Pre-Admission Screening and Resident Review (PASRR)

December 10, 2019

Alexandria Childers-Scott RN, BSN
Nursing Facility Care Specialist

IDAHO DEPARTMENT OF HEALTH & WELFARE

PASRR: Federal Regulations

PASRR: Regulation Explained

- PASRR was created in 1987 by the Omnibus Budget Reconciliation Act of 1984 (OBRA 87) and section 1919 of the Social Security Act (Part 2, Subtitle C of Title IV, Public Law 100-203).

- The law required all states to:
  - Establish a preadmission screening program to prevent inappropriate admissions of persons who are mentally ill (MI), intellectually disabled or have related conditions (ID/DD or RC).
  - Transition inappropriately placed nursing facility residents with mental illness (MI), intellectual disabilities (ID), or related conditions (RC) to alternate least restrictive living settings.
  - Identify Specialized Rehabilitative Services and Specialized Services to individuals while living in the nursing facility.
  - Conduct additional resident reviews of residents identified with MI, ID or RC.

PASRR: Regulation Explained

- The Act also specifies:
  - Medicaid certified nursing facilities are prohibited from admitting any new resident, regardless of payor, with mental illness, intellectual/developmental disability or related condition unless the state has determined if the individual requires nursing facility services and if that individual requires specialized services.

  - Federal financial participation (Medicaid monies) will not provide for a resident's stay without a complete PASRR
    - Reimbursement to nursing facilities are only authorized if the PASRR is complete, at least a Level I and, if necessary, the Abbreviate Level II and Level II
    - Retroactive payments are not allowed

PASRR: State Authorities

- PASRR federal regulation requires the state Medicaid agency to oversee and manage the PASRR process. It, also, requires each state to designate a mental health authority and an intellectual disability authority.

- Idaho's State PASRR Authorities are:
  - **The Bureau of Long Term Care** – Medicaid Authority, oversight and management of PASRR
  - **The Division of Behavioral Health** – Mental Health Authority, responsible for evaluations and determinations for individuals with mental illness
  - **The Bureau of Developmental Disability Services** – Intellectual Disability Authority, responsible for evaluations and determinations for individuals with intellectual/developmental disabilities or related conditions

PASRR: Purpose

- PASRR was implemented in an effort to prevent the unnecessary placement or 'warehousing' of individuals with mental illness or intellectual disabilities in nursing facilities.

- If a participant with serious mental illness or intellectual disability needs to be placed in a nursing facility, an evaluation must take place to see if **specialized services** are needed.

- **Specialized services** are services that exceed services typically offered by a nursing facility

The goal of PASRR is ensure individuals that would benefit from additional specialized services have the ability to utilize those services in order to promote a successful nursing facility stay, whether it be short term or long term.

PASRR: Idaho Process, General Policies and Helpful Hints

PASRR: Terminology and Roles

Terminology:

- **Level I (aka 'The 87')** – the first step in the PASRR process, a screening tool for identify those with possible serious mental illness, intellectual/developmental disabilities and related conditions.

- **Abbreviated Level II (aka 'The 90')** – the second step in the PASRR process, an evaluation to determine if further evaluation is warranted.

- **Level II (aka 'The 88' or 'The 89')** – the last step in the PASRR process, a face to face evaluation completed by a mental health clinician or an ID/DD professional.

PASRR: Terminology and Roles

Roles:

- **Screener** – the professional that completes the Level I/87
- **Nurse Reviewer** – a registered nurse with the Bureau of Long Term Care responsible for initial evaluation of the 87 and supporting documentation
- **Mental Health** – typically referring to Idaho's Mental Health Authority, the Division of Behavioral Health, responsible for determinations as to whether specialized services are appropriate
- **DD Staff** – refers to Idaho's Intellectual Disability Authority, responsible for ID/DD and related conditions evaluations

Screener, Nurse Reviewer, Mental Health and ID/DD staff are working as a TEAM to ensure each individual admitting to a nursing facility is adequately screened and, if needed, evaluated for mental health, ID/DD and related conditions.

PASRR: Fast Facts and Helpful Hints

Fast Facts

- BLTC reviewed 7,233 PASRRs in 2018, with Region 4 reviewing 25% of the total
- Each year the number of PASRR reviews increase on average by 7%
- BLTC completed 13,739 A&D Waiver assessments in 2018
- Each year the number of A&D Waiver assessments increase on average by 5.5%
- The number of BLTC Nurse Reviewers has not increased
- On average it takes 30 minutes to complete a PASRR, if the Level I and supporting documentation are complete and accurate then it takes much less time, if the Level I and supporting documentation are not complete and accurate it can take much longer

PASRR: Fast Facts and Helpful Hints

Number One Tip for Success

Accuracy saves everyone time: Submitting a complete Level I and supporting documentation the first time **speeds things up for everyone**, including facility staff (you), Medicaid staff, and the individual

PASRR: Fast Facts and Helpful Hints

Additional Helpful Hints:

- **PASRRs are completed in the order they are received.** Noting "ASAP" or the time of discharge on a PASRR will not move a PASRR up in the queue

- **PASRRs received after 3pm on Friday** may not be completed until Monday if it requires further review by either DBH or BDDS

- **Always contact the regional office if you need information regarding a PASRR.** Nurse Reviewers alternate days to review PASRR. Contacting the regional office is the **fastest** way to be routed to the Nurse Reviewer who can assist you that day

PASRR: Fast Facts and Helpful Hints

When calling the regional office:

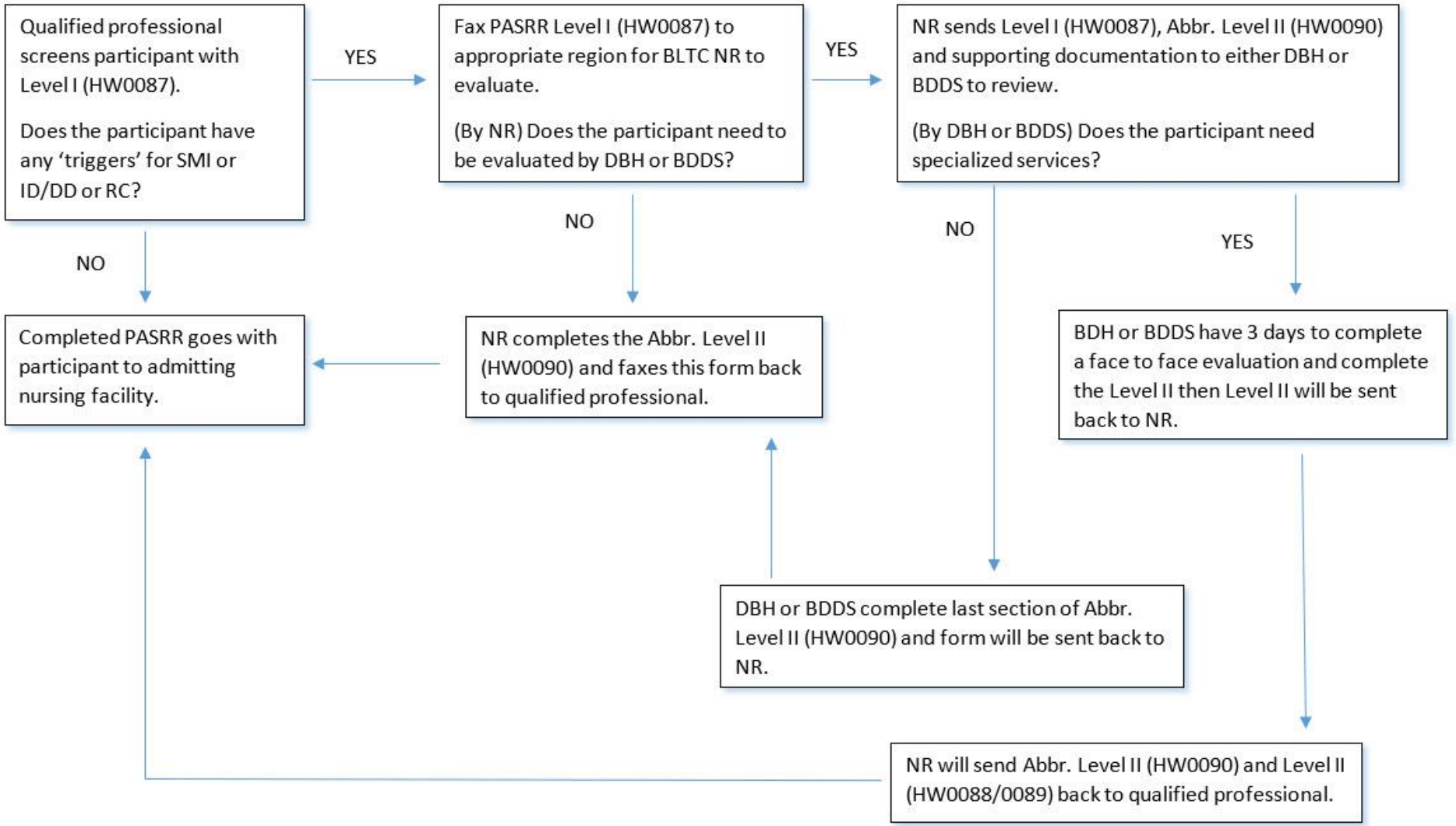
- **Indicate which region you are calling from and mention PASRR when you call.** Support Staff transfer numerous calls each day, this helps them know where to direct your call

- **Don't ask for a specific Nurse Reviewer** They could be out of the office completing assessments and you won't get a call back

When leaving a message:

- Be brief and concise
- Indicate your region
- Provide the name of the individual you are calling about

PASRR: PASRR Process Workflow



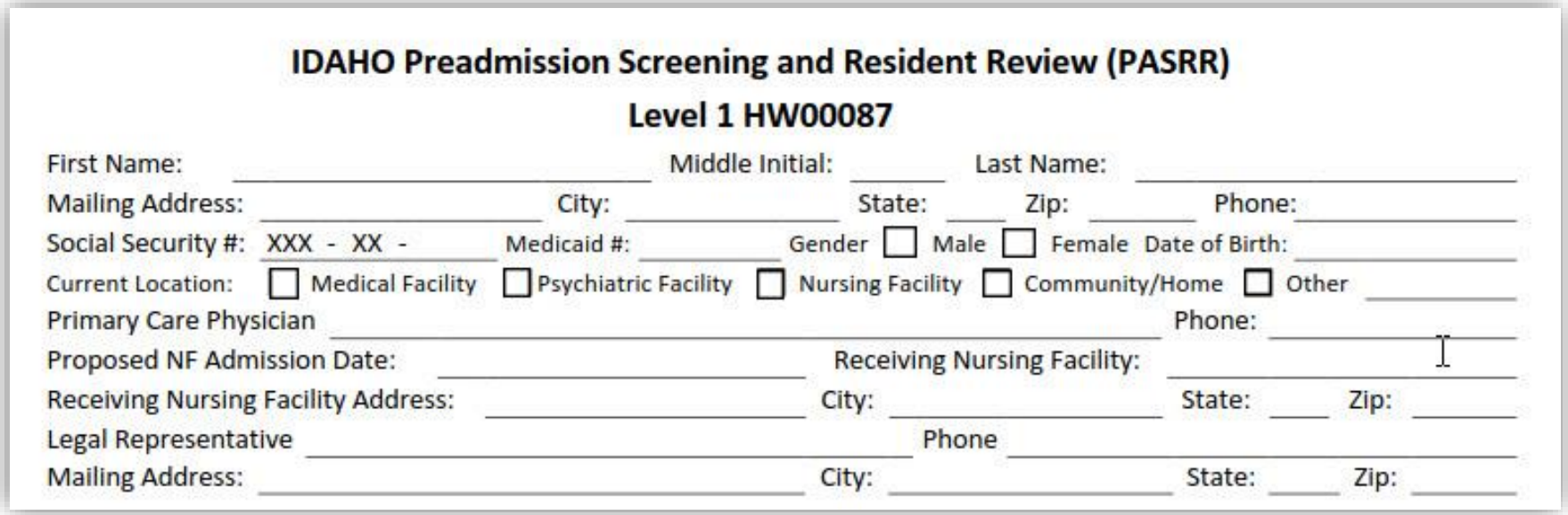
PASRR: Level I

PASRR: Level I (87)

- First step in the PASRR process
- Must be completed by a physician, physician's extender, hospital discharge planner (registered nurse or social worker) or a community care manager RN (registered nurse working in the community)
- Should not be completed by a nursing facility due to conflict of interest
- Nursing facilities can complete the Level I if there is a significant change or another update is needed
- The Level I screen is designed to capture false positives and minimize false negatives

The goal of the Level I is to determine if the individual does or may have a serious mental illness, intellectual/developmental disability or related condition.

PASRR: Level I (87)



IDAHO Preadmission Screening and Resident Review (PASRR)

Level 1 HW00087

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: XXX - XX - _____ Medicaid #: _____ Gender ☐ Male ☐ Female Date of Birth: _____

Current Location: ☐ Medical Facility ☐ Psychiatric Facility ☐ Nursing Facility ☐ Community/Home ☐ Other _____

Primary Care Physician _____ Phone: _____

Proposed NF Admission Date: _____ Receiving Nursing Facility: _____

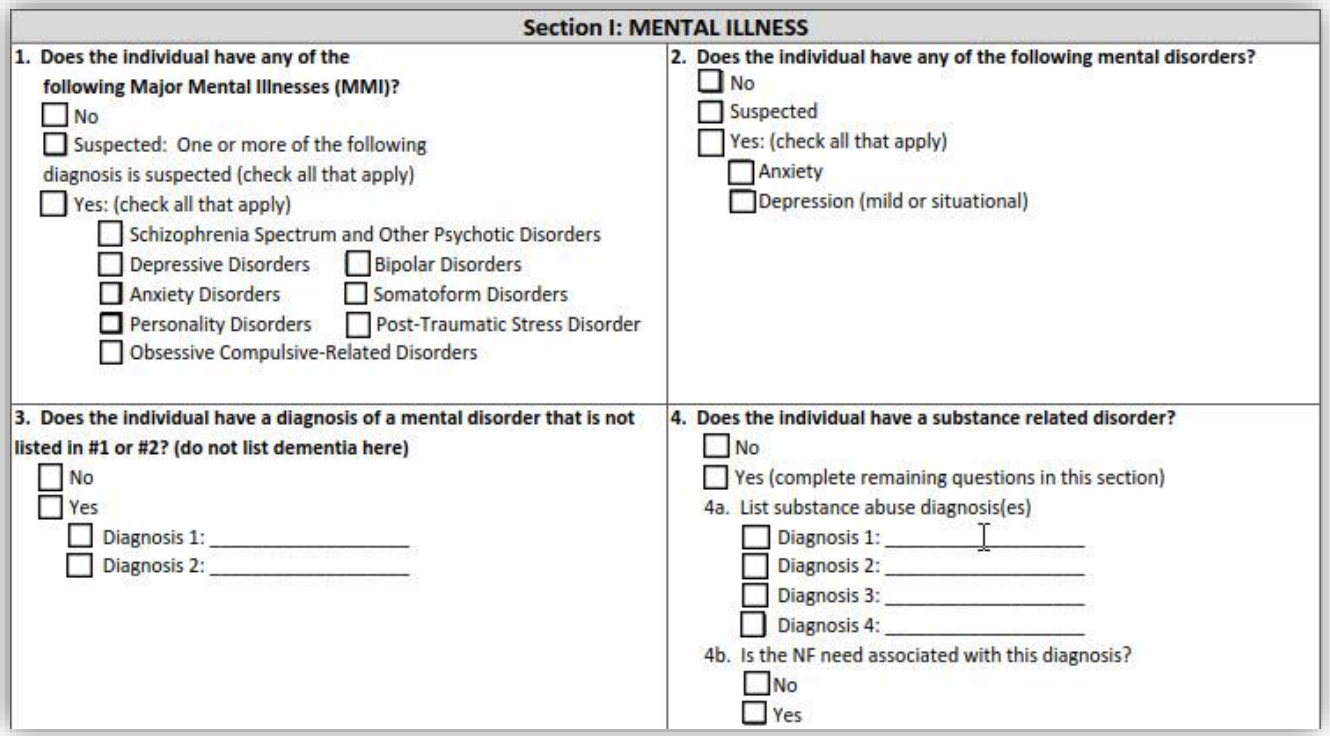
Receiving Nursing Facility Address: _____ City: _____ State: _____ Zip: _____

Legal Representative _____ Phone _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

- **All areas need to be completed** unless legal representative is not applicable
- Common areas that are missed
  - Social Security Number
  - Date of Birth
  - Admission Date
  - Nursing Facility
  - Legal Representative Contact Information

PASRR: Level I (87)



Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

- ☐ No
- ☐ Suspected: One or more of the following diagnosis is suspected (check all that apply)
- ☐ Yes: (check all that apply)
  - ☐ Schizophrenia Spectrum and Other Psychotic Disorders
  - ☐ Depressive Disorders
  - ☐ Bipolar Disorders
  - ☐ Anxiety Disorders
  - ☐ Somatoform Disorders
  - ☐ Personality Disorders
  - ☐ Post-Traumatic Stress Disorder
  - ☐ Obsessive Compulsive-Related Disorders

2. Does the individual have any of the following mental disorders?

- ☐ No
- ☐ Suspected
- ☐ Yes: (check all that apply)
  - ☐ Anxiety
  - ☐ Depression (mild or situational)

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)

- ☐ No
- ☐ Yes
  - ☐ Diagnosis 1: _____
  - ☐ Diagnosis 2: _____

4. Does the individual have a substance related disorder?

- ☐ No
- ☐ Yes (complete remaining questions in this section)

4a. List substance abuse diagnosis(es)

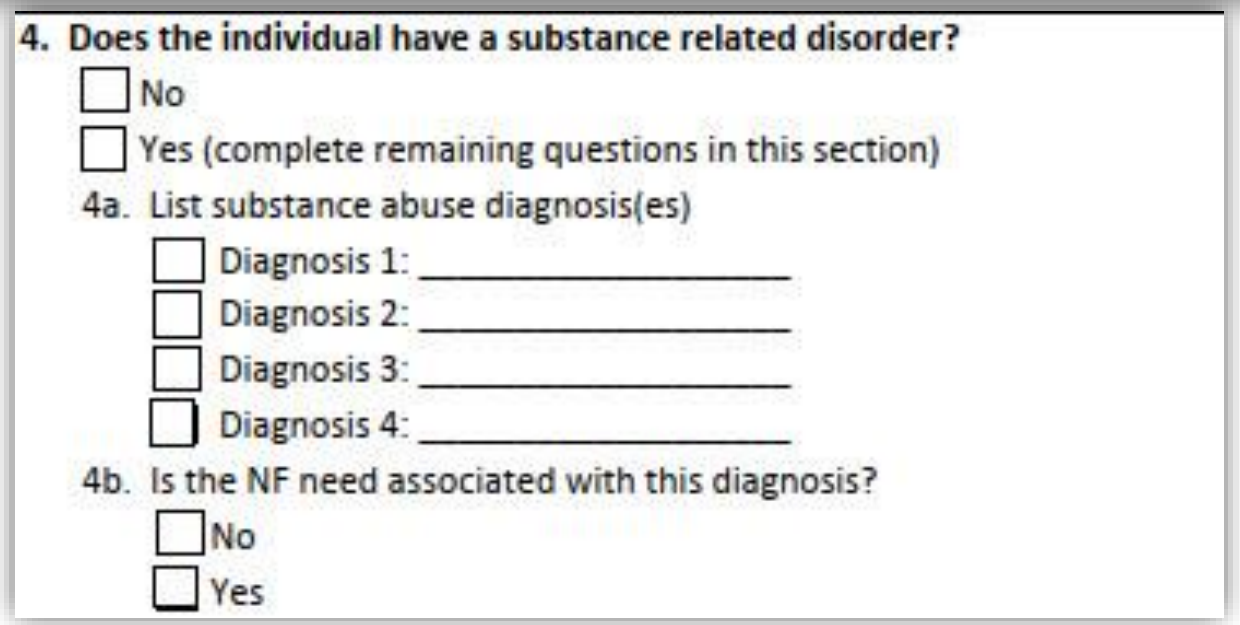
- ☐ Diagnosis 1: _____
- ☐ Diagnosis 2: _____
- ☐ Diagnosis 3: _____
- ☐ Diagnosis 4: _____

4b. Is the NF need associated with this diagnosis?

- ☐ No
- ☐ Yes

- Questions 1 & 2: An individual cannot have **both** Major Depressive Disorder and mild/situational depression, as with Anxiety, it should be **either/or**
- Question 3: Any mental health diagnosis not otherwise listed and not a symptom of a medical condition

PASRR: Level I (87)



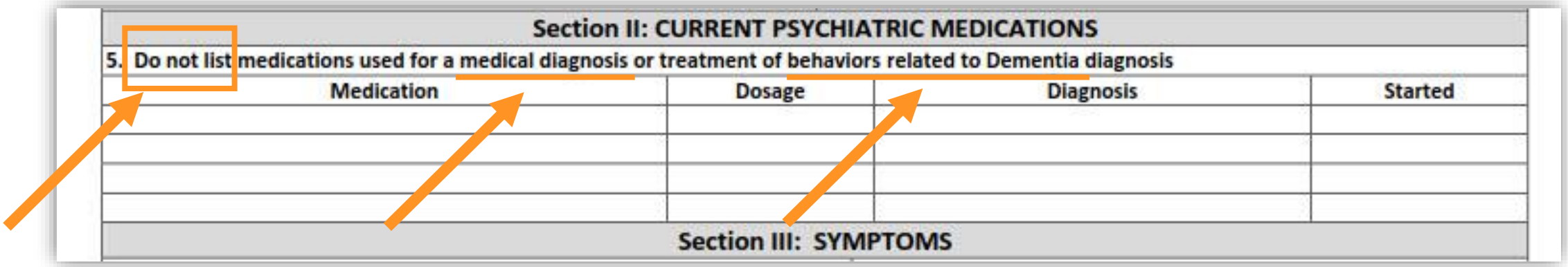
4. Does the individual have a substance related disorder?
   - ☐ No
   - ☐ Yes (complete remaining questions in this section)

   4a. List substance abuse diagnosis(es)
   - ☐ Diagnosis 1: _____
   - ☐ Diagnosis 2: _____
   - ☐ Diagnosis 3: _____
   - ☐ Diagnosis 4: _____

   4b. Is the NF need associated with this diagnosis?
   - ☐ No
   - ☐ Yes

- If the Level I is otherwise ***negative*** and the individual uses tobacco – mark **NO** and **DO NOT** write 'tobacco' in any of the diagnoses
- If the Level I is otherwise ***positive***, mark **YES** and **DO** write 'tobacco' as a diagnosis
- Opioid dependence is **NOT** a substance abuse disorder – dependence is part of addiction but can also be from chronic opioid use
- Use clinical judgement to determine if alcohol use is a concern
- If the individual has been in recovery for 2 years or more, please indicate this (can write it in white space next to diagnosis)

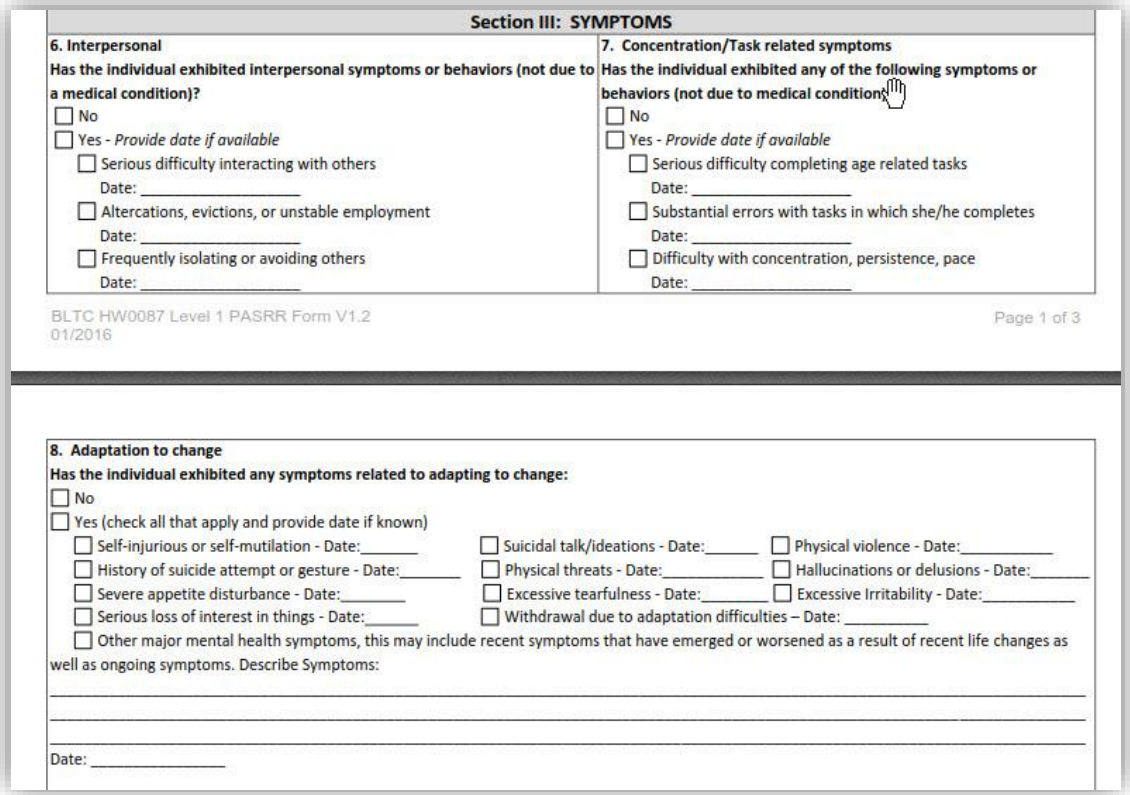
PASRR: Level I (87)



Section II: CURRENT PSYCHIATRIC MEDICATIONS			
5. Do not list medications used for a medical diagnosis or treatment of behaviors related to Dementia diagnosis			
Medication	Dosage	Diagnosis	Started
Section III: SYMPTOMS			

- Medication listed here should be for the treatment of **mental health conditions only**
- ***DO NOT*** list medications that are used for a **medical condition** (i.e. Cymbalta for tobacco cessation, Haldol for end of life agitation, etc.)
- Medications used for comfort at end of life should **NEVER** be listed here or anywhere else on the Level I
  - The medication list should specify which medications are used for end of life comfort such as ‘for anxiety/agitation at end of life’ or ‘for anxiety/agitation related to comfort care’
- Nurse reviewers do cross check this list with the discharge/admission medication list

PASRR: Level I (87)



Section III: SYMPTOMS

6. Interpersonal

Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?

- ☐ No
- ☐ Yes - *Provide date if available*
  - ☐ Serious difficulty interacting with others
    Date: _____
  - ☐ Altercations, evictions, or unstable employment
    Date: _____
  - ☐ Frequently isolating or avoiding others
    Date: _____

7. Concentration/Task related symptoms

Has the individual exhibited any of the following symptoms or behaviors (not due to medical condition)

- ☐ No
- ☐ Yes - *Provide date if available*
  - ☐ Serious difficulty completing age related tasks
    Date: _____
  - ☐ Substantial errors with tasks in which she/he completes
    Date: _____
  - ☐ Difficulty with concentration, persistence, pace
    Date: _____

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8. Adaptation to change

Has the individual exhibited any symptoms related to adapting to change:

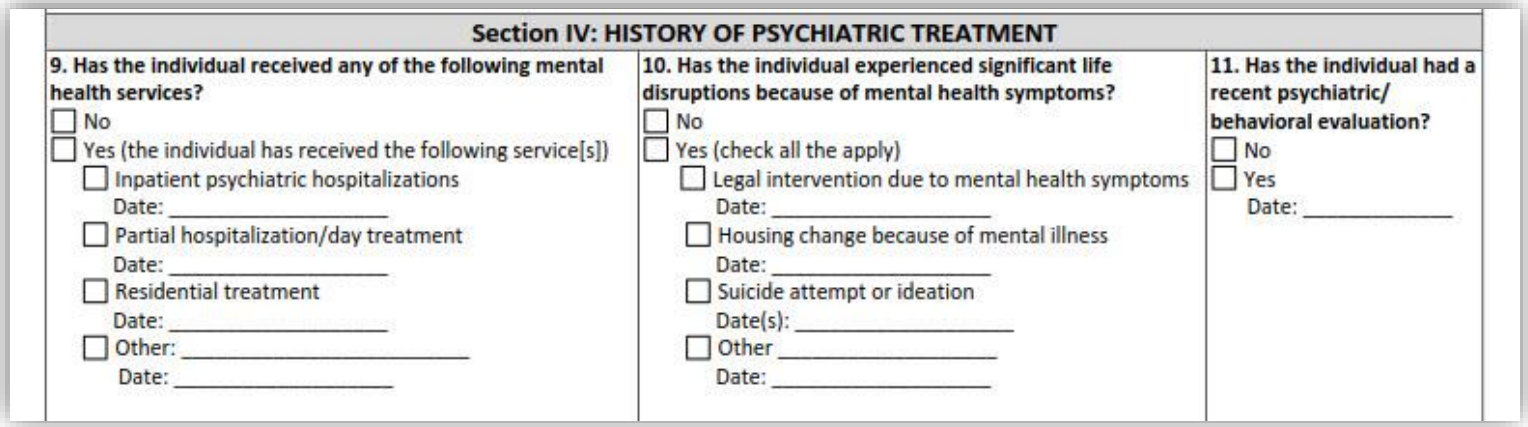
- ☐ No
- ☐ Yes (check all that apply and provide date if known)
  - ☐ Self-injurious or self-mutilation - Date:_____
  - ☐ Suicidal talk/ideations - Date:_____
  - ☐ Physical violence - Date:_____
  - ☐ History of suicide attempt or gesture - Date:_____
  - ☐ Physical threats - Date:_____
  - ☐ Hallucinations or delusions - Date:_____
  - ☐ Severe appetite disturbance - Date:_____
  - ☐ Excessive tearfulness - Date:_____
  - ☐ Excessive Irritability - Date:_____
  - ☐ Serious loss of interest in things - Date:_____
  - ☐ Withdrawal due to adaptation difficulties – Date: _____
  - ☐ Other major mental health symptoms, this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms:

_____
_____
_____

Date: _____

- **Each question in this section pertains to symptoms caused by a mental health condition**
- **Dementia is not a mental health condition**

PASRR: Level I (87)



Section IV: HISTORY OF PSYCHIATRIC TREATMENT

9. Has the individual received any of the following mental health services?

- ☐ No
- ☐ Yes (the individual has received the following service[s])
  - ☐ Inpatient psychiatric hospitalizations
    Date: _____
  - ☐ Partial hospitalization/day treatment
    Date: _____
  - ☐ Residential treatment
    Date: _____
  - ☐ Other: _____
    Date: _____

10. Has the individual experienced significant life disruptions because of mental health symptoms?

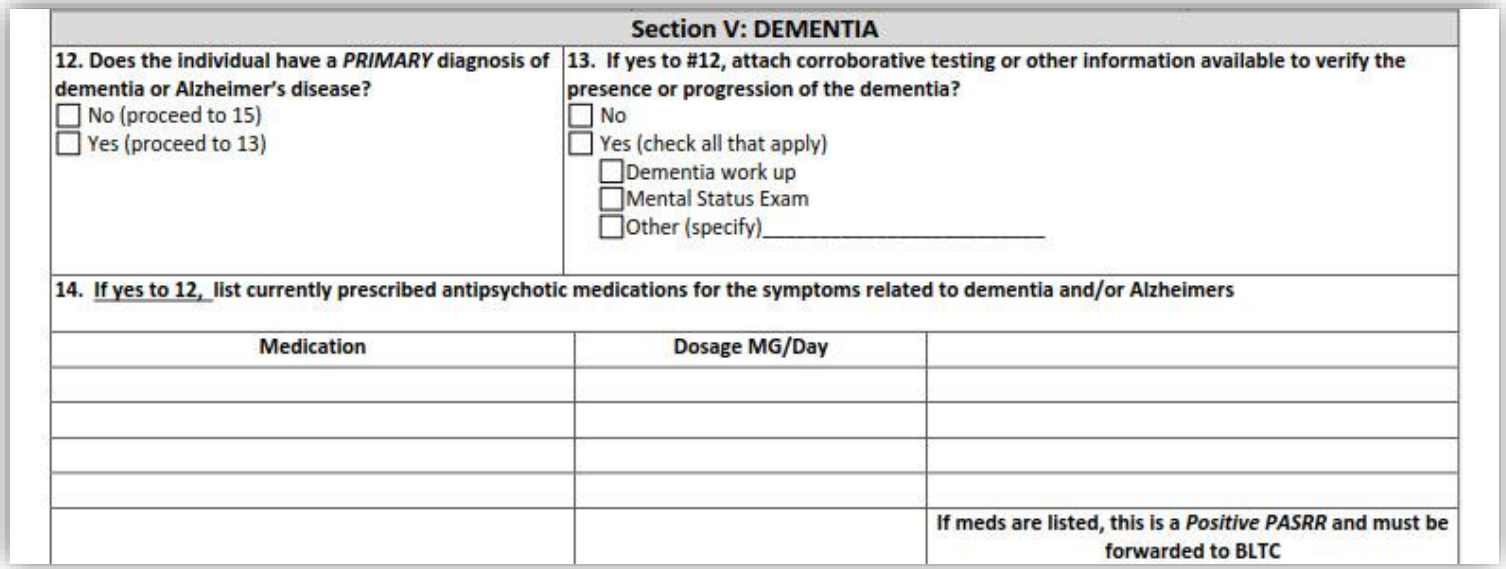
- ☐ No
- ☐ Yes (check all the apply)
  - ☐ Legal intervention due to mental health symptoms
    Date: _____
  - ☐ Housing change because of mental illness
    Date: _____
  - ☐ Suicide attempt or ideation
    Date(s): _____
  - ☐ Other _____
    Date: _____

11. Has the individual had a recent psychiatric/ behavioral evaluation?

- ☐ No
- ☐ Yes
  Date: _____

- Include dates (does not need to be exact)
- **Question 11:** If yes, please include evaluation (if possible) in documentation submitted with Level 1
  - If evaluation is unavailable, please indicate the provider (if possible)

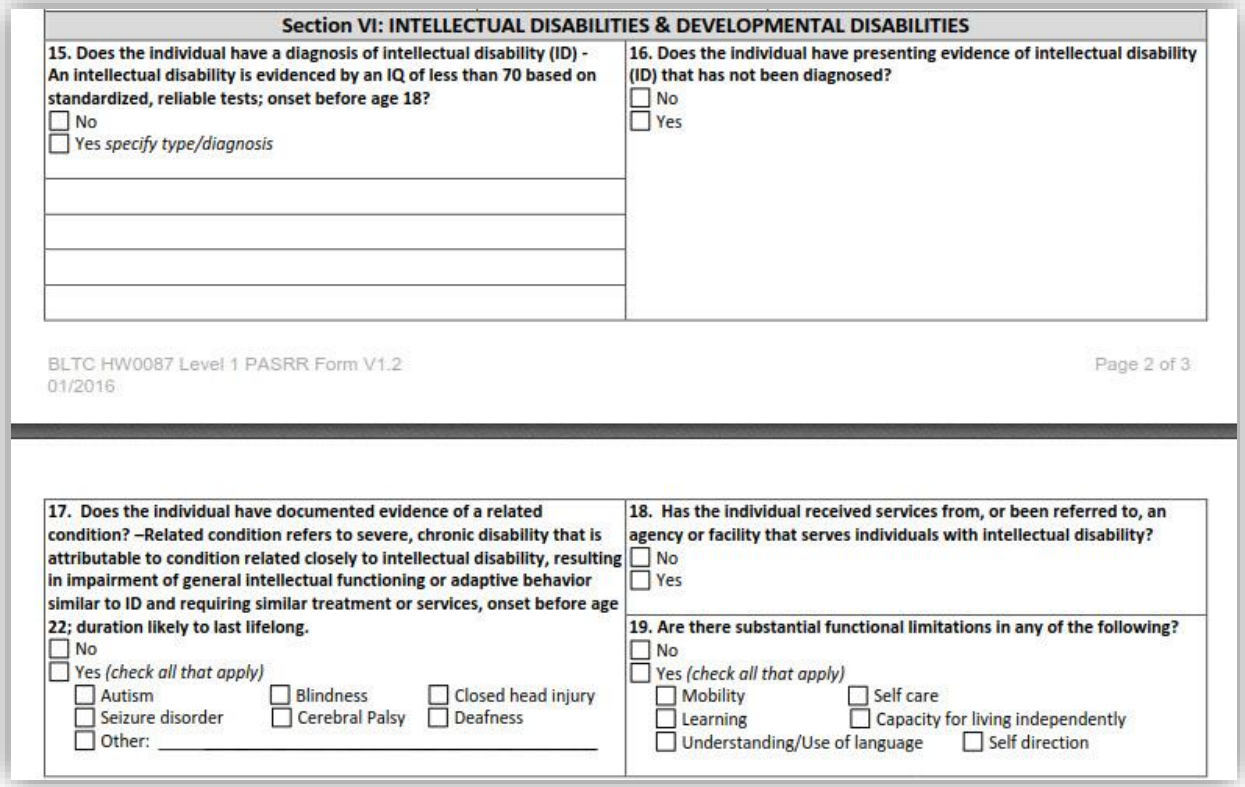
PASRR: Level I (87)



Section V: DEMENTIA		
12. Does the individual have a *PRIMARY* diagnosis of dementia or Alzheimer's disease? ☐ No (proceed to 15) ☐ Yes (proceed to 13)	**13. If yes to #12, attach corroborative testing or other information available to verify the presence or progression of the dementia?** ☐ No ☐ Yes (check all that apply) ☐ Dementia work up ☐ Mental Status Exam ☐ Other (specify)_____	
14. If yes to 12, list currently prescribed antipsychotic medications for the symptoms related to dementia and/or Alzheimers		
Medication	**Dosage MG/Day**	
		If meds are listed, this is a *Positive PASRR* and must be forwarded to BLTC

- **Question 12:** Only mark yes if the dementia is a **primary diagnosis**
- **Question 13:** Use "other" section to include notes from primary or other care provider
- **Question 14:** Only for listing antipsychotic medications for **managing symptoms of dementia**.
  - ***Namenda, Aricept, Exelon*** and antidepressants should **NOT** be listed here.

PASRR: Level I (87)



Section VI: INTELLECTUAL DISABILITIES & DEVELOPMENTAL DISABILITIES

15. Does the individual have a diagnosis of intellectual disability (ID) - An intellectual disability is evidenced by an IQ of less than 70 based on standardized, reliable tests; onset before age 18?
☐ No
☐ Yes *specify type/diagnosis*

16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?
☐ No
☐ Yes

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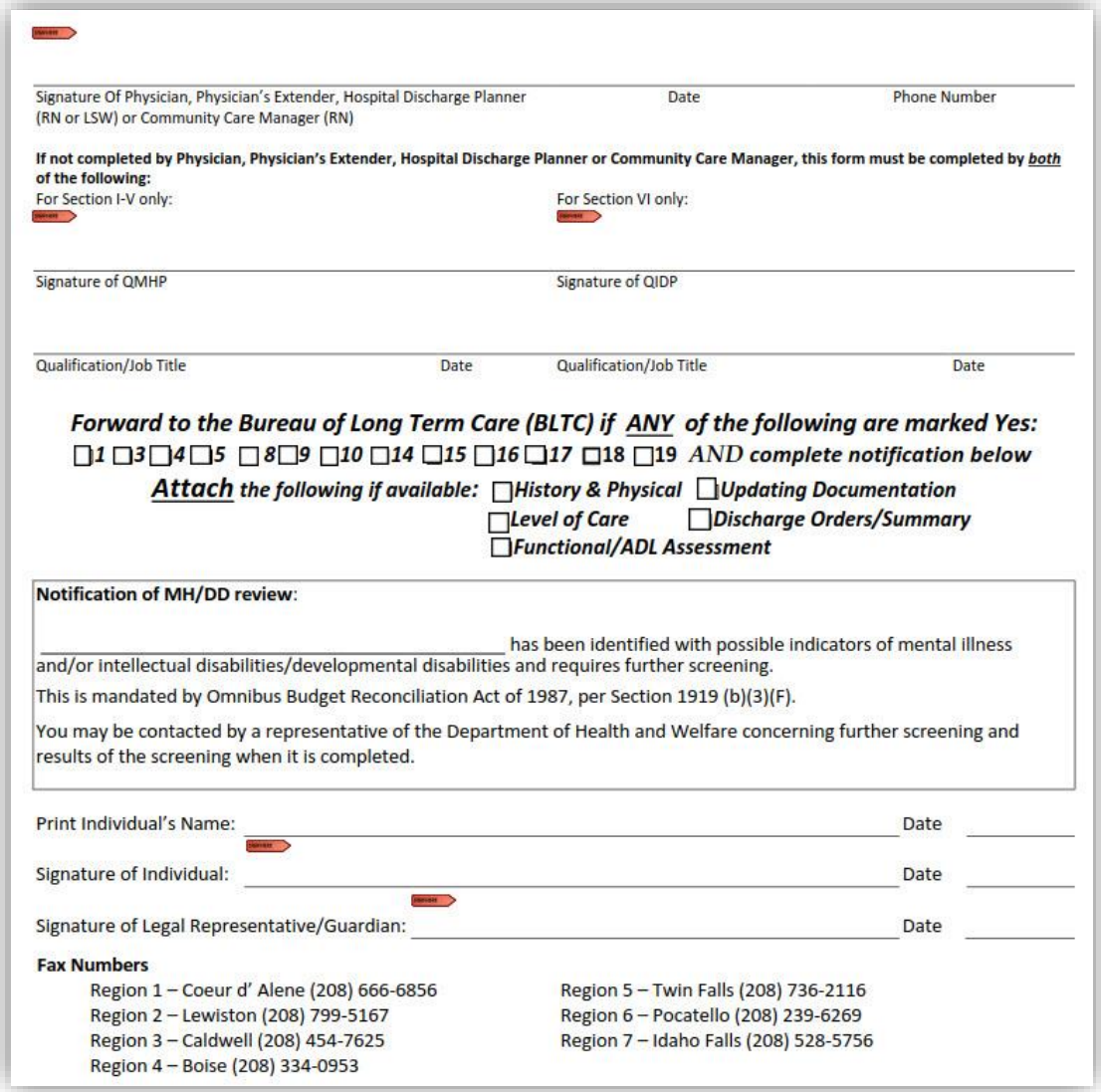
17. Does the individual have documented evidence of a related condition? –Related condition refers to severe, chronic disability that is attributable to condition related closely to intellectual disability, resulting in impairment of general intellectual functioning or adaptive behavior similar to ID and requiring similar treatment or services, onset before age 22; duration likely to last lifelong.
☐ No
☐ Yes *(check all that apply)*
☐ Autism ☐ Blindness ☐ Closed head injury
☐ Seizure disorder ☐ Cerebral Palsy ☐ Deafness
☐ Other: _____

18. Has the individual received services from, or been referred to, an agency or facility that serves individuals with intellectual disability?
☐ No
☐ Yes

19. Are there substantial functional limitations in any of the following?
☐ No
☐ Yes *(check all that apply)*
☐ Mobility ☐ Self care
☐ Learning ☐ Capacity for living independently
☐ Understanding/Use of language ☐ Self direction

- Only applies to diagnoses of ID/DD or related condition
- **Question 15:** diagnosis of an intellectual disability diagnosed **prior to age 18**
- **Question 17:** diagnosis of a developmental disability diagnosed **prior to age 22**
- **Question 19:** applies to individuals that screen positive for an ID/DD or related condition only

PASRR: Level I (87)



Signature Of Physician, Physician's Extender, Hospital Discharge Planner (RN or LSW) or Community Care Manager (RN) | Date | Phone Number

If not completed by Physician, Physician's Extender, Hospital Discharge Planner or Community Care Manager, this form must be completed by *both* of the following:

For Section I-V only: | For Section VI only:

Signature of QMHP | Signature of QIDP

Qualification/Job Title | Date | Qualification/Job Title | Date

Forward to the Bureau of Long Term Care (BLTC) if ANY of the following are marked Yes:

☐1 ☐3 ☐4 ☐5 ☐8 ☐9 ☐10 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 *AND complete notification below*

***Attach** the following if available:* ☐*History & Physical* ☐*Updating Documentation* ☐*Level of Care* ☐*Discharge Orders/Summary* ☐*Functional/ADL Assessment*

Notification of MH/DD review:

_____ has been identified with possible indicators of mental illness and/or intellectual disabilities/developmental disabilities and requires further screening.

This is mandated by Omnibus Budget Reconciliation Act of 1987, per Section 1919 (b)(3)(F).

You may be contacted by a representative of the Department of Health and Welfare concerning further screening and results of the screening when it is completed.

Print Individual's Name: _____ Date _____

Signature of Individual: _____ Date _____

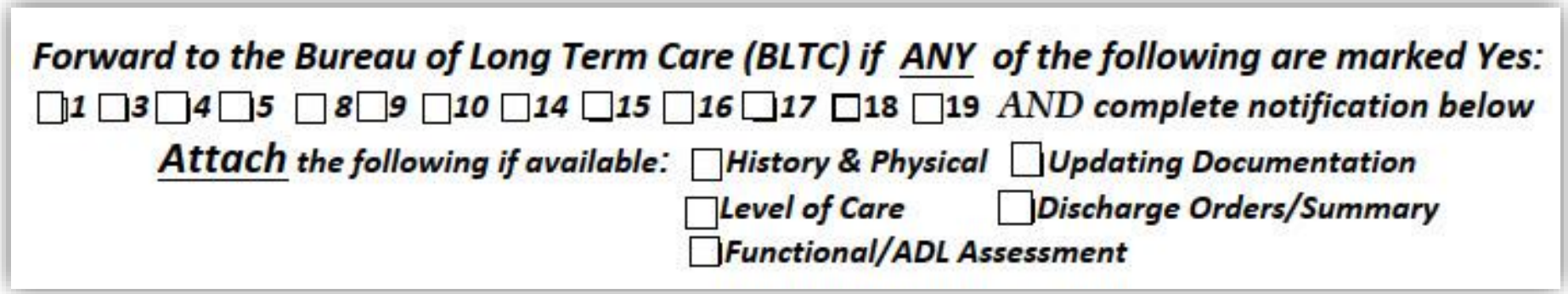
Signature of Legal Representative/Guardian: _____ Date _____

Fax Numbers

Region 1 – Coeur d' Alene (208) 666-6856
Region 2 – Lewiston (208) 799-5167
Region 3 – Caldwell (208) 454-7625
Region 4 – Boise (208) 334-0953
Region 5 – Twin Falls (208) 736-2116
Region 6 – Pocatello (208) 239-6269
Region 7 – Idaho Falls (208) 528-5756

- Requires two signatures:
  - Screener, and
  - Individual or their legal representative
- If the legal representative signs, ensure representative's contact information is listed in demographic area located on page 1 of the Level I
- If a signature cannot be obtained by either the individual or the legal representative, follow your organization's policy for verbal permission

PASRR: Level I (87)


Forward to the Bureau of Long Term Care (BLTC) if ANY of the following are marked Yes:
☐1 ☐3 ☐4 ☐5 ☐8 ☐9 ☐10 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 AND complete notification below
Attach the following if available: ☐History & Physical ☐Updating Documentation
☐Level of Care ☐Discharge Orders/Summary
☐Functional/ADL Assessment

- If any box listed above has a check, **send to BLTC**
- If not, BLTC does not need to review
- **Documentation:**
  - Recent history and physical (hospice agencies can include a face to face and recent RN comprehensive assessment)
  - Discharge/Admission orders with prognosis, medication list and level of care
  - Psych/Mental evaluations, if applicable
  - Other documentation should **only** be included if it concerns **mental health or ID/DD diagnoses**

PASRR: Level I (87)

Fax Numbers

Region 1 – Coeur d' Alene (208) 666-6856
Region 2 – Lewiston (208) 799-5167
Region 3 – Caldwell (208) 454-7625
Region 4 – Boise (208) 334-0953
Region 5 – Twin Falls (208) 736-2116
Region 6 – Pocatello (208) 239-6269
Region 7 – Idaho Falls (208) 528-5756

- Fax to region to the region the individual is **currently in** (not to where they are going or where they live)
- **Do not fax to any other number** unless a nurse reviewer has offered another number

PASRR: Level I (87)

Recommendations:

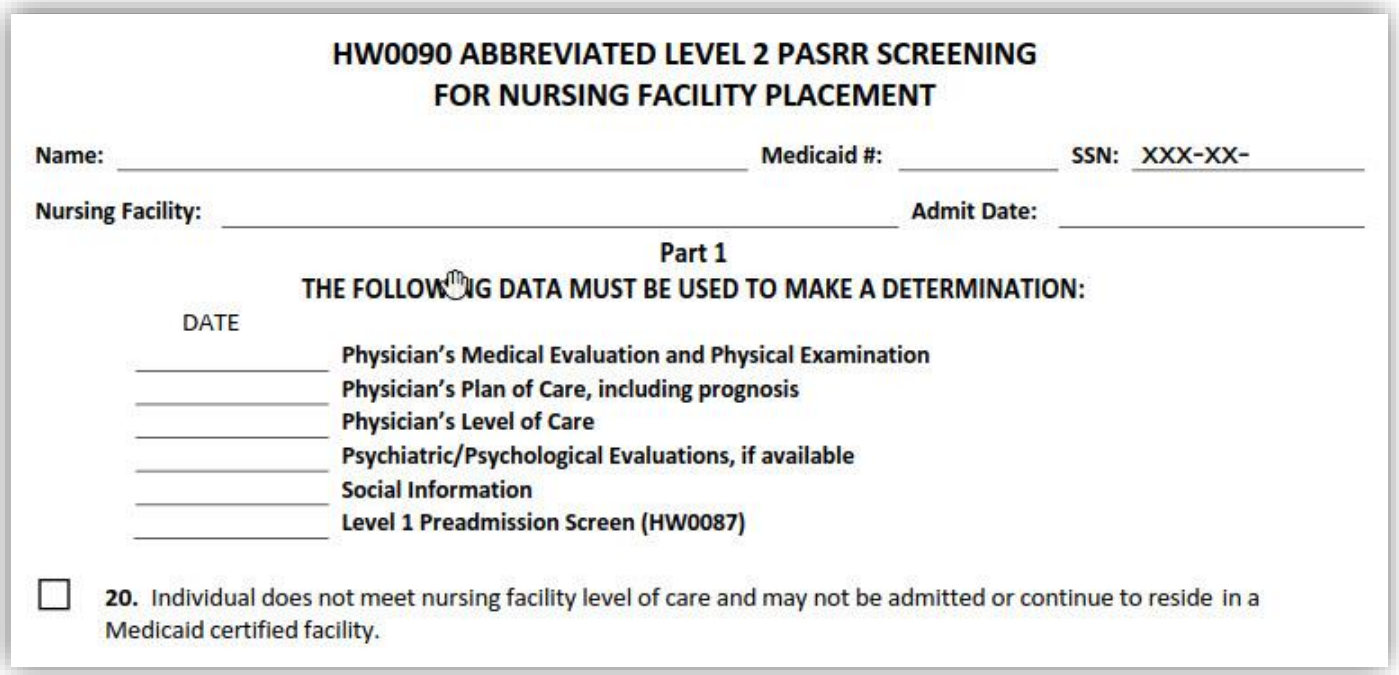
- Review the Level I and all documentation prior to submission
- Keep form and documentation simple
- Feel free to highlight, underline, asterisk areas in submitted documentation you would like the nurse reviewer ‘catch’
- Add a written summary, if needed, to clarify concerns or discharge plans

PASRR:
Abbreviated Level II

PASRR: Abbreviated Level II

- Federal regulation requires state PASRR programs to have at least a Level I and a Level II
- Many states opted to utilize an abbreviated Level II or a Level 1.5
- An abbreviated Level II allows the state to make certain determinations without a full Level II to be completed, meaning face to face evaluations are only completed when necessary
- These determinations must be approved through the Centers of Medicaid and Medicare before the state can implement in practice
- Some determinations can be made by the nurse reviewer and some require agreement from either the Division of Behavioral Health or Bureau of Developmental Disability Services

PASRR: Abbreviated Level II



HW0090 ABBREVIATED LEVEL 2 PASRR SCREENING FOR NURSING FACILITY PLACEMENT

Name: _____ **Medicaid #:** _____ **SSN:** XXX-XX-_____

Nursing Facility: _____ **Admit Date:** _____

Part 1

THE FOLLOWING DATA MUST BE USED TO MAKE A DETERMINATION:

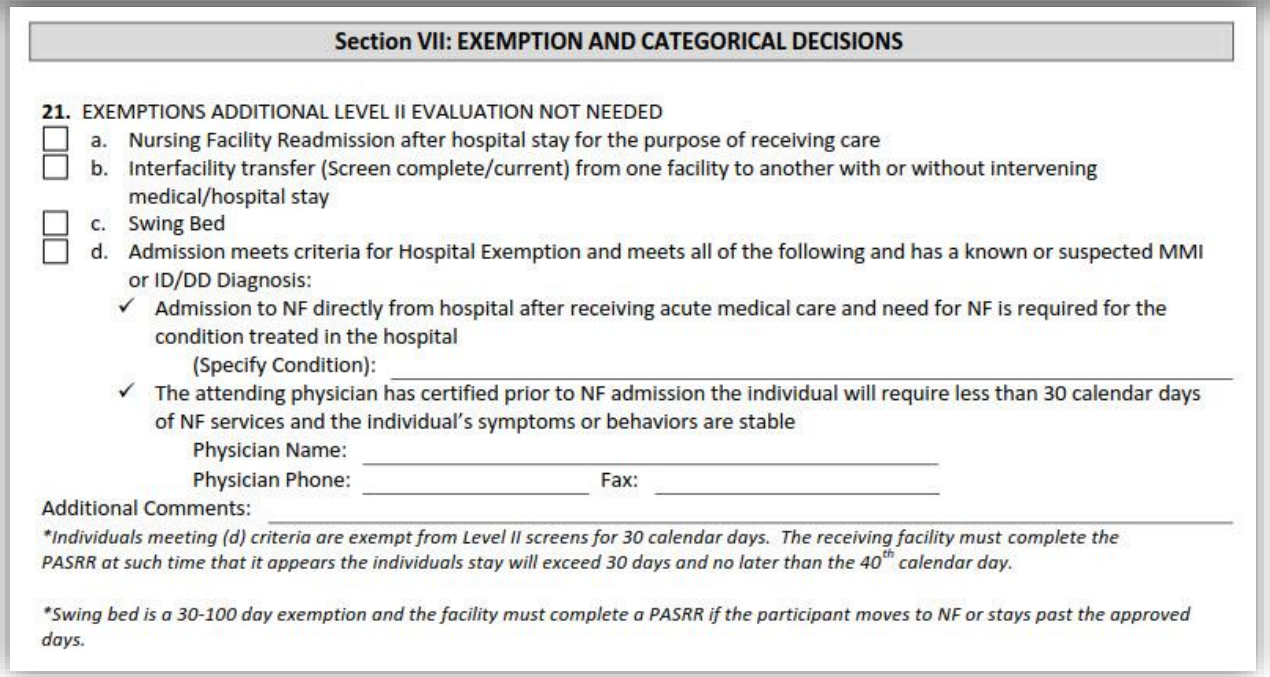
DATE

_____ **Physician's Medical Evaluation and Physical Examination**
_____ **Physician's Plan of Care, including prognosis**
_____ **Physician's Level of Care**
_____ **Psychiatric/Psychological Evaluations, if available**
_____ **Social Information**
_____ **Level 1 Preadmission Screen (HW0087)**

☐ **20.** Individual does not meet nursing facility level of care and may not be admitted or continue to reside in a Medicaid certified facility.

- Completed by the BLTC nurse reviewer
- It is rare for BLTC to indicate an individual does not meet nursing facility level of care

PASRR: Abbreviated Level II



Section VII: EXEMPTION AND CATEGORICAL DECISIONS

21. EXEMPTIONS ADDITIONAL LEVEL II EVALUATION NOT NEEDED

- ☐ a. Nursing Facility Readmission after hospital stay for the purpose of receiving care
- ☐ b. Interfacility transfer (Screen complete/current) from one facility to another with or without intervening medical/hospital stay
- ☐ c. Swing Bed
- ☐ d. Admission meets criteria for Hospital Exemption and meets all of the following and has a known or suspected MMI or ID/DD Diagnosis:
  - ✓ Admission to NF directly from hospital after receiving acute medical care and need for NF is required for the condition treated in the hospital
    (Specify Condition): _____
  - ✓ The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable
    Physician Name: _____
    Physician Phone: _____ Fax: _____

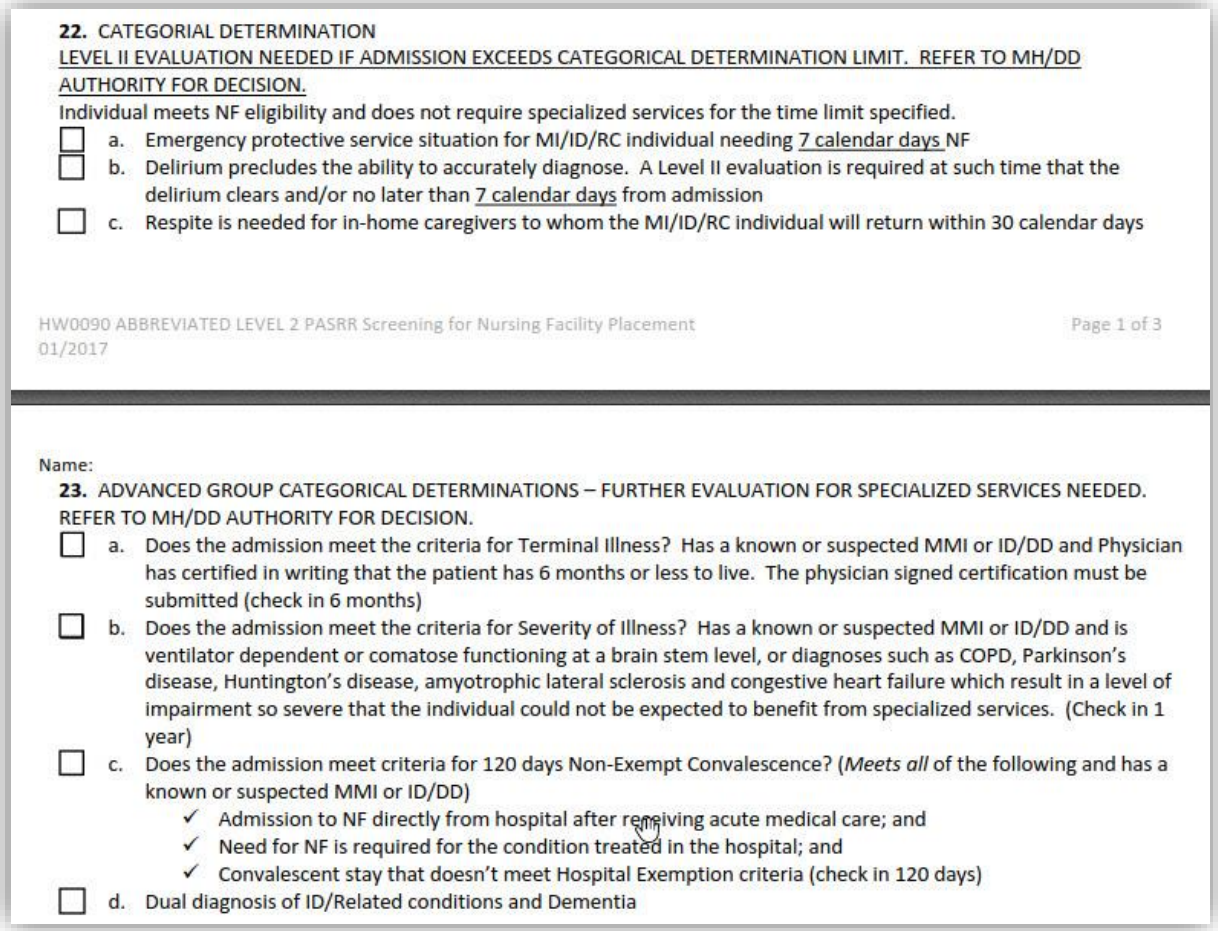
Additional Comments: _____

**Individuals meeting (d) criteria are exempt from Level II screens for 30 calendar days. The receiving facility must complete the PASRR at such time that it appears the individuals stay will exceed 30 days and no later than the 40th calendar day.*

**Swing bed is a 30-100 day exemption and the facility must complete a PASRR if the participant moves to NF or stays past the approved days.*

- These determinations are made by a nurse reviewer and do not require any further evaluation by the Division of Behavioral Health or the Bureau of Developmental Disability Services
- If the individual is expected to be in the facility for less than 30 days, this needs to be indicated on the discharge/admission orders
- Physician's name needs to be clearly written if not electronically signed

PASRR: Abbreviated Level II



22. CATEGORIAL DETERMINATION
LEVEL II EVALUATION NEEDED IF ADMISSION EXCEEDS CATEGORICAL DETERMINATION LIMIT. REFER TO MH/DD AUTHORITY FOR DECISION.
Individual meets NF eligibility and does not require specialized services for the time limit specified.

- ☐ a. Emergency protective service situation for MI/ID/RC individual needing 7 calendar days NF
- ☐ b. Delirium precludes the ability to accurately diagnose. A Level II evaluation is required at such time that the delirium clears and/or no later than 7 calendar days from admission
- ☐ c. Respite is needed for in-home caregivers to whom the MI/ID/RC individual will return within 30 calendar days

HW0090 ABBREVIATED LEVEL 2 PASRR Screening for Nursing Facility Placement Page 1 of 3
01/2017

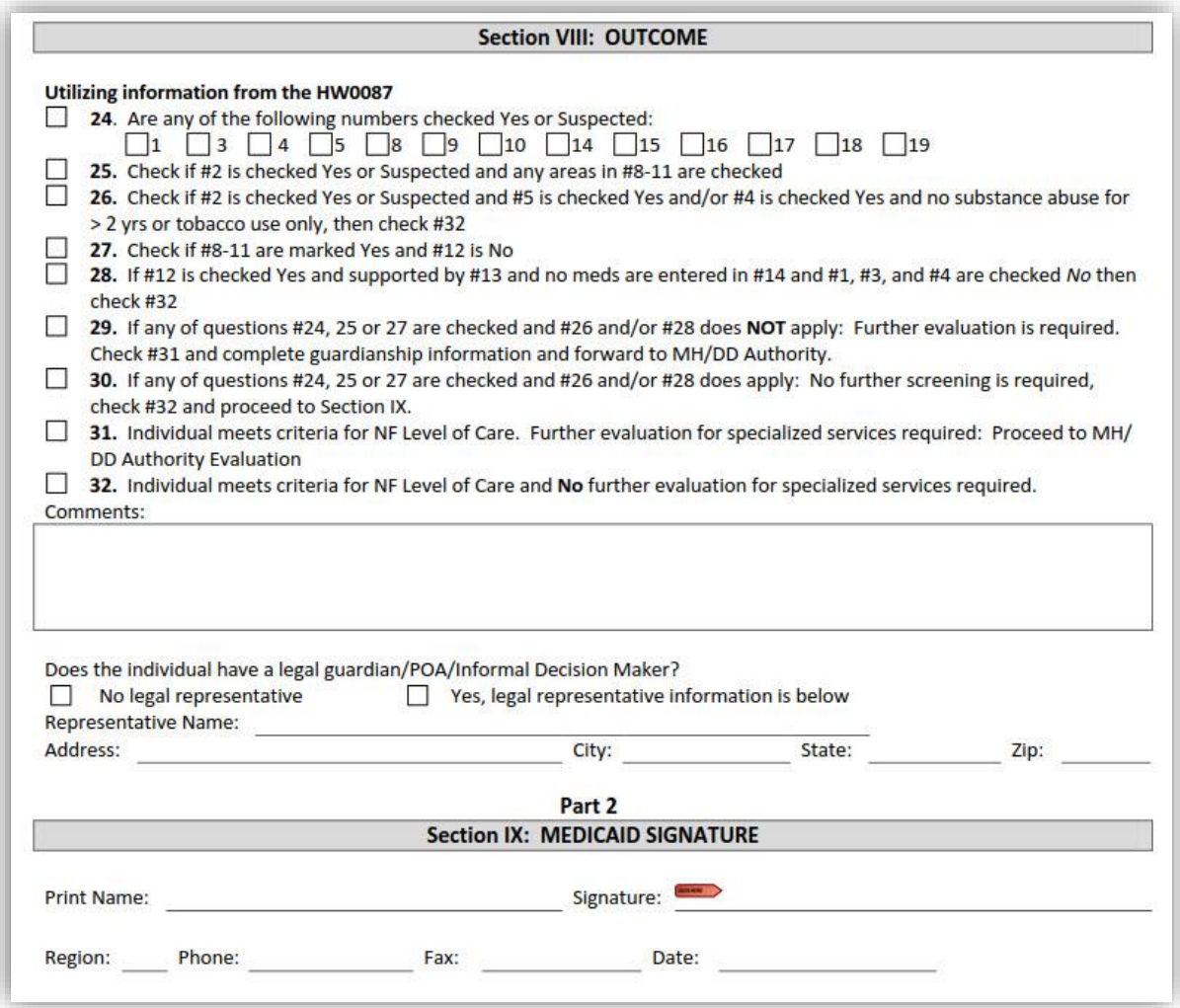
Name:

23. ADVANCED GROUP CATEGORICAL DETERMINATIONS – FURTHER EVALUATION FOR SPECIALIZED SERVICES NEEDED. REFER TO MH/DD AUTHORITY FOR DECISION.

- ☐ a. Does the admission meet the criteria for Terminal Illness? Has a known or suspected MMI or ID/DD and Physician has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted (check in 6 months)
- ☐ b. Does the admission meet the criteria for Severity of Illness? Has a known or suspected MMI or ID/DD and is ventilator dependent or comatose functioning at a brain stem level, or diagnoses such as COPD, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. (Check in 1 year)
- ☐ c. Does the admission meet criteria for 120 days Non-Exempt Convalescence? (*Meets all* of the following and has a known or suspected MMI or ID/DD)
  - ✓ Admission to NF directly from hospital after receiving acute medical care; and
  - ✓ Need for NF is required for the condition treated in the hospital; and
  - ✓ Convalescent stay that doesn't meet Hospital Exemption criteria (check in 120 days)
- ☐ d. Dual diagnosis of ID/Related conditions and Dementia

- These determinations must have agreement from the Division of Behavioral Health or the Bureau of Developmental Disability Services
- Terminal Illness and Severity of Illness: need supporting documentation provided by Level I screener

PASRR: Abbreviated Level II



Section VIII: OUTCOME

Utilizing information from the HW0087

☐ **24.** Are any of the following numbers checked Yes or Suspected:
☐1 ☐3 ☐4 ☐5 ☐8 ☐9 ☐10 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19

☐ **25.** Check if #2 is checked Yes or Suspected and any areas in #8-11 are checked

☐ **26.** Check if #2 is checked Yes or Suspected and #5 is checked Yes and/or #4 is checked Yes and no substance abuse for > 2 yrs or tobacco use only, then check #32

☐ **27.** Check if #8-11 are marked Yes and #12 is No

☐ **28.** If #12 is checked Yes and supported by #13 and no meds are entered in #14 and #1, #3, and #4 are checked *No* then check #32

☐ **29.** If any of questions #24, 25 or 27 are checked and #26 and/or #28 does **NOT** apply: Further evaluation is required. Check #31 and complete guardianship information and forward to MH/DD Authority.

☐ **30.** If any of questions #24, 25 or 27 are checked and #26 and/or #28 does apply: No further screening is required, check #32 and proceed to Section IX.

☐ **31.** Individual meets criteria for NF Level of Care. Further evaluation for specialized services required: Proceed to MH/DD Authority Evaluation

☐ **32.** Individual meets criteria for NF Level of Care and **No** further evaluation for specialized services required.

Comments:

Does the individual have a legal guardian/POA/Informal Decision Maker?

☐ No legal representative ☐ Yes, legal representative information is below

Representative Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Part 2

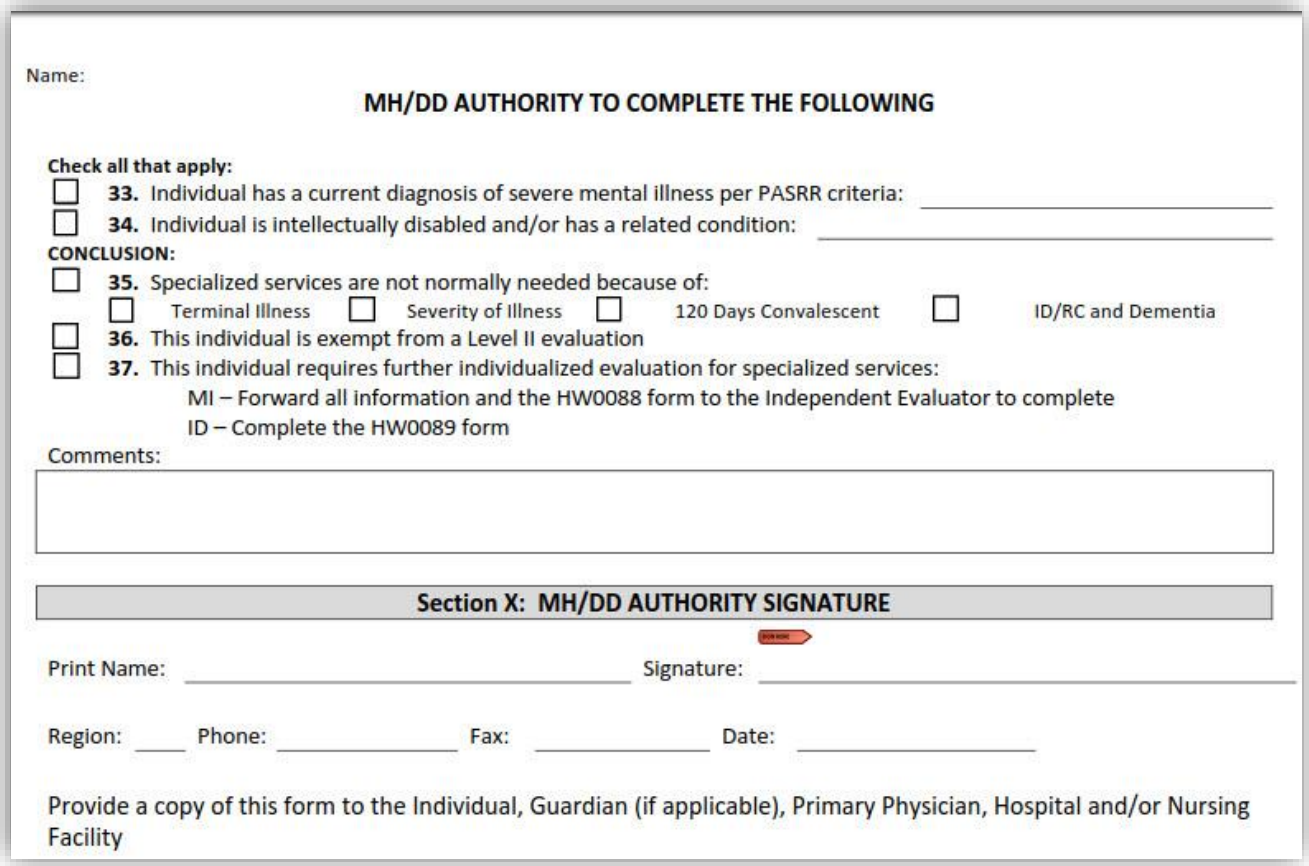
Section IX: MEDICAID SIGNATURE

Print Name: _____ Signature: _____

Region: ____ Phone: _____ Fax: _____ Date: _____

- Completed by BLTC nurse reviewers only
- Nurse Reviewers follow this process flow and send on for further review as indicated

PASRR: Abbreviated Level II



Name:

MH/DD AUTHORITY TO COMPLETE THE FOLLOWING

Check all that apply:

☐ **33.** Individual has a current diagnosis of severe mental illness per PASRR criteria: _____

☐ **34.** Individual is intellectually disabled and/or has a related condition: _____

CONCLUSION:

☐ **35.** Specialized services are not normally needed because of:

☐ Terminal Illness ☐ Severity of Illness ☐ 120 Days Convalescent ☐ ID/RC and Dementia

☐ **36.** This individual is exempt from a Level II evaluation

☐ **37.** This individual requires further individualized evaluation for specialized services:

MI – Forward all information and the HW0088 form to the Independent Evaluator to complete

ID – Complete the HW0089 form

Comments:

Section X: MH/DD AUTHORITY SIGNATURE

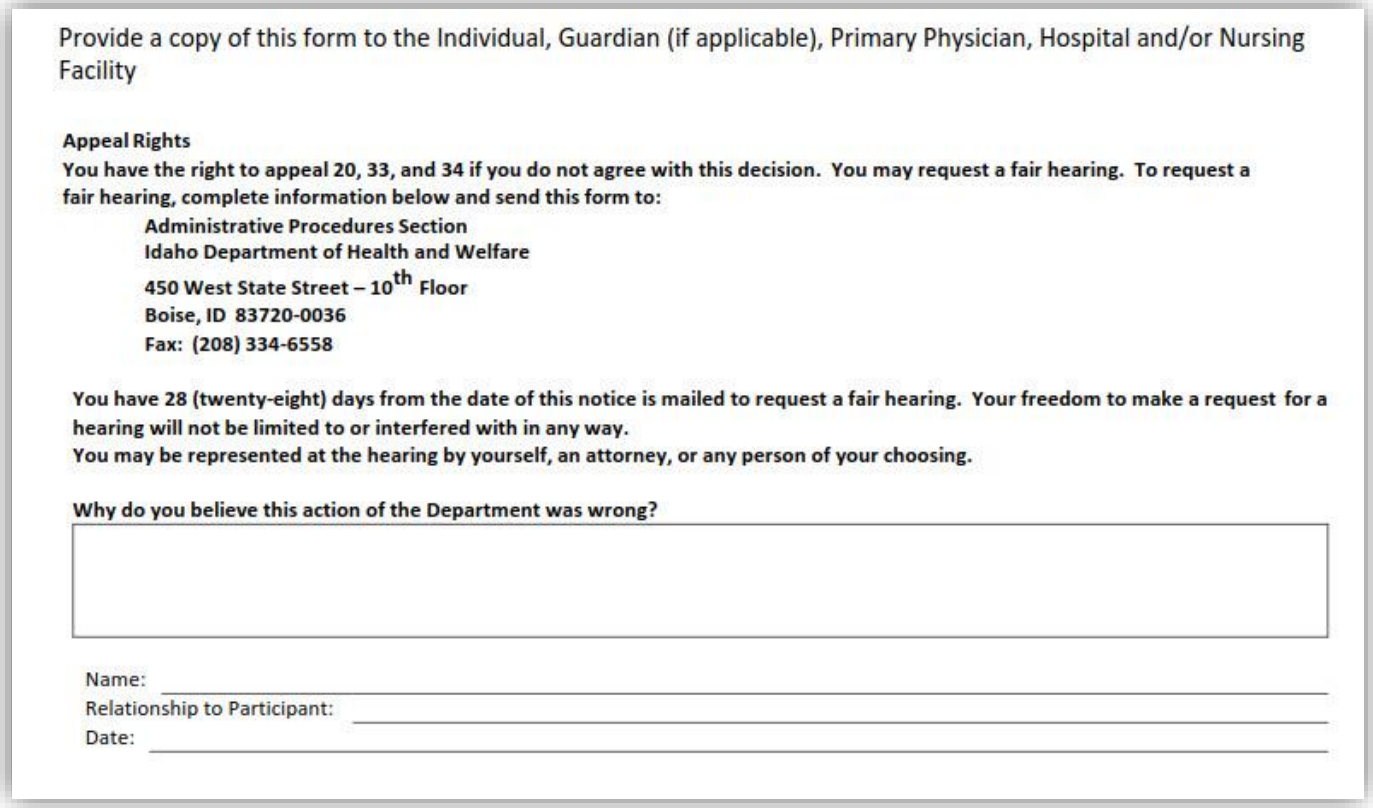
Print Name: _____ Signature: _____

Region: ____ Phone: _____ Fax: _____ Date: _____

Provide a copy of this form to the Individual, Guardian (if applicable), Primary Physician, Hospital and/or Nursing Facility

- Completed only by the Division of Behavioral Health and/or the Bureau of Developmental Disability Services
- Use Box 37 to indicate that further evaluation is required (if applicable)
- A copy of the Abbreviated Level II should be provided to the nursing facility, primary care provider and the individual and/or legal representative.

PASRR: Abbreviated Level II



Provide a copy of this form to the Individual, Guardian (if applicable), Primary Physician, Hospital and/or Nursing Facility

Appeal Rights

You have the right to appeal 20, 33, and 34 if you do not agree with this decision. You may request a fair hearing. To request a fair hearing, complete information below and send this form to:

Administrative Procedures Section
Idaho Department of Health and Welfare
450 West State Street – 10th Floor
Boise, ID 83720-0036
Fax: (208) 334-6558

You have 28 (twenty-eight) days from the date of this notice is mailed to request a fair hearing. Your freedom to make a request for a hearing will not be limited to or interfered with in any way.
You may be represented at the hearing by yourself, an attorney, or any person of your choosing.

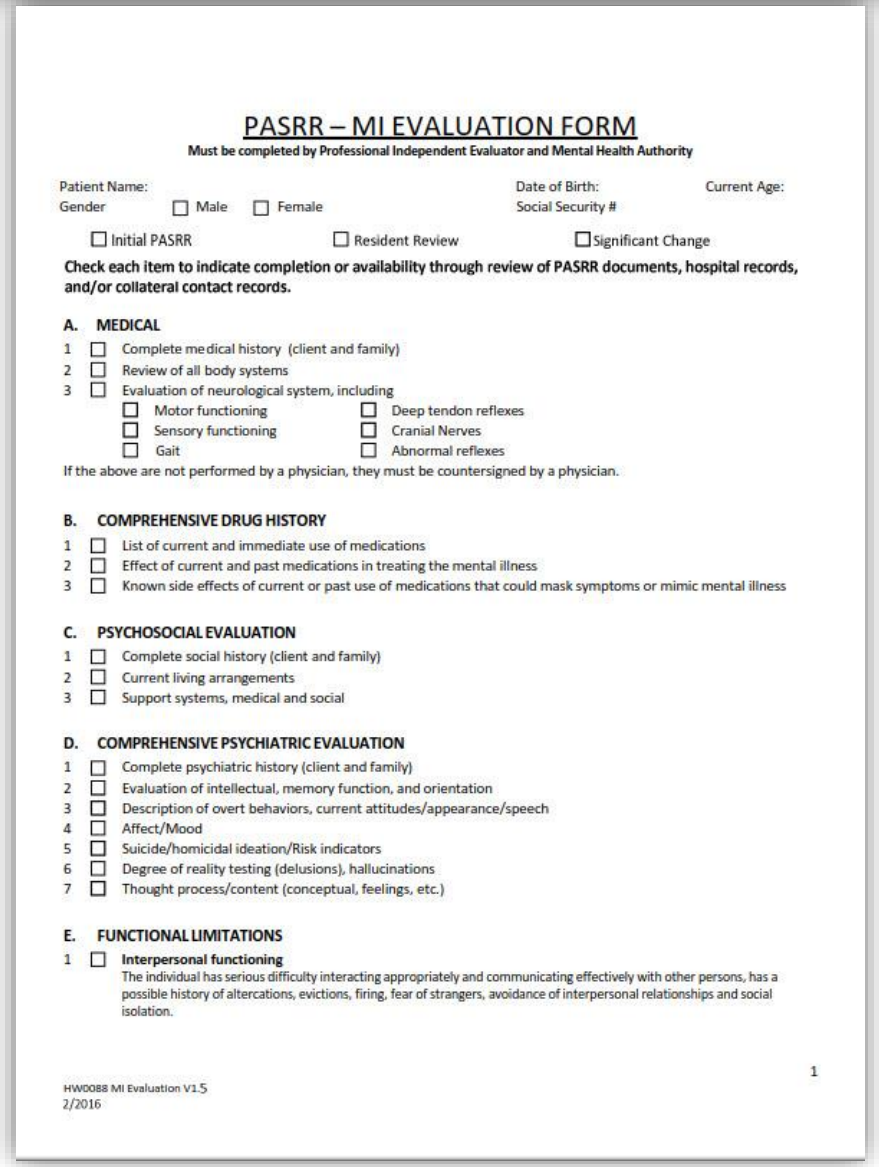
Why do you believe this action of the Department was wrong?

Name: _____
Relationship to Participant: _____
Date: _____

- Individuals wishing to be admitted to a nursing facility have the right to appeal the decision on the Abbreviated Level II and Level II, cannot appeal the Level I
- Individuals can decline the PASRR process in it's entirety but will not be able to admit to a Medicaid certified nursing facility

PASRR: Level II

PASRR: Level II Serious Mental Illness



PASRR – MI EVALUATION FORM

Must be completed by Professional Independent Evaluator and Mental Health Authority

Patient Name: Date of Birth: Current Age:
Gender ☐ Male ☐ Female Social Security #

☐ Initial PASRR ☐ Resident Review ☐ Significant Change

Check each item to indicate completion or availability through review of PASRR documents, hospital records, and/or collateral contact records.

A. MEDICAL

1 ☐ Complete medical history (client and family)
2 ☐ Review of all body systems
3 ☐ Evaluation of neurological system, including
- ☐ Motor functioning
- ☐ Sensory functioning
- ☐ Gait
- ☐ Deep tendon reflexes
- ☐ Cranial Nerves
- ☐ Abnormal reflexes

If the above are not performed by a physician, they must be countersigned by a physician.

B. COMPREHENSIVE DRUG HISTORY

1 ☐ List of current and immediate use of medications
2 ☐ Effect of current and past medications in treating the mental illness
3 ☐ Known side effects of current or past use of medications that could mask symptoms or mimic mental illness

C. PSYCHOSOCIAL EVALUATION

1 ☐ Complete social history (client and family)
2 ☐ Current living arrangements
3 ☐ Support systems, medical and social

D. COMPREHENSIVE PSYCHIATRIC EVALUATION

1 ☐ Complete psychiatric history (client and family)
2 ☐ Evaluation of intellectual, memory function, and orientation
3 ☐ Description of overt behaviors, current attitudes/appearance/speech
4 ☐ Affect/Mood
5 ☐ Suicide/homicidal ideation/Risk indicators
6 ☐ Degree of reality testing (delusions), hallucinations
7 ☐ Thought process/content (conceptual, feelings, etc.)

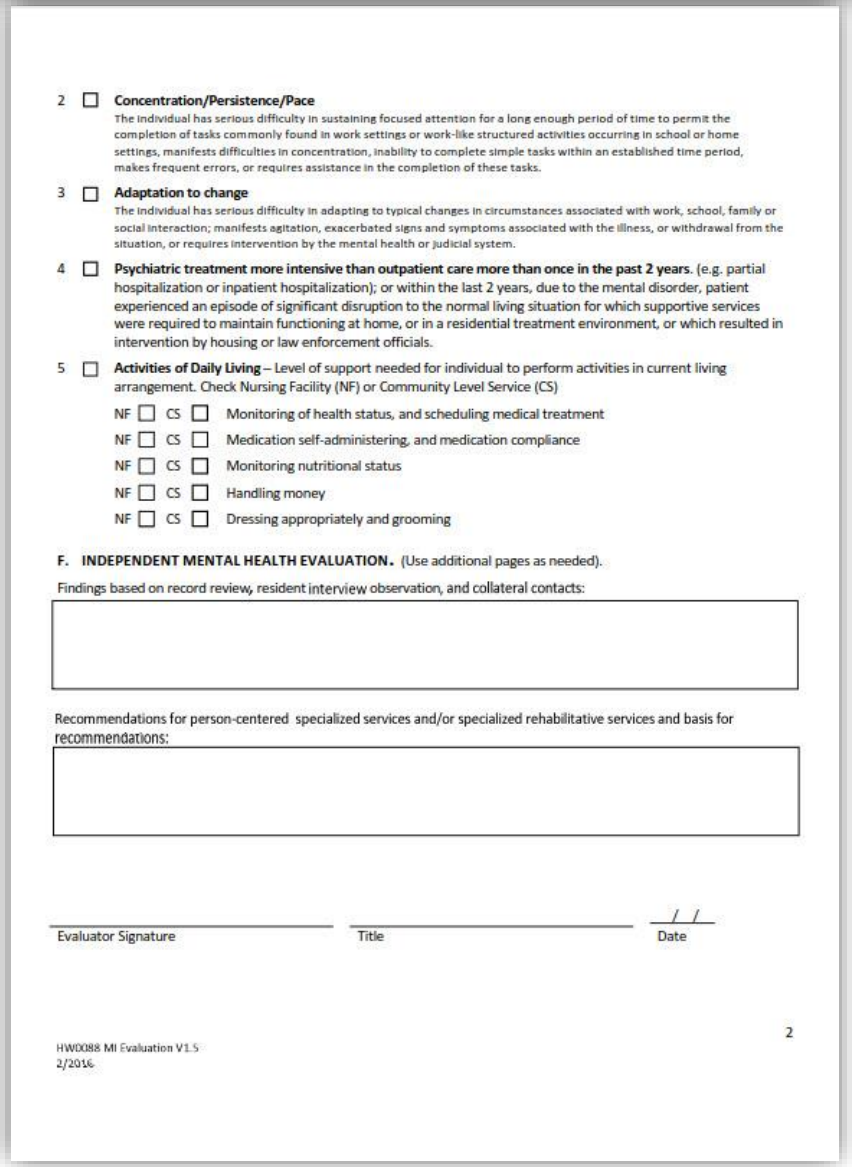
E. FUNCTIONAL LIMITATIONS

1 ☐ **Interpersonal functioning**
The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.

1

HW0088 MI Evaluation V1.5
2/2016

PASRR: Level II Serious Mental Illness



2 ☐ **Concentration/Persistence/Pace**
The individual has serious difficulty in sustaining focused attention for a long enough period of time to permit the completion of tasks commonly found in work settings or work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

3 ☐ **Adaptation to change**
The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interaction; manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

4 ☐ **Psychiatric treatment more intensive than outpatient care more than once in the past 2 years**. (e.g. partial hospitalization or inpatient hospitalization); or within the last 2 years, due to the mental disorder, patient experienced an episode of 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.

5 ☐ **Activities of Daily Living** – Level of support needed for individual to perform activities in current living arrangement. Check Nursing Facility (NF) or Community Level Service (CS)

NF ☐ CS ☐ Monitoring of health status, and scheduling medical treatment
NF ☐ CS ☐ Medication self-administering, and medication compliance
NF ☐ CS ☐ Monitoring nutritional status
NF ☐ CS ☐ Handling money
NF ☐ CS ☐ Dressing appropriately and grooming

F. INDEPENDENT MENTAL HEALTH EVALUATION. (Use additional pages as needed).

Findings based on record review, resident interview observation, and collateral contacts:

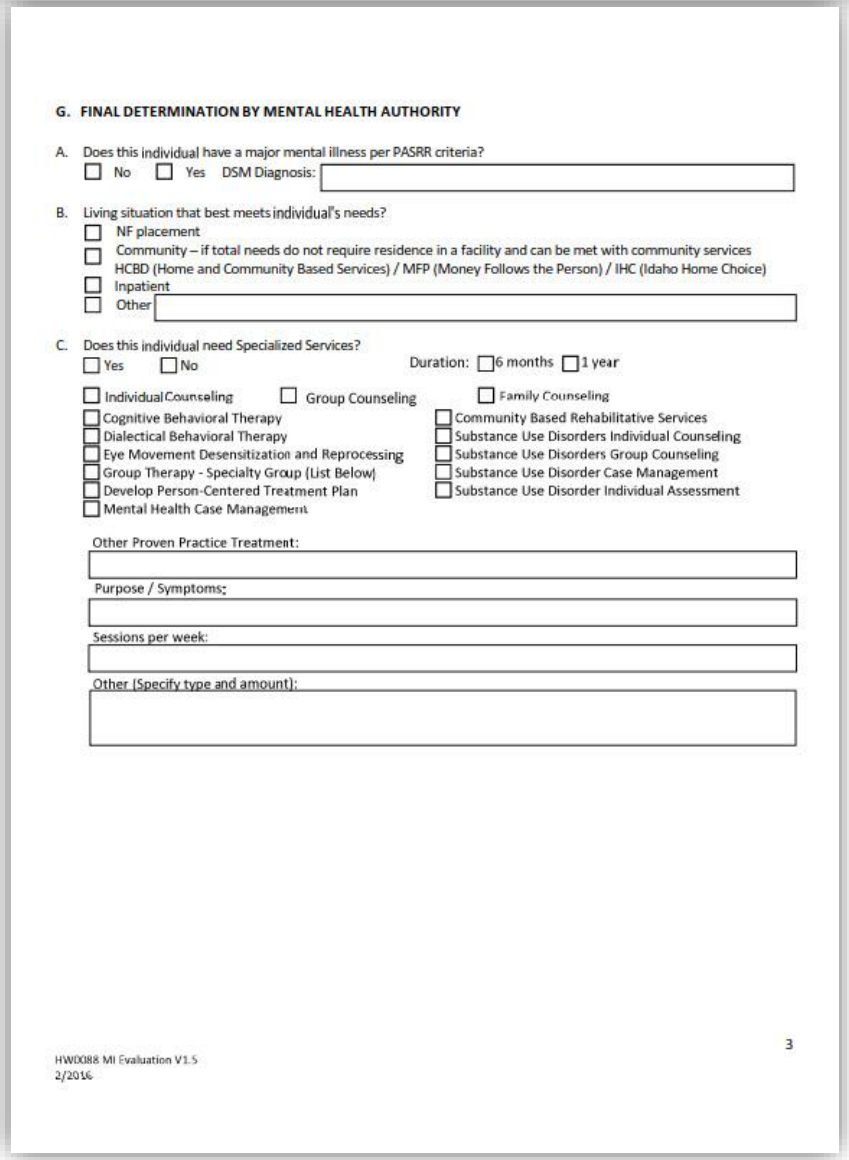
Recommendations for person-centered specialized services and/or specialized rehabilitative services and basis for recommendations:

Evaluator Signature _____ Title _____ Date ___/___/___

2

HW0088 MI Evaluation V1.5
2/2016

PASRR: Level II Serious Mental Illness



G. FINAL DETERMINATION BY MENTAL HEALTH AUTHORITY

A. Does this individual have a major mental illness per PASRR criteria?
☐ No ☐ Yes DSM Diagnosis: _____

B. Living situation that best meets individual's needs?
☐ NF placement
☐ Community – if total needs do not require residence in a facility and can be met with community services HCBD (Home and Community Based Services) / MFP (Money Follows the Person) / IHC (Idaho Home Choice)
☐ Inpatient
☐ Other _____

C. Does this individual need Specialized Services?
☐ Yes ☐ No Duration: ☐ 6 months ☐ 1 year

☐ Individual Counseling ☐ Group Counseling ☐ Family Counseling
☐ Cognitive Behavioral Therapy
☐ Dialectical Behavioral Therapy
☐ Eye Movement Desensitization and Reprocessing
☐ Group Therapy - Specialty Group (List Below)
☐ Develop Person-Centered Treatment Plan
☐ Mental Health Case Management
☐ Community Based Rehabilitative Services
☐ Substance Use Disorders Individual Counseling
☐ Substance Use Disorders Group Counseling
☐ Substance Use Disorder Case Management
☐ Substance Use Disorder Individual Assessment

Other Proven Practice Treatment:

Purpose / Symptoms:

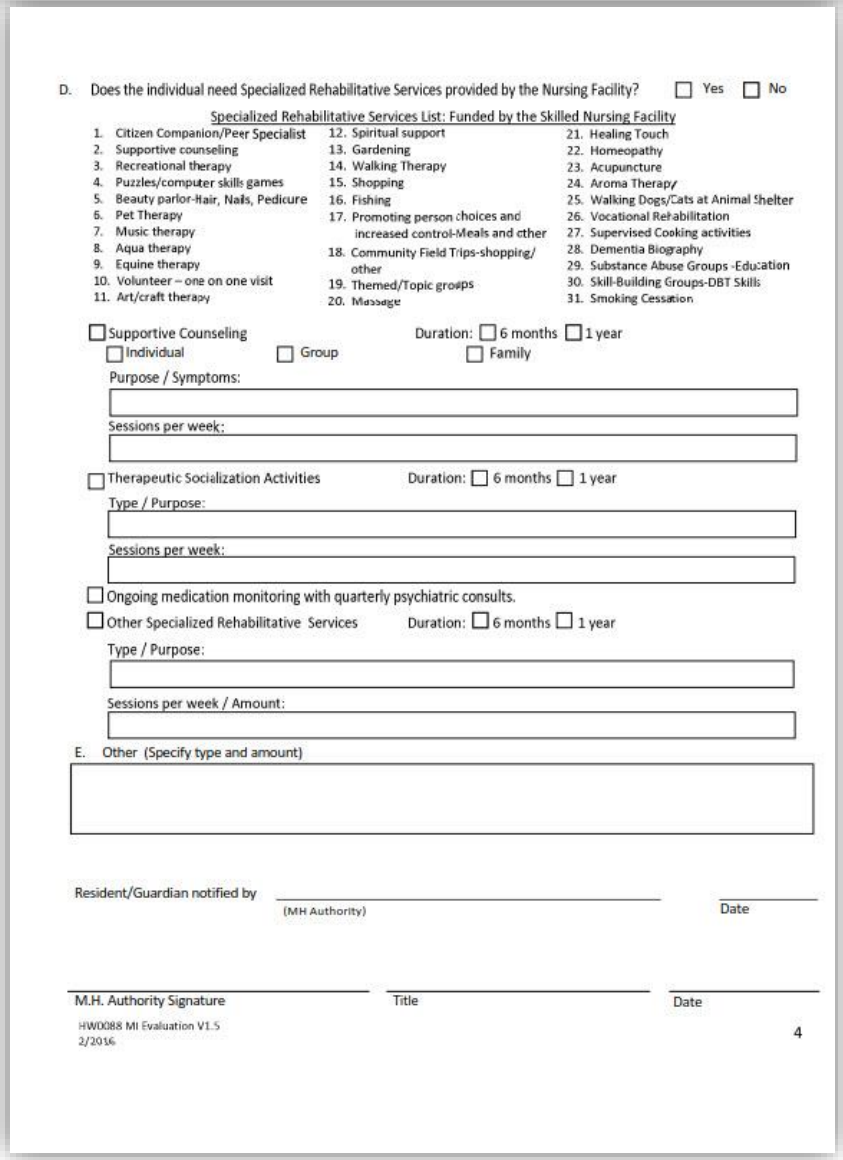
Sessions per week:

Other (Specify type and amount):

3

HW0088 MI Evaluation V1.5
2/2016

PASRR: Level II Serious Mental Illness



D. Does the individual need Specialized Rehabilitative Services provided by the Nursing Facility? ☐ Yes ☐ No

Specialized Rehabilitative Services List: Funded by the Skilled Nursing Facility

1. Citizen Companion/Peer Specialist
2. Supportive counseling
3. Recreational therapy
4. Puzzles/computer skills games
5. Beauty parlor-Hair, Nails, Pedicure
6. Pet Therapy
7. Music therapy
8. Aqua therapy
9. Equine therapy
10. Volunteer – one on one visit
11. Art/craft therapy
12. Spiritual support
13. Gardening
14. Walking Therapy
15. Shopping
16. Fishing
17. Promoting person choices and increased control-Meals and other
18. Community Field Trips-shopping/ other
19. Themed/Topic groups
20. Massage
21. Healing Touch
22. Homeopathy
23. Acupuncture
24. Aroma Therapy
25. Walking Dogs/Cats at Animal Shelter
26. Vocational Rehabilitation
27. Supervised Cooking activities
28. Dementia Biography
29. Substance Abuse Groups -Education
30. Skill-Building Groups-DBT Skills
31. Smoking Cessation

☐ Supportive Counseling Duration: ☐ 6 months ☐ 1 year
☐ Individual ☐ Group ☐ Family

Purpose / Symptoms:

Sessions per week:

☐ Therapeutic Socialization Activities Duration: ☐ 6 months ☐ 1 year

Type / Purpose:

Sessions per week:

☐ Ongoing medication monitoring with quarterly psychiatric consults.

☐ Other Specialized Rehabilitative Services Duration: ☐ 6 months ☐ 1 year

Type / Purpose:

Sessions per week / Amount:

E. Other (Specify type and amount)

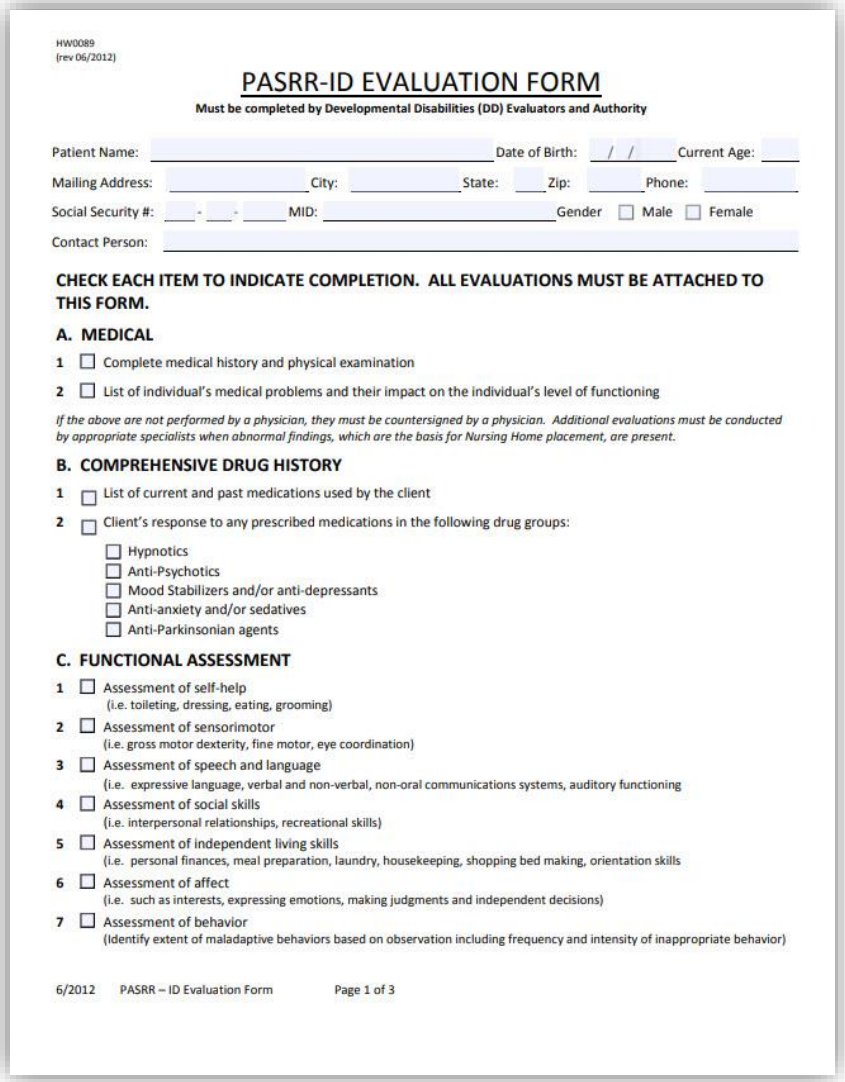
Resident/Guardian notified by _____ (MH Authority) _____ Date

M.H. Authority Signature _____ Title _____ Date

HW0088 MI Evaluation V1.5
2/2016

4

PASRR: Level II ID/DD or Related Condition



HW0089
(rev 06/2012)

PASRR-ID EVALUATION FORM

Must be completed by Developmental Disabilities (DD) Evaluators and Authority

Patient Name: _____ Date of Birth: __/__/____ Current Age: ____

Mailing Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Social Security #: ___-___-____ MID: _____ Gender ☐ Male ☐ Female

Contact Person: _____

CHECK EACH ITEM TO INDICATE COMPLETION. ALL EVALUATIONS MUST BE ATTACHED TO THIS FORM.

A. MEDICAL

1 ☐ Complete medical history and physical examination

2 ☐ List of individual's medical problems and their impact on the individual's level of functioning

If the above are not performed by a physician, they must be countersigned by a physician. Additional evaluations must be conducted by appropriate specialists when abnormal findings, which are the basis for Nursing Home placement, are present.

B. COMPREHENSIVE DRUG HISTORY

1 ☐ List of current and past medications used by the client

2 ☐ Client's response to any prescribed medications in the following drug groups:

- ☐ Hypnotics
- ☐ Anti-Psychotics
- ☐ Mood Stabilizers and/or anti-depressants
- ☐ Anti-anxiety and/or sedatives
- ☐ Anti-Parkinsonian agents

C. FUNCTIONAL ASSESSMENT

1 ☐ Assessment of self-help
(i.e. toileting, dressing, eating, grooming)

2 ☐ Assessment of sensorimotor
(i.e. gross motor dexterity, fine motor, eye coordination)

3 ☐ Assessment of speech and language
(i.e. expressive language, verbal and non-verbal, non-oral communications systems, auditory functioning

4 ☐ Assessment of social skills
(i.e. interpersonal relationships, recreational skills)

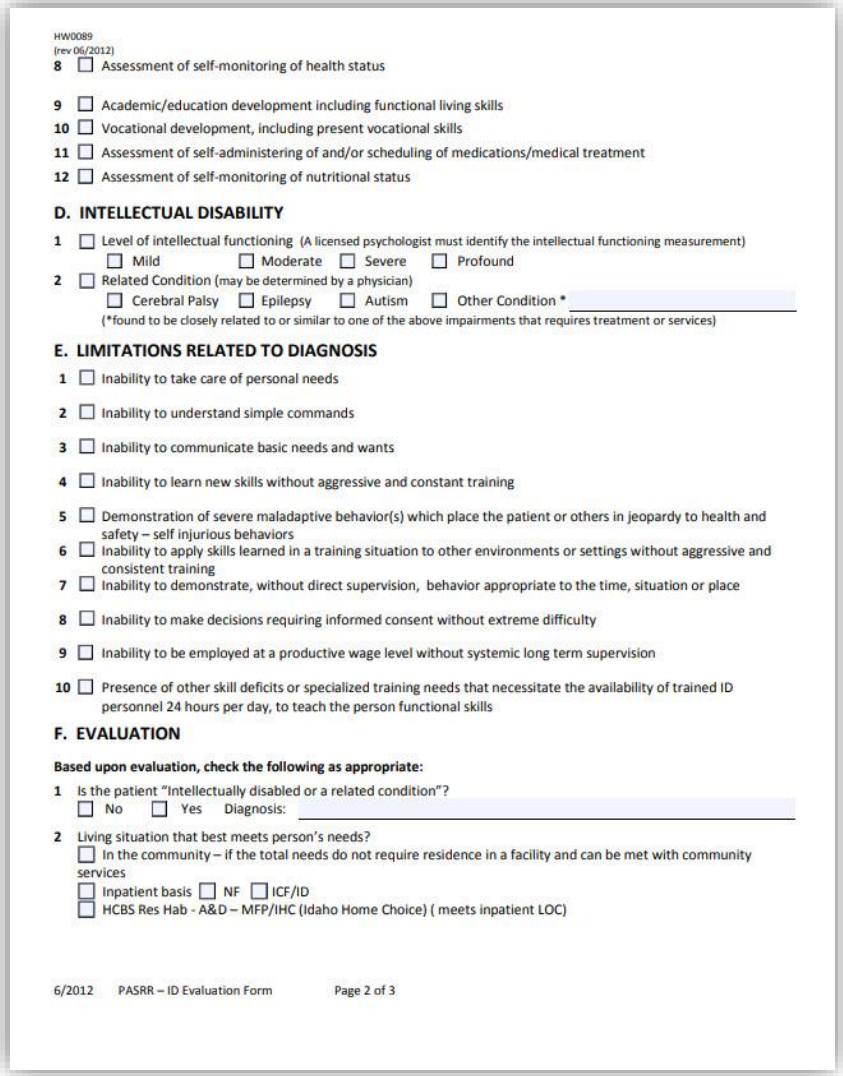
5 ☐ Assessment of independent living skills
(i.e. personal finances, meal preparation, laundry, housekeeping, shopping bed making, orientation skills

6 ☐ Assessment of affect
(i.e. such as interests, expressing emotions, making judgments and independent decisions)

7 ☐ Assessment of behavior
(Identify extent of maladaptive behaviors based on observation including frequency and intensity of inappropriate behavior)

6/2012 PASRR – ID Evaluation Form Page 1 of 3

PASRR: Level II ID/DD or Related Condition



HW0089
(rev 06/2012)

8 ☐ Assessment of self-monitoring of health status

9 ☐ Academic/education development including functional living skills
10 ☐ Vocational development, including present vocational skills
11 ☐ Assessment of self-administering of and/or scheduling of medications/medical treatment
12 ☐ Assessment of self-monitoring of nutritional status

D. INTELLECTUAL DISABILITY

1 ☐ Level of intellectual functioning (A licensed psychologist must identify the intellectual functioning measurement)
☐ Mild ☐ Moderate ☐ Severe ☐ Profound
2 ☐ Related Condition (may be determined by a physician)
☐ Cerebral Palsy ☐ Epilepsy ☐ Autism ☐ Other Condition * _____
(*found to be closely related to or similar to one of the above impairments that requires treatment or services)

E. LIMITATIONS RELATED TO DIAGNOSIS

1 ☐ Inability to take care of personal needs

2 ☐ Inability to understand simple commands

3 ☐ Inability to communicate basic needs and wants

4 ☐ Inability to learn new skills without aggressive and constant training

5 ☐ Demonstration of severe maladaptive behavior(s) which place the patient or others in jeopardy to health and safety – self injurious behaviors
6 ☐ Inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training
7 ☐ Inability to demonstrate, without direct supervision, behavior appropriate to the time, situation or place

8 ☐ Inability to make decisions requiring informed consent without extreme difficulty

9 ☐ Inability to be employed at a productive wage level without systemic long term supervision

10 ☐ Presence of 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

F. EVALUATION

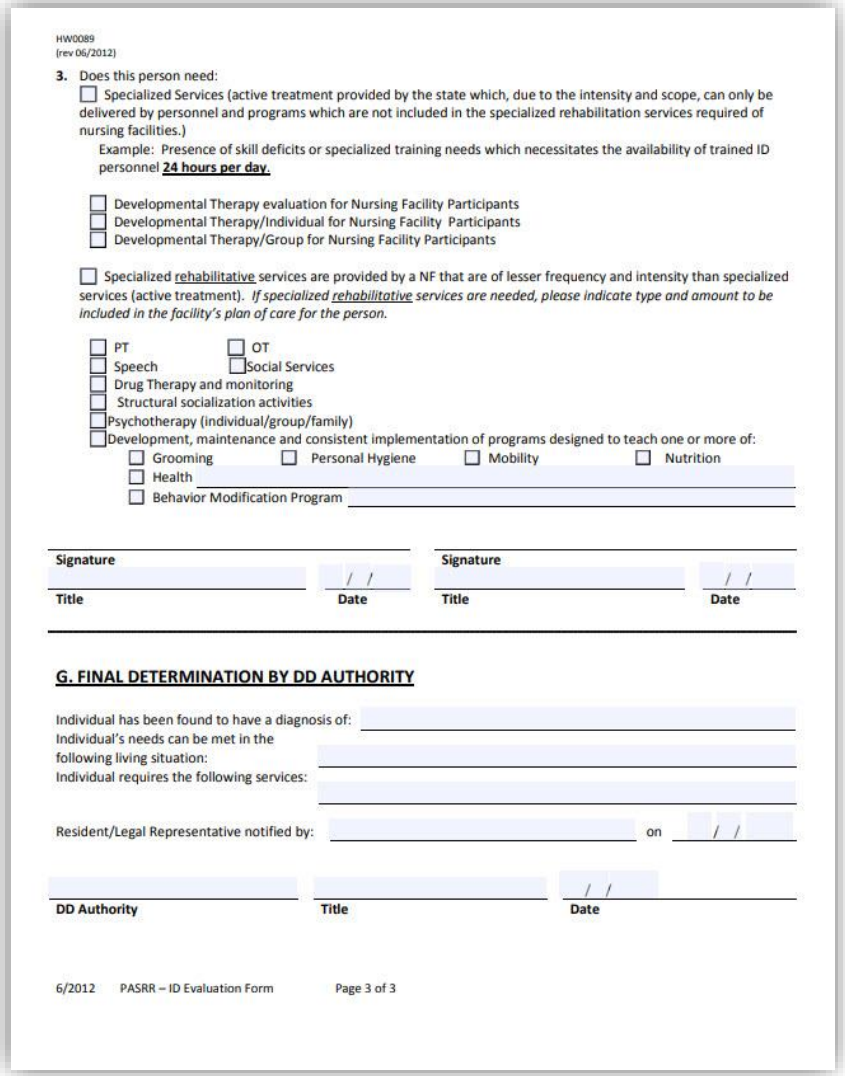
Based upon evaluation, check the following as appropriate:

1 Is the patient "Intellectually disabled or a related condition"?
☐ No ☐ Yes Diagnosis: _____

2 Living situation that best meets person's needs?
☐ In the community – if the total needs do not require residence in a facility and can be met with community services
☐ Inpatient basis ☐ NF ☐ ICF/ID
☐ HCBS Res Hab - A&D – MFP/IHC (Idaho Home Choice) (meets inpatient LOC)

6/2012 PASRR – ID Evaluation Form Page 2 of 3

PASRR: Level II ID/DD or Related Condition



HW0089
(rev 06/2012)

3. Does this person need:

☐ Specialized Services (active treatment provided by the state which, due to the intensity and scope, can only be delivered by personnel and programs which are not included in the specialized rehabilitation services required of nursing facilities.)

Example: Presence of skill deficits or specialized training needs which necessitates the availability of trained ID personnel **24 hours per day.**

☐ Developmental Therapy evaluation for Nursing Facility Participants
☐ Developmental Therapy/Individual for Nursing Facility Participants
☐ Developmental Therapy/Group for Nursing Facility Participants

☐ Specialized rehabilitative services are provided by a NF that are of lesser frequency and intensity than specialized services (active treatment). *If specialized rehabilitative services are needed, please indicate type and amount to be included in the facility's plan of care for the person.*

☐ PT ☐ OT
☐ Speech ☐ Social Services
☐ Drug Therapy and monitoring
☐ Structural socialization activities
☐ Psychotherapy (individual/group/family)
☐ Development, maintenance and consistent implementation of programs designed to teach one or more of:
☐ Grooming ☐ Personal Hygiene ☐ Mobility ☐ Nutrition
☐ Health _____
☐ Behavior Modification Program _____

Signature		Signature	
Title	Date	Title	Date

G. FINAL DETERMINATION BY DD AUTHORITY

Individual has been found to have a diagnosis of: _____
Individual's needs can be met in the following living situation: _____
Individual requires the following services: _____

Resident/Legal Representative notified by: _____ on ___/___/___

DD Authority	Title	Date
		___/___/___

6/2012 PASRR – ID Evaluation Form Page 3 of 3

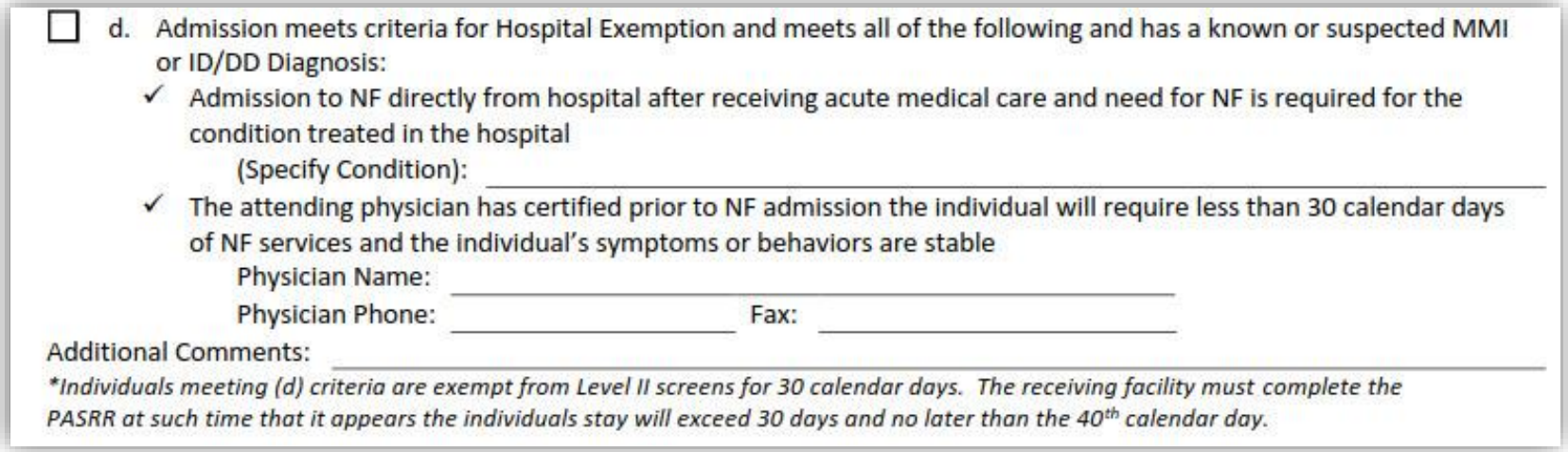
PASRR: Abbreviated Level II and Level II Tips

- Nursing facilities are responsible for ensuring the PASRR is completed and submitted to DXC in it's entirety, including all signatures and all forms
  - Level I (00087)
  - Abbreviated Level II (00090), if applicable
  - Level II (00088 and/or 00089), if applicable

- If a PASRR is incomplete, it will move to BLTC PASRR Discrepancy Process
  - BLTC will check internal records
  - Will either approve payment or alert the regional nurse manager to follow up with the facility to have the PASRR completed
  - An unsigned PASRR is enough to deny payment
  - Out of State PASRRs are accepted, if complete. BLTC should be alerted if any special services are recommended.

PASRR: Additional Information

PASRR: 30 – Day Exemption



☐ d. Admission meets criteria for Hospital Exemption and meets all of the following and has a known or suspected MMI or ID/DD Diagnosis:

- ✓ Admission to NF directly from hospital after receiving acute medical care and need for NF is required for the condition treated in the hospital
  (Specify Condition): _____
- ✓ The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable
  Physician Name: _____
  Physician Phone: _____ Fax: _____

Additional Comments: _____

**Individuals meeting (d) criteria are exempt from Level II screens for 30 calendar days. The receiving facility must complete the PASRR at such time that it appears the individuals stay will exceed 30 days and no later than the 40th calendar day.*

- **A PASRR is required for all admissions regardless of length of stay**
- If the individual's anticipated stay is ***less than 30 days***, it should be clearly written on the discharge/admission
- **30-Day Exemptions are granted by a BLTC Nurse Reviewer on the Abbreviated Level II (90)**, it is not a true exemption from Idaho PASRR process

PASRR: 30 – Readmission vs Leave of Absence

The determining factor is whether the individual is ***admitting to*** or ***returning to*** the nursing facility.

Nursing Facility Readmission

- Readmissions to a nursing facility can use a previous Level I as long as it is still accurate.
  - This Level 1 still needs to be submitted to BLTC for review
  - A BLTC nurse reviewer will provide a new Abbreviated Level II
- If the Level I is no longer accurate, complete a new Level I and submit to BLTC for review

Admitting: If the nursing facility will be submitting a long-term case file, the nursing facility is admitting the individual and a PASRR is required.

Nursing Facility Leave of Absence

- Nursing facilities can utilize a Leave of Absence (LOA) for individuals that are temporarily out of the facility for **3 days or less** due to a home visit or hospital stay.
- A PASRR **does not** need to be completed.

Returning: If the nursing facility is not submitting a long-term case file **and** will be indicating an LOA on the monthly claim, a PASRR is **not** required.

PASRR: 30 – Readmission vs Leave of Absence

- Nursing facilities are responsible for submitting updated Level I's to BLTC when a significant change occurs

- Significant changes are:
  - any medication changes from those listed on the Level I to a different drug class, such as antidepressants to an anxiolytic
  - a dosage increase of double or more of medication(s) listed on previous Level I
  - a decline in condition (such as the onset or progression of dementia) that indicates specialized services are no longer beneficial for the individual
  - an improvement in condition that indicates the individual may benefit from specialized services
  - a new mental health or developmental/intellectual disability diagnosis

- Updating Level I's allows for faster hospital discharges and nursing facility admissions

Questions/Comments?

PASRR: 30 – Readmission vs Leave of Absence

Idaho PASRR Help

- PASRR Forms and Information – including BLTC regional phone numbers and fax number
  https://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidNursingFacilityInformation/Pre-admissionScreeningandResidentReview/tabid/4572/Default.aspx
- Check MedicAide Newsletter around the 5th of each month
  https://www.idmedicaid.com/MedicAide%20Newsletters/Forms/All.aspx
- DXC Website – Trading Partner Account LTC User Guide
  https://www.idmedicaid.com/User%20Guides/Forms/AllItems.aspx
- Call or email Alex Childers-Scott
  ***policy and process questions only, no urgent PASRR calls, for urgent PASRR matters call BLTC regional office
  Alexandria.Childers-Scott@dhw.Idaho.gov
  208-364-1891

Rules and Regulations

- PASRR Technical Assistance Center (PTAC)
  pasrrassist.org
- Code of Federal Regulation on PASRR
  www.ecfr.gov
  Title 42, Chapter IV, Subchapter G, Part 483, Subpart C
- Idaho Administrative Code
  adminrules.idaho.gov/rules/current/16/index.html
  16.03.10.227-229