

PRA Disclosure Statement

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INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*	Payer Information*																						
<p>1. Facility Information A. Facility Name _____ _____</p> <p>B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5A. Patient Last Name _____</p> <p>5B. Patient Identification Number _____</p> <p>6. Birth Date _____ MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply)</p> <table style="width:100%; border: none;"> <tr> <td style="padding-left: 20px;">American Indian or Alaska Native</td> <td style="text-align: right;">A. _____</td> </tr> <tr> <td style="padding-left: 40px;">Asian</td> <td style="text-align: right;">B. _____</td> </tr> <tr> <td style="padding-left: 20px;">Black or African American</td> <td style="text-align: right;">C. _____</td> </tr> <tr> <td style="padding-left: 40px;">Hispanic or Latino</td> <td style="text-align: right;">D. _____</td> </tr> <tr> <td style="padding-left: 20px;">Native Hawaiian or Other Pacific Islander</td> <td style="text-align: right;">E. _____</td> </tr> <tr> <td style="padding-left: 40px;">White</td> <td style="text-align: right;">F. _____</td> </tr> </table> <p>10. Marital Status (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced) _____</p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p>	American Indian or Alaska Native	A. _____	Asian	B. _____	Black or African American	C. _____	Hispanic or Latino	D. _____	Native Hawaiian or Other Pacific Islander	E. _____	White	F. _____	<p>20. Payment Source A. Primary Source _____</p> <p>B. Secondary Source _____</p> <p><i>(01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers' Compensation; 07 - Crippled Children's Services; 08 - Developmental Disabilities Services; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 - No-Fault Auto Insurance; 51 - Medicare MCO; 52 - Medicaid MCO)</i></p>										
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Medical Information*																							
<p>21. Impairment Group _____</p> <p style="text-align: right; margin-right: 20px;">Admission Discharge</p> <p>Condition requiring admission to rehabilitation; code according to Appendix A, attached.</p> <p>22. Etiologic Diagnosis _____ <i>(Use an ICD-9-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation)</i></p> <p>23. Date of Onset of Impairment _____ MM / DD / YYYY</p> <p>24. Comorbid Conditions: Use ICD-9-CM codes to enter up to ten medical conditions</p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%;">A. _____</td> <td style="width: 50%;">B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> <tr> <td>G. _____</td> <td>H. _____</td> </tr> <tr> <td>I. _____</td> <td>J. _____</td> </tr> </table>	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	<p>25. Is patient comatose at admission? _____ 0 - No, 1 - Yes</p> <p>26. Is patient delirious at admission? _____ 0 - No, 1 - Yes</p> <p>27. Swallowing Status _____</p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: right;">Admission Discharge</td> </tr> <tr> <td colspan="2">3 - <u>Regular Food</u>: solids and liquids swallowed safely without supervision or modified food consistency</td> </tr> <tr> <td colspan="2">2 - <u>Modified Food Consistency/ Supervision</u>: subject requires modified food consistency and/or needs supervision for safety</td> </tr> <tr> <td colspan="2">1 - <u>Tube /Parenteral Feeding</u>: tube / parenteral feeding used wholly or partially as a means of sustenance</td> </tr> </table> <p>28. Clinical signs of dehydration _____</p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: right;">Admission Discharge</td> </tr> <tr> <td colspan="2"><i>(Code 0 - No; 1 - Yes) e.g., evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation</i></td> </tr> </table>		Admission Discharge	3 - <u>Regular Food</u> : solids and liquids swallowed safely without supervision or modified food consistency		2 - <u>Modified Food Consistency/ Supervision</u> : subject requires modified food consistency and/or needs supervision for safety		1 - <u>Tube /Parenteral Feeding</u> : tube / parenteral feeding used wholly or partially as a means of sustenance			Admission Discharge	<i>(Code 0 - No; 1 - Yes) e.g., evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation</i>	
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Admission Information*																							
<p>12. Admission Date _____ MM / DD / YYYY</p> <p>13. Assessment Reference Date _____ MM / DD / YYYY</p> <p>14. Admission Class _____ <i>(1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</i></p> <p>15. Admit From _____ <i>(01 - Home; 02 - Board & Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</i></p> <p>16. Pre-Hospital Living Setting _____ <i>(Use codes from item 15 above)</i></p> <p>17. Pre-Hospital Living With _____ <i>(Code only if item 16 is 01 - Home; Code using 1 - Alone; 2 - Family/Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</i></p> <p>18. Pre-Hospital Vocational Category _____ <i>(1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability)</i></p> <p>19. Pre-Hospital Vocational Effort _____ <i>(Code only if item 18 is coded 1 - 4; Code using 1 - Full-time; 2 - Part-time; 3 - Adjusted Workload)</i></p>	<p>*The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.</p>																						

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Function Modifiers*	39. FIM™ Instrument*		
	ADMISSION	DISCHARGE	GOAL
<p>Complete the following specific functional items prior to scoring the FIM™ Instrument:</p>			
	ADMISSION	DISCHARGE	
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	
30. Bladder Frequency of Accidents (Score as below)	<input type="checkbox"/>	<input type="checkbox"/>	
7 - No accidents 6 - No accidents; uses device such as a catheter 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days			
<i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.</i>			
	ADMISSION	DISCHARGE	
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	
32. Bowel Frequency of Accidents (Score as below)	<input type="checkbox"/>	<input type="checkbox"/>	
7 - No accidents 6 - No accidents; uses device such as an ostomy 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days			
<i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i>			
	ADMISSION	DISCHARGE	
33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>	
34. Shower Transfer	<input type="checkbox"/>	<input type="checkbox"/>	
<i>(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) See training manual for scoring of Item 39K (Tub/Shower Transfer)</i>			
	ADMISSION	DISCHARGE	
35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>	
36. Distance Traveled in Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
<i>(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)</i>			
	ADMISSION	DISCHARGE	
37. Walk	<input type="checkbox"/>	<input type="checkbox"/>	
38. Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
<i>(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)</i>			
<p>39. FIM™ Instrument*</p>			
	ADMISSION	DISCHARGE	GOAL
SELF-CARE			
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPHINCTER CONTROL			
G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFERS			
I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOCOMOTION			
L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION			
N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL COGNITION			
P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FIM LEVELS			
<i>No Helper</i>			
7 Complete Independence (Timely, Safely)			
6 Modified Independence (Device)			
<i>Helper - Modified Dependence</i>			
5 Supervision (Subject = 100%)			
4 Minimal Assistance (Subject = 75% or more)			
3 Moderate Assistance (Subject = 50% or more)			
<i>Helper - Complete Dependence</i>			
2 Maximal Assistance (Subject = 25% or more)			
1 Total Assistance (Subject less than 25%)			
0 Activity does not occur; Use this code only at admission			

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INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Discharge Information*	Quality Indicators																		
<p>40. Discharge Date _____ MM / DD / YYYY</p> <p>41. Patient discharged against medical advice? _____ (0 - No, 1 - Yes)</p> <p>42. Program Interruption(s) _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates (Code only if Item 42 is 1 - Yes)</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">A. 1st Interruption Date _____</td> <td style="width: 50%;">B. 1st Return Date _____</td> </tr> <tr> <td style="text-align: center;">MM / DD / YYYY</td> <td style="text-align: center;">MM / DD / YYYY</td> </tr> <tr> <td>C. 2nd Interruption Date _____</td> <td>D. 2nd Return Date _____</td> </tr> <tr> <td style="text-align: center;">MM / DD / YYYY</td> <td style="text-align: center;">MM / DD / YYYY</td> </tr> <tr> <td>E. 3rd Interruption Date _____</td> <td>F. 3rd Return Date _____</td> </tr> <tr> <td style="text-align: center;">MM / DD / YYYY</td> <td style="text-align: center;">MM / DD / YYYY</td> </tr> </table> <p>44A. Discharge to Living Setting (01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</p> <p>44B. Was patient discharged with Home Health Services? _____ (0 - No; 1 - Yes) (Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)</p> <p>45. Discharge to Living With _____ (Code only if Item 44A is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>46. Diagnosis for Interruption or Death _____ (Code using ICD-9-CM code)</p> <p>47. Complications during rehabilitation stay (Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay)</p> <table style="width: 100%;"> <tr> <td>A. _____</td> <td>B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> </table>	A. 1 st Interruption Date _____	B. 1 st Return Date _____	MM / DD / YYYY	MM / DD / YYYY	C. 2 nd Interruption Date _____	D. 2 nd Return Date _____	MM / DD / YYYY	MM / DD / YYYY	E. 3 rd Interruption Date _____	F. 3 rd Return Date _____	MM / DD / YYYY	MM / DD / YYYY	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	<p>Pressure Ulcers</p> <p>Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage.</p> <p>48A. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.</p> <p>Number of Stage 2 pressure ulcers _____ Admission Discharge</p> <p>48B. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p> <p>Number of Stage 3 pressure ulcers _____ Admission Discharge</p> <p>48C. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</p> <p>Number of Stage 4 pressure ulcers _____ Admission Discharge</p> <p>Worsening in Pressure Ulcer Status Since Admission Indicate the number of current pressure ulcers that were not present or were at a lesser stage at admission. If no current pressure ulcer at a given stage, enter 0.</p> <p>49A. Stage 2. Enter Number: _____</p> <p>49B. Stage 3. Enter Number: _____</p> <p>49C. Stage 4. Enter Number: _____</p> <p>Healed Pressure Ulcers.</p> <p>50A. Were pressure ulcers present on admission? _____ (0 - No; 1 - Yes)</p> <p>Indicate the number of pressure ulcers that were noted on admission that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since admission, enter 0. (Code only if item 50A is 1 - yes)</p> <p>50B. Stage 2 Enter Number _____</p> <p>50C. Stage 3 Enter Number _____</p> <p>50D. Stage 4 Enter Number _____</p>
A. 1 st Interruption Date _____	B. 1 st Return Date _____																		
MM / DD / YYYY	MM / DD / YYYY																		
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