SECTION III
THE FIM™ INSTRUMENT

UNDERLYING PRINCIPLES FOR USE OF THE FIM™ INSTRUMENT

By design, the FIM™ instrument includes only a minimum number of items. It is not intended to incorporate all the activities that could possibly be measured, or that might need to be measured, for clinical purposes. Rather, the FIM instrument is a basic indicator of severity of disability that can be administered comparatively quickly and therefore can be used to generate data on large groups of people. As the severity of disability changes during rehabilitation, the data generated by the FIM instrument can be used to track such changes and analyze the outcomes of rehabilitation.

The FIM instrument includes a seven-level scale that designates major gradations in behavior from dependence to independence. This scale rates patients on their performance of an activity taking into account their need for assistance from another person or a device. If help is needed, the scale quantifies that need. The need for assistance (burden of care) translates to the time/energy that another person must expend to serve the dependent needs of the disabled individual so that the individual can achieve and maintain a certain quality of life.

The FIM instrument is a measure of disability, not impairment. The FIM instrument is intended to measure what the person with the disability actually does, whatever the diagnosis or impairment, not what (s)he ought to be able to do, or might be able to do under different circumstances. As an experienced clinician, you may be well aware that a depressed person could do many things (s)he is not currently doing; nevertheless, the person should be assessed on the basis of what (s)he actually does. Note also that there is no provision to consider an item "not applicable." **All FIM instrument items (39A - 39R) must be completed.**

The FIM instrument was designed to be discipline-free. Any trained clinician, regardless of discipline, can use it to measure disability. Under a particular set of circumstances, however, some clinicians may find it difficult to assess certain activities. In such cases, a more appropriate clinician may participate in the assessment. For example, a given assessment can be completed by a speech pathologist who assesses the communication items, a nurse who is more knowledgeable with respect to bowel and bladder management, a physical therapist who has the expertise to evaluate transfers, and an occupational therapist who scores self-care and social cognition items.

*For the full manual, visit:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html

You must read the definitions of the items carefully before beginning to use the FIM instrument, committing to memory what each activity includes. Rate the subject only with respect to the specific item. For example, when rating the subject with regard to bowel and bladder management, do not take into consideration whether (s)he can get to the toilet. That information is measured during assessments of Walk/Wheelchair and Transfers: Toilet.

To be categorized at any given level, the patient must complete either all of the tasks included in the definition or only one of several tasks. If all must be completed, the series of tasks will be connected in the text of the definition by the word "and." If only one must be completed, the series of tasks will be connected by the word "or." For example, Grooming includes oral care, hair grooming, washing the hands, washing the face, and either shaving or applying make-up. Communication includes clear comprehension of either auditory or visual communication.

Implicit in all of the definitions, and stated in many of them, is a concern that the individual perform these activities with reasonable safety. With respect to level 6, you must ask yourself whether the patient is at risk of injury while performing the task. As with all human endeavors, your judgment should take into account a balance between an individual's risk of participating in some activities and a corresponding, although different risk if (s)he does not.

Because the data set is still being refined, your opinions and suggestions are considered very important. We are also interested in any problems you encounter in collecting and recording data.

The FIM instrument may be added to information that has already been gathered by a facility. This information may include items such as independent living skills, ability to take medications, to use community transportation, to direct care provided by an aide, or to write or use the telephone, and other characteristics such as mobility outdoors, impairments such as blindness and deafness, and pre-morbid status.

Do not modify the FIM instrument itself.

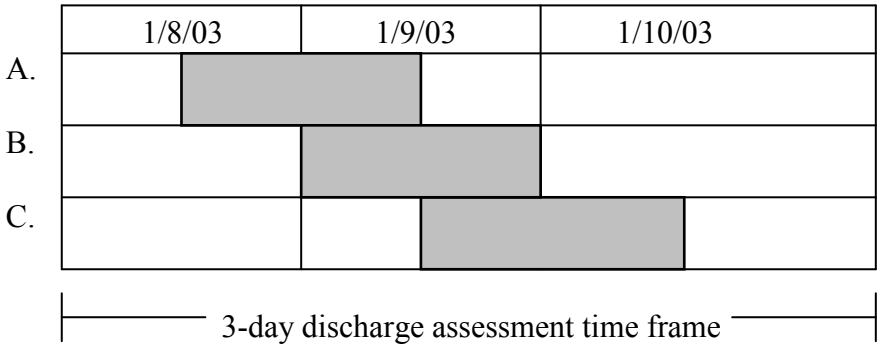
PROCEDURES FOR SCORING THE FIM™ INSTRUMENT AND FUNCTION MODIFIERS

Each of the 18 items comprising the FIM™ instrument has a maximum score of seven (7), which indicates complete independence. A score of one (1) indicates total assistance. A code of zero (0) may be used for some items to indicate that the activity does not occur. Use only whole numbers. For the Function Modifiers, the score range is a minimum of 1 and a maximum of 7, except for Items 35 and 36, where the maximum score is three (3), and for some Function Modifiers a code of 0 may be used. The following rules will help guide you in your administration of the FIM instrument.

1. Admission FIM scores must be collected during the first 3 calendar days of the patient's current rehabilitation hospitalization that is covered by Medicare. These scores must be based upon activities performed during the **entire** 3-calendar-day admission time frame.

2. The discharge assessment time frame encompasses the day of discharge and the two calendar days prior to the day of discharge. Completion of the FIM items at discharge, with the exception of items reflecting bowel and bladder function, should reflect the lowest functional score within any 24-hour period within the three calendar days comprising the discharge assessment. At discharge, all FIM items except bowel and bladder should be assessed within the same 24-hour period. The diagram below depicts three possible scenarios meeting this definition:

   Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03.



   In scenario A, the FIM items would be scored in a 24-hour period between 1/8 and 1/9/03. In scenario B, the FIM items would be scored in a 24-hour period, all on 1/9/03. In scenario C, the FIM items would be scored in a 24-hour period beginning on 1/9 and ending on 1/10/03. Note that in each of these examples, all FIM items (with an exception for bladder and bowel as listed below) were scored within the same 24-hour period, and the lowest level of function was scored for each item.

Scoring the lowest level of function provides a way to measure the amount of assistance (burden of care) the individual requires from another person to carry out daily living activities.

Exception: Rather than assessing the bladder and bowel function modifiers and associated FIM items within a 24-hour period within the discharge assessment time frame, these items must be scored according to previously established look-back periods. At discharge, function modifiers concerning level of assistance for bladder and bowel (Items 29 and 31) have a look-back period of 3 days (the day of discharge and the two calendar days immediately prior to discharge). Function modifiers concerning frequency of accidents for bladder and bowel (Items 30 and 32) have a look-back period of 7 days (the day of discharge and the six calendar days immediately prior to discharge). The diagram below depicts how these items must be assessed at discharge:

Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03. The 3-day look-back period for bladder and bowel level of assistance would be 1/8, 1/9 and 1/10/03. The 7-day look-back period for bladder and bowel frequency of accidents would be 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/03.

	01/4/03	01/5/03	01/6/03	01/7/03	01/8/03	01/9/03	01/10/03
Bladder, Bowel Level of Assistance							
Bladder, Bowel Frequency of Accidents							

Note: As stated previously on page II-19 of this manual, comorbid conditions recognized or diagnosed on the day of discharge or on the day prior to the day of discharge are not allowed to be entered in item number 24. Therefore, if the 24-hour time period chosen to determine the score of most of the Function Modifiers and the associated elements of the FIM items encompasses the day of discharge or the day prior to the day of discharge then the comorbidities that are first recognized or diagnosed during such a 24-hour time period can't be recorded in item 24.

3. At admission, most **FIM items** use an assessment time period of 3 calendar days. For the **Function Modifiers** Bladder Frequency of Accidents and Bowel Frequency of Accidents (Items 30 and 32), a 7-day assessment time period is needed. The admission assessment for bladder and bowel accidents would include the 4 calendar days prior to the rehabilitation admission, as well as the first 3 calendar days in the

rehabilitation facility.

In the event that information about bladder and/or bowel accidents prior to the rehabilitation admission is unavailable, record scores for items 30 and 32 that are based upon the number of accidents **since** the rehabilitation admission.

4. The **FIM scores** and **Function Modifier scores** should reflect the patient's actual performance of the activity, not what the patient should be able to do, not a simulation of the activity, or not what they are expected to do in a different environment (e.g., home).

5. If differences in function occur in different environments or at different times of the day, record the *lowest* (most dependent) score. In such cases, the patient usually has not mastered the function across a 24-hour period, is too tired, or is not motivated enough to perform the activity out of the therapy setting. There may be a need to resolve the question of what is the most dependent level by discussion among team members.

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

6. The **FIM scores** and **Function Modifier scores** should be based on the best available information. Direct observation of the patient's performance is preferred; however, credible reports of performance may be gathered from the medical record, the patient, other staff members, family, and friends. The medical record may also provide additional information about bladder and bowel accidents and inappropriate behaviors.

7. Record a **Function Modifier score** for EITHER Tub Transfer (Item 33) OR Shower Transfer (Item 34) but not both. Leave the other transfer item blank. Please note that the mode for this item does not need to be the same at admission and discharge.

8. Record the **FIM score** that best describes the patient's level of function for *every* FIM item (Items 39A through 39R). No FIM item should be left blank.

9. For some **FIM items** (e.g., Walk/Wheelchair (39L), Comprehension (39N), and Expression (39O)) there are boxes next to the functional score box that are to be used to indicate the more frequent mode used by the patient for that item. To indicate the more frequent mode, place the appropriate letter in each box (i.e., W for Walk, C for Wheelchair, or B for Both for Item 39L (Walk/Wheelchair); A for Auditory, V for Visual, or B for Both for Item 39N (Comprehension); and V for Vocal, N for

Nonvocal, and B for Both for Item 39O (Expression)).

Note: or items 39N (Comprehension) and 39O (Expression) the mode at admission does not have to match the mode at discharge.

10. The mode of locomotion for the **FIM item** Walk/Wheelchair (39L) must be the same on admission and discharge. Some patients may change the mode of locomotion from admission to discharge, usually wheelchair to walking. In such cases, you should code the admission mode and score based on the *more frequent mode of locomotion at discharge*. If, at discharge, the patient uses both modes (walk, wheelchair) equally, score Item 39L using the Walk scores from Item 37 for both admission and discharge.[1]

11. When the assistance of two helpers is required for the patient to perform the tasks described in an item, score level 1 - Total Assistance.

12. A code of 0 may be used for some **FIM items** and some **Function Modifiers** to indicate that the activity does not occur at any time during the assessment period. (For a summary of the scoring rules concerning the use of the 0 code, see the table at the end of this section). A code of 0 means that the patient does not perform the activity and a helper does not perform the activity for the patient, at any time during the assessment period. Use of this code should be rare for most items, and justification for the use of 0 should be documented in the medical record. Possible reasons why the patient does not perform the activity may include the following:
    - The patient does not attempt the activity because the clinician determines that it is unsafe for the patient to perform the activity (e.g., going up and down stairs for patient with lower extremity paralysis).
    - The patient cannot perform the activity because of a medical condition or medical treatment (e.g., walking for the patient who is unable to bear weight on lower extremities).
    - The patient refuses to perform an activity (e.g., the patient refuses to dress in clothing other than a hospital gown or the patient refuses to be dressed by a helper).

13. For certain **FIM items**, a code of 0 may be used on **admission** but not at **discharge**. However, code 0 may NOT be used for Bladder Management (Items 29, 30 and 39G), Bowel Management (Items 31, 32 and 39H), or the cognitive items (Items 39N through 39R) at either admission or discharge.

14. If a **FIM activity** does not occur at the time of **discharge** record a score of 1 – Total Assistance. If a patient expires while in the rehabilitation facility, record a score of Level 1 for all discharge FIM items.

15. For the **Function Modifiers Items 33 through 38**, a code of 0 may be used on admission and discharge.

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

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

IRF-PAI Item	Can code "0 - Activity does not occur", be used during the Admission Assessment?	Can code "0 - Activity does not occur", be used during the Discharge Assessment?
Function Modifiers		
29 Bladder Level of Assistance	No	No
30 Bladder Frequency of Accidents	No	No
31 Bowel Level of Assistance	No	No
32 Bowel Frequency of Accidents	No	No
33 Tub Transfer	Yes	Yes
34 Shower Transfer	No	No
35 Distance Walked	Yes	Yes
36 Distance Traveled in Wheelchair	Yes	Yes
37 Walk	Yes	Yes
38 Wheelchair	Yes	Yes
FIM Items*		
39A Eating	Yes	No
39B Grooming	Yes	No
39C Bathing	Yes	No
39D Dressing - Upper	Yes	No
39E Dressing - Lower	Yes	No
39F Toileting	Yes	No
39G Bladder	No	No
39H Bowel	No	No
39I Transfers: Bed, Chair, Wheelchair	Yes	No
39J Transfers: Toilet	Yes	No
39K Transfers: Tub, Shower	Yes	No
39L Walk/Wheelchair	Yes	No
39M Stairs	Yes	No
39N Comprehension	No	No
39O Expression	No	No
39P Social Interaction	No	No
39Q Problem Solving	No	No
39R Memory	No	No

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

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, cuing, 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.

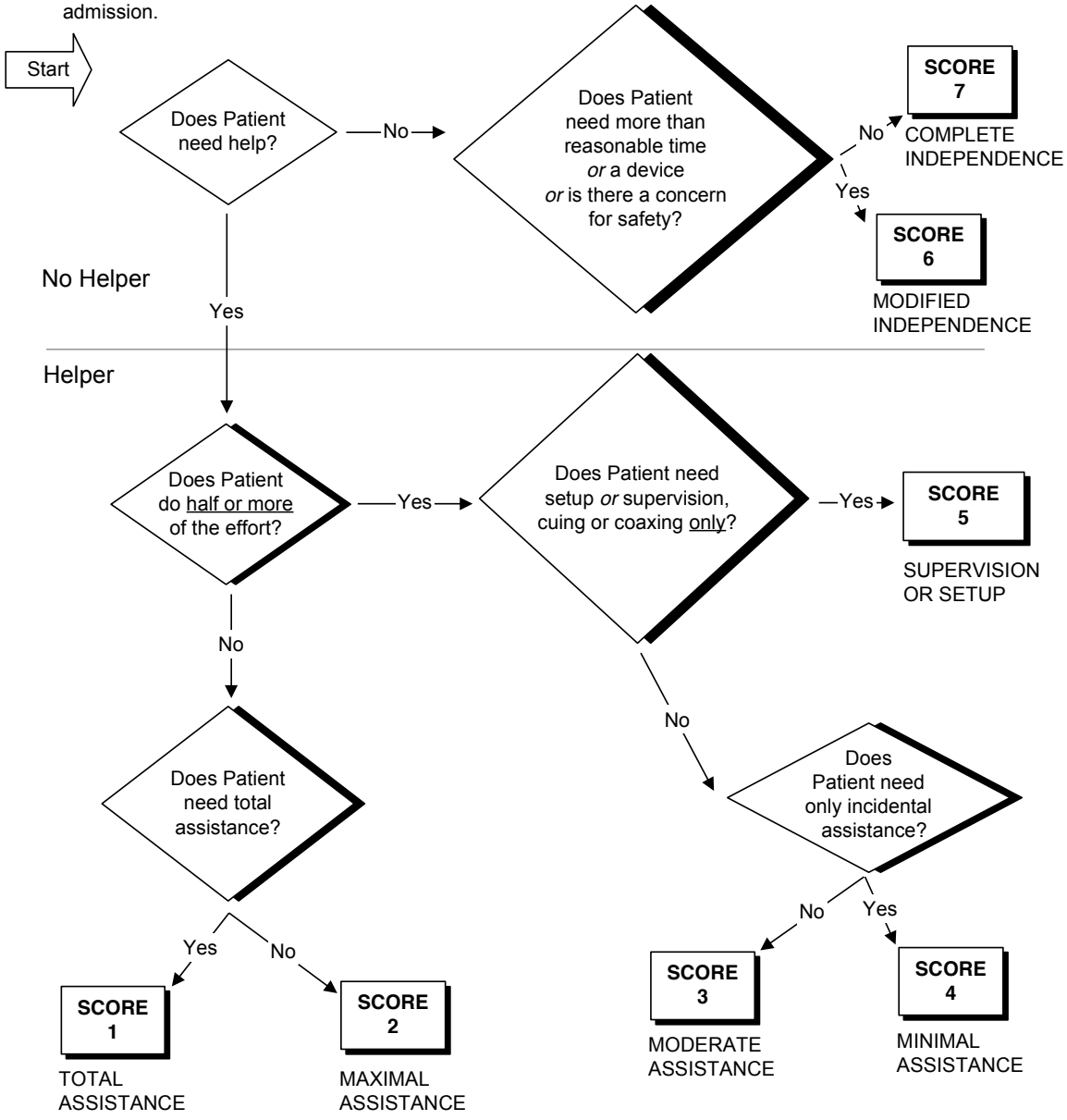
1 Total Assistance—The patient expends less than 25% of the effort.

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.



Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

		Admission	Discharge
29.	Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30.	Bladder Frequency of Accidents (Score as below)	☐	☐

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

Enter in Item 39G (Bladder) the lower *(more dependent) score from Items 29 and 30 above*

		Admission	Discharge
31.	Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32.	Bowel Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31and 32 above.

		Admission	Discharge
33.	Tub Transfer	☐	☐
34.	Shower Transfer	☐	☐

(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	☐	☐
36.	Distance Traveled in Wheelchair	☐	☐

(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	☐	☐
38.	Wheelchair	☐	☐

(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)

39. FIM™ Instrument*

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

FIM LEVELS

No Helper

7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

Helper - Modified Dependence

5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence

2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission