Helpful Hints for Rating the FIM® Instrument for the IRF-PAI
Helpful Hints for Rating the FIM® Instrument for the IRF-PAI
Uniform Data System for Medical Rehabilitation, October 9, 2009

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General Hints

- Each of the 18 items that compose the FIM® instrument has a maximum rating of seven (7), which indicates complete independence. A rating of one (1) indicates total assistance. A code of zero (0) may be used for some items to indicate that the activity does not occur.
- Use only whole numbers when rating FIM® items.
- For the function modifiers, the allowable rating range is a minimum of 1 and a maximum of 7. The maximum rating is 3 for the following items:
  - Item 35, Distance Walked
  - Item 36, Distance Traveled in Wheelchair
A code of 0 may be used on admission and discharge for the following function modifiers:
  - Item 33, Tub Transfer
  - Item 35, Distance Walked
  - Item 36, Distance Traveled in Wheelchair
  - Item 37, Walk
  - Item 38, Wheelchair
- Admission FIM® ratings must be collected during the first 3 calendar days of the patient’s current rehabilitation hospitalization that is covered by Medicare Part A fee for service. These ratings must be based upon activities performed during the entire 3-calendar-day admission time frame.
- The discharge assessment time frame encompasses the day of discharge and the 2 calendar days prior to the day of discharge. Completion of the FIM® items at discharge, with the exception of items that reflect bowel and bladder function, should reflect the lowest functional rating within any 24-hour period within the 3 calendar days that compose the discharge assessment. At discharge, all FIM® items except item 39G, Bladder Management, and item 39H, Bowel Management, should be assessed within the same 24-hour period.

For example, the assessment time frame for a patient discharged on 1/10/09 would be 1/8/09, 1/9/09, and 1/10/09, as shown below.

<table>
<thead>
<tr>
<th></th>
<th>1/8/09</th>
<th>1/9/09</th>
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<tbody>
<tr>
<td>A.</td>
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<td>C.</td>
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The following scenarios meet the definition above:
- **Scenario A**: The FIM® items are rated in a 24-hour period that begins on 1/8/09 and ends on 1/9/09.
- **Scenario B**: The FIM® items are rated in a 24-hour period that begins and ends on 1/9/09.
- **Scenario C**: The FIM® items are rated in a 24-hour period that begins on 1/9/09 and ends on 1/10/09.
All FIM® items (with an exception for Bladder Management and Bowel Management, as listed below) must be rated within the same 24-hour period. Rate the lowest level of function for each item. Rating the lowest level of function provides a way to measure the amount of assistance (i.e., the burden of care) the patient requires from another person to carry out activities of daily living.

**Exception:** The bladder and bowel function modifiers and associated FIM® items must be rated according to previously established look-back periods rather than within a 24-hour period within the discharge assessment time frame. At discharge, item 29, Bladder Level of Assistance, and item 31, Bowel Level of Assistance, have a look-back period of 3 days—the day of discharge and the 2 calendar days immediately prior to discharge. Item 30, Bladder Frequency of Accidents, and item 32, Bowel Frequency of Accidents, have a look-back period of 7 days—the day of discharge and the 6 calendar days immediately prior to discharge.

For example, the assessment time frame for a patient discharged on 1/10/09 would be 1/8/09, 1/9/09, and 1/10/09. The 7-day look-back period for item 30, Bladder Frequency of Accidents, and item 32, Bowel Frequency of Accidents, would be 1/4/09, 1/5/09, 1/6/09, 1/7/09, 1/8/09, 1/9/09, and 1/10/09.

<table>
<thead>
<tr>
<th>1/4/09</th>
<th>1/5/09</th>
<th>1/6/09</th>
<th>1/7/09</th>
<th>1/8/09</th>
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<tbody>
<tr>
<td>Bladder Level of Assistance and Bowel Level of Assistance</td>
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<tr>
<td>Bladder Frequency of Accidents and Bowel Frequency of Accidents</td>
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**Note:** Comorbid conditions recognized or diagnosed on the day of discharge or on the day prior to the day of discharge may not be entered in item 24. Therefore, if the 24-hour time period chosen to determine the rating of most of the function modifiers and the associated elements of the FIM® items encompasses the day of discharge or the day prior to the day of discharge, the comorbidities that are first recognized or diagnosed during such a 24-hour time period cannot be record in item 24.

- At admission, most FIM® items use an assessment time period of 3 calendar days. Two function modifiers—item 30, Bladder Frequency of Accidents, and item 32, Bowel Frequency of Accidents—require a 7-day assessment time period. The admission assessment for bladder and bowel accidents would include the 4 calendar days prior to the rehabilitation admission and the first 3 calendar days in the rehabilitation facility.

**Note:** If information about bladder and bowel accidents prior to the rehabilitation admission is unavailable, record ratings for items 30 and 32 that are based upon the number of accidents since the rehabilitation admission.

- FIM® ratings and function modifier ratings should reflect the patient’s actual performance—not what the patient should be able to do, not a simulation of an activity, and not what the patient is expected to do in a different environment (e.g., home).
• If differences in function occur in different environments or at different times of the day, record the lowest (most dependent) rating. In such cases, the patient usually has not mastered the function across a 24-hour period, is too tired, or is not motivated enough to perform the activity out of the therapy setting. Team members may need to discuss this issue to determine the most dependent level.

**Note:** The patient’s rating on measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, a patient who can routinely ambulate more than 150 feet throughout the day with supervision (a rating of 5 for Locomotion: Walk, Wheelchair), but who ambulates only 20 feet at night to use the toilet because the bed is 20 feet from the toilet, should receive a Walk rating of 5 rather than a lower rating.

• FIM® ratings and function modifier ratings should be based on the best available information. Although direct observation of the patient’s performance is preferred, credible reports of performance may be gathered from the medical record, the patient, other staff members, family, and friends. The medical record may also provide additional information about bladder and bowel accidents and inappropriate behaviors.

• Record a function modifier rating for either item 33, Tub Transfer, or item 34, Shower Transfer, but not both. Leave the other transfer item blank.

**Note:** For these function modifiers, the mode at admission does not have to match the mode at discharge.

• Record the FIM® rating that best describes the patient’s level of function for every FIM® item (items 39A through 39R). No FIM® item should be left blank.

• The assessment form features functional rating boxes next to each FIM® item. Some FIM® items have an additional box next to the item’s functional rating box. This box should be used to indicate the more frequent mode used by the patient for that item. Place the appropriate letter in each box:
  • Item 39L, Locomotion: Walk, Wheelchair: W for walk, C for wheelchair, or B for both
  • Item 39N, Comprehension: A for auditory, V for visual, or B for both
  • Item 39O, Expression: V for vocal, N for nonvocal, or B for both

**Note:** For item 39N, Comprehension, and item 39O, Expression, the mode at admission does not have to match the mode at discharge.

• The mode of locomotion for item 39L, Locomotion: Walk, Wheelchair, must be the same on admission and discharge. Some patients may change modes from admission to discharge, usually wheelchair to walking. In such cases, you should 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, rate item 39L using the Walk ratings from item 37 for both admission and discharge.

• If the patient requires assistance from two helpers to perform the tasks described in an item, rate the patient level 1, Total Assistance, for that item.
A code of 0 may be used for some FIM® items and some function modifiers to indicate that an activity does not occur at any time during the assessment period. A code of 0 means that the patient does not perform the activity and that a helper does not perform the activity for the patient at any time during the assessment period.

Use of this code should be rare for most items, and justification for the use of 0 should be documented in the medical record. Possible reasons why the patient does not perform the activity include the following:

- The patient does not attempt the activity because the clinician determines that it is unsafe for the patient to perform the activity (e.g., going up and down stairs for a patient with lower extremity paralysis).
- The patient cannot perform the activity because of a medical condition or medical treatment (e.g., walking for a patient who is unable to bear weight on lower extremities).
- The patient refuses to perform an activity (e.g., the patient refuses to dress in clothing other than a hospital gown or refuses to be dressed by a helper).

For certain FIM® items, a code of 0 may be used on admission but not at discharge. (See the chart that appears at the end of this section.) However, code 0 may not be used for Bladder Management (items 29, 30, and 39G), Bowel Management (items 31, 32, and 39H), or the cognitive items (items 39N, 39O, 39P, 39Q, and 39R) at either admission or discharge.

If a FIM® activity does not occur at the time of discharge, rate the patient level 1, Total Assistance, for that item.

Prior to recording a code of 0, the clinician completing the assessment must consult with other clinicians, the patient’s medical record, the patient, and the patient’s family members to determine whether the patient performed (or was observed performing) the activity. Do not use code 0 to indicate that the clinician did not observe the patient performing the activity; use the code only when the activity did not occur.

Patients who receive assistance from a helper may never be rated level 6 or level 7. For example, a patient who needs frequent reminders would be level 5 for cueing/prompting needs.

- Level 5 indicates setup or supervision, cueing, or coaxing. It does not involve touching unless such touching is part of setup (e.g., applying a prosthesis or orthosis).
- If a patient functions well with basic daily information but needs cues or prompting from a helper for complex/abstract information (less than 10 percent of the time), rate the patient level 5.
- If a patient requires steadying, touching, minimal, incidental, or contact guard assistance while performing motor items, rate the patient level 4.
- If a patient needs help with lifting one limb only—such as lifting a leg onto a bed while performing a transfer—rate the patient level 4 for Transfers: Bed, Chair, Wheelchair.
- If a patient requires lifting assistance (i.e., more than just one limb), rate the patient level 3 or lower. The actual rating will depend on the amount of lifting assistance required.
- If a patient needs help with lifting two limbs—such as lifting both legs into a tub—rate the patient level 3 for Transfers: Tub, Shower.
• If a patient performs just more than half of a task, rate the patient level 3 for that task. For example, if a helper asks a patient to repeat information “just less than half of the time,” indicating that the patient performs without repetition just over half the time, rate the patient level 3 for Expression.

• If a patient performs less than half of a task (i.e., the patient puts forth less than 50 percent of the effort), rate the patient level 2.

• If a patient is totally dependent for care, performs less than 25 percent of an activity, or requires two or more helpers, rate the patient level 1.
## Can I Use Code 0, Activity Does Not Occur?

<table>
<thead>
<tr>
<th>Function Modifier</th>
<th>Admission Assessment</th>
<th>Discharge Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 29, Bladder Level of Assistance</td>
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</tr>
<tr>
<td>Item 30, Bladder Frequency of Accidents</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Item 31, Bowel Level of Assistance</td>
<td>No</td>
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</tr>
<tr>
<td>Item 32, Bowel Frequency of Accidents</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Item 33, Tub Transfer</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Item 34, Shower Transfer</td>
<td>No</td>
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</tr>
<tr>
<td>Item 35, Distance Walked</td>
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<tr>
<td>Item 36, Distance Traveled in Wheelchair</td>
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<td>Yes</td>
</tr>
<tr>
<td>Item 37, Walk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Item 38, Wheelchair</td>
<td>Yes</td>
<td>Yes</td>
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</table>

<table>
<thead>
<tr>
<th>FIM® Item</th>
<th>Admission Assessment</th>
<th>Discharge Assessment</th>
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<tbody>
<tr>
<td>Item 39A, Eating</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Item 39B, Grooming</td>
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</tr>
<tr>
<td>Item 39C, Bathing</td>
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</tr>
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<td>Item 39D, Dressing – Upper Body</td>
<td>Yes</td>
<td>No</td>
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<td>Item 39E, Dressing – Lower Body</td>
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<td>Item 39F, Toileting</td>
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<td>Item 39G, Bladder Management</td>
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<td>Item 39H, Bowel Management</td>
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<td>Item 39I, Transfers: Bed, Chair, Wheelchair</td>
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<td>Item 39J, Transfers: Toilet</td>
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</tr>
<tr>
<td>Item 39K, Transfers: Tub, Shower</td>
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<tr>
<td>Item 39L, Locomotion: Walk, Wheelchair</td>
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</tr>
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<td>Item 39M, Locomotion: Stairs</td>
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</tr>
<tr>
<td>Item 39N, Comprehension</td>
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<tr>
<td>Item 39O, Expression</td>
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<tr>
<td>Item 39P, Social Interaction</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Item 39Q, Problem Solving</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Item 39R, Memory</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Eating

Eating includes the ability to use suitable utensils to bring food to the mouth, as well as the ability to chew and swallow the food once the meal is presented in the customary manner on a table or tray. The patient performs this activity safely.

Assistance may be required with any of the following elements:

- Picking up a utensil
- Scooping food
- Bringing hand to mouth
- Chewing and swallowing
- Drinking from a cup or glass

Assistive devices include universal cuffs, adaptive utensils, and dentures (if the patient must have them to eat). Setup may include cutting food, opening containers, or applying an orthosis.

If the patient eats by mouth without assistance (level 7) but also requires tube feedings (i.e., nasogastric or gastrostomy tube), the FIM® rating will range from level 6, Modified Independence, to level 1, Total Assistance, depending on the patient’s level of participation:

- If the patient performs the tube feedings independently, rate the patient level 6, Modified Independence.
- If the patient requires only cueing to complete the tube feeding, rate the patient level 5, Supervision/Setup.
- If the patient requires a helper to administer the feeding entirely, rate the patient level 1, Total Assistance.

A patient may eat some of his food by mouth without help (level 7) and also via tube feedings administered by a helper (level 1). Assign the lower rating—in this case, level 1, Total Assistance—to reflect the patient’s dependence on a helper to administer the tube feedings. Likewise, if a patient eats just a few bites of food by mouth and receives the bulk of his nutrition through a feeding tube provided by a helper, rate the patient level 1, Total Assistance.

The following helpful hints should help you complete the Eating rating:

- If a patient receives IV fluids for hydration or nutrition, and a helper administers the IV, rate the patient level 1, Total Assistance.
- If a patient has a gastrostomy tube, and a helper flushes it with water for hydration, rate the patient level 1, Total Assistance.
- If a patient has a gastrostomy tube but is not relying upon it for hydration or nutrition, and a helper flushes the tube to maintain patency only, this is not rated for Eating, and you should rate the patient as if the gastrostomy tube was not required.
- If the patient requires dentures, rate the patient level 6, Modified Independence.
- If a helper inserts the dentures for the patient, rate the patient level 5, Supervision/Setup.
Grooming

Grooming includes oral care, hair grooming (brushing or combing hair), washing the hands (including rinsing and drying), washing the face (including rinsing and drying), and either shaving the face or applying make-up. If a patient neither shaves nor applies make-up, then this item includes only the first four tasks. The patient performs the activity safely. This item includes obtaining articles necessary for grooming.

Grooming does not include such tasks as shampooing hair, caring for nails, flossing teeth, or applying deodorant. Setup includes gathering articles necessary for grooming.

Do not include help to get to the sink or to get into and out of the bathroom.

If a patient uses equipment but does not receive any assistance from a helper, rate the patient level 6, Modified Independence.

If a patient requires only prior preparation (e.g., placing soap, opening a denture packet, or placing grooming equipment within reach) or supervision (including cueing, coaxing, instructions, or encouragement), rate the patient level 5, Supervision/Setup.

If a patient requires physical assistance with grooming, determine the percent of grooming effort by assessing the patient’s need for assistance with the following grooming tasks:

- Oral care (brushing teeth or cleaning dentures)
- Grooming hair (combing or brushing hair)
- Washing, rinsing, and drying hands
- Washing, rinsing, and drying the face
- Shaving the face or applying make-up

Each of the tasks listed above represents approximately 20 percent of grooming tasks. If a patient requires more than supervision or setup assistance (level 5), calculate a “percentage of grooming tasks” based on the number of grooming tasks the patient completes.

Note that shaving the face and applying make-up should be disregarded for those who do not perform these tasks. If neither task is applicable, then the rating for this item will be based on the other four activities (oral care, hair grooming, washing the hands, and washing the face). In this case, each grooming task is equivalent to approximately 25 percent of grooming tasks.

If a patient sits in a wheelchair and performs grooming tasks at a sink, do not consider the wheelchair an assistive device for this item.
Bathing

**Bathing** includes washing, rinsing, and drying the body. Do **not** include the back, neck, face, hands, or hair.

Do **not** include help required to get into the bathroom/shower area or to get into and out of the tub or shower. This assistance will be rated under the item Transfers: Tub, Shower.

If a patient uses equipment (e.g. wash mitt) but does not receive any assistance from a helper, rate the patient level 6, Modified Independence.

If a patient requires only prior preparation (e.g., placing bathing equipment within reach, checking the water temperature) or supervision (including cueing, coxing, instructions, or encouragement), rate the patient level 5, Supervision/Setup.

If a patient requires **physical assistance** with washing, rinsing, and drying, determine the number of areas the patient bathes:

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 foot)
10. Right lower leg (including foot)

Each bathing area represents approximately 10 percent of the total bathing tasks. If a patient requires more than supervision or setup assistance (level 5), calculate a “percentage of bathing tasks” based on the number of areas the patient bathes without help. For example, if a patient washes, rinses, and dries the chest, left arm, left upper leg, and abdomen, then the patient bathes four areas, or approximately 40 percent of the body. This patient should be rated level 2, Maximal Assistance, for Bathing.

If a patient has had one or more amputations, do not count activities that involve the affected limbs. If a patient has a below-the-knee amputation, for example, rate this item based on the remaining nine areas of the body.
**Dressing – Upper Body**

*Dressing – Upper Body* includes dressing and undressing as well as applying and removing a prosthesis or orthosis (if applicable).

If a patient uses equipment (e.g., reacher, button hook) but does not receive any assistance from a helper, rate the patient level 6, Modified Independence.

**Note:** Do not consider the patient’s use of an assistive device, such as a cane or walker, to get to and from the closet when rating this item. Use of such assistive devices will be assessed under the item Locomotion: Walk, Wheelchair.

Abdominal binders and thoracic-lumbar-sacral orthoses (TLSO) are considered orthoses. The application of an orthosis or prosthesis will affect the FIM® rating. If a patient applies a prosthesis or orthosis but does not use it as an assistive device for dressing, rate the patient level 7, Complete Independence.

If a patient applies an orthosis or prosthesis and uses it as an assistive device to complete dressing the upper body, rate the patient level 6, Modified Independence.

If a patient requires a helper to apply a prosthesis or orthosis (i.e., for setup) and then completes dressing the upper body, rate the patient level 5, Supervision/Setup.

If a patient requires only prior preparation (e.g., getting clothes out of the closet, putting clothes away, applying a prosthesis or orthosis) or supervision (including cueing, coaxing, instructions, or encouragement), rate the patient level 5, Supervision/Setup.

To determine the percent of dressing effort (level 4 or lower), many clinicians find it helpful to determine the Dressing – Upper Body rating by first identifying the steps involved in dressing the upper body. For example, putting on a T-shirt includes four major steps:

1. Thread the right sleeve.
2. Thread the left sleeve.
3. Pull the head through the shirt neckline.
4. Pull the shirt over the trunk.

A patient who performs three of the four steps is performing approximately 75 percent of the upper body dressing tasks and should be rated level 4, Minimal Assistance.

If a patient wears more than one piece of clothing on the upper body, the rating for this item should reflect all upper body dressing tasks. For example, putting on a bra and sweatshirt includes seven major steps. Putting on the bra would include three major steps (depending on the type of bra and how the patient puts on the bra):

1. Thread the right bra strap.
2. Thread the left bra strap.
3. Hook the bra.

Putting on the sweatshirt would include four major steps:

1. Thread the right sleeve.
2. Thread the left sleeve.
3. Pull the head through the shirt neckline.
4. Pull the shirt over the trunk.

A patient who performs four of the seven steps is performing just over half of the upper body dressing tasks and should be rated level 3, Moderate Assistance.

Note: If a patient holds on to a walker while retrieving clothes from a closet, rate the patient level 6, Modified Independence. If a helper steadies the patient during the reach into the closet, rate the patient level 4, Minimal Assistance.
Dressing – Lower Body

Dressing – Lower Body includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable.

If a patient uses equipment (e.g., reacher, long-handed shoehorn) but does not receive any assistance from a helper, rate the patient level 6, Modified Independence.

Note: Do not consider the patient’s use of an assistive device, such as a cane or walker, to get to and from the closet when rating this item. Use of such assistive devices will be assessed under the item Locomotion: Walk, Wheelchair.

If a patient applies a prosthesis or orthosis but does not use it as an assistive device for dressing, rate the patient level 7, Complete Independence.

If a patient applies a prosthesis or orthosis and uses it as an assistive device to complete lower body dressing, rate the patient level 6, Modified Independence.

If a helper applies the patient’s prosthesis or orthosis, after which the patient completes dressing the lower body independently, rate the patient level 5, Supervision/Setup.

If a patient requires only prior preparation (e.g., getting clothes out of the closet, putting clothes away, applying a prosthesis or orthosis) or supervision (including cueing, coaxing, instructions or encouragement), rate the patient level 5, Supervision/Setup.

Antiembolic stockings are considered an orthosis. If a helper applies the stockings, rate the patient level 5, Supervision/Setup.

If a helper provides minimal or incidental assistance while the patient dresses or undresses the lower body—for example, buttoning pants, zipping a zipper, fastening a belt, tying shoelaces, applying one sock, or applying one shoe—rate the patient level 4, Minimal Assistance.

If a patient puts on pants and underwear and requires assistance to put on shoes and socks, then the patient is performing 50 percent of the dressing activity for the lower body and requires assistance from a helper. Rate the patient level 3, Moderate Assistance.

If a patient requires a helper to complete more than half of the effort to dress or undress the lower body, rate the patient level 2, Maximal Assistance. For example, if a helper puts on a patient’s underwear, pants, and socks, after which the patient slips on shoes, then the helper is performing the majority of the activity, and the patient is performing less than half of the effort.

If a patient performs less than 25 percent of the activity—for example, only rolling from side to side or “bridging” as a helper completes dressing the lower body—rate the patient level 1, Total Assistance.

Note: If a patient holds on to a walker while retrieving clothes from a closet, rate the patient level 6, Modified Independence. If a helper steadies the patient during the reach into the closet, rate the patient level 4, Minimal Assistance.
Toileting

**Toileting** includes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal. It does not include assistance provided to get onto or off of the toilet. **Toileting is based on continent episodes of bladder and bowel management only.** If a patient is incontinent of bladder and bowel, then Toileting cannot be rated during the episode. You must wait for the patient to have a continent episode before rating this item.

Exception: If the patient is incontinent of every bowel and bladder episode during the 3-day assessment period, rate the patient level 1, Total Assistance.

If a patient uses equipment (e.g., grab bars for steadying) but does not receive any assistance from a helper, rate the patient level 6, Modified Independence.

If a patient requires only prior preparation or supervision—including cueing, coaxing, instructions, or encouragement—rate the patient level 5, Supervision/Setup.

If the patient requires **physical assistance**, rate the patient based on the **need for assistance** with the following three tasks:

1. Adjusting clothing prior to use of a toilet or bedpan
2. Cleansing the perineal area
3. Adjusting clothing after use of a toilet or bedpan

If a patient needs only **steadying assistance** during one or more toileting tasks, rate the patient level 4, Minimal Contact Assistance. If a patient needs only **incidental assistance**, such as pulling up one side of the patient’s sweatpants, rate the patient level 4, Minimal Contact Assistance.

Each toileting task represents about one-third (33 percent) of Toileting. If a patient requires more than supervision or setup assistance (level 5), calculate a “percentage of toileting tasks” based on the number of toileting tasks the patient completes on his own. For example, if a patient pulls his pants down, requires assistance from a helper to perform perineal care, and then pulls his pants up, the patient performs two of the three steps (66 percent) and should be rated level 3, Moderate Assistance.

If a patient requires different levels of toileting assistance for voiding and bowel movement, record the lower rating.

If a patient has a Foley catheter and does not have a bowel movement (and toileting subsequently does not occur), use code 0, Activity Does Not Occur.
**Bladder Management**

**Bladder Management** includes the intentional control of the urinary bladder and equipment or medication used for control. Assess and record a FIM® rating based on the patient’s need for assistance associated with bladder management and the frequency of accidents. Record the lower rating for Bladder Management.

**Note:** Bladder Management does not include getting to and from the bathroom or transferring onto and off a toilet.

If a patient voids independently, but a helper performs intermittent straight catheterizations for the patient, rate the patient level 1, Total Assistance.

Consider each voiding and catheterization as separate episodes of bladder management. If the levels of assistance for bladder episodes are different, record the lowest rating.

If a patient has one accident (level 5 for Frequency of Accidents) but requires a helper to change linen or clothing (level 1 for Level of Assistance), record the lower rating (level 1 in this example).

Medications used for bladder management are agents. If the patient uses such medications, rate the patient level 6, Modified Independence.

Rate the Level of Assistance and Frequency of Accidents function modifiers separately. Use the lower rating when assigning a rating for Bladder Management.

If a patient is on hemodialysis or peritoneal dialysis, has no accidents or does not void, and does not use equipment, rate the patient level 7, Complete Independence, for Bladder Management.

Scanning the bladder is a medical procedure and should not be considered when rating this item.

**Bladder Level of Assistance (3-day look-back period)**

If a patient uses equipment or medication but does not receive any assistance from a helper, rate the patient level 6, Modified Independence, for Level of Assistance.

If a patient uses a urinal and empties it himself, rate the patient level 6, Modified Independence.

If a patient uses an absorbent pad and applies it without assistance from a helper, rate the patient level 6, Modified Independence.

If a helper places any equipment (e.g., urinal, bedpan) within reach of a patient or empties any equipment (e.g., bucket from a bedside commode), rate the patient level 5, Supervision/Setup, for Bladder Level of Assistance. If a helper positions a urinal or bedpan, rate the patient level 4, Minimal Assistance. If a helper positions and holds a urinal or bedpan, removes it, and empties it, rate the patient level 2, Maximal Assistance.

If a patient is independent with bladder management during part of the day but requires supervision or setup during another part of the day, record the lower rating—in this case, level 5, Supervision/Setup.

If a patient has bladder accidents (i.e., wetting of linen or clothing with urine), and a helper changes linen or clothing, rate the patient level 1, Total Assistance.

If a patient uses an absorbent pad, and a helper must apply or change it, rate the patient level 1, Total Assistance.
Bladder Frequency of Accidents (7-day look-back period)

At level 7, the patient does not have any accidents.

At level 6, the patient does not have any accidents but uses an assistive device (e.g., urinal, bedpan, absorbent pad, commode, or medication) for control.

At level 5, the patient has had 1 accident in the past 7 days.

At level 4, the patient has had 2 accidents in the past 7 days.

At level 3, the patient has had 3 accidents in the past 7 days.

At level 2, the patient has had 4 accidents in the past 7 days.

At level 1, the patient has had 5 or more accidents in the past 7 days.

If a patient uses an absorbent pad, and the urine is contained within the pad, no accident has occurred.

If a patient uses equipment or medication for bladder management but has no accidents, rate the patient level 6, Modified Independence.
Bowel Management

Bowel Management includes complete and intentional control of bowel movements and use of any necessary equipment or agents for bowel control. Assess the patient’s need for assistance associated with bowel management and the frequency of accidents. Record the lower FIM® rating for Bowel Management.

Note: Bowel Management does not include getting to and from the bathroom or transferring onto and off a toilet.

Bowel Level of Assistance (3-day look-back period)

If a patient is on a bowel program and using suppositories, the patient’s rating may range from level 6, Modified Independence, to level 1, Total Assistance.

Medications used for bowel management are agents. If the patient uses such medications, rate the patient level 6, Modified Independence. Natural laxatives (e.g., prune juice, herbal teas) used for bowel management are not agents.

At level 6, the patient manages his own bowel program. This includes inserting his own suppository and performing his own preparation and cleanup.

At level 5, a helper provides assistance with either prior preparation or cleanup, or a helper provides cueing, coaxing, or instructions.

At level 4, a helper inserts a suppository but does not provide any digital stimulation. (The patient’s body performs this work on its own.)

At level 1, the patient does not participate in his bowel program—a helper provides all the effort. If the patient has an accident, a helper is required to change linen or clothing. If a helper changes the absorbent pad or performs digital stimulation, rate the patient level 1, Total Assistance.

If a helper administers an enema to the patient, rate the patient level 1, Total Assistance.

Bowel Frequency of Accidents (7-day look-back period)

At level 7, the patient does not have any accidents.

At level 6, the patient does not have accidents but uses an assistive device (e.g., bedside commode, ostomy, or medications) for control.

At level 5, the patient has had 1 accident in the past 7 days.

At level 4, the patient has had 2 accidents in the past 7 days.

At level 3, the patient has had 3 accidents in the past 7 days.

At level 2, the patient has had 4 accidents in the past 7 days.

At level 1, the patient has had 5 or more accidents in the past 7 days.
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, starting and ending in a supine position. This item includes bed mobility.

If a patient uses a wheelchair, rate the patient level 7, Complete Independence, if the patient manages all wheelchair parts without help and does not use the arm rests during the transfer.

Bed rails and walkers are considered assistive devices for this item if a patient requires them to complete transfers.

At level 6, the patient requires raising of the head of the bed to help with transferring from a supine to a sitting position but does not require a helper.

At level 5, the patient requires setup, cueing, coaxing, or supervision.

At level 4, the patient requires touching, steadying, or contact guard assistance or requires a helper to lift only one leg onto or off the bed.

At level 3, the patient requires lifting for part of the transfer (either to bring the patient to a standing position or to help lower the patient), or a helper lifts both of the patient’s legs onto or off of the bed.

At level 2, the patient requires assistance for both lifting (to come to a standing position) and lowering (to come to a sitting position).

At level 1, a helper performs all tasks, the patient utilizes a mechanical lift, or the patient requires more than one helper.

If transfers into and out of bed require different levels of assistance, record the lower rating (i.e., the rating that reflects the higher burden of care).

Rate this item based on the patient’s overall functional performance. Do not try to assign levels for each component (bed mobility, supine to sit, etc.).
Transfers: Toilet

Transfers: Toilet includes safely getting on and off a standard toilet.

The FIM® rating must incorporate the patient’s approach to the toilet once the patient is in the bathroom. For example, if a patient walks and requires touching assistance to step to the toilet once in the bathroom, but the patient can then sit and stand with supervision, rate the patient level 4, Minimal Assistance. If a patient approaches from a wheelchair, the patient, once in the bathroom, must be capable of operating and positioning the wheelchair next to the toilet (i.e., parking, locking brakes, lifting foot rests and arm rests if possible) as part of the toilet transfer. For example, if a patient enters a bathroom, positions the wheelchair next to a toilet, removes the foot rest, and then transfers onto and off the toilet, rate the patient level 7, Complete Independence.

Assistive devices include sliding boards, grab bars, wheelchair armrests, raised toilet seats, and bedside commodes.

At level 5, the patient requires setup, cueing, coaxing, or supervision.

At level 4, the patient requires touching, steadying, or contact guard assistance.

At level 3, the patient requires lifting for part of the transfer, either to bring the patient to a standing position or to help lower the patient.

At level 2, the patient requires assistance for both lifting (to come to a standing position) and lowering (to come to a sitting position).

At level 1, a helper performs all tasks, the patient utilizes a mechanical lift, or the patient requires more than one helper.
**Transfers: Tub, Shower**

*Transfers: Tub, Shower* includes getting into and out of a tub or shower. The patient performs the activity safely.

This item must be rated “wet.” Simulations of the activity are *not* allowed. Thus, the patient must be fully undressed and wet for this item to be rated correctly.

The rating for this item must incorporate the patient’s approach to the tub or shower once the patient is in the bathroom.

For this item, assistive devices include sliding boards, grab bars, tub benches, and shower chairs.

At level 5, the patient requires setup, cueing, coaxing, or supervision.

At level 4, the patient requires touching, steadying, or contact guard assistance. If the patient requires lifting of one leg only, rate the patient level 4.

At level 3, the patient requires lifting for part of the transfer, either to bring the patient to a standing position or to help lower the patient. If a helper lifts both legs for the patient, rate the patient level 3.

At level 2, the patient requires assistance for both lifting (to come to a standing position) and lowering (to come to a sitting position).

At level 1, a helper performs all tasks, the patient utilizes a mechanical lift, or the patient requires more than one helper. At level 1, the patient transfers from a bed to a shower chair on wheels in the bedroom, after which a helper pushes the chair into a walk-in shower.
Locomotion: Walk, Wheelchair

**Locomotion: Walk** includes walking on a level surface once a patient is in a standing position. The patient performs the activity safely.

**Locomotion: Wheelchair** includes using a wheelchair on a level surface once a patient is in a seated position. The patient performs the activity safely.

Record walk and wheelchair ratings on both admission and discharge. The admission and discharge ratings must be based on the **same mode of locomotion**. In other words, if a patient is expected to walk at the time of discharge, then the patient’s ability to walk is recorded at the time of admission. This allows a facility to document the progress of the patient’s walking skills between admission and discharge. If a patient is expected to travel in a wheelchair at the time of discharge, then wheelchair skills should be documented at the time of admission. Both modes should be documented on the function modifiers. The corresponding mode anticipated for discharge is then recorded in item 39L.

This item has two associated function modifiers: one for the distance traveled and another that accounts for the level of assistance or device needed. When rating item 37, Walk, and item 38, Wheelchair, you **must** take into account the distances traveled by the patient, which are recorded in item 35, Distance Walked, and item 36, Distance Traveled in Wheelchair.

**Example:** A patient ambulates 140 feet with minimal assistance from a helper. The patient should be rated level 2 (50–149 feet) for item 35, Distance Walked, and also rated level 2 for item 37, Walk.

If a patient ambulates 150 feet without a device (i.e., independently) and does so in a safe and timely manner, rate the patient level 7, Complete Independence.

If a patient uses a wheelchair, the highest possible rating is level 6, Modified Independence, provided that the patient can use the wheelchair on both a 3 percent grade and multiple surfaces.

If a patient travels 150 feet or more and uses a device (e.g., wheelchair, walker, cane, adapted shoe, AFO, or prosthesis) for mobility, rate the patient level 6, Modified Independence.

If a patient travels 150 feet but requires verbal cues or supervision, rate the patient level 5, Supervision/Setup.

Level 5 contains a “household exception” for a patient who is independently mobile (i.e., mobile without a helper) for 50 feet, with or without an assistive device.

If a patient travels 50–149 feet with one helper, rate the patient level 2.

If a patient travels less than 50 feet or requires two helpers, rate the patient level 1, Total Assistance.

Remember that the mode of locomotion (walk or wheelchair) **must** match on both admission and discharge.

If a patient uses a wheelchair on admission to get to and from therapy or to travel around the rehab unit, you **cannot** use code 0 for item 36, Distance Traveled in Wheelchair, or item 38, Wheelchair. Rate these function modifiers even if you expect the patient to walk on discharge.

The rating for this item must be based on the patient’s performance without rest periods or breaks.
Locomotion: Stairs

Locomotion: Stairs includes going up and down 12 to 14 stairs (one flight) indoors in a safe manner. When rating this item, focus on two aspects:

1. Number of stairs
2. Level of assistance and the use of devices

If a patient manages to go up and down 12 to 14 stairs independently, rate the patient level 7, Complete Independence.

If a patient manages to go up and down 12 to 14 stairs without a helper but uses an assistive device (e.g., handrails, cane, AFO), rate the patient level 6, Modified Independence.

Level 5 includes a “household exception” for patients at home who go up and down 4 to 6 stairs independently (i.e., without a helper), with or without an assistive device.

If a patient manages 4 to 11 stairs with assistance, rate the patient level 2 or lower.

If a patient manages 3 or fewer stairs with assistance from a helper or requires more than one helper, rate the patient level 1, Total Assistance.

If a patient manages 12 to 14 stairs but requires the use of a handrail, rate the patient level 6, Modified Independence.
**Comprehension**

**Comprehension** includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures).

Determine whether a patient better comprehends auditory or visual means and whether an assistive device is required (rather than preferred). Glasses are considered an assistive device for a patient who relies on vision to comprehend. Most patients rely primarily on hearing for auditory comprehension, so a hearing aid should be considered an assistive device in this regard. The rating for this item should reflect the amount of time, over a 24-hour period, that a patient understands auditory or visual communication.

Generally, most patients have one primary mode of comprehension, although it is possible to select “both” when coding this item.

If a patient understands complex and abstract information but uses an assistive device (e.g., hearing aid), rate the patient level 6, Modified Independence. An interpreter is not considered an assistive device.

If a patient understands complex or abstract information but requires prompting (e.g., repetition) less than 10 percent of the time to understand the message, rate the patient level 5, Standby Prompting.

If a patient understands only basic information, rate the patient level 5, Standby Prompting, or lower.

If a patient understands only commonly used expressions, single words, or gestures, then a helper will likely provide a great deal of assistance to the patient. Rate the patient level 2, Maximal Prompting.

Rate this item across all environments (e.g., patient care unit, therapy gym).

Rate this item based on the patient’s usual language. Note that this might not be English.

**Note:** The modes at admission and discharge do not have to match.

The cognitive items should be rated with input from all team members. Do not rely solely on evaluations from a specific discipline.

When rating cognitive items, you must rate the patient’s performance over a 24-hour period. Do not simply use the lowest rating. Thus, you should have one rating for each day when you assign ratings for cognitive items.

**Example:** You rate the patient level 4 for the first day, level 5 for the second day, and level 5 for the third day. Assign the lowest rating—level 4, Minimal Assistance—to the patient on the IRF-PAI.
Expression

Expression includes clear vocal or non-vocal expression of language. This item includes either intelligible speech or clear expression of language using writing or a communication device.

Determine whether a patient uses primarily vocal or nonvocal means of expression. The rating for this item should reflect the amount of time, over a 24-hour period, that a patient can express himself through vocal or nonvocal language.

If a patient expresses complex and abstract information clearly and intelligibly, rate the patient level 7, Complete Independence.

If a patient expresses complex and abstract information with some difficulty but self-corrects as needed, rate the patient level 6, Modified Independence.

If a patient expresses complex and abstract information but uses an assistive device (e.g., communication board) to do so, rate the patient level 6, Modified Independence. An interpreter is not considered an assistive device.

If a patient expresses complex or abstract information but requires prompting from a helper less than 10 percent of the time to express a message, rate the patient level 5, Standby Prompting.

If a patient expresses only basic information, rate the patient level 5, Standby Prompting, or lower.

If a patient expresses only single words or simple gestures, then a helper is likely to provide a great deal of assistance to help the patient. Rate the patient level 2, Maximal Prompting.

Rate this item across all environments (e.g., patient care unit, therapy gym).

Rate this item based on the patient’s usual language. Note that this might not be English.

**Note:** The modes of expression at admission and discharge do not have to match.

The cognitive items should be rated with input from all team members. Do not rely solely on evaluations from a specific discipline.

When rating cognitive items, you must rate the patient’s performance over a 24-hour period. Do not simply use the lowest rating. Thus, you should have one rating for each day when you assign ratings for cognitive items.

**Example:** You rate the patient level 4 for the first day, level 5 for the second day, and level 5 for the third day. Assign the lowest rating—level 4, Minimal Assistance—to the patient on the IRF-PAI.
Social Interaction

Social Interaction includes skills related to getting along with others and participating with them in therapeutic and social situations. It represents how a patient deals with his own needs together with the needs of others.

When rating this item, answer three questions:

1. Is the patient cooperating?
2. Is the patient participating?
3. Is the patient exhibiting any inappropriate behaviors?

The rating for this item should reflect the amount of time, over a 24-hour period, that a patient interacts appropriately. Thus, each day of the admission assessment period should have only one rating.

Medications treated as agents include antidepressants and anti-anxiety medications. You must ascertain why the patient is on the medication, however. If a patient requires medication of this type for social interaction (i.e., to govern mood or behavior), rate the patient level 6, Modified Independence.

If a patient uses physical or chemical restraints to prevent (or in response to) socially inappropriate behavior, rate the patient level 2 or lower.

If a patient requires one-to-one supervision, rate the patient level 1, Total Assistance.

Examples of inappropriate behavior include the following:

- Use of foul language
- Temper tantrums or outbursts
- Inappropriate laughing or crying

The cognitive items should be rated with input from all team members. Do not rely solely on evaluations from a specific discipline.

When rating cognitive items, you must rate the patient’s performance over a 24-hour period. Do not simply use the lowest rating. Thus, you should have one rating for each day when you assign ratings for cognitive items.

**Example:** You rate the patient level 4 for the first day, level 5 for the second day, and level 5 for the third day. Assign the lowest rating—level 4, Minimal Assistance—to the patient on the IRF-PAI.
Problem Solving

Problem Solving includes skills related to solving problems of daily living. This involves 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.

Problem Solving includes five important steps:

1. Recognizing that a problem is present
2. Making appropriate decisions
3. Initiating steps and readjusting to changing circumstances
4. Carrying out a sequence of steps
5. Evaluating the solution

The rating for this item should reflect the amount of time, over a 24-hour time period, that a patient requires redirection. Thus, each day of the admission assessment period should have only one rating.

If a patient takes more than a reasonable time to solve problems, rate the patient level 6, Modified Independence.

If a patient requires cueing only in unfamiliar environments, rate the patient level 5, Supervision.

If a patient can neither recognize basic problems nor make appropriate decisions, rate the patient level 1, Total Assistance.

The cognitive items should be rated with input from all team members. Do not rely solely on evaluations from a specific discipline.

When rating cognitive items, you must rate the patient’s performance over a 24-hour period. Do not simply use the lowest rating. Thus, you should have one rating for each day when you assign ratings for cognitive items.

Example: You rate the patient level 4 for the first day, level 5 for the second day, and level 5 for the third day. Assign the lowest rating—level 4, Minimal Assistance—to the patient on the IRF-PAI.
Memory

Memory includes skills related to recognizing and remembering during the performance of daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information, particularly verbal and visual information. The functional evidence of memory includes 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.

Memory has three key components:
1. Recognizing people frequently encountered
2. Remembering daily routines
3. Executing requests without reminders

The rating for this item should reflect the amount of time, over a 24-hour period, that a patient requires prompting for skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Thus, each day of the admission assessment period should have only one rating.

For this item, a memory book, log book, or cue cards are considered assistive devices. If a patient uses such a device without cueing or additional reminders, rate the patient level 6, Modified Independence. If a helper reminds or cues the patient to use such a device, rate the patient level 5, Supervision.

For commands and tasks, follow these guidelines:
- At level 7, the patient recalls three of three tasks.
- At level 6, the patient recalls three of three tasks with mild difficulty, self-corrects when needed, or uses an assistive device.
- At level 5, the patient recalls three of three tasks but requires cues 10 percent of the time.
- At level 4, the patient recalls two of three tasks.
- At level 3, the patient recalls two of two tasks.
- At level 2, the patient recalls one of two tasks.
- At level 1, the patient recalls one or none of two tasks and requires constant cues.

The cognitive items should be rated with input from all team members. Do not rely solely on evaluations from a specific discipline.

When rating cognitive items, you must rate the patient’s performance over a 24-hour period. Do not simply use the lowest rating. Thus, you should have one rating for each day when you assign ratings for cognitive items.

Example: You rate the patient level 4 for the first day, level 5 for the second day, and level 5 for the third day. Assign the lowest rating—level 4, Minimal Assistance—to the patient on the IRF-PAI.