

CMS Chronic Condition Data Warehouse

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
1	BENE_ID	BENE_ID	Encrypted 723 Beneficiary ID	CHAR	15	A unique CCW beneficiary identifier field that is specific to the Chronic Condition Warehouse. This field is encrypted prior to delivery to researchers. The BENE_ID field is used to cross-reference data for each beneficiary across all claim and assessment data files.	
2	ASMT_ID	ASMT_ID	Encrypted Assessment ID	CHAR	15	This number is assigned when an assessment record is processed in the Chronic Condition Warehouse. This field is encrypted prior to delivery to researchers. It identifies lines that are submitted from the same assessment.	
3	AGENT_ID	AGENT_ID	Agent ID	CHAR	9	This is the identification of the current software agent used by the facility to handle the computerization of the assessment requirement, if applicable.	
4	ASBGVRDT	ASMT_BGN_VRSN_DT	Assessment Beginning Version Date	DATE	8	Beginning date of the submission file that contains the version of this assessment	
5	ASCRVRNO	ASMT_CRCTN_VRSN_NUM	Assessment Correction Version Number	CHAR	2	The number of the assessment.	00 = Original, 01 = First correction, 02 = Second correction, etc.
6	ASNDVRDT	ASMT_END_VRSN_DT	Assessment Ending Version Date	DATE	8	Ending date of the submission file that contains the version of this assessment	
7	IRFASIID	IRF_ASMT_INT_ID	Encrypted D16Assessment Internal ID	CHAR	10	This field is used a a key to uniquely identify an assessment and to tie together all the different tables that compose one assessment record received from a facility.	
8	ASMTMDCD	ASMT_MOD_CD	Assessment Modification Code	CHAR	1	A code designating the version of the assessment.	C = Current, M = Modified, X = Inactive
9	CLCDAGTX	CALCTD_AGE_TXT	Calculated Age Code	CHAR	5	A preliminary calculation made prior to determining the CMG group. Age is computed on the basis of the difference between the Admission Date (Item 12) and the Birth Date (Item 6).	
10	CLCCMGTX	CALCTD_CMG_TXT	Calculated CMG Code	CHAR	10	The Case-Mix Group code that is calculated from the data submitted to the NACD.	
11	CLCMVRTX	CALCTD_CMG_VRSN_TXT	Calculated CMG Version Code	CHAR	10	The version code of the CMG Grouper on the NACD.	

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
12	CLGNVSTX	CALCTD_CGNTV_SCALE_TXT	Calculated Cognitive Scale Code	CHAR	5	A preliminary calculation made prior to determining the CMG group. The cognitive score is based upon 5 variables that are taken from Item 39 on the IRF-PAI form.	
13	CLMTSCTX	CALCTD_MOTOR_SCALE_TXT	Calculated Motor Scale Code	CHAR	5	A preliminary calculation made prior to determining the CMG group. The motor score is based upon 12 variables that are taken from Item 39 on the IRF-PAI form.	
14	ORGASIID	ORGNL_ASMT_INT_ID	Encrypted D189Original Assessment Internal ID	CHAR	10	Original version (ASMT INT ID) of this assessment where Correction Number is 00.	
15	PRVNTRNO	PRVDR_INT_NUM	Provider Internal Number	CHAR	10	This field is used as a key to uniquely identify a provider in the CSP_PRVDR table.	
16	RSDTCHTS	RSDNT_CHG_TS	Resident Data Update Timestamp	DATE	8	The late updated date and time of resident data.	
17	RSMTCRCD	RSDNT_MATCH_CRTR_CD	Resident Match Criteria Code	CHAR	2	This field is used in determining if a record should be written to the resident history table. It is a number showing which of the resident matching criteria was positive for a match, and is zero if it is a new resident.	
18	SFTWR_ID	SFTWR_ID	Software ID	CHAR	9	This field contains the identification number of the software vendor or agent the provider is using to automate the assesement requirement.	
19	SFTWVRSN	SFTWR_VRSN	Software Version	CHAR	10	This field contains the version number of the vendor software being used by the facility or the facility's agent to automate the assessment submission process.	
20	STATE_CD	STATE_CD	State Code	CHAR	2	The two-digit state abbreviation.	
21	SUBMSNDT	SUBMSN_DT	Submission Date	DATE	8	The date the submission was received by the system.	
22	SBMSSQNO	SUBMSN_SQNC_NUM	Submission Sequence Number	CHAR	10	Submission Sequence Number	
23	SBMTCMTX	SBMTD_CMG_TXT	Submitted CMG Code	CHAR	10	The Case-Mix Group code that is submitted by the facility. This CMG code is calculated by the software the facility utilizes.	
24	SBCMVRTX	SBMTD_CMG_VRSN_TXT	Submitted CMG Version Code	CHAR	10	The version code of the CMG Grouper that was used by the facility's software in the calculation of the submitted CMG code.	

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
25	TRGT_DT	TRGT_DT	Target Date	DATE	8	For MDS, the target date is the R4 Discharge Date for any discharge, the A4A Reentry Date for any re-entry and the A3A Assessment Reference Date for any other type of assessment. For IRF-PAI, the Target Date is 12: Admission Date. For SB the Target Date is the same as the Event Date and is equal to the following dates: 10a (A3A - Assessment Reference Date, 15 (R4) - Discharge Date and 16 (A4A) - Reentry Date.	
26	VRSN_CD1	VRSN_CD1	Version Code 1	CHAR	5	This code represents the version of the form actually completed in the hospital.	
27	VRSN_CD2	VRSN_CD2	Version Code 2	CHAR	5	This code represents the version of the data specifications used to create the data record for submission to the National System.	
28	_1B	FAC_MDCR_PRVDR_NUM	(1B) Facility Medicare Provider Number	CHAR	12	Facility Medicare Provider Number assigned by CMS.	
29	_6	BIRTH_DT	(6) Birth Date	DATE	8	The patient's birthdate.	
30	_8	GNDR_CD	(8) Gender Code	CHAR	1	The patient's gender.	1 = Male, 2 = Female
31	_9A	ETH_AMRCN_INDN_AK_NTV_SW	(9A) Race: American Indian/Alaskan Native	CHAR	1	The patient's race or ethnic category: American Indian or Alaskan Native.	0 = No, 1 = Yes
32	_9B	ETH_ASN_SW	(9B) Race: Asian	CHAR	1	The patient's race or ethnic category: Asian.	0 = No, 1 = Yes
33	_9C	ETH_AFRCN_AMRCN_SW	(9C) Race: Black or African American	CHAR	1	The patient's race or ethnic category: Black or African American.	0 = No, 1 = Yes
34	_9D	ETH_HSPNC_LTN_SW	(9D) Ethnicity: Hispanic or Latino	CHAR	1	The patient's race or ethnic category: Hispanic or Latino.	0 = No, 1 = Yes
35	_9E	ETH_NTV_HI_PCFC_ISLDR_SW	(9E) Race: Native Hawaiian or other Pacific Islander	CHAR	1	The patient's race or ethnic category: Native Hawaiian or other Pacific Islander.	0 = No, 1 = Yes
36	_9F	ETH_WHT_SW	(9F) Race: White	CHAR	1	The patient's race or ethnic category: White	0 = No, 1 = Yes
37	_10	MRTL_STUS_CD	(10) Marital Status	CHAR	2	The patient's marital status at the time of admission.	01 = Never married, 02 = Married, 03 = Widowed, 04 = Separated, 05 = Divorced
38	_11	ZIP_CD	(11) ZIP code of patients pre-hospital residence	CHAR	5	The 5-digit ZIP code of the patient's pre-hospital residence.	
39	_12	ADMSN_DT	(12) Admission Date	DATE	8	The date that the patient begins receiving Part A covered Medicare services in an inpatient rehabilitation facility.	

CMS Chronic Condition Data Warehouse

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
40_13		ASMT_RFRNC_DT	(13) Assessment Reference Date	DATE	8	The third calendar day of the rehabilitation stay, which represents the last day of the 3-day admission assessment time period. These three calendar days are the days during which the patient's clinical condition should be assessed.	
41_14		ADMSN_CLS_CD	(14) Admission Class	CHAR	2	The patient's admission classification.	01 = Initial Rehab, 02 = Evaluation, 03 = Readmission, 04 = Unplanned Discharge, 05 = Continuing Rehabilitation.
42_15		ADMT_FROM_CD	(15) Admit From (at date of admission)	CHAR	2	The living setting from which the patient was admitted to rehabilitation.	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, 12 = Alternate Level of Care Unit, 13 = Subacute Setting, 14 = Assisted Living Residence
43_16		PRE_HOSP_LVG_SET_CD	(16) Pre-Hospital Living Setting	CHAR	2	The setting where the patient was living prior to being hospitalized.	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, 12 = Alternate Level of Care Unit, 13 = Subacute Setting, 14 = Assisted Living Residence
44_17		PRE_HOSP_LVG_WTH_CD	(17) Pre-Hospital Living With	CHAR	2	The relationship of any individuals who resided with the patient prior to the patient's hospitalization. This item is used only if code 01 (Home) in Item 16 (Prehospital Living Setting) was coded.	01 = Alone, 02 = Family/Relatives, 03 = Friends, 04 = Attendant, 05 = Other
45_18		PRE_HOSP_VCTNL_CTGRY_CD	(18) Pre-Hospital Vocational Category	CHAR	2	Indicates the vocational status of the patient prior to hospitalization.	01 = Employed, 02 = Sheltered, 03 = Student, 04 = Homemaker, 05 = Not Working, 06 = Retired for Age, 07 = Retired for Disability
46_19		PRE_HOSP_VCTNL_EFRT_CD	(19) Pre-Hospital Vocational Effort	CHAR	2	The patient's vocational effort prior to hospitalization (if Item 18 - Pre-hospital Vocational Category is coded 1-4).	01 = Full-time, 02 = Part-time, 03 = Adjusted Workload

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
47	_20A	PRMRY_PMT_SRC_CD	(20A) Primary Payment Source	CHAR	2	A code indicating the primary source of payment for inpatient rehabilitation services.	01 = Blue Cross, 02 = Medicare non-MCO, 03 = Medicaid non-MCO, 04 = Commercial Insurance, 05 = MCO HMQ, 06 = Workers Compensation, 07 = Crippled Childrens 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
48	_20B	SCNDRY_PMT_SRC_CD	(20B) Secondary Payment Source	CHAR	2	A code indicating the secondary source of payment for inpatient rehabilitation services.	01 = Blue Cross, 02 = Medicare non-MCO, 03 = Medicaid non-MCO, 04 = Commercial Insurance, 05 = MCO HMQ, 06 = Workers Compensation, 07 = Crippled Childrens 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
49	_21A	IMPRMNT_GRP_ADMSN_CD	(21a) Impairment Group: Admission	CHAR	9	The Impairment Group Code (IGC) that best describes the primary reason for admission to the rehabilitation program. Each IGC consists of a two-digit number (indicating the major Impairment Group) followed by a decimal point and 1 to 4 additional digits identifying the subgroup.	
50	_21D	IMPRMNT_GRP_DSCHRG_CD	(21d) Impairment Group: Discharge	CHAR	9	The Impairment Group Code (IGC) that best describes the primary impairment at discharge from the rehabilitation program. Each IGC consists of a two-digit number (indicating the major Impairment Group) followed by a decimal point and 1 to 4 additional digits identifying the subgroup.	
51	_22	ETLGC_DGNS_CD	(22) Etiologic Diagnosis Code (ICD-9 Code)	CHAR	7	The ICD-9 code that indicates the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group).	

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
52_23		ONST_DT	(23) Date of Onset	DATE	8	The onset date of the impairment that was coded in Item 21 (Impairment Group).	
53_24A		CMRBD_COND_A_CD	(24A) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
54_24B		CMRBD_COND_B_CD	(24B) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
55_24C		CMRBD_COND_C_CD	(24C) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
56_24D		CMRBD_COND_D_CD	(24D) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
57_24E		CMRBD_COND_E_CD	(24E) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
58_24F		CMRBD_COND_F_CD	(24F) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	

CMS Chronic Condition Data Warehouse

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
59	_24G	CMRBD_COND_G_CD	(24G) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
60	_24H	CMRBD_COND_H_CD	(24H) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
61	_24I	CMRBD_COND_I_CD	(24I) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
62	_24J	CMRBD_COND_J_CD	(24J) Comorbid Conditions (ICD-9 Code)	CHAR	7	An ICD-9 code for comorbid conditions. A comorbidity is a specific condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.	
63	_25	CMTS_SW	(25) Comatose: Admission	CHAR	1	A code indicating whether the patient is diagnosed as comatose or in a persistent vegetative state at the time of admission.	0 = No, 1 = Yes
64	_26	DLRS_SW	(26) Delirious: Admission	CHAR	1	A code indicating whether the patient has exhibited symptoms of delirium at time of admission. Delirium may be manifested as disoriented thinking, being easily distracted, disorganized speech, restlessness, lethargy, or altered perceptions or awareness of surroundings.	0 = No, 1 = Yes

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
65	_27A	SWLWG_ADMSN_CD	(27a) Swallowing Status: Admission	CHAR	2	A code used to describe the patient's swallowing status at time of admission.	01 = Tube/Parenteral Feeding: tube/parenteral feeding used wholly or partially as a means of sustenance, 02 = Modified Food Consistency/Supervision: subject requires modified food consistency and/or needs supervision for safety, 03 = Regular Food: solids and liquids swallowed safely without supervision or modified food consistency
66	_27D	SWLWG_DSCHRG_CD	(27d) Swallowing Status: Discharge	CHAR	2	A code describing the patient's swallowing status at time of discharge.	01 = Tube/Parenteral Feeding: tube/parenteral feeding used wholly or partially as a means of sustenance, 02 = Modified Food Consistency/Supervision: subject requires modified food consistency and/or needs supervision for safety, 03 = Regular Food: solids and liquids swallowed safely without supervision or modified food consistency
67	_28A	DHYDRTN_ADMSN_SW	(28a) Clinical Signs of Dehydration: Admission	CHAR	1	A code indicating whether the patient exhibits signs of dehydration at time of admission.	0 = No, 1 = Yes
68	_28D	DHYDRTN_DSCHRG_SW	(28d) Clinical Signs of Dehydration: Discharge	CHAR	1	A code indicating whether the patient exhibits signs of dehydration at time of discharge.	0 = No, 1 = Yes
69	_29A	BLADR_ASTNC_ADMSN_CD	(29a) Bladder Level of Assistance: Admission	CHAR	2	A score indicating the level of assistance needed for the patient's bladder management at admission. Bladder management - level of assistance includes the safe use of equipment or agents for bladder management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
70	_29D	BLADR_ASTNC_DSCHRG_CD	(29d) Bladder Level of Assistance: Discharge	CHAR	2	A score indicating the level of assistance needed for the patient's bladder management at discharge. Bladder management - level of assistance includes the safe use of equipment or agents for bladder management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence
71	_30A	BLADR_ACDNT_ADMSN_CD	(30a) Bladder Frequency of Accidents: Admission	CHAR	2	A score indicating the frequency of bladder accidents at admission. Bladder accidents refers to the act of wetting linen or clothing with urine, and includes bedpan and urinal spills.	01 = Five or more accidents in the past 7 days, 02 = Four accidents in the past 7 days, 03 = Three accidents in the past 7 days, 04 = Two accidents in the past 7 days, 05 = One accident in the past 7 days, 06 = No accidents, uses device such as catheter, 07 = No accidents.
72	_30D	BLADR_ACDNT_DSCHRG_CD	(30d) Bladder Frequency of Accidents: Discharge	CHAR	2	A score indicating the frequency of bladder accidents at discharge. Bladder accidents refers to the act of wetting linen or clothing with urine, and includes bedpan and urinal spills.	01 = Five or more accidents in the past 7 days, 02 = Four accidents in the past 7 days, 03 = Three accidents in the past 7 days, 04 = Two accidents in the past 7 days, 05 = One accident in the past 7 days, 06 = No accidents, uses device such as catheter, 07 = No accidents.
73	_31A	BWL_ASTNC_ADMSN_CD	(31a) Bowel Level of Assistance: Admission	CHAR	2	A score indicating the level of assistance needed for the patient's bowel management at admission. Bowel management - level of assistance includes the safe use of equipment or agents for bowel management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
74	_31D	BWL_ASTNC_DSCHRG_CD	(31d) Bowel Level of Assistance: Discharge	CHAR	2	A score indicating the level of assistance needed for the patient's bowel management at discharge. Bowel management - level of assistance includes the safe use of equipment or agents for bowel management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence
75	_32A	BWL_ACDNT_ADMSN_CD	(32a) Bowel Frequency of Accidents: Admission	CHAR	2	A score indicating the frequency of bowel accidents at admission. Bowel accidents refers to the act of soiling linen or clothing with stool, and includes bedpan spills.	01 = Five or more accidents in the past 7 days, 02 = Four accidents in the past 7 days, 03 = Three accidents in the past 7 days, 04 = Two accidents in the past 7 days, 05 = One accident in the past 7 days, 06 = No accidents, uses device such as ostomy, 07 = No accidents.
76	_32D	BWL_ACDNT_DSCHRG_CD	(32d) Bowel Frequency of Accidents: Discharge	CHAR	2	A score indicating the frequency of bowel accidents at discharge. Bowel accidents refers to the act of soiling linen or clothing with stool, and includes bedpan spills.	01 = Five or more accidents in the past 7 days, 02 = Four accidents in the past 7 days, 03 = Three accidents in the past 7 days, 04 = Two accidents in the past 7 days, 05 = One accident in the past 7 days, 06 = No accidents, uses device such as ostomy, 07 = No accidents.
77	_33A	TUB_TRNSFR_ADMSN_CD	(33a) Tub Transfer: Admission	CHAR	2	A score indicating the patient's ability to get into and out of a tub at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

CMS Chronic Condition Data Warehouse

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
78	_33D	TUB_TRNSFR_DSCHRG_CD	(33d) Tub Transfer: Discharge	CHAR	2	A score indicating the patient's ability to get into and out of a tub at discharge.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
79	_34A	SHWR_TRNSFR_ADMSN_CD	(34a) Shower Transfer: Admission	CHAR	2	A score indicating the patient's ability to get into and out of a shower at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
80	_34D	SHWR_TRNSFR_DSCHRG_CD	(34d) Shower Transfer: Discharge	CHAR	2	A score indicating the patient's ability to get into and out of a shower at discharge.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
81	_35A	DSTNC_WLKD_ADMSN_CD	(35a) Distance Walked: Admission	CHAR	2	A code indicating the distance the patient walked at admission.	00 = Activity does not occur, 01 = Less than 50 feet, 02 = 50 to 149 feet, 03 = 150 feet
82	_35D	DSTNC_WLKD_DSCHRG_CD	(35d) Distance Walked: Discharge	CHAR	2	A code indicating the distance the patient walked at discharge.	00 = Activity does not occur, 01 = Less than 50 feet, 02 = 50 to 149 feet, 03 = 150 feet
83	_36A	DSTNC_WC_ADMSN_CD	(36a) Distance Traveled in Wheelchair: Admission	CHAR	2	A code indicating the distance the patient traveled in a wheelchair at admission.	00 = Activity does not occur, 01 = Less than 50 feet, 02 = 50 to 149 feet, 03 = 150 feet
84	_36D	DSTNC_WC_DSCHRG_CD	(36d) Distance Traveled in Wheelchair: Discharge	CHAR	2	A code indicating the distance the patient traveled in a wheelchair at discharge.	00 = Activity does not occur, 01 = Less than 50 feet, 02 = 50 to 149 feet, 03 = 150 feet
85	_37A	WLK_ADMSN_CD	(37a) Walk: Admission	CHAR	2	A score indicating the patient's ability to walk on a level surface at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

CMS Chronic Condition Data Warehouse

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
86	_37D	WLK_DSCHRG_CD	(37d) Walk: Discharge	CHAR	2	A score indicating the patient's ability to walk on a level surface at discharge.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
87	_38A	WC_ADMSN_CD	(38a) Wheelchair: Admission	CHAR	2	A score indicating the patient's ability to use a wheelchair on a level surface once seated at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
88	_38D	WC_DSCHRG_CD	(38d) Wheelchair: Discharge	CHAR	2	A score indicating the patient's ability to use a wheelchair on a level surface once seated at discharge.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
89	_39AA	EATG_ADMSN_CD	(39Aa) Self-Care: Eating: Admission	CHAR	2	A score indicating the patient's ability to eat at admission. 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.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
90	_39AD	EATG_DSCHRG_CD	(39Ad) Self-Care: Eating: Discharge	CHAR	2	A score indicating the patient's ability to eat at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
91	_39AG	EATG_GOAL_CD	(39Ag) Self-Care: Eating: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for eating at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
92	_39BA	GRMG_ADMSN_CD	(39Ba) Self-Care: Grooming: Admission	CHAR	2	A score indicating the patient's ability to groom at admission. Grooming includes oral care, hair grooming (combing or brushing hair), washing the hands, face, and either shaving the face or applying make-up. If the patient neither shaves nor applies make-up, grooming includes only the first four tasks. This items includes obtaining articles necessary for grooming.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
93	_39BD	GRMG_DSCHRG_CD	(39Bd) Self-Care: Grooming: Discharge	CHAR	2	A score indicating the patient's ability to groom at discharge. Grooming includes oral care, hair grooming (combing or brushing hair), washing the hands, face, and either shaving the face or applying make-up. If the patient neither shaves nor applies make-up, grooming includes only the first four tasks. This items includes obtaining articles necessary for grooming.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
94	_39BG	GRMG_GOAL_CD	(39Bg) Self-Care: Grooming: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for grooming at discharge. Grooming includes oral care, hair grooming (combing or brushing hair), washing the hands, face, and either shaving the face or applying make-up. If the patient neither shaves nor applies make-up, grooming includes only the first four tasks. This items includes obtaining articles necessary for grooming.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
95	_39CA	BATHG_ADMSN_CD	(39Ca) Self-Care: Bathing: Admission	CHAR	2	A score indicating the patient's ability to bathe at admission. Bathing includes washing, rinsing, and drying the body from the neck down in either a tub, shower, or sponge/bed bath.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
96	_39CD	BATHG_DSCHRG_CD	(39Cd) Self-Care: Bathing: Discharge	CHAR	2	A score indicating the patient's ability to bathe at discharge. Bathing includes washing, rinsing, and drying the body from the neck down in either a tub, shower, or sponge/bed bath.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
97	_39CG	BATHG_GOAL_CD	(39Cg) Self-Care: Bathing: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for bathing at discharge. Bathing includes washing, rinsing, and drying the body from the neck down in either a tub, shower, or sponge/bed bath.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
98	_39DA	DRSG_UPR_ADMSN_CD	39Da) Self-Care: Dressing-Upper: Admission	CHAR	2	A score indicating the patient's ability to dress the upper body at admission. Dressing the upper body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
99	_39DD	DRSG_UPR_DSCHRG_CD	(39Dd) Self-Care: Dressing-Upper: Discharge	CHAR	2	A score indicating the patient's ability to dress the upper body at discharge. Dressing the upper body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
100	_39DG	DRSG_UPR_GOAL_CD	(39Dg) Self-Care: Dressing-Upper: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve to dress the upper body at discharge. Dressing the upper body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
101	_39EA	DRSG_LWR_ADMSN_CD	(39Ea) Self-Care: Dressing-Lower: Admission	CHAR	2	A score indicating the patient's ability to dress the lower body at admission. Dressing the lower body includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
102	_39ED	DRSG_LWR_DSCHRG_CD	(39Ed) Self-Care: Dressing-Lower: Discharge	CHAR	2	A score indicating the patient's ability to dress the lower body at discharge. Dressing the lower body includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
103	_39EG	DRSG_LWR_GOAL_CD	(39Eg) Self-Care: Dressing-Lower: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve to dress the lower body at discharge. Dressing the lower body includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
104	_39FA	TOILTG_ADMSN_CD	(39Fa) Self-Care: Toileting: Admission	CHAR	2	A score indicating the patient's ability to maintain perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
105	_39FD	TOILTG_DSCHRG_CD	(39Fd) Self-Care: Toileting: Discharge	CHAR	2	A score indicating the patient's ability to maintain perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
106	_39FG	TOILTG_GOAL_CD	(39Fg) Self-Care: Toileting: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve the ability to maintain perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
107	_39GA	SPHNCTR_BLADR_ADMSN_CD	(39Ga) Sphincter Control - Bladder: Admission	CHAR	2	A score indicating the level of assistance needed for the patient's bladder management at admission. Bladder management - level of assistance includes the safe use of equipment or agents for bladder management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
108	_39GD	SPHNCTR_BLADR_DSCHRG_CD	(39Gd) Sphincter Control - Bladder: Discharge	CHAR	2	A score indicating the level of assistance needed for the patient's bladder management at discharge. Bladder management - level of assistance includes the safe use of equipment or agents for bladder management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
109	_39GG	SPHNCTR_BLADR_GOAL_CD	(39Gg) Sphincter Control - Bladder: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for bladder management at discharge. Bladder management - level of assistance includes the safe use of equipment or agents for bladder management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
110	_39HA	SPHNCTR_BWL_ADMSN_CD	(39Ha) Sphincter Control - Bowel: Admission	CHAR	2	A score indicating the level of assistance needed fo the patient's bowel management at admission. Bowel management - level of assistance includes use of equipment or agents for bowel management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
111	_39HD	SPHNCTR_BWL_DSCHRG_CD	(39Hd) Sphincter Control - Bowel: Discharge	CHAR	2	A score indicating the level of assistance needed fo the patient's bowel management at discharge. Bowel management - level of assistance includes use of equipment or agents for bowel management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
112	_39HG	SPHNCTR_BWL_GOAL_CD	(39Hg) Sphincter Control - Bowel: Goal	CHAR	2	A score indicating the desired goal for the level of assistance needed for the patient's bowel management at discharge. Bowel management - level of assistance includes use of equipment or agents for bowel management.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
113	_39IA	BED_CHR_WC_ADMSN_CD	(39Ia) Transfers - Bed, chair, wheelchair: Admission	CHAR	2	A score indicating the patient's ability to transfer 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 at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
114	_39ID	BED_CHR_WC_DSCHRG_CD	(39Id) Transfers - Bed, chair, wheelchair: Discharge	CHAR	2	A score indicating the patient's ability to transfer 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 at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
115	_39IG	BED_CHR_WC_GOAL_CD	(39Ig) Transfers - Bed, chair, wheelchair: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve the ability to transfer 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 at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
116	_39JA	TOILT_ADMSN_CD	(39Ja) Transfers - Toilet: Admission	CHAR	2	A score indicating the patient's ability to safely get on and off a toilet at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
117	_39JD	TOILT_DSCHRG_CD	(39Jd) Transfers - Toilet: Discharge	CHAR	2	A score indicating the patient's ability to safely get on and off a toilet at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
118	_39JG	TOILT_GOAL_CD	(39Jg) Transfers - Toilet: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve to safely get on and off a toilet at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
119	_39KA	TUB_SHWR_ADMSN_CD	(39Ka) Transfers - Tub, Shower: Admission	CHAR	2	A score indicating the patient's ability to get into and out of a tub or shower at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
120	_39KD	TUB_SHWR_DSCHRG_CD	(39Kd) Transfers - Tub, Shower: Discharge	CHAR	2	A score indicating the patient's ability to get into and out of a tub or shower at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
121	_39KG	TUB_SHWR_GOAL_CD	(39Kg) Transfers - Tub, Shower: Goal	CHAR	2	A score indicating the desired goal for the patient to get into and out of a tub or shower at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
122	_39LA	WLK_WC_ADMSN_CD	(39La) Locomotion - Walk/wheelchair: Admission	CHAR	2	A score indicating the patient's ability to walk or use a wheelchair on a level surface at admission. This item indicates the most frequent mode of locomotion the patient uses - 'walk' or 'wheelchair'.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
123	_39LAA	WLK_WC_BOTH_ADMSN_CD	(39Laa) Locomotion - Walk/wheelchair/both: Admission	CHAR	1	A score indicating the patient's ability to both walk and use a wheelchair at admission. This item indicates that the patient uses 'both' means of locomotion about equally.	B = Both, C = Wheelchair, W = Walk

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
124	_39LD	WLK_WC_DSCHRG_CD	(39Ld) Locomotion - Walk/wheelchair: Discharge	CHAR	2	A score indicating the patient's ability to walk or use a wheelchair on a level surface at discharge. This item indicates the most frequent mode of locomotion the patient uses - 'walk' or 'wheelchair'.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
125	_39LDD	WLK_WC_BOTH_DSCHRG_CD	(39Ldd) Locomotion - Walk/wheelchair/both: Discharge	CHAR	1	A score indicating the patient's ability to both walk and use a wheelchair at discharge. This item indicates that the patient uses 'both' means of locomotion about equally.	B = Both, C = Wheelchair, W = Walk
126	_39LG	WLK_WC_GOAL_CD	(39Lg) Locomotion - Walk/wheelchair: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve to walk or use a wheelchair on a level surface at discharge. This item indicates the most frequent mode of locomotion the patient uses - 'walk' or 'wheelchair'.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
127	_39MA	STR_ADMSN_CD	(39Ma) Locomotion - Stairs: Admission	CHAR	2	A score indicating the patient's ability to go up and down 12 to 14 stairs (one flight) indoors in a safe manner at admission.	00 = Activity did not occur, 01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
128	_39MD	STR_DSCHRG_CD	(39Md) Locomotion - Stairs: Discharge	CHAR	2	A score indicating the patient's ability to go up and down 12 to 14 stairs (one flight) indoors in a safe manner at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
129	_39MG	STR_GOAL_CD	(39Mg) Locomotion - Stairs: Goal	CHAR	2	A score indicating the desired goal for the patient's ability to go up and down 12 to 14 stairs (one flight) indoors in a safe manner at discharge.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
130	_39NA	CMPRHNSN_ADMSN_CD	(39Na) Communication - Comprehension: Admission	CHAR	2	A score indicating the patient's ability to comprehend at admission. Comprehension includes understanding of either auditory or visual communication (for example, writing, sign language, gestures).	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
131	_39NAA	CMPRHNSN_ADTRY_VISL_ADMSN_CD	(39Naa) Communication - Auditory/Visual/Both: Admission	CHAR	1	A score indicating the patient's ability to comprehend at admission. Comprehension includes understanding of either auditory or visual communication (for example, writing, sign language, gestures). The more usual mode of comprehension ('Auditory' or 'Visual') is evaluated; 'Both' indicates auditory and visual are used about equally.	A = Auditory, B= Both, V = Visual
132	_39ND	CMPRHNSN_DSCHRG_CD	(39Nd) Communication - Comprehension: Discharge	CHAR	2	A score indicating the patient's ability to comprehend at discharge. Comprehension includes understanding of either auditory or visual communication (for example, writing, sign language, gestures).	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
133	_39NDD	CMPRHNSN_ADTRY_VISL_DSCHRG_CD	(39Ndd) Communication - Auditory/Visual/Both: Discharge	CHAR	1	A score indicating the patient's ability to comprehend at discharge. Comprehension includes understanding of either auditory or visual communication (for example, writing, sign language, gestures). The more usual mode of comprehension ('Auditory,' or 'Visual') is evaluated; 'Both' indicates auditory and visual are used about equally.	A = Auditory, B= Both, V = Visual
134	_39NG	CMPRHNSN_GOAL_CD	(39Ng) Communication - Comprehension: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for comprehension at discharge. Comprehension includes understanding of either auditory or visual communication (for example, writing, sign language, gestures).	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
135	_39OA	EXPRSN_ADMSN_CD	(39Oa) Communication - Expression: Admission	CHAR	2	A score indicating the patient's ability for expression at admission. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
136	_39OAA	EXPRSN_VCL_NVCL_ADMSN_CD	(39Oaa) Communication - Vocal/Nonvocal/Both: Admission	CHAR	1	A score indicating the patient's ability for expression at admission. 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. The more usual mode of expression ('Vocal' or 'Nonvocal') is evaluated; 'Both' indicates vocal and nonvocal are used about equally.	B = Both, N = Nonvocal, V = Vocal
137	_39OD	EXPRSN_DSCHRG_CD	(39Od) Communication - Expression: Discharge	CHAR	2	A score indicating the patient's ability for expression at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
138	_39ODD	EXPRSN_VCL_NVCL_DSCHRG_CD	(39Odd) Communication - Vocal/Nonvocal/Both: Discharge	CHAR	1	A score indicating the patient's ability for expression at discharge. 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. The more usual mode of expression ('Vocal' or 'Nonvocal') is evaluated; 'Both' indicates vocal and nonvocal are used about equally.	B = Both, N = Nonvocal, V = Vocal

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
139	_39OG	EXPRSN_GOAL_CD	(39Og) Communication - Expression: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for expression at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
140	_39PA	SCL_INTRCTN_ADMSN_CD	(39Pa) Social Cognition - Social Interaction: Admission	CHAR	2	A score indicating the patient's ability for social interaction at admission. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
141	_39PD	SCL_INTRCTN_DSCHRG_CD	(39Pd) Social Cognition - Social Interaction: Discharge	CHAR	2	A score indicating the patient's ability for social interaction at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
142	_39PG	SCL_INTRCTN_GOAL_CD	(39Pg) Social Cognition - Social Interaction: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for social interaction at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
143	_39QA	PRBLM_SLVG_ADMSN_CD	(39Qa) Social Cognition - Problem Solving: Admission	CHAR	2	A score indicating the patient's ability for problem solving at admission. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
144	_39QD	PRBLM_SLVG_DSCHRG_CD	(39Qd) Social Cognition - Problem Solving: Discharge	CHAR	2	A score indicating the patient's ability for problem solving at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
145	_39QG	PRBLM_SLVG_GOAL_CD	(39Qg) Social Cognition - Problem Solving: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for problem solving at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
146	_39RA	MEMRY_ADMSN_CD	(39Ra) Social Cognition - Memory: Admission	CHAR	2	A score indicating the patient's ability to remember at admission. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
147	_39RD	MEMRY_DSCHRG_CD	(39Rd) Social Cognition - Memory: Discharge	CHAR	2	A score indicating the patient's ability to remember at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
148	_39RG	MEMRY_GOAL_CD	(39Rg) Social Cognition - Memory: Goal	CHAR	2	A score indicating the desired goal for the patient to achieve for memory at discharge. 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.	01 = Helper - Complete Dependence/Total Assistance (Subject less than 25%), 02 = Helper - Complete Dependence/Maximal Assistance (Subject 25% or more), 03 = Helper - Modified Dependence/Moderate Assistance (Subject 50% or more), 04 = Helper - Modified Dependence/Minimal Assistance (Subject 75% or more), 05 = Helper - Modified Dependence/Supervision (Subject 100%), 06 = No Helper/Modified Independence (Device), 07 = No Helper/Complete Independence (Timely, Safely)
149	_40	DSCHRG_DT	(40) Discharge Date	DATE	8	This date determines the year of the assessment. The date the patient is discharged from the rehabilitation facility.	0 = No, 1 = Yes
150	_41	DSCHRG_AGNST_MDCL_ADV_C_SW	(41) Patient Discharged Against Medical Advice	CHAR	1	A code indicating whether the patient was discharged against medical advice.	0 = No, 1 = Yes
151	_42	PGM_INTRPTN_SW	(42) Program Interruption(s)	CHAR	1	A code indicating whether the Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days.	0 = No, 1 = Yes
152	_43A	TRNSFR_1_DT	(43A) First Interruption Date	DATE	8	The date when the patient leaves the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	
153	_43B	RTRN_1_DT	(43B) First Return Date	DATE	8	The date when the patient returns to the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
154	_43C	TRNSFR_2_DT	(43C) Second Interruption Date	DATE	8	The second date when the patient leaves the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	
155	_43D	RTRN_2_DT	(43D) Second Return Date	DATE	8	The date when the patient returns to the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	
156	_43E	TRNSFR_3_DT	(43E) Third Interruption Date	DATE	8	The third date when the patient leaves the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	
157	_43F	RTRN_3_DT	(43F) Third Return Date	DATE	8	The date when the patient returns to the inpatient rehabilitation facility in a program interruption situation (Item 42 - a situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days).	
158	_44A	DSCHRG_TO_LVG_SETG_CD	(44A) Discharge to Living Setting	CHAR	2	A code indicating the setting to which the patient is discharged.	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

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
159	_44B	DSCHRG_WTH_HOME_HLTH_SRVC_SW	(44B) Was Patient Discharged with Home Health Services?	CHAR	1	A code indicating whether the patient was discharged with Home Health Services (if the patient was discharged to a community-based setting, i.e., Item 44A is coded 01 - Home; 02 - Board and Care; 03 - Transitional Living; 14 - Assisted Living Residence).	0 = No, 1 = Yes
160	_45	DSCHRG_TO_LVG_WTH_CD	(45) Discharge to Living With	CHAR	2	A code which indicates with whom the resident will be living if Item 44A (Discharge to Living Setting) is coded 01 - Home.	01 = Alone, 02 = Family/Relatives, 03 = Friends, 04 = Attendant, 05 = Other
161	_46	DGNS_TRNSFR_DEATH_CD	(46) Diagnosis for Interruption or Death (ICD-9 Code)	CHAR	7	An ICD-9 code indicating the reason for the program interruption or death.	
162	_47A	CMPLCTN_DRNG_REHAB_A_CD	(47A) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	
163	_47B	CMPLCTN_DRNG_REHAB_B_CD	(47B) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	
164	_47C	CMPLCTN_DRNG_REHAB_C_CD	(47C) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	
165	_47D	CMPLCTN_DRNG_REHAB_D_CD	(47D) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
166	_47E	CMPLCTN_DRNG_REHAB_E_CD	(47E) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	
167	_47F	CMPLCTN_DRNG_REHAB_F_CD	(47F) Complications During Rehabilitation Stay (ICD-9 Code)	CHAR	7	An ICD-9-CM code indicating the complications or comorbidities that began after the rehabilitation stay started. This code identifies conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.	
168	_48A	SOB_EXRTN_ADMSN_SW	(48a) Shortness of Breath With Exertion: Admission	CHAR	1	A code which indicates whether the patient reports one or more episodes of becoming 'breathless' or short of breath (dyspneic), or the patient is observed to be short of breath with mild exertion, such as during bathing or transferring, on at least one occasion at the time of admission.	0 = No, 1 = Yes
169	_48D	SOB_EXRTN_DSCHRG_SW	(48d) Shortness of Breath With Exertion: Discharge	CHAR	1	A code which indicates whether the patient reports one or more episodes of becoming 'breathless' or short of breath (dyspneic), or the patient is observed to be short of breath with mild exertion, such as during bathing or transferring, on at least one occasion at the time of discharge.	0 = No, 1 = Yes
170	_49A	SOB_REST_ADMSN_SW	(49a) Shortness of Breath At Rest: Admission	CHAR	1	A code which indicates whether the patient reports one or more episodes of becoming 'breathless' or short of breath (dyspneic), or the patient is observed to be short of breath while at rest (e.g., while sitting, talking) on at least on occasion at the time of admission.	0 = No, 1 = Yes
171	_49D	SOB_REST_DSCHRG_SW	(49d) Shortness of Breath At Rest: Discharge	CHAR	1	A code which indicates whether the patient reports one or more episodes of becoming 'breathless' or short of breath (dyspneic), or the patient is observed to be short of breath while at rest (e.g., while sitting, talking) on at least on occasion at the time of discharge.	0 = No, 1 = Yes

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
172	_50A	DFCLTY_CLRG_ARWY_ADMSN_SW	(50a) Weak Cough and Difficulty Clearing Airway Secretions: Admission	CHAR	1	A code which indicates whether the patient reports or is observed to be unable to cough effectively to expel respiratory secretions or sputum from the mouth on at least one occasion at the time of admission.	0 = No, 1 = Yes
173	_50D	DFCLTY_CLRG_ARWY_DSCHRG_SW	(50d) Weak Cough and Difficulty Clearing Airway Secretions: Discharge	CHAR	1	A code which indicates whether the patient reports or is observed to be unable to cough effectively to expel respiratory secretions or sputum from the mouth on at least one occasion at the time of discharge.	0 = No, 1 = Yes
174	_51A	MOST_SVR_PN_RATE_ADMSN_CD	(51a) Rate the Highest Level of Pain Reported by the Patient Within the Assessment Period: Admission	CHAR	2	A rating indicating the highest level of pain reported by the patient within the assessment period regardless of whether taking pain medication at the time of admission. Pain refers to any type of physical pain or discomfort in any part of the body.	00 = 00, 01 = 01, 02 = 02, 03 = 03, 04 = 04, 05 = 05, -6 = 06, 07 = 07, 08 = 08, 09 = 09, 10 = 10
175	_51D	MOST_SVR_PN_RATE_DSCHRG_CD	(51d) Rate the Highest Level of Pain Reported by the Patient Within the Assessment Period: Discharge	CHAR	2	A rating indicating the highest level of pain reported by the patient within the assessment period regardless of whether taking pain medication at the time of discharge. Pain refers to any type of physical pain or discomfort in any part of the body.	00 = 00, 01 = 01, 02 = 02, 03 = 03, 04 = 04, 05 = 05, -6 = 06, 07 = 07, 08 = 08, 09 = 09, 10 = 10
176	_52AA	HIGHST_PRSR_ULCR_ADMSN_CD	(52Aa) Highest Current Pressure Ulcer stage: Admission	CHAR	2	A code indicating the highest current pressure ulcer stage at the time of admission.	00 = No pressure ulcer, 01 = Any area of persistent skin redness (Stage 1), 02 = Partial loss of skin layers (Stage 2), 03 = Deep craters in the skin (Stage 3), 04 = Breaks in skin exposing muscle or bone (Stage 4), 05 = Not stageable (necrotic eschar predominant; no prior staging available)
177	_52AD	HIGHST_PRSR_ULCR_DSCHRG_CD	(52Ad) Highest Current Pressure Ulcer stage: Discharge	CHAR	2	A code indicating the highest current pressure ulcer stage at the time of discharge.	00 = No pressure ulcer, 01 = Any area of persistent skin redness (Stage 1), 02 = Partial loss of skin layers (Stage 2), 03 = Deep craters in the skin (Stage 3), 04 = Breaks in skin exposing muscle or bone (Stage 4), 05 = Not stageable (necrotic eschar predominant; no prior staging available)

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
178	_52BA	PRSR_ULCR_ADMSN_CNT	(52Ba) Number of Current Pressure Ulcers: Admission	CHAR	2	The number of pressure ulcers, including ulcers that cannot be accurately staged at the time of admission.	
179	_52BD	PRSR_ULCR_DSCHRG_CNT	(52Bd) Number of Current Pressure Ulcers: Discharge	CHAR	2	The number of pressure ulcers, including ulcers that cannot be accurately staged at the time of discharge.	
180	_52CA	LRGST_PRSR_ULCR_ADMSN_NUM	(52Ca) Length Multiplied by Width: Admission	CHAR	2	A score indicating the largest pressure ulcer's open surface area at the time of admission.	00 = 0 cm, 01 = <0.3 cm, 02 = 0.3 to 0.6 cm, 03 = 0.7 to 1.0 cm, 04 = 1.1 to 2.0 cm, 05 = 2.1 to 3.0 cm, 06 = 3.1 to 4.0 cm, 07 = 4.1 to 8.0 cm, 08 = 8.1 to 12.0 cm, 09 = 12.1 to 24.0 cm, 10 = >24 cm
181	_52CD	LRGST_PRSR_ULCR_DSCHRG_NUM	(52Cd) Length Multiplied by Width: Discharge	CHAR	2	A score indicating the largest pressure ulcer's open surface area at the time of discharge.	00 = 0 cm, 01 = <0.3 cm, 02 = 0.3 to 0.6 cm, 03 = 0.7 to 1.0 cm, 04 = 1.1 to 2.0 cm, 05 = 2.1 to 3.0 cm, 06 = 3.1 to 4.0 cm, 07 = 4.1 to 8.0 cm, 08 = 8.1 to 12.0 cm, 09 = 12.1 to 24.0 cm, 10 = >24 cm
182	_52DA	EXDT_AMT_ADMSN_CD	(52Da) Exudate Amount: Admission	CHAR	2	A code indicating the amount of exudate (drainage) present after removing the dressing and applying any topical agent to the ulcer for the largest pressure ulcer at the time of admission.	00 = None, 01 = Light, 02 = Moderate, 03 = Heavy
183	_52DD	EXDT_AMT_DSCHRG_CD	(52Dd) Exudate Amount: Discharge	CHAR	2	A code indicating the amount of exudate (drainage) present after removing the dressing and applying any topical agent to the ulcer for the largest pressure ulcer at the time of admission.	00 = None, 01 = Light, 02 = Moderate, 03 = Heavy
184	_52EA	TISUE_TYPE_ADMSN_CD	(52Ea) Tissue Type: Admission	CHAR	2	A code that indicates the type of tissue that occupies the majority of the ulcer bed of the largest pressure ulcer at the time of admission.	00 = Closed/resurfaced: The wound is completely covered with epithelium (new skin), 01 = Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 02 = Granulation tissue: Pink or beefy red tissue with a shiny, moist granular appearance, 03 = Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous, 04 = Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.

IRF PAI Assessment Files Data Dictionary

Variable Sequence	Short SAS Name	Long SAS Name	Label	Data Type	Data Length	Description	Codes
185	_52ED	TISUE_TYPE_DSCHRG_CD	(52Ed) Tissue Type: Discharge	CHAR	2	A code that indicates the type of tissue that occupies the majority of the ulcer bed of the largest pressure ulcer at the time of discharge.	00 = Closed/resurfaced: The wound is completely covered with epithelium (new skin), 01 = Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 02 = Granulation tissue: Pink or beefy red tissue with a shiny, moist granular appearance, 03 = Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous, 04 = Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.
186	_52FA	TOT_PUSH_SCRE_ADMSN_NUM	(52Fa) Total PUSH Score: Admission	CHAR	2	The sum of the scores of the three items (52C + 52D + 52E) to derive the toatl PUSH tool score at the time of admission.	
187	_52FD	TOT_PUSH_SCRE_DSCHRG_NUM	(52Fd) Total PUSH Score: Discharge	CHAR	2	The sum of the scores of the three items (52C + 52D + 52E) to derive the toatl PUSH tool score at the time of discharge.	
188	_53A	STNDG_BAL_PRBLM_ADMSN_SW	(53a) Standing Balance Problem: Admission	CHAR	1	A code indicating whether the patient reports at least one episode of dizziness, vertigo, or light-headedness while sitting or standing at the time of admission.	0 = No, 1 = Yes
189	_53D	STNDG_BAL_PRBLM_DSCHRG_SW	(53d) Standing Balance Problem: Discharge	CHAR	1	A code indicating whether the patient reports at least one episode of dizziness, vertigo, or light-headedness while sitting or standing at the time of discharge.	0 = No, 1 = Yes
190	_54	TOT_FALL_DRNG_REHAB_STAY_NUM	(54) Total Number of Falls During the Rehabilitation Stay: Discharge	CHAR	3	The total number of falls during the rehabilitation stay recorded at the time of discharge.	
191	RQSTSNDT	RQST_SENT_DT	Sent Date	DATE	8	The two-digit state abbreviation.	