PASRR

Pre-Admission Screening & Resident Review Manual

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Pre-Admission Screening Resident Review (PASRR)

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Omnibus Reconciliation Act of 1987 (OBRA)
Pre-Admission Screening Resident Review (PASRR)

INTRODUCTION

The Omnibus Reconciliation Act of 1987 (OBRA) and P.L. 100-203, Section 4211 (c) (7), and OBRA 1990 contain provisions with major implications for persons with mental illness or intellectual disability/related condition applying or residing in a nursing facility. The provisions were designed to eliminate the practice of inappropriately placing persons with mental illness, intellectual disability/related conditions in Medicaid certified nursing facilities. This Act mandates The Department for Behavioral Health, Developmental and Intellectual Disability Services (DBHDID), to establish a Pre-Admission Screening Resident Review (PASRR) for all persons requesting admission to or currently residing in a nursing facility. Through the PASRR evaluation, the Department determines whether:

(1) The person requires nursing facility level of care and whether NF level of care is the least restrictive environment in which care may be provided.

(2) If so, whether the person requires specialized services (active treatment).

Specifically, the PASRR program must assure the following:

1. As of January 1, 1989, no person may be admitted to a Medicaid certified nursing facility without first being screened for mental illness or intellectual disability/related condition. This provision applies regardless of the source of the nursing facility payment.

2. As a result of this screening component (referred to as Level I), persons who appear to have a mental illness or intellectual disability/related condition will undergo a comprehensive assessment (referred to as Level II) to determine the need for nursing facility care and specialized services (active treatment).

3. As of April 1,1990, all persons presently residing in nursing facilities, who entered the facility prior to January 1,1989, will have been screened for mental illness or intellectual disability/related condition (referred to as the initial resident review).

4. October 19,1996, the President signed P.L. 104-315, which amends Title XIX of the Social Security Act to repeal the requirement for annual resident review. The amendment requires nursing facilities to notify the State Mental Health Mental Retardation authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who has a serious mental illness or intellectual disability/related condition. The change in condition must affect either the resident’s need for continued nursing facility placement or for specialized services. A review and determination under Section 1919 (e) (7) of the Act must be done promptly after a nursing facility notifies the State Community Mental Health Mental Retardation centers (CMHMRC) that there has been a significant change in the resident’s physical or mental condition.

1.1 Responsible Agencies

1. **The Center for Medicare and Medicaid Services (CMS)**

   The federal agency which administers the Medicaid program

2. **Department for Medicaid Services (DMS)**

   The single designated state agency for the administration of the Title XIX program under the Social Security Act and is; therefore, responsible for the administering the medical assistance program, including the issuance of policies, rules and regulations on program matters and making payments for vendor services provided to eligible recipients under the State Plan. As a condition of approval of the State Medicaid Plan, Kentucky is required to operate a (PASRR) program that meets the CMS regulatory requirements and is responsible for the following:

   a) Assuring that the state mental health, developmental and intellectual disability authorities, who are charged with making the required determinations, fulfill their statutory responsibilities.

   b) Assuring that the state's PASRR program operates as it should, in accordance with the statute and OBRA regulations.

   c) Assuring that the accounting, auditing, and enforcement of PASRR funding takes place; this includes withholding payment in cases of non-compliance, and specifying an evaluation instrument that identifies applicants with mental health, developmental and intellectual disability/related conditions. DMS cannot countermand determinations made by DBHDID either in the claims process, utilization review, or state survey.

   d) Assuring that the two determinations are needs based for consistent analysis of data.

   e) Assuring that nursing facilities do not admit or retain individuals with mental illness or intellectual disability/related conditions unless he or she has been screened and found to be appropriate for placement.

   f) Assuring that the resident assessments conducted by the nursing facility are coordinated with the state's PASRR evaluations, as required by Section 1919(b) (3) (E) of the Act.

   g) Assuring individuals who must be discharged under Section 1919(e) (7) (C) of the Act are discharged.

3. Department for Behavioral Health, Developmental and Intellectual Disability Services (DBHDID)

The DBHDID is responsible for assuring that the PASRR Level II evaluations are conducted and determinations are made in accordance with Federal regulations and DMS instructions. DBHDID authorities retain ultimate control and responsibility for the performance of their statutory obligations.

4. Community Mental Health/Mental Retardation Centers (CMHMRC)

The DBHDID subcontracts with the 14 Community Mental Health Mental Retardation Boards, which operate local centers throughout the state, to conduct the PASRR Level II evaluations for persons who have serious mental illness and/or intellectual disability/related conditions.

5. Peer Review Organization (PRO)

The designated Peer Review Organization (PRO) provides level of care determination for all Medicaid residents applying to or residing in Medicaid Certified Nursing Facilities. PRO staff reviews nursing facility residents' charts for accuracy in use of PASRR related MAP forms, timeliness of referrals, receipt from the CMHMRC's of the Response to Referral forms and/or the completed Level II evaluations, and for compliance with specialized services recommendations.

6. Long Term Care Facilities (NF)

PASRR applies to facilities for which the state survey agency has granted a NF License and the department has granted certification for Medicaid participation. Swing beds are exempt from the PASRR process. If the individual resides in a Personal Care Home, the Level II evaluation would be completed in the PCH. If PASRR criteria are met, the individual would be transferred to the nursing facility.

1.2 Penalty for Non-Compliance

1. State

The State must implement a PASRR program that meets the statutory requirements of 483.100 – 483.138. Failure by the State to operate a PASRR program in accordance with these requirements could lead to compliance actions against the State under Section 1904 of the Act "…particularly, the failure to implement the clear statutory mandates, such as subjecting all categories of individuals with mental illness or intellectual disability/related conditions (Medicaid, Medicare, and private pay) to PASRR and requiring nursing facility not admit unscreened individuals, would be reviewed as a failure to meet Medicaid state plan requirements. Compliance proceedings could result in loss of Federal Financial Participation (FFP) in the state's Medicaid nursing home program until compliance is achieved."

2. Nursing Facility

It is the responsibility of the nursing facility to assure that the PASRR Level I screens are conducted on all applicants to the nursing facility, regardless of payer source, and that referrals for Level II evaluations are made when indicated. According to Section 1919 (e) (7) (D) of the OBRA Act, failure to comply with the PASRR requirements may jeopardize Medicaid eligibility retroactive to the admission date to the applicant who was not appropriately screened, as well as the facility participation in the Medicaid program.

3. Individual

Individuals who are found to have a serious mental illness or intellectual disability/related condition through the Level I screen must participate in the Level II evaluation in order to be admitted to, or remain in, a Medicaid Certified Nursing Facility regardless of payment source.

Per 907 KAR 1:755, Section 3: Deemed consent for PASRR. An individual applying for admission to or requesting a continued stay in a nursing facility participating in Medicaid shall be deemed to have given consent for the department to make the determination of appropriateness for the individual to Specified 42 U.S.C 1396r.

1.3 Definitions

1. Mental Illness

An individual is considered to have a serious mental illness if he/she meets the following: a mental illness diagnosis, level of impairment, and duration of mental illness/recent treatment.

a) Diagnosis

The individual has a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, (DSM) which includes a schizophrenic; mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; other psychotic disorders; or other mental disorder that may lead to chronic disability. This does not include a primary diagnosis of dementia, including Alzheimer’s disease or a related disorder; or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above.

b) Level of impairment

The disorder results in functional limitations in major life activities such as: interpersonal functioning; concentration; persistence and pace; and adaption to change. These functional limitations must be evident within the last three to six months and must be appropriate for the person’s developmental stage.

c) Recent Treatment/Duration of illness

The individual has experienced at least one of the following:

i. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization, therapeutic rehabilitation, or inpatient hospitalization); **or**

ii. Within the last two years, due to the mental disorder, experienced a significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

2. Intellectual Disability and Related Conditions

Intellectual disability is defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) Intellectual Disability: Definition, Classification, and Systems of Supports (Eleventh edition) as a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

The provisions of this section also apply to persons with “related conditions” as defined by 42 CFR 435.1009. “Persons with related conditions” refers to individuals who have severe, chronic disability meeting all of the following conditions:

a) It is attributable to:

i. Cerebral Palsy or epilepsy; or

ii. Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required for these persons.

b) It is manifested before the person reaches age 22.

c) It is likely to continue indefinitely.

d) It results in substantial functional limitations in three (3) or more of the following areas of major life activities:

i. Self-care:

ii. Understanding and the use of language;

iii. Learning;

iv. Mobility;

v. Self-direction; or

vi. Capacity for independent living.

Examples of diagnosis that may indicate the condition if all of the above criteria are met include: autism, blindness/severe visual impairment, cerebral palsy, cystic fibrosis, deafness/severe hearing impairment, head injury, epilepsy/seizure disorder, multiple sclerosis, spina bifida, muscular dystrophy, orthopedic impairment, or spinal condition.

3. Dual Diagnosis

For purposes of PASRR, a person is considered dually diagnosed if he/she meets the criteria for serious mental illness and has a diagnosis of intellectual disability/related condition.

1.4 Specialized Services (Active Treatment)

1. Mental Illness

Specialized services (active treatment) is defined as the implementation of an individualized plan of care developed and supervised by a physician and provided by an interdisciplinary team of Qualified Mental Health Professionals (QMHP) that prescribes specific therapies and activities for the persons who are experiencing an acute episode of acute mental illness which necessitates continuous supervision by trained mental health personnel. Specialized services (active treatment) require the level of intensity provided in a psychiatric in-patient setting.

Due to Specialized Services only referring to inpatient psychiatric care for mental health, it is vital for each evaluator to specifically identify mental services required to meet the individual’s needs to be provided by the nursing facility. The evaluator will complete the “Recommended PASRR Services” form and explain these service recommendations to nursing facility staff such as the director of nursing or the social service director. **Evaluators should follow up with nursing facility staff to assure the recommendations are included in the resident’s plan of care.**

2. Intellectual Disability

Specialized services for intellectual disability/related condition is a continuous program for each resident which include aggressive, consistent implementation of a program specified by DBHDID that is directed towards the acquisition of behaviors necessary to function with as much self-determination and independence as possible and the prevention or deceleration of regression of current optimal functional status. These services may be provided in the nursing facility or in a less restrictive environment such

as a community placement provided through Supports for Community Living (SCL), Michelle P. or, Home and Community Based Waiver (HCBW) funding, or other community placement with appropriate community supports. In making this determination, DBHDID must determine the extent to which the person's status compares with each of the following characteristics:

a) Inability to:

  i. Take care of most personal care needs;

  ii. Understand simple commands;

  iii. Communicate basic needs and wants;

  iv. Be employed at a productive wage level without systematic long-term supervision or support;

  v. Learn new skills without aggressive and consistent training;

  vi. Apply skills learned in a training situation to other environments or settings without aggressive and consistent training;

  vii. Demonstrate behavior appropriate to the time, situation, or place without direct supervision; and

  viii. Make decisions requiring informed consent without extreme difficulty.

b) Demonstration of severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and

c) Presence of other skill deficits or specialized training needs that necessitate the availability of trained ID/DD personnel, to teach the person functional skills.

3. Services of Lesser Intensity

Nursing facilities are required by OBRA 1990 to provide mental health, intellectual disability/related condition services, which are of a lesser intensity than specialized services to all residents who need such services. The PASRR evaluator is expected, as a part of the evaluation, to specifically identify these services required to meet the individual's needs. The evaluator will complete the "Recommended PASRR Services" form and explain these service recommendations to nursing facility staff such as the director of nursing or the social service director. **Evaluators should follow up with nursing facility staff to assure the recommendations are included in the resident's plan of care.**

2.1 Description

The Level I screening process is designed to identify individuals with mental illness or intellectual disability/related condition. A Medicaid-certified nursing facility is responsible for assuring that the Level I is conducted prior to admission on all new applicants' regardless of payment source, and for all initial resident reviews. The nursing facility is also responsible for initiating a Level I for current residents who experience a significant change in physical or mental condition that requires a subsequent review. These criteria are identified on the MAP-409-5 form, PASRR Significant Change/Discharge Data.

2.2 MAP 409-1

The form used for Level I screening is the MAP 409-1. This form includes the following screening criteria for mental illness/intellectual disability/related condition:

1. a diagnosis of mental illness, intellectual disability or related condition (except primary diagnosis of dementia, such as Alzheimer's disease or a related disorder for persons with mental illness);

2. functional impairments/limitations in major life activities due to mental illness (within the last three (3) to six (6) months); or

3. recent treatment for mental illness (within the last two (2) years (e.g. therapeutic rehabilitation program or in-patient psychiatric admission) OR

4. Significant disruption to the normal living situation which required supportive services to be maintained in the home or residential setting, or which resulted in intervention by housing or law officials.

2.3 Screens for Exception and Delayed Evaluations

If the person appears to have a mental illness or intellectual disability/related condition based on the Level I screening criteria, then the person completing the MAP 409-1 reviews documentation to determine if the person meets the following.

1. Dementia Diagnosis

An individual is considered to have dementia if he/she has a primary diagnosis of dementia; including Alzheimer's disease, or related disorder, or a non-primary diagnosis of dementia, unless the primary diagnosis is a major mental disorder. For these persons, the PASRR process ends. A dementia diagnosis does not exempt a person with intellectual disability/related condition from Level II evaluation process.

2. Exempted Hospital Discharge (Admission to Nursing Facility for Less Than thirty (30) days)

An exempted hospital discharge means an individual with a diagnosis of mental illness or intellectual disability/related condition who meets NF level of care:

a) is admitted to any nursing facility directly from a hospital after receiving acute in-patient care at the hospital

b) requires nursing facility care for the condition for which he/she received care in the hospital; and

c) whose attending physician has certified before admission to the facility that the individual is likely to require less than thirty (30) days nursing facility care.

If an individual who enters the nursing facility as an exempted hospital discharge is later found to require more than thirty days of nursing facility care, the nursing facility **must** refer the individual for a PASRR Level II evaluation as soon as it is known. The CMHMRC must conduct a PASRR evaluation within forty (40) calendar days of admission.

3. Advanced Group Determination for Nursing Level of Care (Provisional Admission for Less than 14 Days)

An advanced group determination, or provisional admission, is one in which the Level I reviewer, after nursing facility certification, takes in to account certain diagnoses or the need for a particular service which clearly indicates that admission into or residence in a nursing facility is normally needed. Persons who enter the nursing facility under the provisional admission category do not require an individualized evaluation to determine that specialized services are needed prior to admission. However, a request for a Level II PASRR should be made with each provisional admission if he/she is not going to be discharged within fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth day of admission date until a PASRR determination is made authorizing nursing facility level of care. The PASRR evaluation must be completed within nine (9) working days of the Level I referral.

Provisional admission includes:

a) A diagnosis of delirium as defined in the DSM {IIIR}, allows for a fourteen (14) day admission pending further assessment, when an accurate diagnosis cannot be made until the delirium clears.

b) Respite is allowed to in-home caregivers to whom the person with mental illness or intellectual disability/related condition is expected to return following a stay of fourteen (14) days or less

Note: Convalescent Care, Terminal Illness, and Severity of Illness Categories no longer exist.

2.4 Written Notice of Level I finding

In the case of a first time identification of mental illness or intellectual disability/related condition, the Level I reviewer must provide written notice to the individual or resident and his or her legal representative that the individual is suspected of having mental illness, intellectual disability, or a related condition and is being referred for a Level II evaluation.

2.5 Requests for PASRR Level II Evaluations

A request for a PASRR Level II evaluation follows the completion of a positive Level I using the MAP 409-1 form. In most instances, only a nursing facility with an available bed (vacancy) will request a PASRR evaluation for a new admission or advance group determination for provisional admission. An acute care hospital may not initiate a Level I referral to CMHMRC. However, to facilitate the placement of persons with mental illness or intellectual disability/related condition who would be difficult to place within the confines of the routine PASRR placement procedures, two (2) exceptions have been made, as follows:

1. A nursing facility without a vacancy can request a PASRR Level II evaluation upon the completion of a positive MAP 409 as long as there is a reasonable expectation that the person will be admitted when a vacancy occurs. However, the Level II evaluation should only be completed when admission to a nursing facility is expected to take place within 3 working days.

2. DBHDID and DMS have designated the following agency staff as appropriate to initiate a request for a PASRR evaluation directly to the CMHMRC:

   a) State Guardianship officers;
   b) CMHMRC staff;
   c) Department for Community Based Services adult services staff, with approval of center PASRR coordinator;
   d) State operated or contracted psychiatric hospital discharge planners; and
   e) Private psychiatric hospital discharge planners, with approval of center PASRR coordinator.

The referral source (i.e., state guardianship, psychiatric hospitals, etc.) is expected to be reasonably sure that the individual, if a Medicaid recipient, will meet the nursing facility level of care criteria, and is also expected to provide the information needed. A specific nursing facility should be identified prior to evaluation since PASRR determinations should be based on the scope of services provided by the particular facility.

A request for a subsequent Level II evaluation will occur when the nursing facility and/or PRO determines that a resident has experienced a significant change in their physical or mental condition, which will impact the individual's need for continued placement or their need for specialized services.

3.1 Description

As a result of the Level I screening, persons who appear to have mental illness and/or intellectual disability/related condition, must undergo a Level II comprehensive evaluation. The Level II evaluation determines whether the person:

1. Requires level of nursing facility care provided by NF and these needs cannot be met in a less restrictive environment; and if so;

2. Requires specialized services (active treatment) for mental illness/intellectual disability/related condition.

3.2 Evaluation Information

1. Information to be Collected

a) Specific data for mental illness, including:
- **i.** a comprehensive history and physical examination (to include a complete medical history, review of all body systems, and neurological system evaluation)
- **ii.** additional evaluations conducted by appropriate specialists;
- **iii.** a comprehensive drug history;
- **iv.** a comprehensive psychiatric evaluation and documentation of psychiatric treatment
- **v.** a psychosocial evaluation and;
- **vi.** a functional assessment of activities of daily living ability.

b) Specific data for intellectual disability or related conditions include:

A comprehensive history and physical examination to include:

- **i.** medical problems and impact on independent functioning

- **ii.** current medications and the response of the applicant or resident to particular psychotropic medications;

- **iii.** self-monitoring of health status, medical treatments, and nutritional status;

- **iv.** development of skill areas such as self-help, sensorimotor, speech and language, social, academic/educational, independent living, and vocational;

- **v.** the presence of identifiable maladaptive or inappropriate behaviors; and

- **vi.** A psychological evaluation or “Supporting documentation” to validate the ID or related condition diagnosis which includes:

(1) A Psychological or Psycho-educational Report of the assessment results of at least an individual test of intelligence resulting in an IQ score and the results of an assessment of adaptive behavior abilities and shall be signed by the Licensed Psychologist, Licensed Psychological Associate, or Certified Psychologist with Autonomous Functioning who prepared the report. The assessment resulting in an Intelligence Quotient (IQ) must have been conducted before the age of 18 for diagnosis of an Intellectual Disability or age 22 for a diagnosis of a Developmental Disability (DD).

(2) If a record prior to the age of 18 for an applicant with an intellectual disability or 22 for an applicant with a developmental disability cannot be obtained, the following shall qualify as supporting documentation:

- Individual Education Plan (IEP) documentation which contains IQ score and report or description of adaptive behavior skills; or
- The results of the Psychological Assessment submitted during the course of guardianship proceedings.

(3) Results of a current Psychological Assessment to include evidence of onset prior to 18 for an intellectual disability or 22 for a developmental disability obtained through a comprehensive developmental history. The Assessment shall also provide documentation ruling out factors or conditions which may contribute to diminished cognitive or adaptive functioning, such as Severe Mental Illness, chronic substance abuse, or medical conditions.

c) Specific data for dual diagnosis of mental illness and ID/related condition include:

i. The complete Level II evaluation for intellectual disability/related condition; and
ii. The mental status/psychiatric assessment portion of the comprehensive evaluation for mental illness (pages 2 & 3 of the MI Level II evaluation, it is not necessary to complete two cover pages)

d) Individualized evaluation information that is necessary to determine if it is appropriate for the individual with mental illness or intellectual disability/related condition be placed in a nursing facility or in another appropriate setting should be gathered throughout all applicable portions of the PASRR evaluation. The two (2) determinations relating to the need for nursing facility level of care and specialized services are inter-related and must be based upon a comprehensive analysis of all data concerning the individual.

e) Evaluators may use relevant evaluative data obtained prior to initiation of pre-admission screening or a subsequent review if the data are considered valid and accurate and reflect the current functional status of the individual. More information may be needed to supplement and verify the timeliness and accuracy of the existing data.

f) Findings of each evaluation must correspond to the person's current functional status as documented in medical and social history records.

Note: Nursing facility resident's rights include the right to refuse treatment, including specialized services. However, a resident's refusal of treatment must be persistent and consistently documented in the resident's record.

g) For PASRR determination, findings must be issued in the form of a written evaluation report which:

i. Identifies the name and professional title of the person(s) who performed the evaluation(s) and the date on which each portion of the evaluation was administered.

ii. Provides a summary of the medical and social history, including the positive traits or developmental strengths and needs;

iii. Identifies the recommendations for treatment which include:

(1) The specific nursing services required to meet the evaluated person's needs if nursing facility services are recommended.
(2) Any specific intellectual disability/related condition or mental health services which are of lesser intensity than specialized services, if specialized services (active treatment) are not recommended;
(3) If specialized services are recommended, identifies the specific intellectual disability/related condition or mental health services required to meet the evaluated person's needs; and
(4) If specialized services are recommended, the recommendation is reviewed and signed by a board-certified psychiatrist for a person with mental illness, or a licensed psychologist for a person with intellectual disability/related condition
(5) Includes the basis for the report's conclusions.

2. Information from Other Sources

Current and relevant assessment information obtained from other sources may be used. The decision concerning the timeliness and appropriateness of the information is the responsibility of the person completing the PASRR evaluation. Copies of the information must be attached to the PASRR evaluation.

In completing the PASRR evaluation for current residents, Center staff may be reviewing and using information that is already part of the resident's record. If existing information is incorporated into the Center's PASRR evaluation, the information must be summarized on the PASRR evaluation form, including the source (i.e., date, name, title of person, etc.). The referenced information does not have to be attached to the PASRR evaluation form returned to the facility.

3. Participation by Individual and Family

The applicant must be seen and an interview attempted by a PASRR evaluator. In most cases, the evaluation should occur in the applicant's home or current residence/location. If the person is unable to significantly contribute to the interview, the reason must be documented on the evaluation form.

PASRR evaluations must involve:

a) The individual being evaluated

b) The individual's legal representative, if one has been designated under state law; and

c) The individual's family with consent from the individual or legal representative.

4. Permission for Treatment

The DMS has concluded that specific release of information and treatment forms are unnecessary based on state regulations 907 KAR 1:460, Coverage and Payment for PASRR. This states that the regulation is applicable to all individuals desiring admission to, or continued stay in, a Medicaid-certified facility and that any individual seeking admission or continued stay shall be deemed to have given consent for the state to conduct PASRR. HIPAA regulations stipulate that any information collected through the process of identification of a complete plan of care for a patient needs no permission for re-disclosure of additional records collected during this process.

5. Client Signature and Interpretation

Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of the PASRR evaluation be interpreted to the applicant, and where applicable, to a legal representative designated under state law. This is documented by signature on the evaluation form. For persons with intellectual disability/related condition, the findings cannot be made known until the final determination is made by the Division of Developmental and Intellectual Disability (DID) Services PASRR Review Committee.

3.3 Discontinuation/Level II Not Indicated

The PASRR process is to be discontinued if at any time it is found that the applicant does not have a mental illness; intellectual disability/related condition; or has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) for Mental Health only, does not apply to DID. The findings must be documented on the evaluation form and the case record filed to substantiate the billings for time involved with the evaluations.

Dementia Exception Established by the Evaluator

If dementia is suspected on a Level II referral, then the CMHC evaluator may make an exception based on a primary diagnosis of dementia by completing a mental status exam

(must be co-signed by CMHC psychiatrist); verifying documentation in the record of diagnostic testing (such as CT Scan); or other conclusive validation of dementia. Clinical validation of a primary dementia diagnosis should be made by a QMHP through personal interview, unless existing records or interview of care giving staff sufficiently documents primary dementia.

3.4 Types of Evaluations

1. Consultation Contacts

Consultation Contacts are designed to eliminate unnecessary PASRR referrals. A consultation contact is a brief face-to-face conversation or a telephone call between the referral source and PASRR Center staff (qualified mental health/developmental disability professionals (QMHP/QDDP as defined in Part VI, Section 6.3, Personnel PASRR Staff Qualification or professional equivalent about the Level I or referral that does not lead to a PASRR evaluation. Consultation contacts should be limited to no more than 30 minutes (two units) of staff time per contact, with the average time being one unit (15 minutes). During a consultation, the facility may identify specific client(s) or issues which are not client specific. These contacts must be documented, including giving the date, name of person/facility/client, and the purpose of the contact. The record of the contact should be maintained at the Center using the existing Center procedures. The response to referral form should be used for this purpose.

Centers may request reimbursement for consultation contacts. A PASRR consultation unit of service is billed in ¼-hour units and should include the date and type of contact. Consultation contacts do not require client numbers. The Response to Referral Form should be attached and will substantiate additional information.

2. Pre-Admission/New Admission/Re-Admission

A pre-admission is evaluated at a site other than the nursing facility. A person is considered a new/pre-admission for PASRR when the person has triggered a Level I referral and is:

a) requesting admission to a nursing facility for the first time or does not qualify for a re-admission. Re-admission is a category for an individual who has had an initial PASRR, but was discharged from the nursing facility before another referral was made. However, the date of initial admission should be documented on page 1 and included in the summary page;

b) currently residing in the community;

c) residing in a lower level of care (family care or community placement); or

d) residing in a lower level of care within the same facility.

3. Initial Resident Reviews

A person is considered for an Initial Resident Review if she/he is presently in the facility, does not qualify as a new admission, and:

a) was admitted to a Kentucky nursing facility under the exempted hospital discharge exception and remained in the facility beyond thirty (30) days;

b) was admitted to the nursing facility under an advanced group determination as a provisional admission (delirium and respite) and remained beyond fourteen (14) days; or

c) was admitted to the nursing facility and the prior Level I did not trigger a Level II referral and now requires a Level II evaluation because of updated information.

4. Subsequent Review

Nursing facilities must notify the CMHMRC within 21 days after it is found that a (PASRR) individual has a significant change in physical or mental condition. Significant change is defined as a change in a resident's health or mental status which has a bearing on his or her active treatment needs (specialized services needs) or level of care. Upon notification, the CMHMRC must conduct a new Level II evaluation or send a Response to Referral form if appropriate.

3.5 Time Frames for Completing Evaluations

1. Pre-Admissions/New Admissions

a) Pre-admission/new admission Level II evaluations must be completed and forwarded to the appropriate parties within nine (9) working days of referral of the individual with mental illness or intellectual disability/related condition. The nursing facility will fax the Verbal Determination Form to the PRO so as not to delay the admission process.

b) Requests for extensions beyond (9) days from the receipt of the referral requires prior approval from the DBHDID PASRR Coordinator. A letter justifying the delay must accompany the computer summary form. In addition, the CMHMRC must notify the nursing facility staff and referral source immediately, provide the reason for the delay, and give the anticipated date of PASRR completion.

2. Initial Resident Reviews

Initial resident reviews are to be completed within the time frames identified in each category defined below:

a) Exempted Hospital Discharge
If an individual is admitted to the nursing facility under this category, and requires more than thirty (30) days of nursing facility services, an initial resident review must

be completed within nine (9) working days of the Level I referral or within forty (40) calendar days of admission.

b) Provisional Admissions
Individuals admitted to the nursing facility as a provisional placement (for delirium or respite), must receive an initial resident review no later than fourteen (14) days; thereafter, the nursing facility will not be eligible for reimbursement. The evaluation must be completed within fourteen (14) calendar days of admission or nine (9) working days of referral.

c) New to PASRR
If an individual's previous Level I did not trigger a Level II referral and now requires a Level II evaluation due to updated information, the evaluation must be completed within nine (9) working days of the referral.

3. Subsequent Reviews

Individuals referred for a subsequent review must be evaluated and have a determination made within nine (9) working days of referral.

4. Evaluations That Fail to Meet Time Frames

All computer summary forms sent to DBHDID that indicate evaluation determinations were not completed within the time frame must have attached a detailed explanation of the reason for non-compliance.

4.1 Verbal Determination form

The CMHC evaluator may verbally communicate the PASRR determination to the PRO and nursing facility. The evaluator will then fax the verbal determination form.

4.2 PASRR Level II Evaluation Form

This form is used to gather the information in a report format. Staff notes, etc., should also be utilized if additional components are necessary to give a comprehensive evaluation report.

4.3 Personnel

DBHDID contracts with CMHMRC to conduct the Level II PASRR evaluations.

PASRR must be **conducted:**

a) Either independently by one of the qualified mental health professionals so designated in the Kentucky Medical Assistance Manual, or QMRP/professional equivalent, so designated in Section 6.3 of this manual.

b) By a mental health associate who does not meet the above criteria, with a counter-signature by one of these above professionals. A mental health associate may not evaluate persons with intellectual disability or related condition; unless they are also a QMRP or professional equivalent

1. Training

All PASRR coordinators and all CMHMRC staff who bill for PASRR units must complete a PASRR Evaluation Certification Training offered and approved by the DBHDID.

2. Conflict of Interest

PASRR regulations prohibit persons or entities that perform evaluations from having a direct or indirect affiliation or relationship with a nursing facility. Thus, CMHMRC staff that subcontracts with nursing facilities to provide consultation services may not conduct PASRR evaluations in those facilities.

4.4 Distribution of Comprehensive Evaluation Report

1. A copy of the complete evaluation report must be sent to the:

a) Individual and legal representative (if applicable)

b) Appropriate DBHDID division State PASRR Coordinator

c) Admitting or retaining nursing facility

2. **A copy of the coversheet and review of findings must be sent to the:**

    a) Individual's attending physician

    b) Discharging hospital, if individual is seeking nursing facility admission from a hospital

4.5 Out-of-State Referrals

New admissions from out-of-state are subject to Level I screening, and if appropriate, a Level II comprehensive evaluation and determination. The state in which the individual is a resident (or would be at the time he/she becomes eligible for Medicaid) must pay for the PASRR. The state where the individual resides at the time of referral should complete the Level II evaluation, unless a reciprocal agreement between the two states has been made and documented.

4.6 Out-of-Region

If the person requiring the PASRR evaluation is located in a region other than the region where the facility requesting the PASRR is located, the Center in the region where the person is located is responsible for completing the assessment. The Center receiving the initial referral from the nursing facility, will contact the Center where the person is located to request that the PASRR be done in that region and forwarded to the receiving region. Exceptions should be worked out between the Centers. Please indicate on the PASRR Computer Summary form submitted to the DBHDID the region of the nursing facility where the individual was admitted.

4.7 Medical/Specialty Examinations

As previously stated, it is the intent of the DMS that PASRR reimbursement is inclusive of all PASRR costs. However, DMS will reimburse the DBHDID (and subsequently the Centers) for the cost of additional medical/specialty examinations that are needed to complete the PASRR assessment and are beyond the expertise of the PASRR staff to perform.

1. **Procedures for arranging for additional examinations are:**

    a) The Center psychiatrist must authorize the referral and include a statement in the record as to the purpose of the examination and its relationship to the PASRR evaluation.

    b) The Center must pay for the examination and then request reimbursement from DBHDID.

4.8 Thirty-Month Stay

A long-term resident is defined as an individual who has resided in a nursing facility for at least thirty (30) months before the date of the first determination that he/she does not

require nursing facility services. If a long-term resident requires a 30-month stay, he/she may continue to reside in a nursing facility, even if he/she does not meet nursing facility criteria.

For purposes of determining the individual's length of stay in a nursing facility, the evaluator should calculate back from the date on which the individual was initially found **not** to require nursing facility placement. Temporary absences from a nursing facility for hospitalization, therapeutic leave, or home visits are to be included in determining a resident's continuous length of stay. Consecutive residences in more than one nursing facility also should be counted as part of a single length of stay.

Note:** **Any NF resident who meets the 30-month option must have a placement option form completed. The Placement Option Form should be distributed to the NF and DBHDID Coordinator. A copy should also be maintained in the CMHMRC PASRR record.

5.1 Responsibility For Providing Specialized Services

The OBRA and P.L. 100.203 provisions contain major implications for persons with intellectual disability/related condition) who are applying to or residing in a nursing facility. Through review of the Level II evaluation, the Department determines whether the person requires specialized services (active treatment) and nursing facility level of care. These final determinations are communicated to the PASRR Coordinator for each region in a letter from the DBHDID PASRR Coordinator for Intellectual Disability following Committee determination. When specialized services are indicated, there are further instructions in the letter. Staff employed by the Regional Community Mental Health and Mental Retardation Centers are responsible for providing these services. The Memorandum of Agreements between DBHDID and the Regional Community Mental Health and Mental Retardation Centers specifies this as a requirement in part 2.1.18., under Services/Deliverables: "Provide PASRR specialized services to individuals as determined by the PASRR Level II evaluation through a person-centered plan. If a waiting list for specialized services is necessary, then documentation of efforts to provide specialized services in a timely manner shall be maintained."

The following pages define and describe specialized services. It should be noted that specialized services are beyond the scope of nursing facility staff provision, unless ID/DD personnel are involved in the total care of the individual.

5.2 Definition of Specialized Services

Specialized services are defined in 42 CFR 483 120 (a) (2) and 483. 440 (a)(1) as:

...the continuous, aggressive and consistent implementation of a program of specialized and generic training, treatment, health and related services, which are comparable to services an individual receives in an intermediate care facility for the mentally retarded-developmentally disabled (ICF/MR), or in a community-based waiver program which provides services to persons with the Intellectual Disability or a developmental disability in which twenty-four (24) hour supervision is available that is directed toward:

(a) The acquisition of the skills necessary for the person to function with as much self-determination and independence as possible;
(b) The prevention of deceleration of regression or loss of current optimal functional status;
(c) The coordination and interaction, at all times and in all settings, of all staff and the individual served, in the implementation of the specified individual support plan (ISP) objectives for the individual.

5.3 Components of Specialized Services

The components of specialized services include case management/community coaching, person-centered planning, habilitation therapies, recreational/leisure services, positive behavioral supports, and community access supports.

1. Staff Contact

While not a direct, billable contact service, staff interaction is invaluable to those providing specialized services for nursing facility residents. Following are guidelines for establishing and maintaining effective staff contacts.

a) Establish a contact person for each facility. Never make a specialized service visit without informing the facility contact; it is best if this acknowledgement is a face-to-face contact.

b) Maintain written records of each visit, including documentation of the staff contact. This may be done with a staff note or a specially designed form for such contacts.

c) DMS (Department for Medicaid Services) issued a directive to all Kentucky nursing facilities on July 5, 2007, directing that notes from specialized services providers be maintained in the charts of person who have specialized services recommendations. Therefore, the Individualized Service Plan (ISP) and staff notes should be sent to the PASRR contact person for each facility.

d) Attend care-planning conferences for each person receiving specialized services. During these conferences, continue to educate staff regarding integration of the specialized services plan or ISP into the nursing facility care plan. Care plan attendance will also allow you to meet key people involved in the person's day to day total care and allow for better change in condition referrals when/if the he or she improves and no longer requires nursing facility care.

e) Plan regular meetings with the PASRR Coordinator

Tips for improving staff contact/support:

a) Identify and involve nursing facility staff members who work with the individual.

b) Get input from the social worker, nursing staff or any other caregiver who has a working relationship with the individual.

c) Attend nursing facility Care Plan meetings so that you fully understand everyone who has contact with the individual's concerns.

d) Assure that the Individual Support Plan is discussed and included in the nursing facility Care Plan when NF regulations permit.

e) Assure that nursing facility staff has access to tools needed to maintain implementation of the plan.

f) Point out progress toward goals, even slow/small progress.

g) Provide opportunities for nursing facility staff to share in their perspectives; make staff contact at each visit. If visits cannot be made frequently enough, make phone contact and document the contact.

2. Case Management/Community Coach

Specialized services should be initiated by assignment of a Case Manager to develop the Individual Support Plan for each individual with a Specialized Services recommendation. It is recommended that all Case Managers attend DBHDID Level I and Level II Case Management training courses. This may be arranged by calling 502-564-7702 and requesting Level I and Level II training. An additional beneficial training is Person-centered Planning. A complete schedule of training opportunities can be found at: http://dbhdid.ky.gov/ddid/scl-training.asp

3. Person-Centered Planning

This process is central in providing for the needs of those with specialized service recommendations, as it is a plan based on the individual's preferences and values. The plan reflects the needs, wants, and desires of the individual by assisting in fulfilling his/her goals as related to health issues, families, friendships, community inclusion and human services. This is achieved utilizing a facilitator, who may or may not be the Case Manager, and a team of supportive individuals who have true interest in the individual, are willing to take an active role in maintaining goal direction, and are outcome focused to stay active in participation. This plan should be available to all team members and Specialized Services Providers should encourage that a copy be maintained on the nursing facility record, along with the ISP and staff notes.

4. Habilitative Therapies

Nursing facility staff members are responsible for implementing rehabilitative therapies related to acute or chronic medical condition(s). However, when a person has therapy needs that are related to their intellectual or developmental disability, these needs may be considered habilitative in nature. Each nursing facility should be able to provide an evaluation of the person's physical, speech and, occupational therapy needs, whether Medicaid certifies implementation of such services or not. Utilizing these needs evaluations, develop a plan to have them implemented either through a contract service or the nursing home's restorative therapy program. Habilitative therapies enhance quality of life and prevent deceleration in physical and/or psychological conditions.

5. Recreational/Leisure Services

Recreational/Leisure services encompass a wide range of services and are important in promoting community reintegration. Recreational/Leisure services may also be very important for people who may not be able to leave the nursing facility because of the complexity of their medical issues.

a) **Sensory Stimulation**
Senses may be stimulated though sound, touch, smell, sight, taste, and movement. This may be done through one-on-one activities that can include listening to and/or singing or humming to music, providing objects with various textures, providing aroma therapy, playing games that promote identification of scents or pictures, decoration of one's room to heighten sensation, enjoying flavorful snacks, or looking at photographs or books.

b) **Learning a New Skill or Hobby**
This might be anything the person wishes to do within reason with his/her spare time, from as advanced as computer skills training to as simple as using a control pad to switch on room lights.

c) **Pre-Vocational/Vocational And Educational Evaluations**
Assessments for the types of work-related activities and/or further educational opportunities each individual might be suited for and /or interested in.

d) **Participation in Community Activities**
Community activities should be Person Centered and assist the person to acquire new skills and prevent regression of current functional status. These activities will vary from person to person and should change as needed to encourage each person to function with as much self-determination and independence as possible.

e) **Enhancing Communication Abilities**
Depending on the severity of the communication deficit, a speech, occupational or physical therapy evaluation by a certified therapist might be initially indicated. From these initial evaluations, Specialized Services providers can develop plans for utilizing effective speech and communication aides, adaptive equipment aides or suggestions related to specific functional deficits to which specific interventions improve overall communication and awareness.

6. Behavioral Supports

Behavior is a form of communication; it is a way to express happiness, frustration, pain and the need to stop an activity or interaction. All humans communicate in this manner. When asked, we might say we are fine but our behavior may tell those who know us well that we are frustrated or in pain. Communicative functions include making requests, protests or refusals and comments or declarations. It is essential to understand the reason for behaviors. To do this, a caregiver should develop a relationship with the person and observe them. Most behavioral issues are due to the environment which includes the room, smells, lights, other people, staff and activities. Some behaviors can be predicted, such as a person having more difficulty in the evening or being withdrawn or angry when a preferred caregiver is on vacation.

Specialized Services may include positive behavioral supports which establish a plan for caregivers to help the person improve their coping skills and learn how to express themselves in a more acceptable manner. When a particular behavior or set of

behaviors interferes with a person's ability to function as independently as possible or poses a threat to themselves or others, special behavior supports may be indicated.

Studies have shown that maladaptive behavior is caused by or related to many factors such as Physical health issues, mental health issues, life stressors, including past abuse, and sensory issues. One of the first steps to take when trying to determine the cause of behavioral problems is to ensure that any physical or medical conditions have been identified and treated. This is particularly important with individuals who do not use words to communicate or are unable to effectively communicate or articulate pain.

a) Determine Underlying Cause(s) For Behavior

i. Physical Examination/Medical Conditions

Discuss past patterns with a nurse or caregiver who knows the individual. Some fairly common causes include urinary tract infections, ear infections or cerumen impactions, medication side-effects, (especially with newly-prescribed medications), medication interactions, change in bowel or sleep patterns, and undiagnosed medical conditions such as diabetes, hypo or hyperthyroidism, or other endocrine-related disorder.

ii. Mental Illness

If at all possible, have a psychiatrist or QMHP/QMRP with access to psychiatric consultation involved with this aspect of the treatment. It has been noted that aggression in people with intellectual or developmental disability may be a symptom of depression.

iii. Life Stressors:

Talk with the person and caregivers to get an idea of possible long term or acute stressors. What is the person's threshold for tolerating stressful events? Do the person's caregivers believe the person is receiving sufficient supports to cope with stress? Discuss this with caregivers and nurse. Perhaps consultation or treatment from a mental health counselor is needed to help the person cope with stress and to give caregivers suggestions for supporting the person.

iv. Functional Analysis

The functional analysis is performed by a Behavioral Specialist or Psychologist, involves one-on one interview, observation of the individual, interview of care giving staff, and review of the facility chart. Typically the Behavior Specialist or Psychologist asks caregivers to record data about what happened before the problem behavior (antecedent); the behavior itself ; and what happened after the behavioral problem (consequence). This is known as the ABC's of behavioral observation. There might be occasions when the Behavioral Specialist will consult with medical personnel. This is a vital aspect of Behavioral planning.

b) Behavioral Plan Development

A positive behavior support plan typically includes proactive strategies to prevent behavioral problems when triggers noticed, scaled responses to the targeted behavior, and how to improve the person's ability to respond in a more acceptable manner which is also known as replacement behavior. Caregivers need to be trained along with the family and the individual on how to implement the plan.

Supports that may be available:

i. Physical examination which includes diagnostic laboratory studies when necessary
ii. Addressing all identified medical issues
iii. Consistent praise of positive behaviors and behaviors want repeated, such as joining an activity instead of staying in room every day.
iv. Inclusion of medical personnel, which could include therapists, dieticians, or specialists in neurology, otology, gastroenterology, or other specialists
v. Inclusion in nursing facility activities
vi. Involving volunteers to increase one on one time

7. Community Participation

In many cases, individuals are admitted to a nursing facility with an acute medical condition and require only a temporary nursing facility stay. Generally, an improvement in functioning will occur following successful rehabilitation services, or the individual's general medical condition(s) stabilize and therefore no longer require the level of medical monitoring of a nursing facility environment. These persons should be referred by the nursing facility staff for a significant change in condition Level II evaluation. As a Specialized Services provider, you might often be the first to recognize this change. Please notify the appropriate nursing facility staff and the PASRR Coordinator for your specific region.

Some community placements which may be more appropriate for these individuals are provided through various Medicaid Programs, such as Supports for Community Living Waiver, Medicaid Home and Community Based Waiver, Traditional Home Health Services, Michelle P. Waiver, Money Follow the Person, and in cases of developmental disability related to head injuries, Acquired Brain Injury (ABI) and ABI Long Term Care Waiver.

In rare instances, the person's needs might be better met in an ICF/MR setting to help in preparation for an upcoming community placement. ICF/MR placements are considered temporary and appropriate only when all other placements have been determined inappropriate.

5.4 Alternate Placement Options

There is more information regarding these alternate placements, the requirements for meeting criteria and the services offered through each waiver in the following pages. After

choosing the appropriate program, the application should be completed, and a notation that the individual is a PASRR client should accompany the application.
For all waivers, non-medical services may be provided through the consumer-directed option. Medicaid's webpage has information, including contact people for each Waiver.

1. Home & Community Based Waiver (HCBW)

a) Admission Criteria
- **i.** Nursing facility level of care
- **ii.** Application through home health agencies

b) Services Provided
- **i.** Case management
- **ii.** Homemaker
- **iii.** Respite
- **iv.** Minor home adaptation
- **v.** Adult Day Health Care
- **vi.** Personal Care: may receive up to five times weekly depending on assessment of needs
- **vii.** Attendant care: may receive up to five times weekly depending on assessment of needs
- **viii.** Physical, occupational, and speech therapy
- **ix.** Nursing is supervision of attendants only

2. Intermediate Care Facility (ICF/MR)

a) Admission Criteria
- **i.** Meets criteria for ICF/MR level of care and requires specialized services
- **ii.** Admission reviewed by interdisciplinary team
- **iii.** Must be considered temporary and all less restrictive placements denied

b) Services Provided
- **i.** Medical evaluation prior to admission
- **ii.** Physician visit every 60 days (minimal requirement)
- **iii.** Nursing care
- **iv.** Pharmacy care
- **v.** Personal care services
- **vi.** Dental care PT, OT, ST, Dietary, social services, transportation, housekeeping
- **vii.** Behavior supports
- **viii.** Application through Community Mental Health/Mental Retardation Centers

3. Adult Day Health Care Centers (ADHC)

Also offered through the waiver programs

a) Admission Criteria
- **i.** Must meet NF LOC

ii. Functional limitation must be due to ID or DD

b) **Services Provided**
i. Medically necessary services ordered by a physician, including physical, occupational, and speech therapies.
ii. Medication administration
iii. Personal care
iv. Service is considered respite

4. Michelle P. Waiver (MPW)

The Michelle P. Waiver (MPW) is a home- and community-based waiver program within the Kentucky Medicaid program developed for Kentucky citizens as an alternative to institutional care for individuals with intellectual or developmental disabilities. This program offers a variety of services and does not offer residential supports.

a) **Admission Criteria**
i. Has a diagnosis of ID/DD
ii. Meets ICF Level of Care

b) **Services Provided**
i. Case Management
ii. Adult Day Training
iii. Behavioral Supports
iv. Community Living Supports
v. Occupational Therapy
vi. Physical Therapy
vii. Speech Therapy
viii. Supported Employment
ix. Respite
x. Homemaker
xi. Personal Care
xii. Adult Day Health Care
xiii. Attendant Care
xiv. Environmental and M

5. Supports For Community Living (SCL)

This SCL waiver program is a home- and community-based waiver program within the Kentucky Medicaid program and was developed for Kentucky citizens as an alternative to institutional care for individuals with intellectual or developmental disabilities. This program offers many services including residential supports.

a) **Admission Criteria**
i. Has a diagnosis of ID/DD
ii. Meets ICF/MR level of care

b) **Services Provided**
   - **i.** Case Management
   - **ii.** Community Living Supports
   - **iii.** Respite
   - **iv.** Adult Day Training/Children's Day Habilitation
   - **v.** Supported Employment
   - **vi.** Residential Supports
   - **vii.** Behavioral Supports
   - **viii.** Psychological Services
   - **ix.** Occupational Therapy
   - **x.** Physical Therapy
   - **xi.** Speech Therapy
   - **xii.** Specialized Medical Equipment and Supplies

6. Money Follows the Person (MFP)

a) **Admission Criteria**
   - **i.** Have lived in a nursing facility (or a combination of hospitalization in a general hospital and a nursing facility) or ICF/MR for 90 days prior to transition
   - **ii.** Meet nursing facility or ICF/MR level of care and receive services though the Medicaid program in the month prior to transition
   - **iii.** This includes seniors and people with physical disabilities, persons between the ages of 21 and 65 with an acquired brain injury, and persons with intellectual and developmental disabilities

b) **Services Provided**

   The full array of waiver services in packages that meet the individual's needs; which includes nursing services. Additional services include:
   - **i.** Pest eradication
   - **ii.** Household goods
   - **iii.** Household setup
   - **iv.** Food stocking
   - **v.** Pre-transition transportation
   - **vi.** Problem Solving Services: This service was developed to cover unforeseen expenses that might interfere with the participant transitioning (ex. Unpaid previous utility bills, etc.)
   - **vii.** Care giver training: this services was developed to cover expenses incurred by community care givers in participating in training at the facility prior to transition relative to the participant's need in the community, and
   - **viii.** Community Provider Supports: this service was developed to cover expenses incurred by community based providers in participating in care planning at the facility prior to transition relative to the participant's needs in the community

7. Acquired Brain Injury (ABI)

a) **Admission Criteria**
   - **i.** Have a documented brain injury

- **ii.** Meet nursing facility level of care

b) Services Provided

- **i.** Case management
- **ii.** Respite
- **iii.** Behavioral Intervention
- **iv.** Occupational therapy
- **v.** Speech therapy
- **vi.** Environmental modifications
- **vii.** Counseling
- **viii.** Group counseling
- **ix.** Structured day program
- **x.** Specialized medical equipment and supplies
- **xi.** Supported employment
- **xii.** Community residential services

8. Acquired Brain Injury Long-Term Care Program

a) Admission Criteria

b) Services Provided

- **i.** Case management
- **ii.** Respite
- **iii.** Adult Day Training
- **iv.** Behavioral intervention
- **v.** Occupational therapy
- **vi.** Physical therapy
- **vii.** Speech therapy
- **viii.** Residential levels of care
- **ix.** Specialized medical equipment and supplies
- **x.** Family training
- **xi.** Adult day health care
- **xii.** Community living supports
- **xiii.** Supported employment
- **xiv.** Counseling
- **xv.** Group counseling
- **xvi.** Environmental modification
- **xvii.** Nursing supports

9. Consumer Directed Option (CDO)

Consumer direction allows individuals greater freedom of choice, flexibility, and control over their supports and services. It is a feasible option for individuals who do not wish to live in a nursing facility, since it offers choices of who will provide services, what services are needed, how services will be provided, when services will be provided, and where services will be provided. However, it is not an expansion or increase of current services.

CDO is not a program in itself, but an option of service delivery within the Waiver programs.

Admission Criteria
Must be eligible for or currently receiving services through the Home and Community Based Waiver (HCBW), the Supports for Community Living Waiver (SCL), the Acquired Brain Injury (ABI), the ABI Long Term Care Waiver, or the Michelle P. Waiver (MPW).

6.1 Financial

Request for reimbursement shall be made to the Division of Administration and Financial Management within DBHDID. PASRR units include not only face-to-face contact, but time spent in activities such as travel, record keeping, and collateral contacts.

1. Cost report

PASRR activities shall be considered DBHDID fundable services and all associated costs will be accumulated in a separate cost center when preparing the annual cost report.

a) Additional Examinations
The DMS will reimburse the DBHDID for the cost of additional medical/specialty examinations.

b) Evaluations Exceeding $1000
The DMS has asked the DBHDID to review all Level II PASRR evaluations that exceed a total cost of one thousand dollars ($1000.00) and dual diagnosis evaluations that exceed a cost of fifteen hundred dollars ($1500.00). PASRR staff will be asked to submit documentation to the DBHDID justifying the number of units and the variables, such as travel time, professional consultation, and difficulty in securing records that contribute to the increase in the PASRR units. The Explanation of Billing form is located in the forms section of the manual.

6.2 Personnel

1. PASRR Staff Qualifications

PASRR staff must meet the following criteria recognized by the DMS or DBHDID:

a) A Qualified Mental Health Professional (QMHP). In accordance with KRS 202 A.011, a QMHP must be:

iii. A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;

iv. A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.;

v. A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist, or a psychological associate, licensed under the provisions of KRS Chapter 319;

vi. A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two (2) years of clinical experience with mentally ill

persons, or a licensed registered nurse, with a bachelor's degree in nursing from an accredited institution, who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three (3) years of inpatient or outpatient clinical experience in psychiatric nursing and is currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health and mental retardation program;

vii. A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health and mental retardation program;

viii. A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health and mental retardation program; or

ix. A professional counselor credentialed under the provisions of KRS Chapter 335.500 to 335.599 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health and mental retardation program.

b) A Mental Health Associate. Must have a minimum of a bachelor’s degree in a behavioral health-related field. A PASRR conducted by a Mental Health Associate requires a counter-signature by a QMHP.

c) A Qualified Mental Retardation Professional (QMRP). In accordance with KRS 202 B.010, a QMRP must be:

i. A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;

ii. A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist, or a psychological associate licensed under the provisions of KRS Chapter 319;

iii. A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two (2) years of clinical experience of which one (1) year is with mentally retarded persons; or a licensed registered nurse, with a bachelor's degree in nursing from an accredited institution, who has three (3) years of inpatient or outpatient clinical experience of which one (1) year is in the field of mental retardation and is currently employed by an ICF/MR licensed by the cabinet, a hospital, a regional community mental health and mental retardation program, or a private agency or company engaged in the provision of mental retardation services

iv. A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with two (2) years of inpatient or outpatient clinical experience in social work of which one (1) year shall be in the field of mental retardation and is currently employed by an ICF/MR licensed by the cabinet, a hospital, a regional community mental health and mental retardation program, or a private agency or company engaged in the provision of mental retardation services;

v. A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health and mental retardation program; or

vi. A professional counselor credentialed under the provisions of KRS 335.500 to 335.599 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health and mental retardation program.

d) Professional equivalent of bachelor's degree in an identical field with 3 years of related full-time experience.

2. PASRR Certification

All PASRR coordinators and evaluators must complete the PASRR Evaluator Certification training offered and approved by DBHDID. PASRR evaluators must be certified prior to his/her assignment to the PASRR program.

3. PASRR Coordinators

Each region is expected to designate a PASRR Coordinator to be responsible to administer and coordinate the PASRR activities for the region. PASRR Coordinator's duties include, but are not limited to, the following:

a) Assure that all staff who bill for PASRR services are trained and certified in PASRR policies and procedures;

b) Distribute manual revisions, computer summary data, and related information in a timely manner, upon receipt of information from the DBHDID and DMS;

c) Regularly review completed evaluations and records for compliance with policies and procedure, including timelines and content;

d) Be available for consultation to the CMHMRC staff;

e) Coordinate local training for PASRR staff, nursing facilities, and others as needed; and

f) Assure that required forms and information are submitted to the DBHDID. This is to include BH and DD Level II evaluations to be faxed upon completion and monthly Non-Compliance Log submitted via email to DBHDID and DMS.

6.3 Record Keeping

The CMHMRC's shall have a separate file for each person who receives a Level II PASRR evaluation. Every record should include at least the following:

1. Referral (MAP 409-1 and/or Center intake form); other pertinent MAP documents;
2. Initial and Subsequent Comprehensive Evaluation (including necessary attachments);
3. Copies of reports, evaluations, tests, consultations etc.
4. Interpretation of findings;
5. Computer summary forms;
6. Staff notes, if necessary;
7. Correspondence if related to PASRR (which includes the DID letter);
8. Documentation to substantiate units billed. Including billing tickets, if appropriate; and
9. Thirty (30) month placement option forms (when applicable);
10. Receipt of certification for adverse determination letters.

6.4 Determinations for Persons with Mental Illness

Centered-designated PASRR staff is expected to conduct the Level II evaluation and to arrange or provide specialized services, if recommended. Specialized services are narrowly defined as comparable to those services an individual would receive in an acute psychiatric in-patient facility. In addition, the individual must meet the definition of serious mental illness. The law specifically excludes from the Act, individuals who have primary diagnosis of dementia, including Alzheimer's or a related disorder. Center-designated PASRR staff that identify an individual through the PASRR process as being in need of specialized services for mental illness are responsible for developing and implementing a plan for specialized services through the use of existing resources.

1. **Pre-Admission**

   Center-designated PASRR staff is responsible for arranging for the provision of specialized services in the community for those individuals identified in need of such treatment through the PASRR evaluation and for whom nursing facility level of care is not recommended. The staff will work with the individual or the designee in arranging placement, either in a private or state psychiatric facility. If the individual declines specialized services, the CMHMRC evaluator will assess the need for involuntary commitment and proceed, if appropriate. If involuntary commitment proceedings are not warranted, the CMHMRC evaluator will assess the appropriateness of serving the person through out-patient mental health services, and if appropriate, will refer the person to other social service agencies.

2. **Current Residents (More than Thirty (30) Months)**

   Individuals, who have resided in the nursing facility for more than thirty (30) months and have been determined to be in need of specialized services, but not in need of nursing facility care, may choose to remain in the nursing facility and receive services. If the person chooses to be discharged and receive specialized services, the CMHMRC evaluator is not responsible for arranging for the discharge of the individuals to another alternative setting. If the individual returns to the community, CMHMRC evaluator will assess the person for appropriateness of receiving outpatient mental health services.

3. **Current Residents (Less than Thirty (30) Months)**

   If the individual has been in the nursing facility less than thirty (30) months and no longer requires nursing facility level of care, CMHC evaluator will arrange for admission screening either at a private or state psychiatric facility. If the individual declines specialized services, and involuntary commitment proceeding are not indicated (person is dangerous to self and others), then the person may not remain in the nursing facility under auspices of the ADP. The CMHMRC evaluator will work with the nursing facility, the individual, the designee, and other agencies to devise a discharge plan that includes providing mental health services in the community. The Center is not responsible for arranging for the person's discharge from the nursing facility when the person will not voluntarily seek treatment in an inpatient setting or is not appropriate for the involuntary placement.

6.5 Determinations for Persons with Intellectual Disability/Related Condition

The determination function is a consistent and comprehensive analysis of all the data available to determine both an individual's need for nursing facility level of care and need for specialized services. Without exception, any applicant for admission to a nursing facility who has intellectual disability/related condition and who does not require the level of care provided by the nursing facility, regardless of whether specialized services are also needed, are inappropriate for nursing facility placement and must not be admitted.

1. Intellectual Disability/Related Condition: Pre-Admission

Placement of an individual with intellectual disability/related condition in a nursing facility may be considered appropriate only when the individuals needs for treatment do not exceed the level of services which can be delivered in the nursing facility to which the individual is admitted either through nursing facility services alone, or where necessary, through nursing facility services supplemented by specialized services arranged by the local CMHMRC.

2. Intellectual Disability/Related Condition: Current Resident

If DBHDID determines the resident does not require nursing facility level of care and does not require specialized services, regardless of their length of stay, CMHMRC must arrange for a safe and orderly discharge of the resident from the nursing facility and prepare and orient the resident for discharge.

If DBHDID determines the resident does require a nursing facility level of care and does require specialized services, the resident can continue to stay, regardless of their length of stay, in the nursing facility placement if determined appropriate.

If DBHDID determines the resident does not require nursing facility level of care but does require specialized services, for residents of less than thirty (30) months from the date of determination, in consultation with the resident’s family or legal representative and caregivers, CMHMRC must arrange for a safe and orderly discharge of the resident from the nursing facility and prepare and orient resident for discharge and provide for, or arrange for, the provision of specialized services. As of July 2010, this is arranged through a referral process for Money Follows the Person/ KY Transitions staff. These individuals should be referred for services through the Michelle P. Waiver, Home and Community Based Waiver, or the Supports for Community Living Waiver.

If DBHDID determines the resident does not need nursing facility level of care but does require specialized services, for residents of more than thirty (30) months from the date of determination, CMHMRC must offer the resident the choice of remaining in the nursing facility or receiving services in an alternative appropriate setting; inform the resident of the institutional and non-institutional alternatives covered under the State Medicaid plan for the resident, and regardless of the residents choice, provide for, or arrange for, the provision of specialized services.

6.6 DID Committee Review

All level II evaluations (including change of condition) must be sent to the DBHDID for review by the Department PASRR Committee. The individual/family/legal representative is not notified until notice of the determination is received. In order to meet the timeframes set by Federal regulations, the following procedure should be adhered to: Upon completion, **Fax** the PASRR evaluation, including supporting documentation to:

DBHDID PASRR Coordinator
Division of Intellectual Disability
Fax: (502) 564-2284

1. The Division Committee will review for a determination.

2. A letter noting the Committee's decision will be emailed to the submitting region.

3. The CMHMRC will then notify the nursing facility and resident/legal representative of the final determination by sending the appropriate cover letter explaining the findings and appeal process.

4. If the family/legal representative is present during the resident's interview, they may already be aware that the evaluation will include a recommendation for specialized services and they should have been informed of placement options and available services. However, it must be explained to them that the decision is not final until the PASRR Review Committee makes its decision.

5. In situations where an applicant is ready for hospital discharge and a nursing home bed is 'on hold' status, the evaluator may fax the required supporting documentation (listed in Section 3.2 (b)) to DID Coordinator with completed PASRR evaluation to be submitted within 3 business days.

Note: If the individual/legal representative refuses specialized services, this must be documented in the evaluation, or if refused at a later date, the Refusal of Specialized Services form should be utilized for this purpose. A copy should be filed in the residents nursing facility record, the original maintained in the PASRR record, and a copy forwarded to the appropriate coordinator for DBHDID.

6.7 Appeal Process

Federal law requires that there be an appeals procedure for those nursing facility applicants or residents who receive an adverse determination based on the PASRR evaluation.

The DMS must be responsible for maintaining a fair hearing process to accommodate the appeals procedure. The state's hearing system provides one level of appeals with the following requirements:

1. The Center must notify the applicant/resident, or his or her legal representative, within two (2) working days of the determination. The adverse determination letter must be sent by certified mail, with the receipt being maintained in the CMHMRC PASRR record.

2. An applicant, resident, or representative may request a hearing by filing a written request with the DMS within thirty (30) days of the date of the letter. If the request for a hearing is postmarked or received within ten (10) days of the date of the letter, a resident may continue to stay in a nursing facility (if previously admitted) until the final cabinet level hearing. An individual may be represented at the hearing by oneself, a friend or relative, spokesperson or other authorized representative, including legal counsel as specified in 907 KAR 1:563.

The applicant, resident, or representative will be notified of the date, time, and place of the scheduled hearing, which will be conducted within thirty (30) days of the date of the request for a hearing. This notification will also include further instructions as to representation and other rights.

Requests for the appeal hearing should be submitted directly to:

The Division of Administration and Financial Management
Administrative Services Branch
Mail Stop 6W-C
275 East Main Street
Frankfort, KY 40621

The “Cover Letter” Section of the manual includes samples of letters to accompany each type of **evaluation and appeals procedure**. Evaluations with averse determinations for mental illness should be faxed to the DBHDID PASRR Coordinator at 502-564-2284.

7.1 Definition of Forms

1. **Comprehensive Evaluation Forms: Mental Illness and Developmental /Intellectual Disability**

   The Level II Evaluation is conducted as a result of an affirmative response to the Level I screening. Individuals with intellectual disability/related condition will be evaluated on the DID form. Individuals with mental illness will be evaluated on the mental illness form. Persons diagnosed with both mental illness and intellectual disability/related condition will be evaluated on the appropriate sections of both forms. The Comprehensive Medical History/Physical Examinations form has been designed for the Center's use if required information is not available.

2. **Verbal Determination Form**

   This form may be used to communicate the PASRR determination to the PRO and nursing facility.

3. **Response to Referral**

   This form is used to inform the referral source that the level I screen was not indicative of the need for a Level II. This may occur when a referral is received and the person meets exception, such as Alzheimer's disease or other dementia. It may also be used to explain why Level II is not indicated, especially in cases where the referral diagnosis is found to be inaccurate by the CMHC.

4. **PASRR Computer Summary Form**

   The PASRR Computer Summary Form is used to collect the PASRR data keyed into the DBHDID system. This form must be completed and submitted to the DBHDID whenever a Level II evaluation is completed and for evaluations which have been initiated, but then found to be inappropriate. For DID evaluations, do not submit the Computer Summary form to the Department until the letter is received informing of the determinations of the Review Committee. The Department will use this form to generate program information for DMS and CMS reports.

   ***Note:** This form is sent only to the DBHDID. Do not send copies to the nursing facility or to the individual being evaluated. Incomplete computer summaries will be returned.*

5. **Cover Letters to Accompany Copies of Evaluations**

   a) Cover letter to be attached to copy of evaluation sent to nursing facility applicant/legal representative.

   b) Cover letter to be attached to copies of Review of Findings sent to attending physician and discharging hospital (if applicable).

Note: Centers should use their own letterhead for cover letters deleting the explanatory comments from the top of the page.

6. Explanation of Billing form

Use this form to document PASRR BH/ID or related condition evaluations that exceed a total cost of $1000 or for dually diagnosed evaluations that exceed $1500.

7. Notice of Recommended Services through PASRR

This form is to be completed for all persons who are recommended for specialized services or services of lesser intensity. This form should be submitted to the nursing facility with the comprehensive evaluation. It notifies the nursing facility staff that the evaluation contains recommendations that the nursing staff is responsible for providing.

8. Placement Options Form

This form designates options for long term PASRR residents who meet thirty (30) month criteria and who have a diagnosis of BH/ID or related condition.

9. Refusal of Services Form

This form is to be used when a client has a recommendation for specialized services and consistently refuses services.

10. Non-Compliance Logs

This form is used to assist DMS in identifying untimely referrals and recoupment of funds. On the first business day of each month, the Non-Compliance Log must be emailed to DMS and DBHDID. In the event there are no instances of non-compliance, this will be noted on the Log.

7.2 Submittal of Evaluation Forms to Department

The procedures for submitting the PASRR evaluations to the Department are as follows:

Behavioral Health:

Division of Behavioral Health
Attn: State BH PASRR Coordinator
100 Fair Oaks Lane, 4E-D
Frankfort, KY 40621-0001
Fax: (502) 564-2284

Developmental and Intellectual Disabilities:

Division of Developmental and Intellectual Disabilities
Attn: State DID PASRR Coordinator
100 Fair Oaks Lane, 4W-C
Frankfort, KY 40621-0001
Fax: (502) 564-2284

PASRR (Level II) Check List (MI)

Name ____

Evaluation Time Frames Met:

Date of Referral ________________

Date Verbal Given ________________

Date Report Sent ________________

If Evaluation Time Frames NOT Met:

☐ Letter of Explanation attached to Computer Summary Sheet?

Evaluation Performed by Approved Personnel:

☐ PASRR certified evaluator

☐ Physician's review and signature for medical/physical

☐ All sections of evaluation completed

Individual/Guardian Rights:

☐ Individual/Guardian signature obtained

☐ Informed of appeal procedures

Complete Evaluation Report Sent To:

☐ Individual

☐ Legal Guardian

☐ Nursing Facility

Cover Sheet and Review of Findings Sent To:

☐ Attending Physician

☐ Discharging Hospital (if applicable)

If Specialized Services Needed:

☐ Individual informed of community placement options including how, when, and by whom specialized services will be provided

☐ Recommended services through PASRR and evaluation sent to DBHDID

☐ A board eligible psychiatrist counter-signature obtained

☐ **<u>Completed</u> Computer Summary Form Sent to DBHDID**

Instructions for Completing the Behavioral Health Level II PASRR Evaluation

Page 1	**Applicant's Name** First Name & Last Name **Race** White African American American Indian Asian Alaskan Native Native Hawaiian/Pacific Islander Hispanic **Marital Status** Single/Never Married Married Divorced Co-habituating Widowed Separated Unknown **Current Living Arrangements** Indicate the location of the individual at the point of interview or contact. **Legal Guardian** A Court appointed full guardian. This would not include POA's, financial representatives, etc. It is acceptable to list other representatives, but specify the relationship to the applicant. **ADA Accommodations** Americans with Disabilities Act. This would include adaptive devices, interpreters, or any assistive devices needed to perform the evaluation. **Referral Information** Include area codes with phone numbers. **Type of Referral** This should be consistent on all evaluations. However, there are instances when dually diagnosed residents require an update for only one diagnosis. Please indicate which by checking the appropriate box. **Mental Illness** An individual who meets the criteria on the MAP-409 for a serious mental illness. **Intellectual Disability** An individual who meets the criteria on the MAP-409 for intellectual disability.

	<u>Related Condition</u> A condition similar to intellectual disability usually caused by a developmental delay during childhood (prior to age 22). See the MAP-409 for conditions that might be indicative of a related condition. ***Note that the individual would meet criteria for substantial functional limitations in three or more of the listed major life activities prior to age 22.*** **<u>Dual Diagnosis</u>** An applicant or resident who meets the criteria for both mental illness and intellectual disability or related condition as identified on the MAP-409. **<u>Type of Assessment</u>** **New Admission:** An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days. **Re-Admission:** An individual is a re-admission of he/she was re-admitted to a NF from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are not subject to Level I screening, but may be subject to a Subsequent Review if the person has experienced a significant change in condition as defined in 3.44 of this manual. **Hospital Exemption:** An individual who currently resides in a hospital whose physician has completed the thirty (30 day exemption form stating that nursing facility is needed for management of the problem for which the individual was hospitalized. This stay is expected to be thirty (30) days or less. **Provisional Admission:** A request for a Level II PASRR should be initiated when it appears that the individual admitted under this provisional admission will not be discharged within the fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth (14th) day of the admission date until a PASRR determination is made authorizing nursing facility level of care. There are two (2) categories of provisional admissions. <u>Delirium</u> – An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days. <u>Respite</u> – An individual whose caregiver has requested admission to a NF for not more than two (2) weeks (fourteen (14) days) of relief from caregiver responsibility. **New to PASRR:** An individual who resides in a nursing facility but has not previously had a Level II performed. This is usually someone who was admitted without adequate information to document the existence of a mental illness or intellectual disability/related condition diagnosis prior to admission. **Initial Resident Review:** An individual who was admitted to the nursing facility without a Level II having been performed prior to admission. This could include a hospital exemption, one of the provisional categories (delirium and respite), or an individual who did not appear to meet criteria upon admission, but new information becomes available or circumstances change.

	Significant Change of Condition: A current resident of a NF (who has previously had a Level II evaluation) and experiences a change in physical or mental functioning that will affect that individual's need for either continued nursing facility stay as the least restrictive environment, or might now need specialized services and previously did not. **Subsequent Review:** Significant change in condition line should be documented as the date the MDS triggered a significant change. *The date of admission to the nursing facility is the initial admission date to the facility.* **<u>Informational Sources</u>** Directions for this component are fairly self-explanatory. It should be noted; however, that under record/document review that when previous Level II evaluations are used as an informational resource, this should be documented here
Page 2	**<u>Psychiatric Hospitalization History</u>** Part III, Page III-3 of the PASRR manual documents that release of information is not needed for applicants applying to a Medicaid certified nursing facility. Consult with evaluators from other regions when evaluating someone from a different region as they might have a working relationship with the psychiatric facilities in their regions and be able to obtain this information for you. Interview family members and the applicant. If exact dates are not known, document approximated dates. **<u>Community Based Treatment</u>** Interview the applicant and family members. Contact evaluators from other regions when indicated. Please document treatment in both the public and private sector, including outpatient and Community Supported Services. **<u>History of Cooperation</u>** Regarding previously recommended treatment **<u>Referral Diagnosis</u>** This should be the diagnosis given at the initial referral contact, not the diagnosis you arrived at based on the MSE or additional documentation. These might frequently be different. **<u>Mental Status Assessment</u>** Complete by indicating the appropriate option. If no appropriate options are listed, make note of this in the comments section. Please complete each category within a section and not place one check mark for the total section. **<u>Comments</u>** List diagnostic history, recent improvement or decline of SMI, describe current psychiatric symptoms (mood, orientation, cognition, thought content, etc.)
Page 3	**<u>Tools for MSE</u>** Indicate at the top of Page 3 whether the Mini Folstein or another tool was used to complete the Mental Status evaluation.

	Dementia/Organicity Note whether it is a documented diagnosis or based on the MSE performed during the evaluation. If there is a documented diagnosis, but the results of the MSE performed for the evaluation do not substantiate this, comment on this line. **Axis I** Indicate the current diagnosis believed to be correct based upon MSE and documentation. If there is a disparity between the diagnosis contained in the attached documentation and the current correct diagnosis, please indicate this and why this is clinically indicated on the Other Comments line. **Axis II** As with the mental illness diagnosis, document the current clinically indicated diagnosis. Substantiate any disparity in diagnoses found in attached documentation and contained in the evaluative report. For intellectual disability diagnoses, a psychological evaluation or: “Supporting documentation” to validate the ID/ or related condition diagnosis as specified on p. 14 section 3.2. **Axis III** Document the currently active diagnosis first, and the historically related diagnosis last. Try to include all diagnoses if possible. **Axis IV and Axis V** These may not always be relevant for PASRR purposes, but document these when possible. If unattainable or not applicable, defer theses diagnoses. If dementia is substantiated as the primary diagnosis affecting the applicant’s mental status, document this on the *Other Comments* line and indicate that it is not necessary to complete additional components of the evaluation based on this impression. **Other Comments** Explain if there is a disparity in the current diagnosis versus the referral diagnosis **Medication History** Please list current medications and previous psychotropic medications. Please always include dosage frequency and reason. If a complete current list of medications is attached, this (***see attached medication list***) may be noted on the line for ***currently prescribed medications***. **Previous Psychotropic Medications** List known medications prescribed in the past. Note that sometimes medications previously prescribed will be contained in medication allergies **Mask or Mimic Psychosis** List medications currently prescribed that have potential to affect mental status by masking or mimicking psychosis/depression.

	Self-Management Check appropriate option. If individual is residing in a NF at the time of the evaluation and takes medications as offered, document Not Applicable in this component. Please complete for new admissions. **Side Effects** Note any physical indications of a drug induced movement disorder here. Also note complaints that the individual has that could be medication related. **Allergies** List allergies if available from documentation or the individual's report. Document that information is unavailable if this should be the case. **Drug Abuse** Note abuse of alcohol and/or non-prescribed medication, if available. If not available from records or individual's report, document this.
Page 4	**Reason for Placement** This is not specific nursing facility services that the individual will need, but the reason nursing facility placement is being requested. Please note that this section is requesting identification of changes in status and/or living situation that contributed to the request for placement. **Family and Friends** List family members and friends, especially those interviewed for the evaluation purpose. Include area codes with phone numbers. Please list names and relationship to applicant. **Communication Skills (a)** Check the appropriate option. If impaired, note what action has been taken to overcome this (i.e., communication board, physical cuing, changed vocal intonation, written communication, interpreter, etc.). **Communication Skills (b)** Rank each activity of daily living listed by assigning a number 1-4. **Communication Skills (c)** Add comments if the rank does not provide enough information to clearly address functioning level. **Base Level of Care** Circle the applicable criteria for meeting Medicaid's current level of care. A person must meet at least two to be admitted to a nursing facility under any circumstances **Additional Criteria to be Considered** If the person is a danger to self or others or their care needs (related to behavioral health) are beyond capacity for nursing facility to meet, the person can meet Medicaid level of care but still not be appropriate for nursing facility admission.

<table>
<tr><td></td><td><u>Patient Status</u>
Considering the diagnosis, care needs, services and health personnel required to meet these needs; their needs might be better met in personal care, family or foster care home, or residential care setting.</td></tr>
<tr><td>Page 5</td><td><u>Impact of Medical on Functioning</u>
Describe how the current medical conditions impact functioning (versus mental conditions)
<u>Describe Nursing Facility Services Needed or Receiving</u>
Note the directive “Be very specific”. Possibilities include, but are not limited to; monitoring of vital signs (blood pressure, pulse, respiration), physical therapy, occupational therapy, speech therapy, respiratory therapy, administration and monitoring of medications, laboratory tests for various reasons, including medication levels, accurate diagnosing, monitoring of nutritional status, including recording of intake and output amounts or monitoring of a specialized diet, specific skin treatments, monitoring of indwelling or external catheter, gastric tube, IV site, wound healing or other specific MD ordered treatments.
<u>Comprehensive History and Physical Data: Source of Data</u>
Refer to the specific document that was used as the basis for your determination of level of care. If there have been changes in the individual’s condition since the document was completed, document the change in the appropriate body system component. If the document is complete and current you may refer to it by noting, “See attached document: If performing an evaluation in a medical setting and the discharge summary is not yet available, copy initial systems review and some recent physician progress notes, as the initial systems review often does not yet contain the current medical issues.
<u>Abnormal Findings</u>
Note abnormal findings that need further assessment or have potential to affect the individuals overall needs here.
<u>Referral to Agency or Person</u>
If referred to an outside agency for needed medical information, please note the agency or person here.
<u>Level of Care Certification</u>
This is sometimes very difficult to obtain, and if this is the case, note, “Not obtained” on this line. This is “n/a” for all pre-admissions.</td></tr>
<tr><td>Pages 6 & 7</td><td>Either refer to an attached document or arrange for completion by the professional who performed the systems review. Please note: the physical exam must be completed by a physician, registered nurse, or a physician’s assistant. If not performed by a physician, he/she must review and concur with conclusions.</td></tr>
</table>

Page 8	**Review of Findings** This is the summary that is forwarded to the individual's MD, so a brief but thorough summary is indicated for each component. Please do not leave any sections blank or reference another section of the evaluation. Documentation is required.
Page 9	**Recommendations** Check the appropriately indicated box. **Specialized Services Plan**: Please complete this section or place N/A in the blank if it is not applicable. **Disposition:** Check the appropriately indicated box. **Continue in Process:** All individuals who have had Level II evaluations will continue in the process unless they have a primary diagnosis of dementia. If this is the case, document this here.
Page 10	**Summary** Give a comprehensive account of information contained in the PASRR evaluation. Please note that this section requires a summary of complete findings, determination, and recommendations. Be very clear and specific. (Give a chronological history of nursing facility admissions if applicable).
Page 11	**Time Frames** Note that the date referral received is the date that a decision was made that the referral requires a PASRR evaluation. The date verbal was given is the date a determination was made regarding level of care and specialized services and communicated to the nursing facility (usually the date of the mental status assessment). Date sent is the date the evaluation was mailed to the nursing facility.
Page 12	**Interpretation of Findings** Indicate to whom the findings were sent by checking one of the three options. Be sure the evaluator signs this page. Fax completed Level II evaluation with Interpretation of Findings to DBHDID 502-564-2284.

PASRR (Level II) Cover Sheet
Comprehensive Evaluation
For Mental Illness and Intellectual Disability/Related Condition

Date of Referral:	**Date Assigned to PASRR Staff:**

Name of Center Completing Assessment:

Applicant Identifying Data

Applicant's Name:			**Social Security Number:** - -	
Birth Date: / /	**Sex:** M ☐ F ☐	**Race:**	**Marital Status**	**Spouse**

Evaluation Location:

☐ Home	☐ Relative's Home	☐ Hospital	☐ State Hospital	☐ Hospital Psychiatric Unit
☐ Psychiatric Hospital	☐ SCL/Group Home	☐ ICF/MR	☐ Nursing Facility	☐ Personal, Mini, Family Care Home
☐ Other				

Legal Guardian: ☐ Yes ☐ No	**Name/Telephone number:**

Referral Information

Referral Source: ☐ MAP 409 ☐ Telephone Contact ☐ Subsequent Review (phone/form)

Name:	
Relationship to Applicant:	Telephone:
Facility Requested:	
Address: *(if known)*	
Contact Person:	Telephone:

Type of Referral: (Check One)	☐ Mental Illness	☐ Intellectual Disability	☐ Dual Diagnosis
		☐ Related Condition	☐ MI Portion Only
			☐ DID Portion Only

Type of Assessment: (Check One)

Preadmission	**Initial Resident Review**	**Subsequent Review**
☐ New Nursing Facility Applicant	☐ Hospital Exemption	☐ Significant Change In Condition
☐ (Did Not Meet Readmission	☐ Provisional Admission	
	☐ Delirium	
	☐ Respite	
	☐ New to PASRR	

Give Date of Nursing Facility Admission:

Information for this evaluation was obtained from the following: (List PERSON/AGENCY/DATE of CONTACT)

☐ Applicant (If applicant was unable to significantly contribute to the interview, please identify reason):

☐ Family Members / Legal Representative:

☐ Other Agencies:

☐ Record / Document Review:

This evaluation may be typed or hand written legibly in ink.

Name:	SS#:

Part 1: Comprehensive Evaluation - Mental Illness

Mental Status / Psychiatric Assessment

1. Treatment Review

Psychiatric Hospitalization: Prior admission to state or private psychiatric facilities (give dates, facility and reason for admission)

Community-Based Treatment Involvement with community mental health center, private psychiatric or other treatment facilities (include outpatient and community support services)

History of cooperation with recommended treatment.

2. Referral Diagnosis:

3. Mental Status Assessment (other Mental Status Assessment tools may be utilized)

Mental Status Assessment

Present	Yes	No	Present		Yes	No
Physically Unkempt, Unclean	☐	☐	Orientation	Disoriented to Person	☐	☐
Clothing Disheveled, Dirty	☐	☐		Disoriented to Place	☐	☐
Clothing Atypical, Unusual, Bizarre	☐	☐		Disoriented to Time	☐	☐
Unusual Physical Characteristics	☐	☐				
Slumped	☐	☐	Memory	Impaired Immediate Recall	☐	☐
Rigid, Tense	☐	☐		Impaired Recent Memory	☐	☐
Atypical, Inappropriate	☐	☐		Impaired Remote Memory	☐	☐
Accelerated, Increased Speed	☐	☐	Perception	Illusions	☐	☐
Decreased, Slow	☐	☐		Auditory Hallucinations	☐	☐
Atypical, Peculiar, Inappropriate	☐	☐		Visual Hallucinations	☐	☐
Restless, Fidgety	☐	☐		Other Types of Hallucinations	☐	☐
Anxiety, Fear, Apprehension	☐	☐	Thought Content	Obsessions	☐	☐
Depression, Sadness/Anger,	☐	☐		Compulsions	☐	☐
Hostility	☐	☐		Phobias	☐	☐
Decreased Variability of Expression,	☐	☐		De-realization, Depersonalization	☐	☐
Bizarreness, Inappropriateness				Suicidal Ideation	☐	☐
				Homicidal Ideation	☐	☐
				Delusions	☐	☐
				Paranoia	☐	☐
				Ideas of Reference	☐	☐
				Ideas of Influence	☐	☐
Increased, Loud	☐	☐	Stream Thought	Associational Disturbance	☐	☐
Decreased, Slowed	☐	☐	(As manifested by	Thought Flow Decreased, Slow	☐	☐
Atypical Quality, Slurring	☐	☐	speech) Feeling	Thought Flow Increased	☐	☐
Stammering	☐	☐	(Affect and mood)	Inappropriate to Thought Content	☐	☐
				Increased Liability of Affect	☐	☐
				Predominate Mood is:		
				- Blunted, Absent, Unvarying	☐	☐
				- Euphoric, Elated	☐	☐
				- Angry, Hostile	☐	☐
				- Fearful, Anxious, Apprehensive	☐	☐
				- Depressed, Sad	☐	☐
Domineering	☐	☐	Overt Behaviors	Abuses Substances	☐	☐
Submissive, Overly Compliant	☐	☐		Verbally Abuses Others	☐	☐
Provocative	☐	☐		Physically Abuses Others	☐	☐
Suspicious	☐	☐		Destroys Property	☐	☐
Uncooperative	☐	☐		Physically Abuses Self	☐	☐
				Fearful, Crying, Clinging	☐	☐
				Takes Property from others without Permission	☐	☐
				Performs Repetitive Behaviors (Pacing, Rocking, etc.)	☐	☐
Impaired Level of Consciousness	☐	☐	Comments: (Diagnostic history, recent improvement or decline of SMI, describe current psychiatric symptoms (mood, orientation, cognition, thought content, etc…)			
Impaired Attention Span	☐	☐				
Impaired Abstract Thinking	☐	☐				
Impaired Calculation Ability	☐	☐				
Impaired Intelligence	☐	☐				

Name:	**SS#:**

Please list tools used for mental status/psychiatric assessment:

☐ **Mini Folstein (Score)** ____________ ☐ **Other, Please Specify:** ______________________________

Is organicity/dementia present? ☐ **Yes** ☐ **No How was this substantiated?**

4. DSM IV TR Diagnostic Code & Label Impression based on clinical Data gathered. (CMHMRC staff):

AXIS I	**AXIS IV**
AXIS II	**AXIS V**

AXIS III			

5. Other Comments: (*Explain if there is a disparity in the current diagnosis versus the referral diagnosis*)

IF THE PERSON HAS A PRIMARY DIAGNOSIS OF ORGANIC MENTAL DISORDER
*******************************PASRR PROCESS STOPS HERE************************

(For the purposes of a PASRR evaluation, when a person has more than one diagnosis, the primary diagnosis is the one with the most pervasive symptoms or the condition that is chiefly responsible for the need for treatment. The primary diagnosis may not necessarily be listed first in a chronological listing of problems/conditions.)

Medication History (This section must be completed thoroughly)

1. Documentation of all medications individual has taken in the last year: (<u>Identify below or attach medication list</u>)

a. Currently prescribed

Medication	Dosage	Frequency	Reason

b. Previous psychotropic medications (Please include dosage, frequency and reason):

c. Comment on any medications that could mask or mimic mental illness symptoms.

2. Self-Management of medications (Please complete for new admission)

☐ Without Supervision	☐ Complies Only if Given Choice
☐ With Some Prompting and Supervision	☐ Hoards Medication
☐ Only With Prompting and Supervision	☐ Refuses Medication

3. Does client complain of side effects of medication or are there visible signs of side effects?

4. List all allergies including medication (prescribed or over the counter) allergies and food allergies.

5. Does the client use alcohol or other non-prescribed drugs? Is there a history of alcohol/drug abuse? If yes, identify TYPE, FREQUENCY, AMOUNT AND LENGTH OF USE/ABUSE.

Name:	**SS#:**

Psychosocial Evaluation

1. Reason for Placement: Identify changes in the individual's status and/or living situation that contributed to the request for nursing facility placement.

2. Family/Friends/Support System (list names & phone numbers:

3. Current Functioning Level (ability of person to function in a less restrictive setting):

a. Is the person's ability to communicate and verbalize in expressive/receptive skill areas impaired?
☐ Yes ☐No. If yes, please **describe** the Impairment and what action the evaluator took to overcome this?

b. Please rank person's ability to perform following areas and/or identify current supports provided to assist with activity:

Rank current functioning 1 – 4:
1 - Unable to Perform 3 - Needs Minimum Assistance
2 - Needs Moderate Assistance 4 - Independent

Activities of Daily Living		**Instrumental Activities of Daily Living**			
Eating		Meal Preparation		Laundry	
Dressing		Light Housekeeping		Shoppin	
Bathing		Heavy Housework		Mobility	
Toileting		Money Management		Travel	
Grooming		Nutritional Habits			
Ambulation		Health Monitoring **&** Medication Management			
Transfer					

c. Comments::

Base (Low intensity) Medicaid Nursing Facility Level of Care
In order to meet minimal level of care criteria for admission to a nursing facility, an applicant **must** meet two (2) criteria listed below.
(Check the box(s) that apply)

Assistance with wheelchair ☐
Physical or environmental management for confusion and mild agitation ☐
Must be fed ☐
Assistance with going to bathroom or using bedpan for elimination ☐
Old colostomy care ☐
In-dwelling catheter for dry care ☐
Changes in bed position ☐
Administration of stabilized dosages of medication ☐
Restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition ☐
Administration of injections during time licensed personnel is available ☐
Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care ☐
Routine administration of medical gases after a regimen of therapy has been established. ☐

The following criteria must also be considered…
An individual with a mental illness or mental retardation or a developmental disability meeting the health status and care needs specified above shall meet patient status and still be excluded from coverage in the following situations;
If the department determines that in the individual case the combination of care needs are beyond the capability of the facility and that placement in the facility is inappropriate due to potential danger to the health and welfare of the individual, other patients in the facility or staff of the facility or
The individual does not meet the PASRR criteria for entering or remaining in a facility

Patient Status: (Previously level of care)
A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Name:	SS#:

Medical History / Physical Examination

1. How does the Physical/Medical Condition/Diagnosis impact the individual's ability to function?

2. Describe the nursing facility services presently received, if resident, or recommended, if applicant. Be very specific. (See examples to complete this section in the PASRR Manual p. V-9)

3. The following is Comprehensive History and Physical Data which Includes complete history and review of all body systems, specific evaluation of neurological system in area of motor and sensory functioning, gait, and deep tendon reflexes. Nursing home admission cannot occur until after this requirement has been met. The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, a physician must review and concur with the conditions.

a.		Source of Data:				
		**Date Performed:		**Performed By:		
		Major physical / medical needs:				
		Abnormal finding that requires additional information:				
		Finding	Evaluation Recommended	Date of Referral	To Agency / Person	
		Comments:				

b.	If information is not available, evaluator or CMHC must either conduct the examination and complete the Comprehensive History and Physical Examination Form or refer the applicant to another office for the evaluation. If referred for evaluation, give:				
	Date of referral:		To Agency / Person:		
	Date findings Returned:				
	Summary of Major Physical / Medical Needs:				

3.	Date of Last Minimum Data Set (MDS) Conducted at Facility (if appropriate):	
	Note Major Physical Medical Needs:	
4.	Date of Last Level of Care Certification Performed by Peer Review (if appropriate):	
5.	Other Comments:	

Name:	SS#:

Comprehensive Medical History / Physical Examination

The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's medical condition.

I	**Medical History**	
	1. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
	2. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
	3. Allergies or Drug/Food Sensitivities	4. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

II	**Review of Body Systems - Assess all variables and explain all abnormal findings.**					
	Vital signs:	T:	P:	R:	B/P:	WT:
	General Appearance and Behavior:					
	Skin:					
	Head:					
	Face (include Eyes, Ears, Nose):					
	Mouth, Throat, Neck:					
	Cardiovascular:					
	Pulmonary:					
	Breast:					
	Gastrointestinal:					
	Genitourinary:					

Name:	SS#:

	Rectal:
	Musculoskeletal:
	Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

III	Abnormal Findings - In case of abnormal findings, which are the basis for the individual's nursing home placement, include recommendations for additional information.

IV	Summary of Major Medical/Physical Needs.

	Signature and Professional Title (RN or PA) if not performed by a physician	Date
	Physician Signature (A physician must sign here in order to complete the form)	Date

Name:	SS#:

Part II: Findings and Recommendations

Review of Findings	
	Positive Traits/Developmental Strengths and Weaknesses:
	Medication History:
	Mental Status/Psychiatric Assessment (include dangerousness to self or others):
	Psychosocial Evaluation:
	Medical History/Physical Examination:
	Impact of Physical/Medical Diagnosis on person's ability to function:
	Nursing Facility Care Needs:
	Recommended Services to be included in resident's treatment plan (Clearly describe mental health services needed and how they will benefit the resident):

Name:	SS#:

Recommendations	
1.	Does person need nursing facility care? ☐ Yes ☐ No
2.	Are Specialized Services recommended? ☐ Yes ☐ No
(If yes, Specialized Services Identification Form, this complete evaluation and the Computer Summary Form must be sent to the Division of Mental Health.) Specialized Services (Active treatment) Definition for Mental Illness: Specialized Services is the implementation of an individualized plan of care developed under and supervised by a physician, and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. An applicant with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental disease (IMD) or an inpatient psychiatric hospital.	

Disposition - Check one only. This information must be consistent with the disposition on the PASRR Computer Summary. For assistance, refer to the PASRR Manual.

Admission To or Continued Stay in Nursing Facility
☐ No specialized services recommended
☐ Specialized services recommended
☐ Client declined specialized services
Not Admitted to Nursing Facility
☐ Recommended to state treatment facility / CMHMRC program
☐ Recommended to private treatment facility / community program
☐ No action taken
☐ Admitted to or continued stay in State IMD
☐ Inappropriate PASRR Referral; Meets Exemption -- Process Stops

Name:	SS#:

Summary Report: Based upon the comprehensive analysis of all data gathered concerning the applicant/resident, provide a clear and succinct summary of the findings, determinations and recommendations. This summary should give a clear picture of current functional status, describe treatment and service needs, and identify the most appropriate setting these services should be provided. Also give a chronological history of nursing facility admissions if applicable.

Name:	SS#:

Evaluation Time Frames:

Date of Referral: __________ **Date Verbal Given:** __________ **Date Report Sent:** __________

Signature of Evaluator:

Title: ____________________ Date: ____________________

Counter Signature:

Title: ____________________ Date: ____________________

Signature of Evaluator:

Title: ____________________ Date: ____________________

Counter Signature:

Title: ____________________ Date: ____________________

If other evaluators were responsible for particular sections, please include below:

☐ Mental Status/Psychiatric Assessment

Name, Title, Date: ____________________

☐ Psychological Evaluation

Name, Title, Date: ____________________

☐ Medication History

Name, Title, Date: ____________________

☐ Medical History / Physical Examination

Name, Title, Date: ____________________

Name:	SS#:

INTERPRETATION OF PASRR FINDINGS:

The Center for Medicare and Medicaid Services (CMS) Regulations mandate that the findings of this evaluation be interpreted to: the individual; the legal guardian; or, for a legally competent person who is incapable of understanding the findings, to his/her designated family member or representative.

The findings of this evaluation have been explained to (check one):

- ☐ Individual
- ☐ Legal Guardian
- ☐ Representative

I understand that my signature does not represent my consent or agreement with the findings. I also understand that I have the right to contest the findings if I receive a determination that I do not require nursing facility level of care or that I do not need specialized services. A cover letter accompanying this evaluation explains my appeal rights

______________________________ ______________________________

Individual / Representative (Relationship, if appropriate)

Community Mental Health Center Staff ______________________________

Title ______________________________

NOTE: If signature was not obtained, please document steps taken to obtain signature and note the date the Interpretation of Findings was sent to the individual/representative.

____

____

____

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____

____

Instructions for Completing the Intellectual Disability Level II PASRR Evaluation

Page 1	**Applicant's Name** First Name & Last Name **Race** White African American American Indian Asian Alaskan Native Native Hawaiian/Pacific Islander Hispanic **Marital Status** Single/Never Married Married Divorced Co-habituating Widowed Separated Unknown **Current Living Arrangements** Indicate the location of the individual at the point of interview or contact. **Legal Guardian** A Court appointed full guardian. This would not include POA's, financial representatives, etc. It is acceptable to list other representatives, but specify the relationship to the applicant. **ADA Accommodations** Americans with Disabilities Act. This would include adaptive devices, interpreters, or any assistive devices needed to perform the evaluation. **Referral Information** Include area codes with phone numbers. **Type of Referral** This should be consistent on all evaluations. However, there are instances when dually diagnosed residents require an update for only one diagnosis. Please indicate which by checking the appropriate box. **Mental Illness** An individual who meets the criteria on the MAP-409 for a serious mental illness. **Intellectual Disability** An individual who meets the criteria on the MAP-409 for intellectual disability.

Related Condition

A condition similar to intellectual disability usually caused by a developmental delay during childhood (prior to age 22). See the MAP-409 for conditions that might be indicative of a related condition. ***Note that the individual would meet criteria for substantial functional limitations in three or more of the listed major life activities prior to age 22.***

Dual Diagnosis

An applicant or resident who meets the criteria for both mental illness and intellectual disability or related condition as identified on the MAP-409.

New Admission

An individual is a new admission of he/she is admitted to any NF for the first time or does not qualify as a re-admission. With the exception of certain hospital discharges described herein, all new admissions are subject to Level I screening.

Re-Admission

An individual is a re-admission of he/she was re-admitted to a NF from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are not subject to Level I screening, but may be subject to a Subsequent Review if the person has experienced a significant change in condition as defined in 3.44 of this manual.

Hospital Exemption

An individual who currently resides in a hospital whose physician has completed the thirty (30 day exemption form stating that nursing facility is needed for management of the problem for which the individual was hospitalized. This stay is expected to be thirty (30) days or less.

Provisional Admissions

A request for a Level II PASRR should be initiated when it appears that the individual admitted under this provisional admission will not be discharged within the fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth (14th) day of the admission date until a PASRR determination is made authorizing nursing facility level of care. There are two (2) categories of provisional admissions.

Delirium: An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days.

Respite: An individual whose caregiver has requested admission to a NF for not more than two (2) weeks (fourteen (14) days) of relief from caregiver responsibility.

	New to PASRR An individual who resides in a nursing facility but has not previously had a Level II performed. This is usually someone who was admitted without adequate information to document the existence of a mental illness or intellectual disability/related condition diagnosis prior to admission. **Initial Resident Review** An individual who was admitted to the nursing facility without a Level II having been performed prior to admission. This could include a hospital exemption, one of the provisional categories (delirium and respite), or an individual who did not appear to meet criteria upon admission, but new information becomes available or circumstances change. **Significant Change of Condition** A current resident of a NF (who has previously had a Level II evaluation) and experiences a change in physical or mental functioning that will affect that individual's need for either continued nursing facility stay as the least restrictive environment, or might now need specialized services and previously did not. **Subsequent Review** Significant change in condition line should be documented as the date the MDS triggered a significant change. ***The date of admission to the nursing facility is the initial admission date to the facility.*** **Informational Sources** Directions for this component are fairly self-explanatory. It should be noted; however, that under record/document review that when previous Level II evaluations are used as an informational resource, this should be documented here
Page 2	**Date of Referral** Date the decision was made to complete the Level II **Date Completed** Date the evaluation was performed (face-to-face interview) **Evaluated by** Name and title of the evaluator, along with the date of the face to face interview **Name of Clinician** Name and title of the person who completed the IQ testing. **Date** Enter the date the testing was performed **Is Psychological Attached?** Please check "yes" and attach with the evaluation. If not, check "no".

	DSM IV diagnosis List the diagnosis with the most prominent symptoms on primary AXIS; list secondary if applicable. Document NONE where this applies/or defer if there is a questionable diagnosis. Document AXIS III, IV, and V if they are known and applicable to the situation. **If No Psychological is Available** If an applicant over the age of 18, or 22 for a developmental disability, cannot obtain the required psychological evaluation, the following shall qualify: "Supporting documentation" as it relates to eligibility for placement on the SCL waiting list, which means: (a) A Psychological or Psycho-educational Report of the assessment results of at least an individual test of intelligence resulting in an IQ score and the results of an assessment of adaptive behavior abilities and shall be signed by the Licensed Psychologist: Licensed Psychological Associate; or Certified Psychologist with Autonomous Functioning who prepared the report; or (b) The assessment resulting in an Intelligence Quotient (IQ): 1. Will have been conducted before the age of 18 for diagnosis of an Intellectual Disability or age 22 for a diagnosis of a Developmental Disability (DD); or 2. If record prior to the age of 18 for an applicant with an intellectual disability or 22 for an applicant with a developmental disability cannot be obtained, the following shall qualify as supporting documentation: (a) Individual Education Plan (IEP) documentation which contains IQ score and report or description of adaptive behavior skills; (b) The results of the Psychological Assessment submitted during the course of guardianship proceedings: or 3. Results of a current Psychological Assessment to include evidence of onset prior to 18 for an intellectual disability or 22 for a developmental disability obtained through a comprehensive developmental history. The Assessment shall also provide documentation ruling out factors or conditions which may contribute to diminished cognitive and adaptive functioning, such as Severe Mental Illness, chronic substance abuse, or medical conditions **Medical Problems** List medical problems that are current. If an individual has a history of a disorder that is currently stable and not an active problem, note this in Impact of functioning column. List most current first and less active or historical diagnoses as they occurred in order. If hospitalized, the reason(s) for the hospitalization should be documented first. **Impact on Functioning** List the impact each disease has on ***current*** functional level.
Page 3	**Medications** List medications here. Do not document "see attached list" on this section. Check the appropriate option for the individual's ability to self-administer. **List PRN medications** List ***"prescribed as needed"*** medications and cite the behavior for which they are prescribed. Check those that have been administered for behaviors in the last 60 days.

Pages 4 - 7	**Part C: Independent/Instrumental Activities of Daily Living** For each ADL or IADL, please select the appropriate offering. In some cases, more than one may be selected. Offer descriptive comments to further explain when needed. Please select the appropriate numerical rating for each ADL or IADL as described on the evaluation form, from 1-4. ***Pre-morbid is defined as the highest level of functioning prior to the current illness or the current level of functioning***. Then, based upon the level of assistance required and the reasons for the assistance being needed, select the appropriate option for the service needed and/or receiving.
Page 4	**Self-Help Development: Toileting, Dressing, Grooming, Eating** Be specific regarding the level of assistance required. More than one selection might be appropriate. Add comments if the selection(s) do not adequately describe the level of functioning/assistance needed. Please select the appropriate numerical rating for pre-morbid functioning, so that Committee can estimate the level of functional loss related to illness, aging, or condition that relates to the developmental disability. For instance, a person with Cerebral palsy will likely deteriorate neurologically as they age.
Page 5	**Sensorimotor Development: Ambulation, Speech** Document as specifically as possible. This component is very important for a correct rating of pre-morbid functioning. **Speech and Language** Note whether the applicant has ever spoken, if currently non-communicative. If it appears that he/she has good receptive communication (i.e., responds appropriately to interview), document this.
Page 6	**Social Development: Maladaptive Behaviors** Document to what extent the applicant seeks out interaction. Document activities enjoyed and/or disliked in comments section. If the applicant is unable to communicate, please inquire with caregivers. **Academic/Educational** Document grade in school completed. If known, document why schooling was not sought or was stopped; also in comments section. **Independent Living Skills: Functional Learning** Choose the most appropriate option for IADL functioning.
Page 7	**Vocational Development** Document any workshops or supervised work settings the applicant has attended. A person can be of retirement age, but still wish to work, if this is the case, circle retirement age only; then document the desire to work in the comments section. **Treatment History** Document treatment the applicant has received or is currently receiving. Contact the specific PASRR office where he/she has lived, if not in your region.

	Affective Development Select the most applicable choice for current affective development. Rate pre-morbid abilities for decision making.
Pages 8 & 9	**Comprehensive Medical History/Physical Examination Supplement** Specify either an attached document, or systems review performed by a staff member. If the document referred to is current, you may respond “See the attached document”. If there are changes noted since the referenced document, please note the changes in the appropriate component.
Page 10	**Summary of Findings** Briefly summarize the noted components. This is the summary that is forwarded to the individual’s MD, so a brief, but thorough, summary is indicated. **Recommendations** Check the appropriately indicated box.
Page 11	**Time Frames** Date of referral is that date when a decision was made to proceed with the Level II ID/DD evaluation. Date sent to nursing facility is just that. This date cannot be prior to the Committee letter date. **Specialized Services** This page also contains a description of specialized services. Compare the abilities of the person being evaluated with the criteria on Page 11, listed from 1-8. If most of these can be answered “yes”, this individual may likely require some type of specialized service. **30-Month Placement Option** Select the appropriate option for the determination regarding specialized services. The 30 month option only applies to those evaluations that recommend specialized services. The 30 months is calculated back from the date of the first adverse determination. Adverse meaning that nursing facility is deemed inappropriate.
Page 12	Document the date of the final Committee determination and select the appropriate option by checking the appropriate box. Indicate to which party the interpretation of findings was sent by selecting the appropriate choice. Be sure the evaluator who performed the evaluation signs the interpretation of findings.

PASRR (LEVEL II) CHECKLIST ID/RC

EVALUATION TIME FRAMES MET:

Date of Referral: ___ / ___ / ___
Date Verbal Given: ___ / ___ / ___
Date Report Sent: ___ / ___ / ___

IF NOT, IS:

_____ Letter of Explanation attached to Computer Summary Sheet?

EVALUATION PERFORMED BY APPROVED PERSONNEL:

_____ PASRR certified evaluator
_____ Physician's review and signature for medical/physical specialty examinations
_____ Psychological evaluation for intellectual disability
_____ *All sections of evaluation completed*

INDIVIDUAL/GUARDIAN RIGHTS

_____ Individual/Guardian signature obtained
_____ Informed of appeal procedures (Cover Letter)

COMPLETE EVALUATION REPORT SENT TO:

_____ Individual
_____ Legal Guardian (If applicable)
_____ Nursing Facility

COVER SHEET AND REVIEW OF FINDINGS SENT TO:

_____ Attending Physician
_____ Discharging Hospital (if applicable)

IF SPECIALIZED SERVICES RECOMMENDED:

_____ Evaluation sent to DBHDID for review by PASRR Committee
_____ If intellectual disability, licensed psychologist counter signature obtained.

COMPLETED COMPUTER SUMMARY FORM FAXED TO DBHDID ___

PASRR (Level II) Cover Sheet
Comprehensive Evaluation
For Mental Illness and Intellectual Disability/Related Condition

Date of Referral:	**Date Assigned to PASRR Staff:**

Name of Center Completing Assessment:

Applicant Identifying Data

Applicant's Name:			**Social Security Number:** - -	
Birth Date: / /	**Sex:** M ☐ F ☐	**Race:**	**Marital Status**	**Spouse**

Evaluation Location:

☐ Home	☐ Relative's Home	☐ Hospital	☐ State Hospital	☐ Hospital Psychiatric Unit
☐ Psychiatric Hospital	☐ SCL/Group Home	☐ ICF/MR	☐ Nursing Facility	☐ Personal, Mini, Family Care Home
☐ Other				

Legal Guardian: ☐ Yes ☐ No	**Name/Telephone number:**

Referral Information

Referral Source: ☐ MAP 409 ☐ Telephone Contact ☐ Subsequent Review (phone/form)

Name:

Relationship to Applicant:	Telephone:

Facility Requested:

Address: *(if known)*

Contact Person:	Telephone:

Type of Referral: (Check One)	☐ Mental Illness	☐ Intellectual Disability	☐ Dual Diagnosis
		☐ Related Condition	☐ MI Portion Only
			☐ DID Portion Only

Type of Assessment: (Check One)

Preadmission	**Initial Resident Review**	**Subsequent Review**
☐ New Nursing Facility Applicant	☐ Hospital Exemption	☐ Significant Change In Condition
☐ (Did Not Meet Readmission	☐ Provisional Admission	
	☐ Delirium	
	☐ Respite	
	☐ New to PASRR	

Give Date of Nursing Facility Admission:

Information for this evaluation was obtained from the following: (List PERSON/AGENCY/DATE of CONTACT)

☐ Applicant (If applicant was unable to significantly contribute to the interview, please identify reason):

☐ Family Members / Legal Representative:

☐ Other Agencies:

☐ Record / Document Review:

This evaluation may be typed or hand-written legibly in ink

Name:	SS#:

Level II Comprehensive Evaluation for Intellectual Disability/Related Condition

Referral Date: **Date Completed**:

Evaluated or Reviewed by (include name, title and date):

PART A Diagnosis	Identification of Intellectual Functioning				
Is psychological attached?	☐ Yes		☐ No		
If yes, name and Title of Clinician:			Date of Evaluation:		
DSM IV Current Diagnosis:					
	AXIS I:	Primary		Secondary	
	AXIS II:	Primary		Secondary	
	AXIS III:				
	AXIS IV:				
	AXIS V:				
If no**: Provide history to substantiate ID/DD diagnosis, including age of onset**:					

PART B Medical		
Is physical examination from an appropriate health care professional attached?		
☐	Yes;	Skip physical examination supplement
☐	No;	Physical examination supplement must be completed and attached

List Medical Problems	**Impact on Functioning**

Name:	SS#:

Administration	☐	No medications
	☐	Self-administers
	☐	Self-administers with set up
	☐	Medications must be prepared/administered (oral/injectable) Circle applicable option(s)

List Current Scheduled Medications	

List PRN Medications:	(Check medications administered in the last sixty (60) days for behavioral control; cite behavior in second column.)	
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Name:	SS#:

Part C: Independent/Instrumental Activities of Daily Living/Services Receiving or Indicated

TOILETING		Pre-morbid Numerical Rating:		DRESSING		Pre-morbid Numerical Rating
☐	Independent/changes own incontinence briefs	Comments:		☐	Independent	Comments:
☐	Totally dependent			☐	Totally dependent	
☐	Assistance required (one person each time)			☐	Assistance required	
☐	Bedpan			☐	Stand-by verbal prompts	
☐	Peri-care			☐	Hands on each time	
☐	Ostomy					
☐	Catheter					
☐	Other					

GROOMING		Pre-morbid Numerical Rating:		EATING		Pre-morbid Numerical Rating:
☐	Independent	Comments:		☐	Independent	Comments:
☐	Totally dependent			☐	Totally dependent	
☐	Assistance required			☐	Device	
☐	Stand-by verbal			(feeding tube/IV)		
☐	Help in/out tub or shower			☐	NPO	
☐	Hands on each time			☐	Tray set up	
☐	Other			☐	Assistance required	
				☐	Occasional verbal reminders	
				☐	Physical assistance moving food from plate to mouth	
				☐	Continuous need for verbal instructions	
				☐	Chokes / Swallow study indicated? ☐ Yes ☐ No	
				If already performed, please attach		

In final determination process, an individual may meet base level of care, but still not require nursing facility admission, particularly if needs identified can feasibly be met in an alternate setting with supports.
ACTIVITIES OF DAILY LIVING (toileting, dressing, grooming/bathing eating)
If assistance is required, indicate the type by checking appropriate option or provide a description in the comments section; most categories will require comments for full elaboration.
Rate **pre-morbid** functioning assistance required of each category by assigning the appropriate numerical value; **Pre-morbid means best baseline functional capacity/prior to current illness or current level**.
1. Independent (no or little assistance required) 2. Minimal (limited hands-on or verbal cues) 3.Moderate(assist of 1)
4. Maximum (assist of 2/much hands-on)
A comment section is provided for each component.

Name:	SS#:

SENSORIMOTOR/MOBILITY		Pre-morbid Numerical Rating:		
Ambulation				
☐	Independent	Comments:		
☐	Independent with aid			
☐	Needs assistance			
☐	Totally Dependent/Non-mobile (complete transfer)			
☐	Physical Assistance mobilizing wheelchair, walker, or device			
☐	Physical assistance with transfers			
☐	Physical assistance with bed-positioning			
☐	Stand-by assistance of one for mobilization			
☐	Other			

	Services Received or Identified:	
☐	Receives Physical Therapy	☐ Receives Occupational Therapy
☐	Physical Therapy Evaluation Indicated	
☐	Restorative Nursing Program	☐ Occupational Therapy Evaluation Indicated
☐	Needs evaluation for customized wheelchair and/or adaptive equipment	

SPEECH/LANGUAGE		Pre-morbid Numerical Rating:		
Describe the individual's reaction the interview:				
☐	Adequate Verbal Communication/Easily Understood			
☐	Inadequate Verbal Communication	Comments:		
☐	Communication Device Needed			
☐	Hearing Aide Needed			
☐	None Due to Poorly Responsive State			
☐	Other			
Receptive				
☐	Adequate Verbal Reception			
☐	Inadequate Receptive Communication			
☐	Some Receptive Communication; Understands Simple Commands			
☐	Limited Receptive Communication			
☐	None Due to Poorly Responsive State			
☐	Other			

	Services Received or Identified
☐	Receives Speech Therapy
☐	Speech Therapy Evaluation Indicated
☐	Habilitative Speech Therapy Indicated

Name:	SS#:

SOCIAL DEVELOPMENT	Pre-morbid Numerical Rating		Maladaptive Behaviors
☐ Adequate Social Skills	Specify Maladaptive Behaviors		
☐ Inadequate Social Skills			
☐ Withdrawn/Avoidant of Contact			Comments:
☐ Limited Contact Due to Social Deprivation			
☐ Responds Inappropriately To Situation			

☐ Physically Combative	☐ By History	☐ Other	
	☐ Currently		
☐ Verbally Abusive	☐ Repetitive Verbalizations	☐ Threats to Others	
	☐ Delusions/Hallucinations	☐ Other	

Services Received or Identified:	
☐	NF Can Meet Socialization Needs
☐	Evaluation By ID/DD Staff Indicated

ACADEMIC/EDUCATIONAL	(Pre-morbid functioning does not apply)
☐ No Educational Needs Identified	Comments:
☐ High School Graduate	
☐ High School Graduate, Special Education	
☐ Attended 1-8	
☐ No Formal Schooling	
☐ Other	

Services Received or Identified:	
☐	NF Can Meet Academic Needs
☐	Evaluation By ID/DD Staff Indicated

FUNCTIONAL LEARNING/ INDEPENDENT LIVING SKILLS	Pre-morbid Numerical Rating:		
☐ Functionally Independent			Comments:
☐ Functionally Independent With Supervision			
☐ Completely Dependent For All IADL's			
☐ Requires Assistance With IADL's			
☐ Finances			
☐ Meals			
☐ Transportation			
☐ Other			

Services Received or Identified:	
☐	NF Can Meet Functional Needs
☐	Evaluation By ID/DD Staff Indicated

Name:	SS#:

Name:	Region:
Evaluated or Reviewed by (include name title and date)	

	VOCATIONAL	Pre-morbid Numerical Rating:	
☐	Retirement Age/doesn't wish to work		Comments:
☐	No Vocational Skills/No Potential		
☐	Worked With Minimal Supervision		
☐	Has Never Worked		
☐	Desires To Work		
☐	Capable of Work In Supervised Setting		
☐	Other		

	Services Received or Identified:	Comments:
☐	NF Can Meet Vocational Needs	
☐	Evaluation By ID/DD Staff Indicated	

	TREATMENT HISTORY	Pre-morbid rating does not apply	
☐	Has attended ID/DD programs	List region of treatment _____	Comments:
☐	Is currently attending ID/DD programs		
☐	Is an SCL recipient/ Is placement considered temporary? ☐ Yes ☐No If yes, case manager should request extensions		
☐	Has a history of treatment for MI diagnosis		
☐	Has received ID/DD treatment in another state		
Comments:			

	Services Received or Identified:	Comments:
☐	Doesn't meet criteria for requiring ID/DD services	
☐	Evaluation By ID/DD Staff Indicated	

	AFFECTIVE DEVELOPMENT	Pre-morbid Numerical Rating	Comments:
☐	Has legal guardian		
☐	Independent with decisions		
☐	Needs minimal assistance with decision making		
☐	Family or significant others assist with decisions		
☐	Needs maximum assistance with decisions		
☐	Other		

	Services Received or Identified:	
☐	NF can meet needs related to decisions/needs	
☐	Evaluation By ID/DD Staff Indicated	

Name:	SS#:

Comprehensive Medical History/Physical Examination

A physician, registered nurse or a physician assistant must perform the examination. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's

I. Medical History

1. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
2. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
3. Allergies or Drug/Food Sensitivities	4. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

II. Review of Body Systems (assess all variables and explain all abnormal findings)

Vital signs:	T:	P:	R:	B/P:	HT:	WT:
General Appearance and Behavior:						
Skin:						
Head:						
Face (include Eyes, Ears, Nose):						
Mouth, Throat, Neck:						
Cardiovascular:						
Pulmonary:						
Breast:						

Name:	SS#:

PHYSICAL EXAMINATION SUPPLEMENT

Gastrointestinal:
Genitourinary:
Rectal:
Musculoskeletal:
Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

III. Abnormal Findings

In case of abnormal findings, which are the basis for the applicant's nursing home placement, include recommendations for additional information.

IV. Summary of Major Medical/Physical Needs

Signature and Professional Title (RN, RNP, or PA) if not performed by a physician	Date
Physician Signature (A physician must sign here in order to complete the form)	Date

Name:	SS#:

Summary

Current Medical Issues
Medications
Activities of Daily Living
Psychosocial History *Please describe the response of the applicant/resident to your interview;*
Nursing Facility Needs (Give chronological history of nursing facility admission)

Recommendations

Does applicant meet Medicaid admission criteria?

Yes ☐ No ☐

Does applicant meet admission criteria, but services could be provided in an alternate setting?

Yes ☐ No ☐

NF Resident

☐ Resident meets base Medicaid criteria, but needs could be met in an alternate setting. Does 30 month option apply?

Yes ☐ No ☐

☐ Resident is appropriate for nursing facility, and requires specialized services.

☐ Resident is appropriate for nursing facility, and does not require specialized services.

Name:	SS#:

Date of referral________ Date of determination_________ Date sent to nursing home_________

DISPOSITION/SPECIALIZED SERVICES CRITERIA

A specialized services recommendation is based on the person's developmental strengths and weaknesses and to what extent the person's status compares with each of the following characteristics: The INABILITY to:

1. Take care of most personal care needs;
2. Understand simple commands;
3. Communicate basic needs and wants;
4. Be employed at a productive wage level without systematic long-term supervision or support;
5. Learn new skills without aggressive and consistent training;
6. Apply skills learned in a training situation to other environments or place without direct aggressive and consistent training;
7. Demonstrate behavior appropriate to the time, situation, or place without direct supervision;
8. Make decisions requiring informal consent without extreme difficulty; OR

Demonstrates severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and / or

Has other skill deficits or specialized training needs that necessitate the availability of trained ID personnel, 24 hours per day, to teach the person functional skills.

The responsibility of the PASRR evaluator is to use his/her expertise as a QMRP, or professional equivalent, to recognize strengths and weaknesses as identified in this evaluation, and make recommendations based upon the above criteria. The final determination rests with the DBHDID PASRR Review Committee. Once the final determination has been made, the PASRR Coordinator, Specialized Services Coordinator, and Regional Liaison will be notified by

Committee correspondence; and a person-centered planning process will be initiated to assure the person receives identified services. Regional Liaisons also monitor for compliance with Specialized Services recommendations. The Committee determination letters from the Division of ID will provide additional instructions.

Specialized Services (Active Treatment) Recommended: yes ☐ no ☐

Residence of more than 30 months: yes ☐ no ☐

Signature of ______________________________

Title: ______________________ Date: ______________

Counter Signature: ______________________________

Title: ______________________ Date: ______________

Counter Signature: ______________________________

Title: ______________________ Date: ______________

Name **Social Security Number**

has had a Level II PASRR evaluation for ☐ Intellectual Disability ☐ Developmental Disability,

As mandated by OBRA 1987. The above criteria have been assessed and a determination has been made regarding the need for nursing facility care and specialized services for the above condition. The PASRR Review Committee made the following determinations on

Date **Year**

☐ Meets base Medicaid level of care, but total care needs can be met in alternate setting with supportive services

☐ Meets Medicaid level of care and does not require specialized services. Total care needs can be met in the nursing facility

☐ Meets Medicaid level of care, but requires additional or specialized services in the nursing facility

☐ Does not meet Medicaid base level of care; may not be admitted to a nursing facility

☐ No longer meets Medicaid level of care; must be discharged from nursing facility
Does 30 month option apply? ☐ Yes ☐ No

Interpretation of PASRR Findings

The Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of this evaluation be interpreted and explained to the individual and, where applicable, to a legal representative designated under state law.

The findings of this evaluation have been explained to (check one):

☐ Individual

☐ Legal representative

☐ Other (specify)

I understand that my signature does not mean that I consent to or agree with the findings, but only that the evaluation has been received by me and the first-level hearing rights have been explained to me should I disagree with the determination and wish to appeal.

NOTE: If signature was not obtained, please document steps taken to obtain signature and note the date that the Interpretation of Findings were sent to the applicant/ representative.

Applicant / Representative **Relationship (if appropriate)**

BHID Board Staff **Title**

Date

INSTRUCTIONS FOR COMPLETING PASRR COMPUTER SUMMARY FORM

This form must be completed for every assessment, pre-admission, initial, or subsequent review. If the submission is for an updated disposition, check the update box and **only** complete the first **SEVEN** fields and the appropriate disposition.

Line 1	**Date Submitted to DBHDID** Enter date summary submitted to the Department.
Line 2	**Name of Evaluator** Enter the name of the evaluator who signed off on the evaluation.
Line 3	**Region of the Evaluator** Check the box of the region where the evaluation was performed
Line 4	**Applicant Identifying Number** Enter client social security or identification number.
Line 5	**Name** Enter applicant's name (last name first).
Line 6	**Birthdate** Enter applicant's birthdate and check the appropriate box to identify client's sex (M=male, F=female).
Line 7	**Type of Evaluation** For Section 1: Check the box whether a person has a behavioral health diagnosis, intellectual disability/developmental disability, or dual diagnosis. For DD/ID; a person may have one or both. For Section 2, check appropriate box: 1. Pre-admission/initial (for all persons applying for admission to the nursing facility, or who were admitted under Provisional or Exempt hospital D/C status and are now due the first Level II, or individual s admitted to a nursing facility and the Level I did not trigger a Level II, but new information makes it necessary to have a Level II completed.) 2. Subsequent review (for all persons who have had previous Level IIs, and have experienced a significant change in condition).
Line 8	**Timeframe** Pre-admissions/Initial/Subsequent Reviews a. Enter the date the decision was made that a Level II is indicated b. If applicable, enter the date verbal determination was given to the nursing facility. This must be done within five (5) working days of referral; c. Enter the date written report was sent to the nursing facility, resident, and appropriate others as noted in Manual, Part III, Section 3.a. Timeframes are cited in Section 3.5. d. Enter date of admission to the nursing facility (if known) ***Note: If evaluations do not meet designated timeframes, please attach documentation addressing reason for non-compliance.***

<table>
<tr><td>Line 9</td><td><u>PASRR Referral Appropriate</u>
Check the box Y=Yes or N=No

This section was created to eliminate referrals which did not result in a completed Level II evaluation from entering the PASRR data system. Computer summary sheet need only be submitted for those which an evaluation was begun; but later determined NOT to require a complete evaluation.</td></tr>
<tr><td>Line 10</td><td><u>Nursing Facility Level of Care</u>
If Line 9 is “Yes”, check the appropriate box related to facility level of care (Y=Yes or N=No). Also, place region number that identifies the Community Mental Health Center region where the client’s nursing facility is located. Enter the number of the CMHC completing the evaluation if the applicant is going to a nursing home out-of-state.
<u>Name of Nursing Facility</u>
Enter the exact name of the nursing facility to which the applicant was admitted. Please refer to the NF directory provided by DMS.</td></tr>
<tr><td>Line 11</td><td><u>Requires Specialized Services</u>
Check the box Y=Yes or N=No

If “Yes,” check box whether specialized service was recommended for behavioral health or intellectual disability/developmental disability (circle applicable option(s)
and
Check box whether specialized service treatment site will be in NF or in the community (anywhere other than NF)
and
Check the box whether resident has been in the facility more than thirty (30) months or less than thirty (30) months.</td></tr>
<tr><td>Line 12</td><td><u>Requires Services on a Lesser Intensity than Specialized Services</u>
Check the box Y=Yes or N=No.

If evaluations contain recommendations for improving functioning of individuals and nursing facilities are capable of incorporating these recommendations; indicate “YES”</td></tr>
<tr><td>Line 13</td><td>If applicant/resident has intellectual disability or developmental disability; document whether the PASRR Committee agreed with the determinations</td></tr>
<tr><td>Line 14</td><td><u>Disposition</u>
Disposition 1
This disposition should be checked if applicant:
meets all criteria for admission to or continued stay in a nursing facility; and
does not need specialized services.
Disposition 2
This disposition should be checked if applicant:
meets all criteria for admission to or continued stay in a nursing facility;
requires specialized services; and will receive those services in the nursing facility.</td></tr>
</table>

Disposition 3
This disposition should be checked if applicant
- meets all criteria for admission to or continued stay in a nursing facility;
- requires specialized services, but refuses to receive specialized services.

Disposition 4
This disposition should be checked for an applicant who
- may or may not need nursing facility level of care; but
- requires specialized services and is recommended for admission to a state treatment facility or CMHC program.

Disposition 5
This disposition should be checked for an applicant who
- does not need nursing facility care; and needs specialized services and prefers to go to a private treatment facility or can be treated in a community program.

Disposition 6
This disposition should be checked for an applicant who
- does not meet all criteria for admission to or continued stay in a nursing facility; and does not need specialized services.

Disposition 7
This disposition should be checked if applicant
- is in a psychiatric hospital applying for admission to IMD; or on-going resident reviews continuing to stay in IMD.

Disposition 8
This disposition should be checked if applicant
- is going to a facility out-of-state. Indicate where.

Disposition 9
This disposition should be checked if client
- is already in the system, but has dementia since last evaluation;
- is referred for a Level II and is determined not to have a serious mental illness or intellectual disability/related condition; or
- does not meet criteria for nursing facility level of care; and/or is referred for a Level II and is determined to have dementia.

Disposition 10
This disposition should be checked if applicant
- is in the system; and
- deceased since last evaluation; ***Provide exact date when death occurred.***

Disposition 11
This disposition should be checked if applicant
- was discharged from the nursing facility since last evaluation; ***Provide name of NF, name of place discharged to and exact date*** (e.g. home, exact name of another nursing, SCL, or personal care facility, etc.).

PASRR EVALUATION COMPUTER SUMMARY

☐ **UPDATE**

This form must be submitted for every Level II Evaluation billed to the DBHDID and **must be completed by evaluator**.

NOTE: ANSWER EACH QUESTION COMPLETELY.

DATE SUBMITTED TO DBHDID: ______/_______/____ ____ ____

NAME OF EVALUATOR: ___________________________

REGION OF EVALUATOR:(Check One): 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 10☐ 11☐ 12☐ 13☐ 14☐ 15☐

CLIENT IDENTIFYING NUMBER: ______-- ______-- ________

CLIENT NAME: (Please Print) _____

CLIENT BIRTHDATE: ______/______/______ **SEX:** ☐ **M** ☐ **F**

TYPE OF EVALUATION: (Check One in Each Section)

Section 1

1. ☐ BH
2. ☐ ID/DD (circle)
3. ☐ Dual

Section 2

1. ☐ Pre-Admission/Initial
   ☐ New to Facility/PASRR Pre-Admission
   ☐ Provisional/Initial
   ☐ Exempted Hospital Discharge/Initial
2. ☐ Subsequent Review

TIMEFRAME:

Pre-Admission/Initial/Subsequent Reviews
a. Date of Referral: _____/_____/_____
b. Date Verbal Given: _____/_____/_____
c. Date Written Report Sent to NF _____/_____/______
d. Date of Admission to NF _____/_____/_____

PASRR REFERRAL APPROPRIATE: (Check One) ☐ **Y** ☐ **N**
If yes, continue on. If no, stop and check Disposition #9.

RECOMMEND NURSING FACILITY PLACEMENT: (Check One) ☐ **Y** ☐ **N** **Region:** _____
If yes, continue on. If no, stop and circle Disposition #9

NAME OF NURSING FACILITY PLACEMENT (if applicable) ________________________

REQUIRES SPECIALIZED SERVICES: (Check One) ☐ **Y** ☐ **N** If yes, check all boxes below that apply:

Treatment Type	**Treatment Site**	**Length of Stay in NF**
1. ☐ BH	1. ☐ Nursing Facility	1. ☐ More Than 30 Months
2. ☐ ID/DD (circle)	2. ☐ Community/Other	2. ☐ Less Than 30 Months

REQUIRES SERVICES OF LESSER INTENSITY THAN SPECIALIZED SERVICES: ☐ **Y** ☐ **N**
IF ID/DD/DID COMMITTEE AGREE WITH CMHC DETERMINATION: ☐ **Y** ☐ **N**

DISPOSITION: (Check One)

☐1.	Admission To or Continued Stay in NF; No Specialized Services Recommended
☐2.	Admission To or Continued Stay in NF; With Specialized Services Recommended
☐3.	Admission To or Continued Stay in NF; With Specialized Services/Client Declined
☐4.	Not Admitted to NF or Does Not Need NF Care; Recommended to State Treatment Facility/CMHC Program
☐5.	Not Admitted to NF or Does Not Need NF Care; Recommended to Private Treatment Facility/Community Program
☐6.	Not Admitted to NF; No Action Taken
☐7.	Admission To or Continued Stay in State IMD
☐8.	Admit to Out-of-State Nursing Facility **Where**:
☐9.	Inappropriate Referral/Meets Exemption/Process Stops, Dementia
☐10.	Deceased Date:
☐11.	Discharged **From**: **To**: **Date:**

Evaluation updated 7/29/10

Kentucky PASRR
Verbal Determination Form

Client Name: ____ **Date:** _______________

Social Security No: _________________________________

Birth date: ____

Referral Source: ___________________________________

Nursing Home Requested: _____________________________

Diagnosis: ____

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) and/or its designee (PASRR evaluator) has reviewed the Level II evaluation information and has made the following determination/recommendations:

The applicant is appropriate for admission to a nursing facility. ☐ Yes ☐ No

The current resident of the nursing facility continues to need the level of nursing care received in the nursing facility. ☐ Yes ☐ No

The current resident requires specialized services. ☐ Yes ☐ No

The complete evaluation and determination information will be provided and forwarded to the applicant/resident and/or his legal representative, the nursing facility and other appropriate persons.

NOTE: A verbal determination is not given to nursing facility for persons with ID/DD until the Review Committee has made a determination.

PASRR Evaluator: ____________________________________

PASRR Coordinator: _________________________________

Kentucky PASRR
Response to Referral

TO:
FROM:
DATE:

SUBJECT: Pre-admission Screening and Resident Review (PASRR)
Individual's Name: ____
Facility or Referral Source: ____
Applicant/Resident: ____
ID#: ____

On ________________, this agency received a request for a Level II PASRR evaluation on the above named person.

Referral Information: ____

Reason(s) Level II is not indicated (comment if needed): ________________________________

Based on a review of the referral **and/or consultation with referral source,** the person's case falls into one of the following categories:

☐ Diagnosis is not a major behavioral health diagnosis.
☐ No recent treatment.
☐ Does not meet level of impairment/significant disruption to normal living situation (circle choice(s))
☐ Primary diagnosis of dementia (does not exclude for intellectual disability/related condition)
☐ History does not indicate intellectual disability and/or ID cannot be validated.
☐ Does not meet criteria for related condition/developmental disability.
☐ Change of condition does not affect nursing facility or specialized services needed.

PASRR Evaluator____________________ Date ______________

Kentucky PASRR
EXPLANATION OF PASRR BILLING

NOTE: Utilize this form to justify PASRR MI or DID evaluations that exceed a cost of $1,000.00 for single evaluations and $1,500.00 for dual evaluations.

DATE OF REVIEW: ________/_______/________

TYPE OF EVALUATION: ____Pre-admission ____Initial Review ____Subsequent Review

NAME OF CLIENT (OPTIONAL):____

SOCIAL SECURITY NUMBER: ______-______-______ **UNITS:** _____ RATE**: COST**: _____

Identify those categories that contributed to the billing of units. For each item checked, please provide an explanation for why more units than usual were needed for this evaluation.

☐ Travel Time

____

____

☐ Review of Records and Other Necessary Documents

____

____

☐ Compiling Data and Writing Report

____

____

☐ Utilization of More Than One Professional

____

____

☐ Collateral Contacts with Family or Significant Others

____

____

☐ Other

____

____

STAFF NAME: ____

REGION: ______________________________ **DATE**: ________________________________

FAX TO:

DIVISION OF BEHAVIORAL HEALTH (MI) or DIVISION OF DEVELOPMENTAL AND INTELLECTUAL DISABILITIES (DID)
502-564-2284

KENTUCKY PASRR
Notification of Recommended PASRR Services

Name of individual ________________________________

This evaluation contains recommendations made through the PASRR process. Please see below for the type of services recommended.

***** ***It is recommended that the nursing facility staff incorporate these services into the resident's treatment plan and extremely vital that they are implemented******** Examples of these services could include recommendations for a medication review, change in medication; or medical work-up for an underlying medical condition which might be contributing to the individual's mental status.

SPECIALIZED SERVICES

The Community Mental Health/Mental Retardation Center is responsible for implementing Specialized Services.

SERVICES OF LESSER INTENSITY

Mental illness___ Intellectual/Developmental Disability__

(The following section recommends services to best meet each individual's needs and **MUST** be part of the treatment plan to insure continuity of care)

Description of Services

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

SPECIALIZED SERVICES Mental Illness____ Intellectual/Developmental Disability ______
In-patient treatment has been recommended. A representative will visit to implement needed services.

____

SIGNATURE OF PERSON COMPLETING THIS FORM

Kentucky PASRR Program
Refusal of Specialized Services

A resident's refusal of treatment must be persistently and consistently documented in the resident's record.

I have been informed that I may receive services and supports through the PASRR program.
(Please **PRINT** First and Last Name) ______________________________________

- Adult Day Habilitation services and supports have been explained to me.
  - ☐ I have refused such services and supports.
- Facilitative therapy services and supports have been explained to me.
  - ☐ I have refused such services and supports.
- Recreational/leisure services and supports have been explained to me.
  - ☐ I have refused such services and supports.
- Supported vocational services and supports have been explained to me.
  - ☐ I have refused such services and supports.
- Music/Art therapy services and supports have been explained to me.
  - ☐ I have refused such services and supports.
- Case Management services have been explained to me.
  - ☐ I have refused such services

____
Signature of person named above

____
Date

____
Signature of CHMC Representative

____
Date

KENTUCKY PASRR
Timeframe Non-Compliance Log

Region#_______ Month Reported for: _____________

Individual Referred *(last name, first initial)*	Last 4#'s of SSN	Date of Referral	Date Admitted	Nursing Facility	Comments

Please complete this form on the first business day of each month. Send via email to Vicki Barber at vicki.barber@ky.gov and Tammy Swartz at tammy.swartz@ky.gov with details of each non-compliant referral. If no issues of non-compliance were noted during the previous month, note that in comment section.

KENTUCKY PASRR
PLACEMENT OPTION FORM

Name____

SS #____

Nursing Facility_____ ____

As required by federal regulations, a Pre-admission Screening and Resident Review (PASRR identifies those long-term nursing facility residents with intellectual disability who have been identified as being in need of specialized services (active treatment) for their intellectual disability or related condition. Long-term is defined as thirty (30) months from the date it was first determined that nursing facility services were no longer needed and specialized services for intellectual disability or related condition were needed. These persons have a choice of staying in the facility to have these services provided or moving to an alternate placement, either an Intermediate Care Facility/Intellectual disability (ICF/ID) or a Supports for Community Living Waiver Placement in the community. Specialized services for behavioral health do not take place in a NF; however, a resident who has had a Level II behavioral health evaluation and meets the 30-month criteria shall not be subject to further level of care determinations.

Therefore:

I understand that as a long-term resident of a nursing facility, I have the option of staying and receiving services in the facility, or leaving and receiving specialized services (active treatment) in an alternate placement. These specialized services needs have been identified through the PASRR process and staff from the community behavioral health mental/retardation centers have provided me with an explanation of my placement options. Additionally, as a resident of 30 months or more, there will be no further determinations regarding level of care.

( ) I choose to remain in the nursing facility and receive specialized services there.

( ) I choose to receive specialized services in a Supports for Community Living (SCL) Waiver placement.

( ) I choose to receive specialized services in an ICF/ID.

( ) I chose another community placement and supports.
(specify choice) ____

( ) I am a PASRR client who meets the 30-month requirement. No further determinations regarding level of care are necessary.

____
Signature of Client/Legal Representative

____
Witness

____
Date

____

Person Completing Form/Date

Medicaid Forms

Nursing facilities are responsible for completing, routing, and filing these forms. The forms are useful for PASRR evaluators to have on hand; however, they contain explanations for processes that evaluators are often asked to interpret and follow. **These forms are not to be completed by hospital discharge planners, although discharge planners should cooperate by providing the needed information to the nursing facility.**

A listing of many of these forms can be found at:
http://www.kymmis.com/kymmis/Provider%20Relations/ProviderRelationsForms.aspx

MAP 350 NF – Certification Instructions & Form (03/09)
http://www.kymmis.com/kymmis/pdf/MAP%20350%20NF%20Instruct%202009%20_2_.pdf
http://www.kymmis.com/kymmis/pdf/MAP%20350%20NF%20Form%202009.pdf

MAP 409-1 – Pre-Admission Screening and Resident Review (PASRR) Nursing Facility Identification Screen (LEVEL I)
http://www.kymmis.com/kymmis/pdf/map409.pdf
Used to determine whether criteria are present indicating the need for a completed Level II evaluation. Should be completed by nursing facility staff prior to applicant's admission to the facility.

MAP 409-2 – Exempted Hospital Discharge Physician Certification of Need for Nursing Facility Service
http://www.kymmis.com/kymmis/pdf/map4092.pdf
Please note that the applicant's physician must sign that the applicant will require nursing facility care for thirty (30) days or less for continued treatment for the condition for which he/she received care in the hospital. This form should not be used to hasten hospital discharges when there is clearly not a thirty (30) day exception.

MAP 409-3 – Provisional Admission To A Nursing Facility
http://www.kymmis.com/kymmis/pdf/map4093.pdf
Provisional admission form for cases of delirium and respite. On the form is an explanation of time frames for completing the Level II if this is required.

MAP 409-4 – Notification of Intent To Refer For LEVEL II PASRR
http://www.kymmis.com/kymmis/pdf/map4094.pdf
Used to notify families or responsible parties that the applicant or resident is being referred for a Level II evaluation.

MAP 409-5 – PASRR Significant Change/Discharge Data
http://www.kymmis.com/kymmis/pdf/Significant%20Change%20Memorandum%204095%20plus%20form.pdf
Used to notify the PASRR office that there has been a significant change in the resident's condition that has the potential to affect his or her need for continued nursing facility stay or specialized services. It frequently is forwarded to PASRR offices as referral notification. It is also used to notify PASRR offices of a death or discharge of a PASRR resident.

MAP 620 - Application for SCL Waiver and ICF/MR Services
http://dbhdid.ky.gov/ddid/files/MAP620Form.pdf

COVER LETTERS

The cover letters provided here are examples of what needs to be sent to the appropriate persons/entities designated by the manual when distributing evaluations and other information.

If these sample letters are utilized, please put them on your agency's letterhead.

Also, please customize the letters to convey only information concerning the individual in question.

Do not circle or underline one choice from multiple options.

Send adverse determinations by Certified mail. File the receipt in the resident/ applicant's PASRR chart in the PASRR office

NF Adverse Determination Appeals Letter (Initial)
(Send by Certified mail)

March 5, 2010

Mr. John Doe
1234 Wit's End Drive
Down Home, KY 40000

Dear Mr. Doe:

Federal and state regulations (42 CFR 483.100, *et seq*. and 907 KAR 1:755) require a Preadmission Screening Resident Review (PASRR) evaluation of each nursing facility applicant who has a history of Intellectual/developmental disability, or a serious mental illness, for the purpose of determining the need for nursing facility services and the need for specialized services. **These evaluations are performed by the Community Mental Health Mental Retardation Centers through a contract with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) who administers the PASRR program for the Department of Medicaid Services.**

Please see enclosed a copy of your PASRR evaluation, along with an "Interpretation of Findings" form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. **PLEASE NOTE** that your signature of the "Interpretation of Findings" form does not imply agreement with these findings.

Based on the information reviewed describing your medical diagnosis, care needs, functional abilities, and the services and health personnel required to meet your needs, it has been determined that it is feasible that your needs can be met through alternative institutional or non-institutional services. Therefore:

Your total needs do not require nursing facility placement. The criterion indicated by the check mark below is/are the basis for this determination.

( ) Your medical condition and care needs can be satisfactorily met with services other than intermittent high-intensity nursing care, continuous personal care, or supervision in an institutional setting as set forth in 907 KAR 1:022, Section 4 (3).

( ) You do not meet two (2) of the twelve (12) care needs categories set forth in 907 KAR 1:022, Section 4 (3) (c) and (d); 907 KAR 1:755, Section 1 (5) and Section 7 (3).

( ) Your care needs are beyond the capability of a nursing facility and placement is inappropriate due to potential danger to your health and welfare or that of other patients or staff as set forth in 907 KAR 1:022, Section 4, (4) (b) 1.

( ) You have mental illness and require in-patient psychiatric treatment for specialized services as set forth in 907 KAR 1:0755, Section 1 (16) (a)-(d).

This letter has been forwarded to you and/or your legal guardian. If you disagree with any of the above determinations, you have the right to appeal. PASRR is a Medicaid program and appeals procedures are governed by Medicaid appeals regulations. All appeals must be requested in writing and be postmarked within thirty (30) calendar days of the date of this letter and may be requested solely by you, your legal guardian or authorized representative.

Your request for a hearing must be made by sending a written statement clearly indicating a desire for a hearing and the specific reason for the request.

If your request for a hearing is postmarked or received within ten (10) days of the date of this letter, you may continue to stay in a nursing facility(if already admitted) until the final cabinet level hearing. You may be represented at the hearing by yourself, a friend or relative, spokesperson or other authorized representative, including legal counsel. Your request for a hearing must be made by sending a written statement clearly indicating a desire for a hearing and the specific reason for the request.

Send the request to:

The Division of Administration and Financial Management
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6 W-C
Frankfort, Kentucky 40621

Please preface your request for appeal by noting that denial or adverse determination was based upon PASRR findings or determination.

Please contact me at (555) 123-5000 ext. 1147 if you have any questions regarding the evaluation or process.

Sincerely,

John David
PASRR Evaluator
CMHMRC, Inc.

cc: Nursing Facility

NF Adverse Determination Appeals Letter (Subsequent)
(Send by Certified mail)

March 5, 2010

Mr. John Doe
1234 Wit's End Drive
Down Home, KY 40000

Dear Mr. Doe:

Federal and state regulations (42 CFR 483.100, *et seq.* and 907 KAR 1:755, Section 8), require a PASRR shall be conducted as established in Sections 4 and 5 of the state regulation 907 KAR 1:755, if an individual experiences a significant change in condition. **These evaluations are performed by the Community Mental Health Mental Retardation Centers through a contract with the Department for Behavioral Health, Developmental and Intellectual Disabilities(DBHDID) who administer the PASRR program for the Department of Medicaid Services**.

Please see enclosed a copy of your PASRR evaluation, along with an "Interpretation of Findings" form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. **PLEASE NOTE: Y**our signature of the Interpretation of Findings form does not imply agreement with these findings.

Based on the information reviewed describing your medical diagnosis, care needs, functional abilities, and the services and health personnel required to meet your needs, it has been determined that it is feasible that your needs can be met through alternative institutional or non-institutional services**.** Therefore:

Your total needs no longer require nursing facility placement. The criterion indicated by check mark below is/are the basis for this finding or determination.

( ) Your medical condition and care needs can be satisfactorily met with services other than intermittent high-intensity nursing care, continuous personal care, or supervision in an institutional setting as set forth in 907 KAR 1:022, Section 4 (3).

( ) You no longer meet two (2) of the twelve (12) care need categories as set forth in 907 KAR 1:022 Section 4, (3)(c) and (d) and 907 KAR 1:755, Section 1 (5).

( ) Placement in this facility is inappropriate due to potential danger to the health and welfare to other patients, staff or yourself as set forth in 907 KAR 1:022 Section 4 (4)(b) and 900 KAR 2:050, Section 2, (c) and (d).

( ) You are no longer able to benefit from specialized services for mental retardation or related condition as described in 907 KAR 1:755, Section 1 (17) (a)-(c).

( ) You have a mental illness and require in-patient psychiatric treatment for specialized services as set forth in KAR 1:755, Section 1 (16) (a)-(d).

This letter has been forwarded to you and/ or your legal guardian. If you disagree with any of the above determinations, you have the right to appeal. PASRR is a Medicaid program and appeals procedures are governed by Medicaid appeals regulations. All appeals must be requested in writing and be postmarked within thirty (30) calendar days of the date of this letter and may be requested solely by you, your legal guardian or authorized representative.

Your request for a hearing must be made by sending a written statement clearly indicating a desire for a hearing and the specific reason for the request.

If your request for a hearing is postmarked or received within ten (10) days of the date of this letter, you may continue to stay in a nursing facility (if already admitted) until the final cabinet level hearing. You may be represented at the hearing by yourself, a friend or relative, spokesperson or other authorized representative, including legal counsel. Your request for a hearing must be made by sending a written statement clearly indicating a desire for a hearing and the specific reason for the request.

Send the request to:

The Division of Administration and Financial Management
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6 W-C
Frankfort, Kentucky 40621

Please contact me at (555) 123-5000 ext. 0000 if you have any questions regarding the evaluation or process.

Sincerely,

Joe David
PASRR Evaluator
CMHMRC, Inc.

cc: Nursing Facility

Non-Adverse Letter (Initial)

March 5, 2010

Mr. John Doe
1234 Wit's End Drive
Down Home, KY 40000

Dear Mr. Doe:

Federal and state regulations (42 CFR 483.100, et seq and 907 KAR 1:755) require a Preadmission Screening Resident Review (PASRR) evaluation of each nursing facility applicant who has a history of intellectual disability/developmental disability, or a serious mental illness, for the purpose of determining the need for nursing facility services and the need for specialized services for mental illness or intellectual disability/developmental disability. **These evaluations are performed by the Community Mental Health Mental Retardation Centers through a contract with the Department for Behavioral health, Developmental and Intellectual Disabilities (DBHDID) who administers the PASRR program for the Department of Medicaid Services.** Enclosed is a copy of this evaluation, along with an Interpretation of Findings form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. Please note that your signature of the Interpretation of Findings form does not imply agreement with these findings.

Based on the information we have reviewed that describes your physical and mental status, your nursing care needs, and your functional abilities, it has been determined that you meet nursing facility level of care as cited in 907 KAR 1:022, Section 4 (5), and may be admitted to a nursing facility. You (do/do not) require specialized services for an intellectual or developmental disability or a serious mental illness.

If you require specialized services for an intellectual or developmental disability, some of these services may be identified in the evaluation. Specialized services for mental illness require the level of intensity provided in a psychiatric in-patient hospital.

Please contact me at ( ) ___ - ___ if you have any questions regarding the evaluation or process.

Sincerely,

Joe David
PASRR Evaluator
CMHMRC, Inc.

cc: Nursing Facility

Non-Adverse Letter (Subsequent)

March 5, 2010

Mr. John Doe
1234 Wit's End Drive
Down Home, KY 40000

Dear Mr. Doe:

Federal and state regulations (42 CFR 483.100, et seq and 907 KAR 1:755) require a subsequent PASRR evaluation must be performed due to a significant change in your condition since you were initially admitted to the nursing facility. **These evaluations are performed by the Community Mental Health Mental Retardation Centers through a contract with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) who administers the PASRR program for the Department of Medicaid Services. These evaluations determine whether you continue to require the level of services provided in a nursing facility and whether or not you now require specialized services for (intellectual/developmental/or serious mental illness).** Enclosed is a copy of this evaluation, along with an Interpretation of Findings form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. Please note that your signature of the Interpretation of Findings form does not imply agreement with these findings.

Based on the information we have reviewed that describes your physical and mental status, your nursing care needs, and your functional abilities, it has been determined that you meet nursing facility level of care as set forth in 907 KAR 1:022 Section 4 and 907 KAR 1:755 and may be readmitted or continue to reside in a nursing facility. You (do/do not) require specialized services for an intellectual or developmental disability or serious mental illness.

If you require specialized services for an intellectual or developmental disability, some of these services may be identified in the evaluation. Specialized services for mental illness require the level of intensity provided in a psychiatric in-patient hospital.

Please contact me at ( ) ___ - ___ if you have any questions regarding the evaluation or6process.

Sincerely,

Joe David
PASRR Evaluator
CMHMRC, Inc.

cc: Nursing Facility

MD Notification letter

March 5, 2010

Dr. John Doe
1234 Wit's End Drive
Down Home, KY 40000

Dear John:
Federal regulations require a Preadmission Screening Resident Review (PASRR) evaluation of each nursing facility applicant who has a history of mental retardation or a serious mental illness. Enclosed is a copy of the findings of the evaluation of. Based on these findings, the following recommendations were made:

> (1) (He/She) (does/does not) require the level of care provided in a nursing facility and (may/may not) be admitted to a nursing facility.
> (2) (He/She) (does/does not) require specialized services (active treatment) for (serious mental illness/intellectual or developmental disability).

If you have any questions regarding these findings, please contact me at (555) 123-4567.
Sincerely,

Joe David
PASRR Evaluator
CMHMRC, Inc.

cc: Nursing Facility