance than minimal assistance, they both count as level 4 because the patient is performing 75% or more of the overall effort. Remember that the FIM® instrument measures a person's level of ability in terms of the need for assistance.

Locomotion: Walk, Wheelchair

Q: Why was the distance of 150 feet (45 meters) selected as the criterion for Locomotion: Walk, Wheelchair?

A: The distance of 150 feet (45 meters) represents the approximate length of one city block and is used as the minimum criterion for community ambulation. Traveling this minimum distance would allow an individual to walk from his home to a corner store or a friend's house, or to get from a car to his doctor's office door.

Q: Should I rate a manual wheelchair differently than a motorized wheelchair?

A: No. If the patient travels 150 feet (45 meters) in a manual or motorized wheelchair by himself, rate the patient level 6, Modified Independence.

Q: A patient is admitted to rehabilitation and uses a wheelchair as her more frequent mode of locomotion. During her stay at the rehabilitation unit, the patient walks more than she uses the wheelchair. Should I base the patient's rating on wheelchair mobility, walking, or both?

A: To determine the FIM® rating, consider the expected or actual mode of locomotion **at discharge**. The admission and discharge FIM® ratings for item 42L, Locomotion: Walk, Wheelchair, should always be based on the same mode of locomotion. If the patient changes locomotion modes from admission to discharge—usually wheelchair to walking—record the admission mode and rating based on the more frequent mode of locomotion (walk or wheelchair) at discharge.

If you anticipate that a patient's mode of locomotion will change (for example, from wheelchair to walking) during the rehabilitation program, or if you are unsure what mode a patient will use most often on discharge, rate the patient as follows:

- On admission, record tentative ratings for both modes in pencil on your scoring sheet.
- At discharge, determine the more frequent mode of locomotion, and then record the appropriate rating for this mode.
- Use the admission Locomotion: Walk, Wheelchair rating for the mode identified at discharge.

Q: If a patient doesn't ambulate on admission but ambulates 50 feet (15 meters) at discharge, the rating increases by only one point. Why is the gap between these levels of function so small?

A: The gap between the admission and discharge levels of function in this example is small because the patient still requires assistance from a helper to ambulate a specific distance (50 feet). If the patient ambulates 50 feet (15 meters) independently, rate the patient level 5, Household Ambulation, at discharge. (This rating represents greater progress.)

Q: Does level 5, Household Ambulation, imply independent ambulation status?

A: Yes, albeit to a limited extent. If the patient walks independently a minimum of 50 feet (15 meters), with or without a device, rate the patient level 5, Household Ambulation, for item 42L, Locomotion: Walk, Wheelchair. If the patient ambulates 50 feet (15 meters) but requires supervision or assistance from one person, rate the patient level 2, Maximal Assistance.

If the patient operates a manual or motorized wheelchair independently a minimum of 50 feet (15 meters), rate the patient level 5, Household Ambulation, for item 42L, Locomotion: Walk,

Wheelchair. If the patient wheels 50 feet (15 meters) but requires supervision or assistance from one person, rate the patient level 2, Maximal Assistance.

Q: A patient ambulates 100 feet (30 meters) with only contact guard assistance. Should I rate the patient level 2, Maximal Assistance, because of the distance ambulated?

A: Yes. You must consider the distance plus the assistance when rating Walk or Wheelchair. If the patient ambulates 100 feet (30 meters) with the assistance of one person, rate the patient level 2, Maximal Assistance, for item 42L, Locomotion: Walk, Wheelchair. A helper may provide assistance from supervision up to maximal assistance.

Locomotion: Stairs

Q: Because we have many single-story dwellings in Florida, we are often not as concerned as facilities in other states by the patient's ability to go up and down a full flight of stairs. If stair climbing is not one of our goals, can we disregard this item?

A: No, you cannot; you must rate all eighteen FIM® items. (Even a patient who does not need to climb stairs at home might need to climb stairs in the community.) If the patient does not climb stairs on admission or discharge, rate the patient level l, Total Assistance.

Q: How should I rate a patient who manages a set of training stairs (four stairs)?

A: If the patient manages four stairs (up and down) with assistance, rate the patient level 2, Maximal Assistance. If the patient goes up and down four stairs independently, rate the patient level 5, Household Ambulation. In order to be credited with climbing a full flight of stairs, the patient must go up and descend a four-stair set of training stairs three times with without a break.

Q: How should I rate a patient in a wheelchair who uses an elevator to go between floors? Is the elevator considered an assistive device?

A: No, because the patient does not go up and down stairs. In this case, rate the patient level 1, Total Assistance.

Q: How should I rate a patient who ascends and descends stairs by scooting on his buttocks?

A: If the patient ascends and descends a full flight (twelve to fourteen stairs) but takes more than a reasonable amount of time compared to ambulating, rate the patient level 6, Modified Independence. If the patient performs the task safely in a reasonable amount of time, rate the patient level 7, Complete Independence.

Q: How should I rate a patient who goes up and down four steps (or any number less than twelve) with minimal assistance or supervision? Many of my patients need to go up and down three to six steps but lack the endurance to manage twelve to fourteen steps (or have cardiac restrictions, etc.), so a full flight of stairs is not a goal.

A: If the patient goes up and down four stairs independently, rate the patient level 5, Household Ambulation. If the patient requires touching assistance or supervision to go up and down four stairs, rate the patient level 2, Maximal Assistance.

Q: Our facility does not have a full flight of twelve to fourteen steps, but we have a four-step stair in our physical therapy gym and a six-step stair outdoors. Can we have our patients climb both these stairs multiple times?

A: Yes. A patient can climb a four-step to six-step staircase multiple times, as long as the stair climbing is continuous.

Q: A patient has rheumatoid arthritis and morning stiffness. In the morning, her performance for climbing stairs is rated level 1, Total Assistance; in the evening, it's level 5, Household Ambulation. What is the patient's FIM® rating for this item?

A: If a patient's function varies across settings or by time of day, record the lowest rating. In this example, rate the patient level 1, Total Assistance.

Q: A patient's rating for going **up** stairs is level 3, Modified Assistance, but the patient's rating for going **down** stairs is level 2, Maximal Assistance. How should I rate this patient for this item?

A: If there is a difference in the patient's ability to go up and down the steps, record the lower rating.

Q: A patient manages eight steps (less than a full flight of stairs) with contact guard assistance. How should I rate this patient for this item?

A: If a patient manages only eight steps with supervision from one person, rate the patient level 2, Maximal Assistance, for Locomotion: Stairs. In order to be rated level 3, Moderate Assistance, or higher, the patient must manage a full flight of stairs. In order to be rated level 5, Household Ambulation, the patient must manage four to six steps **independently** (with or without a device).

Comprehension

Q: How should I rate a patient who is unable to understand what I am saying because of a hearing deficit? The patient processes the information, but I must speak in an unusually loud voice in order for him to hear the message.

A: Significantly increasing the volume of your voice and repeating the message are examples of prompting. If this prompting occurs almost all the time, the patient's rating may be as low as level 2, Maximal Prompting. Although one could argue that the assessment combines two issues (auditory comprehension and auditory acuity), from a functional standpoint, one cannot occur without the other. This situation is comparable to one in which a patient needs assistance to dress because of apraxia. Although apraxia is a motor processing deficit, it affects the patient's dressing ability.

Q: How do you define "prompting" for this item?

A: Examples of prompting or cueing include the following:

- Repeating words
- Stressing particular words or phrases
- Using pauses
- Providing visual or gestural cues

Q: I understand that at level 5, Standby Prompting, a helper is involved in Comprehension, but the content of what is understood is different. At level 5, Standby Prompting, it is everyday situations. How should I rate a patient who requires cues to understand complex and abstract information?

A: If the patient understands information about everyday situations (also referred to as "basic daily needs") but requires a helper to understand complex and abstract information, rate the patient level 5, Standby Prompting. The patient meets the criteria described for level 5, Standby Prompting, but is unable to meet the criteria described for level 6, Modified Independence.

Q: How should I rate a patient with aphasia who can understand what people mean by looking at a helper's gestures?

A: Rate the patient level 2, Maximal Prompting. If the patient understands only simple, commonly used vocal expressions or gestures, rate the patient level 2, Maximal Prompting.

Q: How should I rate a patient's ability to express himself or comprehend if he speaks a language I don't understand? Should I consider an interpreter an assistive device?

A: Rate Comprehension and Expression based on the person's ability to comprehend and express in his primary language, which is not always English. Do not consider use of an interpreter when rating these items. If you are unable to understand the patient's language, ask the patient's family, the patient's friends, or an interpreter whether the patient understands complex or abstract ideas.

Expression

Q: Should I rate a patient level 7, Complete Independence, if the patient expresses complex and abstract information in writing or sign language?

A: Yes. At level 7, Complete Independence, expression can be vocal or nonvocal.

Q: How should I rate a patient who expresses himself in simple words only?

A: If the patient expresses his needs in simple words (e.g., "hungry," "sleep") only, rate the patient level 2, Maximal Prompting.

Q: What does "expression of complex and abstract ideas and basic needs and ideas" mean?

A: Complex and abstract ideas include current events, religion, humor, and relationships with others. Basic needs and ideas refer to necessary daily activities, such as nutrition, fluids, elimination, hygiene, and sleep.

Q: How should I rate a patient who expresses himself with simple words only? What if the patient can express himself only by pointing to a communication board with pictures of such items as a pill, a beverage, or food?

A: If the patient expresses his needs in simple words only, rate the patient level 2, Maximal Prompting. If the patient expresses himself by pointing to a communication board with pictures, rate the patient level 2, Maximal Prompting. In both cases, the patient is expressing only basic needs and will require maximal prompting.

Social Interaction

Q: How should I rate a patient who is withdrawn, particularly if this is the patient's typical premorbid behavior?

A: The patient's rating depends on the degree of withdrawal and the effect of the behavior on the patient's ability to get his needs met. If the patient simply chooses activities that are solitary in nature and is considered introverted but exhibits appropriate behaviors in group situations, rate the patient level 7, Complete Independence. If the patient exhibits inappropriate social behavior when in group situations, however—behavior that requires verbal or nonverbal redirection, for example—base the patient's rating on the amount of assistance needed.

Q: How should I rate a patient who is somewhat unsociable with loud, foul, and abusive language but does not otherwise cause trouble?

A: If the patient self-corrects himself, rate the patient level 6, Modified Independence. If the patient's behavior is offensive to others and the patient requires verbal or nonverbal redirection, do not rate the patient higher than level 5, Supervision.

Q: How should I rate a patient who is taking medication for depression?

A: If the patient is taking medication such as antidepressants or antianxiety medications to govern mood or behavior, rate the patient level 6, Modified Independence.

Problem Solving

Q: Could you provide some examples of "routine" problems for this item? Are both the decision and the tasks necessarily exhibited?

A: Examples of routine problems include:

- Asking for help after dropping a spoon on the floor
- Putting on more clothes when cold
- Appropriately asking for assistance prior to a transfer
- Asking for assistance needed to button a shirt

Recognizing that a problem exists and deciding what to do about it are both necessary. Asking for assistance, as in the examples above, may provide one way to solve a problem.

Q: How should I rate a patient who solves routine problems 75% of the time but does not initiate or participate in solving complex problems?

A: If the patient needs occasional assistance with routine problems but does not solve complex problems, rate the patient level 4, Minimal Direction.

Q: Could you give an example of problem solving at level 4, Minimal Direction, and level 5, Supervision?

A: At level 4, Minimal Direction, the patient solves routine problems most of the time and requires occasional cues to complete tasks or self-correct.

At level 5, Supervision, the patient requires supervision to solve problems under unfamiliar conditions, but the patient completes routine, daily personal activities without a significant amount of direction or prompting from a helper (less than 10% of the time).

Memory

Q: Many of us use daybooks. Does this mean that we all function at a level of modified independence with regard to the Memory item?

A: No, it doesn't. Remembering daily routines refers to the ability to recall the flow of a typical day: that we get up, wash ourselves, dress, eat, go to work, return home, etc. The ability to remember specific appointment times is not required.

Q: Can I use the Folstein Mini-Mental State Examination to assess this item?

A: No, you cannot. The FIM® instrument assesses the patient's memory by rating the patient's ability to do the following:

1. Recognize people frequently encountered
2. Remember daily routines
3. Execute requests of others without need for repetition

   These are the "three Rs"—recognize, remember, and requests. A more effective approach is to ask the patient about a typical day, looking for information related to the three Rs. Determine the amount of prompting needed.

Q: At level 7, Complete Independence, is the patient required to remember each of his therapists by name?

A: No. The patient does not need to remember each therapist by name; it is enough that the patient recognizes the therapist as someone he has met previously.

Q: How do I rate this item for a patient who can follow a one-step or two-step command but cannot follow a three-step command?

A: The rating depends on the patient's ability to meet the remaining criteria defined as part of the item's description. For example, if the patient follows an unrelated two-step command (but not a three-step command) without repetition, recognizes people frequently encountered, and recalls his daily routine in general but requires a helper to execute more complex instructions, rate the patient level 4, Minimal Assistance.

Q: How should I rate a patient who uses a memory notebook to remember routine daily schedules?

A: If the patient uses the device independently, rate the patient level 6, Modified Independence. If a helper must remind the patient to use it, rate the patient level 5, Supervision.

Appendix G: Coding the Data Set and Performing Additional Assessments

Hardcopy samples of the coding forms (one for admission/discharge assessments, one for interim/follow-up assessments) are provided in appendix D on page 127. Before you implement the use of these forms at your facility, review the forms to determine which optional fields you will collect data for. The following optional fields are included in your reports:

- Item 14, Gender
- Item 15, Ethnicity
- Item 16, English Language
- Item 17, Marital Status
- Item 18, Payment Source
- Item 19, Gross Rehabilitation Charges
- Item 28, Date of Onset
- Item 33, Admit From
- Item 34, Prehospital Living Setting
- Item 35, Prehospital Living With
- Item 36, Prehospital Vocational Category
- Item 37, Prehospital Vocational Effort
- Item 38, Discharge to Living Setting
- Item 39, Discharge to Living With

The other optional fields are not included in your reports, but you can export all of this data for custom reporting.

Although not required by UDSMR, interim assessments and follow-up assessments are useful tools that can help you track rehabilitation progress and patient outcomes. Samples of these assessment forms are included in appendix D on page 127.

Interim Assessments

Although not required by UDSMR, interim assessments help monitor a patient's progress throughout the rehabilitation stay. Use the definitions, criteria, and information in this guide to complete each interim assessment.

A case record can have more than one interim assessment associated with it.

Follow-Up Assessments

Although not required by UDSMR, follow-up assessments can help your facility meet accreditation standards and measure the post-rehabilitation progress of a discharged patient. Administered 80 to 180 days after discharge, follow-up assessments can provide insight into your program's effectiveness, such as whether patients continue to make gains or whether they experience setbacks.

A case record can have more than one follow-up assessment associated with it.

General Instructions for Follow-Up Coding

Follow-up data should be collected 80 to 180 days after discharge from rehabilitation. The data may be collected by rehabilitation professionals who have been trained in use of the FIM® instrument and have passed the credentialing exam.

The most common data collection method is a telephone interview. Alternate methods include a clinic visit and mailed questionnaire. The decision trees in this guide, beginning on page 35, provide a format for the telephone interview. Ratings may be recorded on the Interim or Follow-Up Assessment Coding Form.

Collecting Follow-Up Data by Telephone Interview

Before discharge, inform the patient orally and in writing that you will contact him by telephone 80 to 180 days after discharge in order to assess his level of everyday functioning. Maintain a follow-up log or database that provides you with a "triggering system" so that phone calls are placed at the appropriate time (80 to 180 days after discharge). At a minimum, the log or database should contain the patient's name, admission and discharge dates, discharge destination, and telephone number for that destination.

UDSMR recommends the following procedure when collecting follow-up data by telephone:

1. Complete the following items prior to placing the phone call:
   a. Item 1, Facility Code
   b. Item 2, Patient Code
   c. Item 21, Admission Date
   d. Item 60, Assessment Type
   e. Item 61, Assessment Date
   f. Item 63, Follow-Up Method
   g. Item 64, Follow-Up Living Setting

   Record this information on the Interim or Follow-Up Coding Form. Doing so before placing the phone call saves you time and helps ensure the collection of correct patient data.
2. Immediately upon contact:
   - Introduce yourself by name.
   - Identify your facility and your role at the facility.
   - State the purpose of the phone call.

- Indicate that you need approximately twenty minutes to complete the interview.
- Ask whether you may proceed.

3. State that you will first ask some preliminary questions, followed by specific questions about everyday activities.
4. Collect the data you need to complete the following items:
   a. Item 62, Follow-Up Information Source
   b. Item 65, Follow-Up Living With
   c. Item 66, Follow-Up Vocational Category
   d. Item 67, Follow-Up Vocational Effort
   e. Item 68, Follow-Up Health Maintenance
   f. Item 69, Follow-Up Therapy
5. Item 70, Follow-Up Diagnoses, requires that you ask about other medical conditions or complications that occurred after discharge from rehabilitation. UDSMR recommends that you record the information reported by the interviewee and then ask the medical record coder to provide you with the appropriate ICD codes for this item.
6. Begin collecting functional assessment data, using the decision trees, beginning on page 35, as a reference.

The process of determining a FIM® rating depends on the format of the follow-up information source's responses. Typically, these responses will take one of three forms:

1. Clear yes/no responses to your questions
2. Words other than those used in the decision tree format
3. Descriptions of behavior that indicates a specific level

If the person to whom you are speaking gives **clear yes/no responses,** follow these steps:

1. Define the item. Read the definition of each item to the person.
2. Begin asking the questions outlined for you. They are closed-ended questions that require a yes or no response.
3. Follow the arrows in the decision tree, and then ask the questions that the response points to. If you arrive at a rating, record it, and then move to the next item.

Example:

Question: "Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is appropriately prepared. Does Joe need help when eating meals?"

Response: "Yes."

Instructions: Follow the arrow down and ask the next question.

Question: "Does Joe provide half or more of the effort when eating?"

Response: "No."

Instructions: Follow the arrow down and ask the next question.

Question: "Does Joe require total assistance to eat, with a helper holding the utensils and bringing all food and liquids to the mouth?"

Response: "No."

Instructions: Follow the arrow to the right. The Eating rating in this example is level 2. Record it on the Follow-Up Coding Form, and then move on to the next item.

If the person to whom you are speaking **reports information in words other than those used in the decision tree format,** follow these steps:

1. Define the item. Read the definition of each item.
2. Begin asking the questions outlined for you. Person responds "free form."
3. Ask follow-up questions as appropriate based on the person's responses, validating the information if needed.

Example:

Question: "Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is appropriately prepared. Does Joe need help when eating meals?"

Response: "Well, I don't know if you'd really call it help." (Explore helper scores.)

Instructions: Follow the arrow down and ask the next question.

Question: "Does Joe provide half or more of the effort when eating?"

Response: "I give him his things and then he does just fine." (Explore setup.)

Instructions: Follow the arrow to the right and ask the next question.

Question: "Does Joe need help opening containers, cutting up meat, and pouring liquids only?"

Response: "I'd say so. I cut up his meat, things like that, but he does all the work after that."

Validate: "You help Joe get ready to eat only?"

Response: "That's right."

Instructions: Follow the arrow to the right. The Eating rating in this example is level 5. Record it on the Follow-Up Coding Form, and then move on to the next item.

If the person being interviewed **immediately describes a behavior that indicates a specific level**, record the level on the Interim or Follow-Up Assessment Coding Form and then move on to the next item.

Example:

Question: "Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is appropriately prepared. Does Joe need help when eating meals?"

Response: "Yes, I feed him every day."

Validate: "Joe is unable to feed himself at all?"

Response: "Yes."

Validate: "Do you also manage the cup or glass so he can drink?"

Response: "Yes."

Instructions: The response describes level 1. Record this rating on the Follow-Up Coding Form, and then move to the next item.

As you can see, you will never have to ask every question for each item. Each response will point you in a certain direction, allowing you to obtain the necessary information with relatively few questions.

Use the boxes on the Interim or Follow-Up Assessment Coding Form to indicate the more usual mode for item 71L, Locomotion: Walk, Wheelchair; item 71N, Comprehension; and item 71O, Expression.

Sample Follow-Up Interview

As you read the sample case study, you may find it helpful to complete the follow-up functional assessment. The correct ratings and rationales are on page 175.

The patient is told upon discharge that he will be contacted by a member of the rehabilitation team and has been given this information in writing. The follow-up log indicates that three patients are due for follow-up assessment this week. (Only one will be presented in this sample.) The log provides the following information about the first patient:

Joe S., Patient #999, is a forty-two-year-old white male who had a stroke with left hemiparesis. He was admitted to rehabilitation on February 1, 2017, and discharged on March 6, 2017. He went home with his wife and two teenage daughters. The follow-up telephone interview will be conducted on June 18, 2017.

Preliminary information: Complete items 1, 2, 21, 60, 61, 63, and 64 on the coding form.

Interviewer: "Hi. My name is [name]. I'm a [rehab nurse, OT, PT, medical records clerk] at [hospital/unit name]. With whom am I speaking?"

Respondent: "This is Mrs. S."

Interviewer: "I'm calling regarding your husband, Joe. He was discharged from our rehabilitation unit three months ago. You may remember that we said at the time that we would be calling in three months to see how Joe is doing at home."

Mrs. S.: "I do remember, now that you mentioned it."

Interviewer: "The reason I'm calling is to ask some background questions, plus some questions about Joe's ability to perform certain daily activities. These are activities that we worked on while he was here on our unit. It's important to us to know whether he is able to do these activities."

Mrs. S.: "I see."

Interviewer: "Would you prefer that I interview you or your husband?"

Mrs. S.: "He's resting now. I'll answer your questions."

Interviewer: "This should take about twenty minutes. Is now a good time?"

Mrs. S.: "Yes, now is fine."

Interviewer: "Is your husband still living at home with you and your daughters?"

Mrs. S.: "Yes."

Interviewer: "Is he working now?"

Mrs. S.: "No, he's not ready to work yet."

Interviewer: "Who is responsible for carrying out Joe's routine personal care and doing home management?"

Mrs. S.: "Joe does his own care, but I do all the home management."

Interviewer: "Is he currently receiving paid therapy?"

Mrs. S.: "No, not anymore."

Interviewer: "Has he been diagnosed with any other medical problems or complications since discharge?"

Mrs. S.: "No."

Interviewer: "Now I'd like to ask you about particular activities. I'll explain the activity and then ask about whether or not help is needed, and, if help is needed, how much."

Mrs. S.: "Okay."

Interviewer: "Eating includes using suitable utensils to bring food from a dish to the mouth, where the food is chewed and swallowed; using a cup or glass to bring liquid to the mouth, where it is swallowed; and managing a variety of food consistencies after a meal has been presented in the customary manner on a table or tray. Does Joe need help to eat?"

Mrs. S.: "Once I cut up his food, he eats by himself."

Interviewer: "Grooming includes oral care (brushing teeth); hair grooming (combing and brushing hair); washing, rinsing, and drying the hands; washing, rinsing, and drying the face; and shaving or applying makeup. Does Joe need help for grooming?"

Mrs. S.: "Just a little."

Interviewer: "Does Joe provide half or more of the effort for grooming?"

Mrs. S.: "Oh, it's much more than that. He just needs help to shave under his chin."

Interviewer: "Bathing includes washing, rinsing, and drying the body from the neck down (excluding the neck and back) in a tub, shower, or sponge/bed bath. The patient performs the activity safely. Does Joe need help for bathing?"

Mrs. S.: "No."

Interviewer: "Does he use an assistive device, such as a long-handled sponge or wash mitt?"

Mrs. S.: "Yes. He uses that bath mitt they gave him in the hospital."

Interviewer: "Dressing: Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or an orthosis when applicable. The patient performs the activity safely. Does Joe need help for upper-body dressing?"

Mrs. S.: "Yes."

Interviewer: "Does he provide half or more of the effort for upper-body dressing?"

Mrs. S.: "I'd say so. He really just needs help to button his shirt."

Interviewer: "Dressing: Lower Body includes dressing and undressing from the waist down as well as applying and removing a prosthesis or an orthosis when applicable. The patient performs the activity safely. Does Joe need help for lower-body dressing?"

Mrs. S.: "Yes. That's the hardest thing for him."

Interviewer: "Does he provide half or more of the effort?"

Mrs. S.: "I'm not really sure. I have to put on his socks and his shoes. He threads his underwear and pants on while he's in bed and then he pulls up his underwear and pants. He doesn't wear a belt. He wears jogging pants, but I have to tie the string."

Interviewer: "Toileting includes maintaining perineal hygiene and adjusting clothing before and after using toilet, commode, bedpan, or urinal after a continent episode. The patient performs the activity safely. Does Joe need help for toileting?"

Mrs. S.: "Just a little."

Interviewer: "Does he provide half or more of the effort?"

Mrs. S.: "Well, let's see. I never thought about it that way. What's toileting again?"

Interviewer: "It includes maintaining perineal hygiene and adjusting clothing before and after using toilet, commode, bedpan, or urinal after a continent episode. The patient performs the activity safely. It's really three things: getting the pants down, cleansing, and getting the pants back up."

Mrs. S.: "He gets his pants down, wipes himself, and actually he can get his pants up too, but while he's wiping and getting his pants up I have to kind of hold on to him so he doesn't lose his balance."

Interviewer: "Bladder Management includes complete and intentional control of urinary bladder and use of any equipment and medication (agents) necessary for bladder control. This item deals with the level of assistance required to complete bladder management tasks and the success of the patient's bladder management program. Does Joe need help with bladder management?"

Mrs. S.: "During the day, he uses a urinal because we only have a bathroom upstairs and he can't take the stairs without my help."

Interviewer: "Who empties the urinal?"

Mrs. S.: "Either me or one of the girls."

Interviewer: "Does Joe ever have any bladder accidents?"

Mrs. S.: "No."

Interviewer: "Bowel Management includes complete intentional control of bowel movements and, if necessary, use of equipment or agents for bladder control. This item deals with the level of assistance required to complete bowel management tasks and the success of the patient's bowel management program. Does Joe need help for bowel management?"

Mrs. S.: "No."

Interviewer: "Does he use an assistive device or medication such as Colace?"

Mrs. S.: "He takes stool softeners."

Interviewer: "Does he ever have bowel accidents?"

Mrs. S.: "No."

Interviewer: "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. Does Joe need help for bed-to-chair transfers?"

Mrs. S.: "Yes."

Interviewer: "Does he provide half or more of the effort for such transfers?"

Mrs. S.: "Yes, he does."

Interviewer: "Does he need supervision, cueing, or coaxing only, or does he need more help than that?"

Mrs. S.: "No. It's more help than that."

Interviewer: "Can you describe the help you give him?"

Mrs. S.: "I help by lifting his left leg in and out of bed and just steadying him."

Interviewer: "Transfers: Toilet includes all aspects of transferring on and off a toilet. This includes safely approaching, sitting down on, and getting up from the toilet. Does Joe need help for toilet transfers?"

Mrs. S.: "It's the same amount of help as the last one."

Interviewer: "Transfers: Tub, Shower includes getting into and out of a tub or shower. The patient performs the activity safely. This item must be rated during an actual performance of the activity, not a simulation. If the patient performs both tub and shower transfers, the rating should be based on the more frequent mode of transfer. Does Joe bathe in a tub or a shower?"

Mrs. S.: "We have a regular tub. He uses that."

Interviewer: "Does Joe need help to get into the tub?"

Mrs. S.: "All I have to do is help him lift his left leg in and out."

Interviewer: "The next question is about the item Locomotion: Walk, Wheelchair. If the patient walks, this item includes walking on a level surface once in a standing position; if the patient uses a wheelchair, it includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. Does Joe usually walk, or does he use a wheelchair?"

Mrs. S.: "He walks. He doesn't use a wheelchair anymore."

Interviewer: "Does Joe need help to walk one hundred fifty feet?"

Mrs. S.: "Yes."

Interviewer: "Does he go at least fifty feet without help? That's roughly two rooms."

Mrs. S.: "No. He can walk one hundred fifty feet, but he uses a walker, and I always stay with him."

Interviewer: "Locomotion: Stairs includes going up and down twelve to fourteen stairs (one flight) indoors in a safe manner. Does Joe need help to go up and down twelve to fourteen stairs?"

Mrs. S.: "Yes, I have to be with him for stairs."

Interviewer: "Does he go up and down a minimum of twelve to fourteen stairs with help?"

Mrs. S.: "Yes, he does."

Interviewer: "Does he need only supervision to go up and down twelve stairs?"

Mrs. S.: "No. I hold on to him and help him move his left leg up to the next stair."

Interviewer: "Does he perform between fifty percent and seventy-four percent of the work, or does he perform more than that?"

Mrs. S.: "I'd say fifty percent to seventy-four percent."

Interviewer: "Comprehension includes understanding of either auditory or visual communication, such as writing, sign language, and gestures. To rate this item, I'll need to evaluate and record Joe's usual mode of comprehension, whether auditory or visual. Does Joe need help to understand conversations or complex ideas?"

Mrs. S.: "No."

Interviewer: "Does he need extra time or require a device such as a hearing aid?"

Mrs. S.: "No."

Interviewer: "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. To rate this item, I'll need to evaluate and record Joe's usual mode of expression, whether vocal or nonvocal. Does Joe need help to express complex ideas?"

Mrs. S.: "No."

Interviewer: "Does he need extra time or need anything to help express his needs?"

Mrs. S.: "No. His speech is just a little slurred because his mouth is slightly weak on one side. It's hard to understand him at times."

Interviewer: "Do you have to ask him to repeat words or sentences?"

Mrs. S: "Sometimes."

Interviewer: "Less than ten percent of the time, or more?"

Mrs. S.: "Less."

Interviewer: "Social Interaction includes skills related to getting along with others 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. Does Joe need help to interact with others in social situations?"

Mrs. S.: "I wouldn't say that he needs help, but he doesn't socialize the way he used to. When people come over, he talks with them, even jokes around, but he doesn't usually do the inviting, doesn't call people on the phone the way he did before. And we've only been out together twice in the last three months since he got home."

Interviewer: "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 initiating, sequencing, and self-correcting tasks and activities to solve problems. Does Joe need help to solve problems of everyday living?"

Mrs. S.: "Yes. All he's concerned about is getting up, getting dressed, getting down stairs, just making it through the day. As far as financial and family problems go, I take care of everything."

Interviewer: "Let me see if I understand what you're saying. Joe takes care of personal problems related to everyday living, but he doesn't participate in financial and family problem solving?"

Mrs. S.: "That's right. He doesn't need any help with handling simple personal problems, but he doesn't help me with the other things."

Interviewer: "This is the last one. Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. In this context, memory 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. Does Joe need help to remember people, routines, and requests?"

Mrs. S.: "No, he doesn't."

Interviewer: "Does he have any difficulty in remembering, or does he help himself to remember by making written lists or keeping a logbook?"

Mrs. S.: "No."

Interviewer: "That completes my questions. Before I hang up, do you have any questions for me?"

Mrs. S.: "I was just curious about what you do with this information."

Interviewer: "We collected this same information when Joe was admitted to the rehabilitation unit and when he was discharged. What we do is track the changes over time so that we can evaluate the effectiveness of our rehabilitation program."

Mrs. S.: "I understand. Thank you."

Interviewer: "We appreciate your time and cooperation. Thank you."

Mrs. S.: "You're welcome."

Interviewer: "Goodbye."

Mrs. S.: "Goodbye."

Answers and Rationales: FIM® Ratings for Follow-Up Call

Item	Rationale
Eating	**Level 5, Supervision:** Joe needs only setup assistance from his wife.
Grooming	**Level 4, Minimal Assistance:** Joe needs help shaving under his chin but performs all other grooming tasks without assistance.
Bathing	**Level 6, Modified Independence:** Joe uses a wash mitt, after which he bathes independently.
Dressing: Upper Body	**Level 4, Minimal Assistance:** Joe only needs assistance to button his shirt. He performs three of four steps.
Dressing: Lower Body	**Level 3, Moderate Assistance:** Joe puts on his underwear and pants, but his wife his jogging pants. She also puts on his socks and shoes. Joe performed more than 50% of the tasks (six of eleven tasks).
Toileting	**Level 4, Minimal Assistance:** Mrs. S. steadies Joe as he performs all three toileting tasks.
Bladder Management	**Level 5, Supervision/Setup:** Joe uses a urinal, which his family empties. Joe has not had any accidents.
Bowel Management	**Level 6, Modified Independence:** Joe uses a stool softener to manage his bowels. He has not had any accidents.
Transfers: Bed, Chair, Wheelchair	**Level 4, Minimal Assistance:** Mrs. S. helps Joe by lifting his left leg in and out of bed and steadying him.
Transfers: Toilet	**Level 4, Minimal Assistance:** Joe needs only steadying assistance.
Transfers: Tub, Shower	**Level 4, Minimal Assistance:** Joe needs assistance to lift his left leg in and out.
Locomotion: Walk, Wheelchair	**Level 5, Supervision/Setup:** Joe walks 150 feet with supervision from his wife.
Locomotion: Stairs	**Level 3, Moderate Assistance:** Joes performs between 50% and 74% of the stair climbing.
Comprehension	**Level 7, Complete Independence:** Joe understands all conversations and complex information.
Expression	**Level 5, Standby Prompting:** Joe slurs his speech and has to be asked to repeat words less than 10% of the time.
Social Interaction	**Level 7, Complete Independence:** Joe does not need help socializing but doesn't initiate interaction like he did before his hospitalization.
Problem Solving	**Level 5, Supervision:** Joe solves routine problems, but not complex ones.
Memory	**Level 7, Complete Independence:** Joe does not have any problem with his memory.