Overview for Use of Code 0 - Activity Does Not Occur for FIM Instrument and Function Modifier Items on the IRF-PAI

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*If activity does not occur at discharge, code FIM items using "1"

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DESCRIPTION OF THE LEVELS OF FUNCTION AND THEIR SCORES

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

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

6 Modified Independence—One or more of the following may be true: the activity requires an assistive device or aid, the activity takes more than reasonable time, or the activity involves safety (risk) considerations.

DEPENDENT - Patient requires another person for either supervision or physical assistance in order to perform the activity, or it is not performed (REQUIRES HELPER).

Modified Dependence: The patient expends half (50%) or more of the effort. The levels of assistance required are defined below.

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

4 Minimal Contact 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 expends between 50 and 74% of the effort.

Complete Dependence: The patient expends less than half (less than 50%) of the effort. Maximal or total assistance is required. The levels of assistance required are defined below.

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

1 Total Assistance—The patient expends less than 25% of the effort.

0 Activity Does Not Occur — The patient does not perform the activity, and a helper does not perform the activity for the patient during the entire assessment time frame. NOTE: Do not use this code only because you did not observe the patient perform the activity. In such cases, consult other clinicians, the patient’s medical record, the patient, and the patient’s family members to discover whether others observed the patient perform the activity.
INSTRUCTIONS FOR THE USE OF THE FIM™ DECISION TREES

General Description of FIM Instrument Levels of Function and Their Scores

To use the FIM™ Decision Tree, begin in the upper left hand corner. Answer the questions and follow the branches to the correct score. You will notice that behaviors and scores above the line indicate that NO HELPER is needed, while behaviors and scores below the bottom line indicate that a HELPER is needed. If an activity does not occur for self-care, transfer or locomotion items on admission, enter code "0" on admission.

Start

Does Patient need help?

No

No Helper

Yes

Helper

Does Patient need more than reasonable time or a device or is there a concern for safety?

No

Complete Independence

Score 7

Yes

Score 6

Modified Independence

Score 5

Does Patient do half or more of the effort?

Yes

Supervision or Setup

Score 4

No

Score 3

Moderate Assistance

Does Patient need only incidental assistance?

Yes

No

Score 2

Maximal Assistance

Total Assistance

Does Patient need setup or supervision, cuing or coaxing only?

No

No

Yes

Yes

Yes

No

SCORE 1

SCORE 2

SCORE 3

SCORE 4

TOTAL ASSISTANCE

MAXIMAL ASSISTANCE

MODERATE ASSISTANCE

MINIMAL ASSISTANCE

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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.

NO HELPER

7 Complete Independence—The patient eats from a dish while managing a variety of food consistencies, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The subject opens containers, butters bread, cuts meat, pours liquids, and uses a spoon or fork to bring food to the mouth, where it is chewed and swallowed. The patient performs this activity safely.

6 Modified Independence—Performance of the activity involves safety considerations, or the patient requires an adaptive or assistive device such as a long straw, spork, or rocking knife; requires more than a reasonable time to eat; or requires modified food consistency or blenderized food. If the patient relies on other means of alimentation, such as parenteral or gastrostomy feedings, then (s)he self-administers the feedings.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cueing, or coaching) or setup (application of orthoses or assistive/adaptive devices), or another person is required to open containers, butter bread, cut meat, or pour liquids.

4 Minimal Contact Assistance—The patient performs 75% or more of eating tasks.

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

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

1 Total Assistance—The patient performs less than 25% of eating tasks, or the patient relies on parenteral or gastrostomy feedings (either wholly or partially) and does not self-administer the feedings.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not eat and does not receive any parenteral/enteral nutrition during the entire assessment time frame. Use of this code should be rare.
EATING

Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is presented in the customary manner on a table or tray. At level 7 the patient eats from a dish while managing all consistencies of food, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The patient uses suitable utensils to bring food to the mouth, food is chewed and swallowed. Performs independently and safely. If activity does not occur, code "0" on admission and "4" on discharge.

Start

Does Patient need help when eating meals or administering parenteral or enteral nutrition?

No

Does Patient need an assistive device to eat or does she take more than reasonable time to eat or is there a concern for safety or does she require modified food consistency or does she administer tube feedings independently?

No

SCORE 7
COMPLETE INDEPENDENCE

Yes

SCORE 6
MODIFIED INDEPENDENCE

No Helper

Yes

Helper

Does Patient perform half or more of eating tasks?

Yes

SCORE 5
SUPERVISION OR SETUP

No

Does Patient require total assistance to eat such as the helper holding the utensil and bringing all food and liquids to the mouth or does she need total assistance with tube feedings?

No

SCORE 1
TOTAL ASSISTANCE

Yes

SCORE 2
MAXIMUM ASSISTANCE

Does Patient need only incidental help such as placement of utensils in her/his hand or occasional help to scoop food onto the fork or spoon?

No

SCORE 3
MODERATE ASSISTANCE

Yes

SCORE 4
MINIMAL CONTACT ASSISTANCE

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

NO HELPER

7 Complete Independence—The patient cleans teeth or dentures, combs or brushes hair, washes the hands*, washes the face*, and either shaves the face or applies make-up, including all preparations. The patient performs this activity safely.

6 Modified Independence—The patient requires specialized equipment (including prosthesis or orthosis) to perform grooming activities, or takes more than a reasonable time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cueing, or coaxing) or setup (application of orthoses or adapted/assistive devices, setting out grooming equipment, or initial preparation such as applying toothpaste to toothbrush or opening make-up containers).

4 Minimal Contact Assistance—The patient performs 75% or more of grooming tasks.

3 Moderate Assistance—The patient performs 50% to 74% of grooming tasks.

2 Maximal Assistance—The patient performs 25% to 49% of grooming tasks.

1 Total Assistance—The patient performs less than 25% of grooming tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform any grooming activities (oral care, hair grooming, washing the hands, washing the face, and either shaving the face or applying make-up), and is not groomed by a helper during the entire assessment time frame. Use of this code should be rare.

COMMENT: Assess only the activities listed in the definition. Grooming does not include flossing teeth, shampooing hair, applying deodorant, or shaving legs. If the subject is bald or chooses not to shave or apply make-up, do not assess those activities.

*including rinsing and drying.
GROOMING

Grooming includes oral care, hair grooming (combing and brushing hair), washing the hands and washing the face, and either shaving the face or applying make-up. If the patient neither shaves nor applies makeup, Grooming includes only the first four tasks. At level 7 the patient cleans his/her teeth or dentures, combs or brushes his/her hair, washes his/her hands and face, and may shave or apply make-up, including all preparations. Performs independently and safely. If activity does not occur, score "0" on admission and "1" on discharge.
BATHING: *Bathing* includes washing, rinsing, and drying the body from the neck down (excluding the neck and back) in either 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 (including prosthesis or orthosis) to bathe, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or 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 Contact 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—The patient performs less than 25% of bathing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not bathe self, and is not bathed by a helper. Use of this code should be rare.

When scoring this item, consider the body as divided up into ten areas or parts. Evaluate how the patient bathes each of the ten areas or parts, with each accounting for 10% of the total:

- chest
- left arm
- right arm
- abdomen
- perineal area
- buttocks
- left upper leg
- right upper leg
- left lower leg, including foot
- right lower leg, including foot
BATHING

Bathing includes bathing (washing, rinsing and drying) the body from the neck down (excluding the back); may be either tub, shower or sponge/bed bath. At level 7 the patient bathes (washes, rinses and dries) the body, excluding the back. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.
DRESSING - UPPER BODY: Dressing – Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses self. 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, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for upper body dressing) when applicable. The patient performs this activity safely.

6 Modified Independence—The patient requires special adaptive closure such as a Velcro® Fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or 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 Contact 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—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. The subject who wears only a hospital gown would be coded “0 – Activity Does Not Occur.” Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

COMMENT: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission assessment time period the IRF’s staff must make every attempt to obtain from any source clothing for the patient.
For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.
DRESSING - UPPER BODY

Dressing Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. Note: this item may include assessment of one to several activities, depending on whether the patient chooses to wear one piece of clothing (a sweater for example) or several pieces of clothing (a bra, blouse and sweater). At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closets; manages bra, pullover garment; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.

![Dressing Upper Body Flowchart]

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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. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses safely. This includes obtaining clothes from their customary places (such as drawers and closets), and may also include managing underpants, slacks, skirt, belt, stockings, shoes, zippers, buttons, and snaps, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for lower body dressing) when applicable.

6 Modified Independence—The patient requires a special adaptive closure such as a Velcro® fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or 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 Contact 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—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. For example, the patient who wears only a hospital gown and/or underpants and/or footwear would be coded “0 – Activity Does Not Occur” for this item. Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

COMMENT: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission assessment time period the
IRF's staff must make every attempt to obtain from any source clothing for the patient. For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.
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. Note: this item typically includes assessment of applying and removing several pieces of clothing. At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closet; manages underpants, slacks or skirt, socks, shoes; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur code "0" on admission and "1" on discharge.
TOILETING: Toileting includes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient safely cleanses self after voiding and bowel movements, and safely adjusts clothing before and after using toilet, bedpan, commode or urinal.

6 Modified Independence—The patient requires specialized equipment (including orthosis or prosthesis) during toileting, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cueing, or coaxing) or setup (application of adaptive devices or opening packages).

4 Minimal Contact 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.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform any of the toileting tasks (perineal cleansing, clothing adjustment before and after toilet use), and a helper does not perform any of these activities for the subject. Use of this code should be rare.
TOILETING

Toileting includes maintaining perineal hygiene and adjusting clothing before and after using toilet or bedpan. If level of assistance for care differs between voiding and bowel movements, record the lower score. At level 7 the patient cleanses self after voiding and bowel movements; adjusts clothing before and after using toilet or bedpan. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.
BLADDER MANAGEMENT - Level of Assistance: Bladder Management - Level of Assistance includes the safe use of equipment or agents for bladder management. (Note: Use these definitions to score the Function Modifier, Item 29; refer to the comment below to score Item 39G).

NO HELPER

7 Complete Independence—The patient controls bladder completely and intentionally without equipment or devices, and is never incontinent (no accidents).

6 Modified Independence—The patient requires a urinal, bedpan, catheter, bedside commode, absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. If catheter is used, the patient cleans, sterilizes, and sets up the equipment for irrigation without assistance. If the individual uses a device, he assembles and applies an external catheter with drainage bags or an ileal appliance without assistance of another person; the patient also empties, puts on, removes, and cleans leg bag, or empties and cleans ileal appliance bag.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cueing, or coaxing) or setup (placing or emptying) of equipment to maintain either a satisfactory voiding pattern or an external device in the past 3 days.

4 Minimal Contact Assistance—The patient requires minimal contact assistance to maintain an external device, and performs 75% or more of bladder management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain an external device, and performs 50% to 74% of bladder management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bladder management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bladder management tasks in the past 3 days.

Do not use code “0” for Bladder Management - Level of Assistance.

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 individuals. This item deals with the level of assistance required to complete bladder management tasks. If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence (see Appendix H, Frequently Asked Questions, for explanation).

A separate Function Modifier, Bladder Management—Frequency of Accidents (Item 30), deals with the success of the bladder management program.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).
BLADDER MANAGEMENT - LEVEL OF ASSISTANCE

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the patient controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Bladder Management, with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the lower score on the FIM™ instrument. Do not use code "0" for Bladder Management.

- **Start**
  - Does Patient need help with bladder management?
  - No → SCORE 7
  - Yes → No → SCORE 6
  - Yes → Helper
  - Does Patient perform half or more of the bladder management tasks?
  - No → SCORE 1
  - Yes → Does Patient need only supervision, cuing, coaxing or help to set out bladder management equipment?
    - No → SCORE 2
    - Yes → Does Patient need only incidental help such as placement of equipment in his/her hand or help to perform just one of the several tasks included in bladder management?
      - No → SCORE 3
      - Yes → SCORE 4
BLADDER MANAGEMENT - Frequency of Accidents: Bladder Management: Frequency of Accidents includes complete intentional control of urinary bladder and, if necessary, use of equipment or agents for bladder control. (Note: Use these definitions to score the Function Modifier, Item 30, refer to the comment below to score Item 39G).

Definition of Bladder Accidents – Bladder accidents refers to the act of wetting linen or clothing with urine, and includes bedpan and urinal spills.

NO HELPER

7  No Accidents—The patient controls bladder completely and intentionally, and does not have any accidents.

6  No Accidents; uses device such as catheter—The patient requires a urinal, bedpan, catheter, bedside commode, absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. The patient has no accidents.

HELPER

5  One (1) bladder accident, including bedpan and urinal spills, in the past 7 days.

4  Two (2) accidents, including bedpan and urinal spills, in the past 7 days.

3  Three (3) accidents, including bedpan and urinal spills, in the past 7 days.

2  Four (4) accidents, including bedpan and urinal spills, in the past 7 days.

1  Five (5) or more accidents, including bedpan and urinal spills, in the past 7 days.

Do not use code “0” for Bladder Management – Frequency of Accidents.

If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence (see Appendix H for explanation).

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 item deals with the frequency of accidents required to complete bladder management tasks.

A separate Function Modifier, Bladder Management—Level of Assistance (Item 29), deals with assistance with bladder management.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).
**BLADDER MANAGEMENT - PART 2 FREQUENCY OF ACCIDENTS**

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the subject controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the lower score on the FIM™ instrument. Do not use code "0" for Bladder Management.

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![Flowchart Diagram](image_url)

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BOWEL MANAGEMENT - Level of Assistance: Bowel Management - Level of Assistance includes use of equipment or agents for bowel management. (Note: Use these definitions to score the Function Modifier, Item 31; refer to the comment below to score Item 39H).

NO HELPER

7 Complete Independence—The patient controls bowels completely and intentionally without equipment or devices, and does not have any bowel accidents.

6 Modified Independence—The patient requires a bedpan, bedside commode, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. If the individual has a colostomy, (s)he maintains it.

HELPER

5 Supervision or Setup—The patient has required supervision (e.g., standing by, cueing, or coaching) or setup of equipment necessary for the individual to maintain either a satisfactory excretory pattern or an ostomy device at any time during the past 3 days.

4 Minimal Contact Assistance—Patient requires minimal contact assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. Patient performs 75% or more of bowel management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. The patient performs 50 to 74% of bowel management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bowel management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bowel management tasks in the past 3 days.

Do not use code “0” for Bowel Management – Level of Assistance.

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 individuals. This item deals with the level of assistance required to complete bowel management tasks.

A separate Function Modifier, Bowel Management—Frequency of Accidents (Item 32), deals with frequency of bowel accidents.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).
**BOWEL MANAGEMENT - LEVEL OF ASSISTANCE**

Bowel Management includes complete and intentional control of bowel movements and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowel completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two variables, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the lower score on the FIM™ Instrument. Do not use code "0" for Bowel Management.

---

**Diagram:**
- **Start**
  - **Does Patient need help with bowel management?**
    - **No**: **SCORE 7** COMPLETE INDEPENDENCE
    - **Yes**: **Does Patient need an assistive device for bowel management (such as a colostomy, bedpan or absorbent pad), or does she usually use medication for bowel control?**
      - **No**: **SCORE 6** MODIFIED INDEPENDENCE
      - **Yes**: **SCORE 5** SUPERVISION OR SETUP

  - **Helper**
    - **Does Patient perform half or more of the bowel management tasks?**
      - **Yes**: **SCORE 2** MAXIMUM ASSISTANCE
      - **No**: **Does Patient require total assistance for bowel management with a helper doing basically all of the handling of equipment?**
        - **Yes**: **SCORE 1** TOTAL ASSISTANCE
        - **No**: **Does Patient need only incidental help such as placement of equipment in his/her hand or help to perform just one of the several tasks included in bowel management?**
          - **No**: **SCORE 4** MINIMAL CONTACT ASSISTANCE
          - **Yes**: **SCORE 3** MODERATE ASSISTANCE

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BOWEL MANAGEMENT - Frequency of Accidents: Bowel Management - Frequency of Accidents includes complete intentional control of bowel movements and (if necessary) use of equipment/agents for bowel control. (Note: Use these definitions to score the Function Modifier, Item 32; refer to the comment below to score Item 39H).

Definition of Bowel Accidents - Bowel accidents refer to the act of soiling linen or clothing with stool, and includes bedpan spills.

NO HELPER

7 No Accidents—The patient controls bowels completely and intentionally without equipment or devices, and is never incontinent (no accidents).

6 No Accidents; uses device such as ostomy—The patient requires a bedpan, bedside commode, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. The patient has no accidents.

HELPER

5 One (1) accident in the past 7 days.

4 Two (2) accidents in the past 7 days.

3 Three (3) accidents in the past 7 days.

2 Four (4) accidents in the past 7 days.

1 Five (5) or more accidents in the past 7 days.

Do not use code "0" for Bowel Management – Frequency of Accidents.

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 item deals with the frequency of accidents required to complete bowel management tasks.

A separate Function Modifier, Bowel Management—Level of Assistance (Item 31), deals with level of assistance associated with bowel management.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).
Bowel Management - Frequency of Accidents

Bowel Management includes complete and intentional control of the bowels and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowels completely and intentionally and has no accidents. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the lower score on the FIM™ instrument. Do not use code "0" for Bowel Management.

Start

Has the patient had bowel accidents in the past 7 days?

No Helper

- No

Does the patient need an assistive device for bowel management (such as an ostomy bag) or does s/he usually use medication for control?

- No

SCORE 7

COMPLETE INDEPENDENCE

- Yes

SCORE 6

MODIFIED INDEPENDENCE

Helper

How many accidents has the patient had in the past 7 days?

1 accident

SCORE 5

1 Accident

2 accidents

SCORE 4

2 Accidents

3 accidents

SCORE 3

3 Accidents

4 accidents

SCORE 2

4 Accidents

5 or more accidents

SCORE 1

5 or More Accidents

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

If in a wheelchair, patient approaches a bed or chair, locks brakes, lifts foot rests, removes arm rest if necessary, and 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, a lift, grab bars, or a special seat/Chair/brace/crutches; or the activity takes more than a reasonable amount of time; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

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

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer to or from the bed or a chair, and is not transferred to or from the bed or a chair by a helper or lifting device. Use of this code should be rare.

COMMENT: During the bed-to-chair transfer, the subject begins and ends in the supine position.
TRANSFERS: BED, CHAIR, WHEELCHAIR

Transfers: Bed, Chair, Wheelchair includes all aspects of transferring from bed to a chair, or wheelchair, or coming to a standing position, if walking is the typical mode of locomotion. At level 7 the subject approaches, sits down on and gets up to a standing position from a regular chair; transfers from bed to chair. Performs independently and safely. If in a wheelchair, 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. Performs independently and safely. If activity does not occur, code "O" on admission and "1" on discharge.

![Flowchart](chart.png)
TRANSFERS: TOILET: Transfers: Toilet includes safely getting on and off a standard toilet.

NO HELPER

7  Complete Independence

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

If in a wheelchair, patient approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, and does 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 such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

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

4  Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3  Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2  Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1  Total Assistance—The patient performs less than 25% of transferring tasks.

0  Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer on or off the toilet/commode, and is not transferred on or off the toilet/commode by a helper or lifting device. For example, the patient uses only a bedpan and/or urinal. Use of this code should be rare.
TRANSFERS: TOILET

Transfers: Toilet includes getting on and off a toilet. At level 7 the subject approaches, sits down on and gets up from a standard toilet. Performs independently and safely. **If in a wheelchair,** approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "4" on discharge.

---

**Diagram Description:**
- **Start**
- **Does Patient need help getting on and off the toilet?**
  - **No**
  - **Score 7**
    - Complete Independence
  - **Yes**
    - **No**
      - **Score 6**
        - Modified Independence
    - **Yes**
      - **Helper**
        - **Does Patient perform half or more of the transferring tasks?**
          - **Yes**
            - **Score 5**
              - Supervision or Setup
          - **No**
            - **Does Patient require total assistance for toilet transfers such as the helper doing basically all the lifting?**
              - **Yes**
                - **Score 1**
                  - Total Assistance
              - **No**
                - **Score 2**
                  - Maximum Assistance
              - **Does Patient need only incidental help such as contact guarding or steadying during toilet transfers?**
                - **Yes**
                  - **Score 3**
                    - Moderate Assistance
                - **No**
                  - **Score 4**
                    - Minimal Contact Assistance

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TRANSFERS: TUB: Transfers: Tub includes getting into and out of a tub. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 33; refer to the comment below to score Item 39K).

NO HELPER

7 Complete Independence

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

If in a wheelchair, the patient approaches a tub, locks brakes, lifts foot rests, removes arm rests if necessary, and does 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 orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPER

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

4 Minimal Contact Assistance—The patient requires no more help than touching, and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Transfers: Tub (Item 33) as “0,” and leave Transfers: Shower (Item 34) blank. Code “0” may be used for Transfers: Tub on admission and discharge.

COMMENT: There is a separate Function Modifier that addresses transfers into a shower stall. Code only Tub (Item 33) or Shower Transfers (Item 34) but not both. That is, if a score is recorded in Item 33, leave Item 34 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).
TRANSFERS: TUB

Transfers: Tub includes getting into and out of a tub. At level 7 the subject approaches, gets in and out of a tub. Performs independently and safely. If in a wheelchair, approaches 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. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge. COMMENT: There is a separate function modifier that addresses transfers into a shower stall. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the score for the more frequent type of transfer.
TRANSFERS: SHOWER: Transfers: Shower includes getting into and out of a shower. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 34; refer to the comment below to score Item 39K).

NO HELPER

7 Complete Independence

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

*If in a wheelchair,* the patient approaches a shower stall, locks brakes, lifts foot rests, removes arm rests if necessary, and does 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 orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPERS

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient requires more help than touching or performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Tub Transfer (Item 33) as "0," and leave Shower Transfer (Item 34) blank. Do not use code "0" for Shower Transfer.

COMMENT: There is a separate Function Modifier that addresses transfers into a tub. Code only Tub (Item 33) or Shower Transfers (Item 34) but not both. That is, if a score is recorded in Item 34, leave Item 33 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).
**TRANSFERS: SHOWER**

Transfers: Shower includes getting into and out of a shower stall. At level 7 the subject approaches, gets in and out of a shower stall. Performs independently and safely. If in a wheelchair, approaches shower, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. Do not use code "0" for Transfers: Shower. **COMMENT:** There is a separate function modifier that addresses transfers into a tub. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the score for the more frequent type of transfer.

---

**Diagram Description**

1. **Start**
   - **Does Patient need help getting into and out of the shower?**
     - **No** → **SCORE 6** (MODIFIED INDEPENDENCE)
     - **Yes** → **Helper**

2. **Helper**
   - **No** → **SCORE 1** (TOTAL ASSISTANCE)
   - **Yes** →
     - **Does Patient perform half or more of the transferring tasks?**
       - **No** → **SCORE 2** (MAXIMUM ASSISTANCE)
       - **Yes** →
         - **Does Patient need an assistive device for shower transfers (such as a grab bar or special seat), or does she take more than reasonable time or is there a concern for safety when she performs transfers?**
           - **No** → **SCORE 7** (COMPLETE INDEPENDENCE)
           - **Yes** → **SCORE 5** (SUPERVISION OR SETUP)
     - **Does Patient require total assistance for shower transfers such as the helper doing basically all the lifting?**
       - **Yes** → **SCORE 3** (MODERATE ASSISTANCE)
       - **No** → **SCORE 4** (MINIMAL CONTACT ASSISTANCE)

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III - 40
LOCOMOTION: WALK: Locomotion: Walk includes walking on a level surface once in a standing position. The patient performs the activity safely. This is the first of two locomotion function modifiers.

NO HELPER

7 Complete Independence—The patient walks a minimum of 150 feet (50 meters) without assistive devices. The patient performs the activity safely.

6 Modified Independence—The patient walks a minimum of 150 feet (50 meters), but uses a brace (orthosis) or prosthesis on leg, special adaptive shoes, cane, crutches, or walkerette; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

5 Exception (Household Locomotion)—The patient walks only short distances (a minimum of 50 feet or 15 meters) independently with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision—The patient requires standby supervision, cueing, or coaxing to go a minimum of 150 feet (50 meters).

4 Minimal Contact Assistance—The patient performs 75% or more of walking effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of walking effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of walking effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or walks to less than 50 feet (15 meters).

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not walk. For example, use 0 if the patient uses only a wheelchair for locomotion or the patient is on bed rest.

COMMENT: If the patient requires an assistive device for locomotion (prosthesis, walker, cane, AFO, adapted shoe, etc.), then the Locomotion: Walk score can never be higher than level 6.

There are two locomotion function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument item 39L, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the more frequent mode of locomotion at discharge on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code “Both.”
**LOCOMOTION: WALK**

Walk includes walking, once in a standing position, on a level surface. At level 7 the patient walks a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used about equally, code “Both.”

Start

- **Does Patient need help to walk 150 feet (50 m)?**
  - Yes → **Does Patient need an assistive device (such as an orthosis, prosthesis, crutches, or walker) to go 150 feet (50 m), or does s/he take more than reasonable time or is there a concern for safety?**
    - Yes → **SCORE 5** (Exception) Household Ambulation
    - No → **SCORE 6** MODIFIED INDEPENDENCE
  - No → **SCORE 7** COMPLETE INDEPENDENCE

**No Helper**

- **Does Patient go at least 50 feet (15 m) without help (with or without a device)?**
  - Yes → **SCORE 5** (Exception) Household Ambulation
  - No

**Helper**

- **Does Patient walk a minimum of 150 feet (50 m) with the assistance of only one helper?**
  - Yes → **SCORE 5**
  - No

- **Does Patient walk less than 50 feet (15 m) or is the assistance of two persons required for ambulation?**
  - Yes → **SCORE 1** TOTAL ASSISTANCE
  - No → **SCORE 2** MAXIMUM ASSISTANCE

- **Does Patient need only supervision, cueing or coaxing to walk a minimum of 150 feet (50 m)?**
  - Yes → **SCORE 5**
  - No

- **Does Patient need only incidental help such as contact guarding or steadying to walk 150 feet (50 m)?**
  - Yes → **SCORE 4** MINIMAL CONTACT ASSISTANCE
  - No → **SCORE 3** MODERATE ASSISTANCE
LOCOMOTION: WHEELCHAIR: Locomotion: Wheelchair includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. This is the second function modifier.

NO HELPER

7 This score is not to be used if the patient uses a wheelchair for Locomotion.

6 Modified Independence—The patient operates a manual or motorized wheelchair independently for a minimum of 150 feet (50 meters); turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3 percent grade; and maneuvers on rugs and over door sills.

5 Exception (Household Locomotion)—The patient operates a manual or motorized wheelchair independently only short distances (a minimum of 50 feet or 15 meters).

HELPER

5 Supervision—The patient requires standby supervision, cueing, or coaxing to go a minimum of 150 feet (50 meters) in a wheelchair.

4 Minimal Contact Assistance—The patient performs 75% or more of locomotion effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of locomotion effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of locomotion effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or wheels less than 50 feet (15 meters).

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not use a wheelchair, and is not pushed in a wheelchair by a helper.

COMMENT: There are two Locomotion function modifiers (Items 37 and 38). Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the more frequent mode of locomotion at discharge on the FIM™ instrument. Indicate the more frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code “Both.” If both are used about equally at discharge, use the score for Walk (Item 37) to complete both the admission and discharge portions of Item 39L.
LOCOMOTION: WHEELCHAIR

Wheelchair includes, once in a seated position, on a level surface. At level 6 the subject wheels a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the most frequent mode of locomotion at discharge on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used equally, code "Both." If activity does not occur, code "0" on admission and "1" on discharge.

Start

Does Patient need help to go 150 feet (50 m) in a wheelchair?

Yes →

No Helper

No →

Yes →

Does Patient go at least 50 feet (17 m) without help?

No →

Yes →

SCORE 6

MODIFIED INDEPENDENCE

(Except) Household Locomotion

Helper

Does Patient go a minimum of 150 feet (50 m) in a wheelchair with the assistance of only one helper?

Yes →

SCORE 5

SUPERVISION

No →

Does Patient wheel less than 50 feet (17 m) or is the assistance of two persons required?

Yes →

SCORE 1

TOTAL ASSISTANCE

No →

SCORE 2

MAXIMUM ASSISTANCE

Does Patient need only supervision, cuing or coaxing to go a minimum of 150 feet (50 m) while in a wheelchair?

Yes →

SCORE 3

MODERATE ASSISTANCE

No →

SCORE 4

MINIMAL CONTACT ASSISTANCE

Does Patient need only incidental help such as around corners or over thresholds?

Yes →

No →
LOCOMOTION: STAIRS: \textit{Locomotion: Stairs} includes going up and down 12 to 14 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; or 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 4 to 6 stairs \textit{independently}, with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

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 Contact 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 4 to 6 stairs, and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25\% of the effort, or requires the assistance of two people, or goes up and down fewer than 4 stairs.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The subject does not go up or down stairs, and a helper does not carry the subject up or down stairs.
LOCOMOTION: STAIRS

Stairs includes going up and down 12 to 14 stairs (one flight). At level 7 the patient goes up and down one flight of stairs without any type of handrail or support. Performs independently and safely. If activity does not occur code "0" on admission and "4" on discharge.

Diagram:

Start

Does patient need help to go up and down 12 to 14 stairs?

Yes → No

Does patient require an assistive device (such as handrails or cane) to go up and down one flight of stairs or does she take more than reasonable time or is there a concern for safety?

Yes → No

Score 7

Complete Independence

Score 6

Modified Independence

Exception (Household Ambulation)

No Helper

No → Yes

Score 5

No Helper

Helper

No → Yes

Score 5

Supervision

Does patient go up and down a minimum of 12 to 14 stairs with the assistance of only one helper?

Yes → No

Does patient need only supervision, cueing or coaching help to go a minimum of 12 to 14 stairs?

Yes → No

Score 3

Moderate Assistance

Score 4

Minimum Assistance

No → Yes

Score 1

Total Assistance

Score 2

Maximum Assistance
COMPREHENSION: Comprehension includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). Evaluate and indicate the more usual mode of comprehension (“Auditory” or “Visual”). If both are used about equally, code “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 readily or with only mild difficulty complex or abstract directions and conversation. The patient does not require prompting, though (s)he may require a hearing or visual aid, other 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 (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. Understands only simple, commonly used spoken expressions (e.g., hello, how are you) or gestures (e.g., waving good-bye, thank you). Requires prompting more than half the time.

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

Do not use code “0” for Comprehension.

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

Comprehension includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). At level 7 the subject understands directions and conversation that are complex or abstract; understands either spoken or written language, not necessarily English. Evaluate and indicate the more usual mode of comprehension ("Auditory" or "Visual"). If both are used about equally, code "Both." Do not use Code "0" for 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 indicate the more usual mode of expression (“Vocal” or “Nonvocal”). If both are used about equally, code “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 (s)he 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. 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 (s)he needs 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.

Do not use code “0” for Expression.

COMMENT: Examples of complex or abstract ideas include (but are not limited to) discussing current events, religion, or relationships with others. Expression of basic needs and ideas refers to the patient’s ability to communicate about necessary daily activities such as nutrition, fluids, elimination, hygiene, and sleep (physiological needs).
**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. At level 7 the subject expresses complex or abstract ideas clearly and fluently. Evaluate and indicate the more usual mode of expression ("Vocal" or "Nonvocal"). If both are used about equally, code "Both". Code "0" is not available for Expression.

![Expression Flowchart]

- **Start**
  - Does Patient need help expressing complex and abstract ideas, such as family matters, current events or household finances?
    - No → SCORE 7
    - Yes → Helper
  - Helper
    - Does Patient express basic needs or ideas (such as hunger, thirst or discomfort) half or more of the time?
      - No → SCORE 4
      - Yes → Does Patient need help to express basic needs only rarely (less than 10% of the time)?
        - Yes → SCORE 6
        - No → Does Patient need help to express basic needs and ideas only occasionally (less than 25% of the time)?
          - Yes → SCORE 3
          - No → Yes
    - Is the Patient basically unable to express or does s/he express inappropriately or inconsistently despite prompting?
      - Yes → SCORE 1
      - No → SCORE 2

**SCORE 1**
TOTAL ASSISTANCE

**SCORE 2**
MAXIMUM PROMPTING

**SCORE 3**
MODERATE PROMPTING

**SCORE 4**
MINIMAL PROMPTING

**SCORE 5**
STANDBY PROMPTING

**SCORE 6**
MODIFIED INDEPENDENCE

**SCORE 7**
COMPLETE INDEPENDENCE
**SOCIAL INTERACTION:** *Social Interaction* includes skills related to getting along 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 may require medication for control.

**HELPER**

5 Supervision—The patient requires supervision (e.g., monitoring, verbal control, cueing, or coaching) only under stressful or unfamiliar conditions, but 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, or not at all, and may need restraint due to socially inappropriate behaviors.

Do not use code “0” for Social Interaction

**COMMENT:** Examples of socially inappropriate behaviors include temper tantrums; loud, foul, or abusive language; excessive laughing or crying; physical attack; or very withdrawn or non-interactive behavior.
SOCIAL INTERACTION

Social interaction includes skills related to getting along 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. At level 7 the subject 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.) Subject does not require medication for control. Code "0" is not available for 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 the initiation, sequencing, and self-correcting of 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, initiates and carries out a sequence of steps to solve complex problems, or requires more than a reasonable time to make appropriate decisions or solve complex problems.

HELPER

5 Supervision—The patient requires supervision (e.g., cueing or coaxing) to solve less routine problems only under stressful or unfamiliar conditions, but no more 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 does not effectively solve problems, and may require constant one-to-one direction to complete simple daily activities. The patient may need a restraint for safety.

Do not use code “0” for Problem Solving.

COMMENT: Examples of complex problem-solving includes activities such as managing a checking account, participating in discharge plans, self-administering medications, confronting interpersonal problems, and making employment decisions. Routine problem-solving includes successfully completing daily tasks or dealing with unplanned events or hazards that occur during daily activities. More specific examples of routine problems include asking for assistance appropriately during 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.
**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, and initiating, sequencing, and self-correcting tasks and activities to solve problems. At level 7 the subject consistently recognizes if there is a problem, 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. Code *0* is not available for Problem Solving.
MEMORY: Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context 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 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 Supervision—The patient requires prompting (e.g., cueing, repetition, reminders) only under stressful or unfamiliar conditions, but no more 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 does not effectively recognize and remember.

Do not use code “0” for Memory.
MEMORY

Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context 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. At level 7 the subject recognizes people frequently encountered, remembers daily routines, and executes requests of others without need for repetition. Code "0" is not available for Memory.

[Diagram of a decision tree for memory assessment]
1 This method of scoring the Walk/Wheelchair item is in accordance with section 412.6.10 "Assessment schedule" of the Final Rule (pages 41389-41930) that allows exceptions to the general rules for the admission and discharge assessments to be specified in this manual.