	Regulatory Compliance Policy	No. COMP-RCC 4.12
	Title: INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF – PAI)	Page: 1 of 5
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Inpatient Rehabilitation Facility – Patient Assessment Instrument

I. SCOPE:

This policy applies to Tenet, its consolidated subsidiaries, and all hospitals and other healthcare operations owned or operated by Tenet’s consolidated subsidiaries (Tenet) that provide Acute Inpatient Rehabilitation Facility services.

II. PURPOSE:


To utilize a comprehensive reliable system for collecting standardized patient assessment data to conform to Centers for Medicare and Medicaid Services (CMS) Regulations.

III. POLICY:

- A.** All patients admitted to a Tenet Inpatient Rehabilitation Facility (IRF) or unit will have a comprehensive, standardized, and reproducible Patient Assessment Instrument (PAI) completed at admission and discharge by an IRF trained clinician. This is required for all admissions in order to track facility compliance of 75% rule through eRehabdata. A facility must utilize the IRF-PAI for assessment of all patients for the purpose of clinical care, program evaluation, or benchmarking.
- B.** All patients must be informed of the Patient Rights and Privacy Act Notice associated with the PAI prior to the initiation of the assessment.

IV. PROCEDURE:

- A. The following steps must be performed to ensure support of payment and quality objectives:**
 - 1. Patient Rights and Privacy Act Notice:
All patients admitted to the Inpatient Rehabilitation Facility (IRF) will be informed of their rights and privacy prior to an assessment being initiated. This process does not replace the need to notify patients of their rights under Health Insurance Portability and Accountability Act (HIPPA).
 - 2. PAI Completion
It is the responsibility of the Case Mix Coordinator or a clinician trained in how to perform a patient assessment using the IRF-PAI, including collection of, recording, and transmitting the patient assessment instrument data to ensure the following:

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- a) The accuracy and thoroughness of the specific data recorded on the PAI
- b) The accuracy of the assessment reference date inserted on the PAI

3. Sources of Information:

- a) Physician orders
- b) Physician progress notes
- c) Nursing notes
- d) Therapy notes
- e) Diagnostic tests and their results
- f) Other associated information such as social worker or case management notes
- g) Clinical record from Acute Care, Skilled Nursing Facility, or home health record
- h) Patient
- i) Patient’s family
- j) Someone personally knowledgeable about the patient’s clinical condition or capabilities.


The assessment process must include direct patient observation and communication with the patient, and when appropriate and to the extent feasible, patient data from the patient’s physician(s), family, someone personally knowledgeable about the patient’s clinical condition or capabilities, the patient’s clinical record and other sources.

A patient’s clinical status for a given time period must be verifiable and consistent with the clinical information independently or separately recorded in the patient’s medical record.

- 4. ICD-9 codes will be coded by HIM coder.

B. Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) Completion

The Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) must be completed for all patients. The IRF-PAI form is available at <http://www.cms.hhs.gov/providers/irfpps/irfpaiform.pdf>.

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C. Assessment Schedule

1. Admission Patient Assessment Instrument


The first day that the Medicare Part A inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility stay is counted as day-one of the patient assessment schedule.

- a) Days 1 through 3 – **Observation**
 - (i) The admission assessment time period is calendar days 1 through 3 of the patient’s current inpatient rehabilitation stay.
 - (ii) Observation is the three days used to collect information on a patient’s status.
- b) Day 3 – **Assessment Reference Date** – Third calendar day.
- c) Day 4 – **Completion Date**
 - (i) Calendar day that follows the admission assessment reference date.
 - (ii) The day the inpatient rehabilitation facility patient assessment FIM statement is filled out.
 - (iii) The deadline date when the process of recording data on the IRF PAI must be completed.
- d) Day 11 – **Encode Date**
 - (i) Seventh calendar day following the Completion Date.
 - (ii) The date when the patient assessment instrument data is entered into the computer software program.

2. Discharge Patient Assessment Instrument

The Discharge assessment time period covers three calendar days and is the discharge assessment reference day and the two calendar days prior to the discharge assessment reference date. Select a specific 24 hour period during that three day period for final FIM assessment score.

- a) Day of Discharge – **Discharge Date.**
The discharge assessment reference date is the actual day the first of either of the following two events occur: 1) the patient is discharged, or 2) the patient stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services.
- b) Day of Discharge – **Discharge Assessment Reference Date.**
- c) Five days post discharge including the day of discharge - **Completion Date.**
Completed on the fifth calendar day that follows the discharge assessment reference date, with the discharge assessment reference date itself being counted as the first day of the five-calendar daytime span.
- d) Eleven days post discharge including the day of discharge –**Encode Date**

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- (i) Seventh calendar day following the Completion Date.
- (ii) The encoded patient assessment data must accurately reflect the patient’s clinical status at the time of the aptness assessment.
- e) Seventeen (17) days post discharge including the day of discharge – **Transmission Date**
 - (i) Transmission is the day when the patient assessment instrument is sent to CMS (Centers for Medicare & Medicaid Services) via the software program.
 - (ii) The facility must transmit both the admission patient assessment and the discharge patient assessments at the same time – by the seventh calendar day in the period beginning with the applicable patient assessment instrument encoding date.


D. Penalties for Late Assessments

If the inpatient rehabilitation facility transmits the patient assessment data more than ten (10) calendar days late; the inpatient rehabilitation facility will be paid a CMG (Case Mix Group) determined payment that will be reduced by 25%.

E. Tracking Log

Each facility will maintain a log specifying the following:

1. Name
2. MR#
3. Admission date
4. Admission reference date
5. Completion by date
6. Actual completion date
7. Encoded by date
8. Actual encoded date
9. Discharge date
10. Discharge reference date
11. Discharge completion by date

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12. Discharge encoded by date
13. Actual discharge encoded date
14. Transmission due date
15. Actual transmission date.

F. Record Storage:

Each rehabilitation facility will maintain a copy of the transmitted IRF PAI form in the patient’s medical record as a legal document. . The data from the transmitted IRF-PAI will be maintained in an electronic computer file format that can be easily obtained for a period not less than five years.

V. REFERENCES

1. 42 CFR Parts 412 and 413, Medicare Program: Prospective Payment System for Inpatient Rehabilitation Facilities, Final Rule, August 7, 2001, pp. 41324-41325; 41328-41329; 41331; 41335; 41411.
2. CMS website for [Inpatient Rehabilitation Facility Patient Assessment Instrument \(IRF PAI\)](#).
3. 42 CFR, Part 412 , Medicare Program: Changes to the Inpatient Rehabilitation Facility Prospective Payment System; Final Rule, August 1, 2003

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

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

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Function Modifiers*	39. FIM™ Instrument*																																																																																																																																																																						
<p>Complete the following specific functional items prior to scoring the FIM™ Instrument:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">ADMISSION</th> <th style="width: 15%; text-align: center;">DISCHARGE</th> </tr> </thead> <tbody> <tr> <td>29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>30. Bladder Frequency of Accidents (Score as below)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3"> 7 - No accidents 6 - No accidents; uses device such as a catheter 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days </td> </tr> <tr> <td colspan="3"> <i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.</i> </td> </tr> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">ADMISSION</th> <th style="width: 15%; text-align: center;">DISCHARGE</th> </tr> <tr> <td>31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>32. 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Shower Transfer</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3"> (Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) See training manual for scoring of Item 39K (Tub/Shower Transfer) </td> </tr> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">ADMISSION</th> <th style="width: 15%; text-align: center;">DISCHARGE</th> </tr> <tr> <td>35. Distance Walked</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>36. 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Wheelchair</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3"> (Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair) </td> </tr> </tbody> </table>		ADMISSION	DISCHARGE	29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	30. Bladder Frequency of Accidents (Score as below)	<input type="checkbox"/>	<input type="checkbox"/>	7 - No accidents 6 - No accidents; uses device such as a catheter 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days			<i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.</i>				ADMISSION	DISCHARGE	31. 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Dressing - Lower</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>F. Toileting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4">SPHINCTER CONTROL</td> </tr> <tr> <td>G. Bladder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>H. Bowel</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4">TRANSFERS</td> </tr> <tr> <td>I. 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Problem Solving</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>R. Memory</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p style="font-size: small; margin-top: 10px;"> W - Walk C - wheelChair B - Both </p> <p style="font-size: small; margin-top: 10px;"> A - Auditory V - Visual B - Both </p> <p style="font-size: small; margin-top: 10px;"> V - Vocal N - Nonvocal B - Both </p>		ADMISSION	DISCHARGE	GOAL	SELF-CARE				A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. 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33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																					
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(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) See training manual for scoring of Item 39K (Tub/Shower Transfer)																																																																																																																																																																							
	ADMISSION	DISCHARGE																																																																																																																																																																					
35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																					
36. Distance Traveled in Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																					
(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)																																																																																																																																																																							
	ADMISSION	DISCHARGE																																																																																																																																																																					
37. Walk	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																					
38. Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																					
(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)																																																																																																																																																																							
	ADMISSION	DISCHARGE	GOAL																																																																																																																																																																				
SELF-CARE																																																																																																																																																																							
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
SPHINCTER CONTROL																																																																																																																																																																							
G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
TRANSFERS																																																																																																																																																																							
I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
LOCOMOTION																																																																																																																																																																							
L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
COMMUNICATION																																																																																																																																																																							
N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
SOCIAL COGNITION																																																																																																																																																																							
P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																				
<p>FIM LEVELS</p> <p><i>No Helper</i></p> <p>7 Complete Independence (Timely, Safely)</p> <p>6 Modified Independence (Device)</p> <p><i>Helper - Modified Dependence</i></p> <p>5 Supervision (Subject = 100%)</p> <p>4 Minimal Assistance (Subject = 75% or more)</p> <p>3 Moderate Assistance (Subject = 50% or more)</p> <p><i>Helper - Complete Dependence</i></p> <p>2 Maximal Assistance (Subject = 25% or more)</p> <p>1 Total Assistance (Subject less than 25%)</p> <p>0 Activity does not occur; Use this code only at admission</p>																																																																																																																																																																							

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INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Discharge Information*	Quality Indicators																																																																			
<p>40. Discharge Date _____ / _____ / _____ MM / DD / YYYY</p> <p>41. Patient discharged against medical advice? _____ (0 - No, 1 - Yes)</p> <p>42. Program Interruption(s) _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates (Code only if Item 42 is 1 - Yes)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>A. 1st Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> <td style="width: 50%; vertical-align: top;"> <p>B. 1st Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>C. 2nd Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>D. 2nd Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>E. 3rd Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>F. 3rd Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> </td> </tr> </table> <p>44A. Discharge to Living Setting _____ (01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</p> <p>44B. Was patient discharged with Home Health Services? _____ (0 - No; 1 - Yes) (Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)</p> <p>45. Discharge to Living With _____ (Code only if Item 44A is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>46. Diagnosis for Interruption or Death _____ (Code using ICD-9-CM code)</p> <p>47. Complications during rehabilitation stay (Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">A. _____</td> <td style="width: 50%;">B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> </table>	<p>A. 1st Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>B. 1st Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>C. 2nd Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>D. 2nd Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>E. 3rd Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>F. 3rd Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	<p>PAIN</p> <p>51. Rate the highest level of pain reported by the patient within the assessment period: Admission: _____ Discharge: _____ (Score using the scale below; report whole numbers only)</p> <table style="width: 100%; border: none; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td> </td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td> </td> </tr> <tr> <td>No</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Worst</td> </tr> <tr> <td>Pain</td><td></td><td></td><td></td><td></td><td>Moderate</td><td></td><td></td><td></td><td></td><td>Possible Pain</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td>Pain</td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p>Pressure Ulcers</p> <p>52A. Highest current pressure ulcer stage Admission _____ Discharge _____ (0 - No pressure ulcer; 1 - Any area of persistent skin redness (Stage 1); 2 - Partial loss of skin layers (Stage 2); 3 - Deep craters in the skin (Stage 3); 4 - Breaks in skin exposing muscle or bone (Stage 4); 5 - Not stageable (necrotic eschar predominant; no prior staging available)</p> <p>52B. Number of current pressure ulcers Admission _____ Discharge _____</p> <p>PUSH Tool v. 3.0 ©</p> <p>SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (C through E) and code total score in F.</p> <p>52C. Length multiplied by width (open wound surface area) Admission _____ Discharge _____ (Score as 0 - 0 cm²; 1 - < 0.3 cm²; 2 - 0.3 to 0.6 cm²; 3 - 0.7 to 1.0 cm²; 4 - 1.1 to 2.0 cm²; 5 - 2.1 to 3.0 cm²; 6 - 3.1 to 4.0 cm²; 7 - 4.1 to 8.0 cm²; 8 - 8.1 to 12.0 cm²; 9 - 12.1 to 24.0 cm²; 10 - > 24 cm²)</p> <p>52D. Exudate amount Admission _____ Discharge _____ 0 - None; 1 - Light; 2 - Moderate; 3 - Heavy</p> <p>52E. Tissue type Admission _____ Discharge _____ 0 - Closed/resurfaced: The wound is completely covered with epithelium (new skin); 1 - Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 2 - Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance. 3- Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous. 4 - Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.</p> <p>52F. TOTAL PUSH SCORE (Sum of above three items – C, D and E) Admission _____ Discharge _____</p>	0	1	2	3	4	5	6	7	8	9	10												No										Worst	Pain					Moderate					Possible Pain						Pain					
<p>A. 1st Interruption Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>	<p>B. 1st Return Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p>																																																																			
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Pain					Moderate					Possible Pain																																																										
					Pain																																																															
Quality Indicators																																																																				
<p>RESPIRATORY STATUS (Score items 48 to 50 as 0 - No; 1 - Yes)</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Admission</th> <th style="width: 20%; text-align: center;">Discharge</th> </tr> </thead> <tbody> <tr> <td>48. Shortness of breath with exertion _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>49. Shortness of breath at rest _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>50. Weak cough and difficulty clearing airway secretions _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Admission	Discharge	48. Shortness of breath with exertion _____	_____	_____	49. Shortness of breath at rest _____	_____	_____	50. Weak cough and difficulty clearing airway secretions _____	_____	_____	<p>SAFETY</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Admission</th> <th style="width: 15%; text-align: center;">Discharge</th> </tr> </thead> <tbody> <tr> <td>53. Balance problem (0 - No; 1 - Yes) e.g., dizziness, vertigo, or light-headedness _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>54. Total number of falls during the rehabilitation stay _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">Discharge _____</td> </tr> </tbody> </table>		Admission	Discharge	53. Balance problem (0 - No; 1 - Yes) e.g., dizziness, vertigo, or light-headedness _____	_____	_____	54. Total number of falls during the rehabilitation stay _____	_____	Discharge _____																																														
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