COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES

PASRR

Pre-Admission Screening and Resident Review Manual

Revised
August 2018

Table of Contents

Part IX: Community Options

Part X: Determinations

Part XI: Records

Part XII: Forms

Part XIII: Financial

Part XIV: Letters and Correspondence

Part I: Introduction and Overview

1.1 Introduction

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long term care. PASRR legislation requires that individuals be assessed when they apply to a nursing facility, and again on a systematic basis after admission (the Resident Review, or RR, initially an annual requirement, changed by subsequent legislation to follow changes in resident status). Though the enabling legislation was passed prior to the 1990 Americans with Disabilities Act (ADA), the regulations that govern PASRR were written post-ADA and reflect the intent of that law. The PASRR regulations also predate the person-centered, community-focused ruling of Olmstead v. L.C. (1999), in which the Supreme Court found that the requirements of Title II of the ADA apply to persons with mental disabilities, and that states must serve qualified individuals "in the most integrated setting appropriate" to their needs.

The Omnibus Reconciliation Act (OBRA) of 1987 and OBRA 1990 contain provisions with major implications for persons with a serious mental illness or an intellectual disability/related condition applying to or residing in a nursing facility. The provisions were designed to eliminate the practice of inappropriately placing persons with a mental illness, an intellectual disability, or a related condition in a nursing facility (NF) participating in the Kentucky Medicaid Program. 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).

On October 19, 1996, Title XIX of the Social Security Act was amended to repeal the requirement for an annual resident review. The amendment requires nursing facilities to notify the state Mental Health Intellectual Disability authority, promptly as applicable, after a significant change in the physical or mental condition of a resident who has a serious mental illness or an intellectual disability/related condition. This change in condition must affect the resident's need either for continued nursing facility placement and/or for specialized services. A review and determination under Section 1919 (e)(7) of the Act must be completed promptly after a nursing facility notifies the state Community Mental Health Center that there has been a significant change in the resident's physical or mental condition.

1.2 Overview of the PASRR process

PASRR federal regulations: 42 CFR 483.100 to 483.480.
PASRR state regulations: 907 KAR 1:022 and 907 KAR 1:755.

PASRR is a federally mandated program that requires all applicants to a nursing facility (NF) participating in the Kentucky Medicaid Program, regardless of payment source, be given a preliminary assessment to determine whether they might have a serious mental illness (MI), an intellectual disability (ID), or a related condition (RC). PASRR is meant to ensure appropriate placement and services for persons with MI/ID/RC in the least restrictive environment that can effectively meet their needs. It has three goals:

1. To identify individuals with a serious mental illness (MI) and/or an intellectual disability/related condition (ID/RC);
2. To ensure those individuals are placed appropriately, whether in the community or in a nursing facility (NF); and
3. To ensure that they receive the services they require for their MI, ID, or RC (wherever they are placed).

The Level I screening is the process that determines which individuals will receive the more in depth Level II evaluation, thus the initial screening serves as the gatekeeper for the state PASRR system. The Level II evaluates and confirms, or disconfirms the diagnosis and PASRR applicability, based on a more comprehensive evaluation and related documentation. It is also used to assess if a PASRR eligible individual meets nursing facility level of care and if so, to assess whether the applicant requires specialized services.

1.3 Nursing Facility Level of Care

In Kentucky, persons seeking admission to a nursing facility must meet the level of care requirements noted in 907 KAR 1:022. This regulation describes minimum care needs and level of care criteria for placement in a nursing facility.

An individual with a stable medical condition manifesting as a combination of at least two or more of the following care needs, shall be determined to meet patient status:

1. Assistance with personal care;
2. Assistance with transferring to or propelling a wheelchair;
3. Physical or environmental management for confusion and mild agitation;
4. Must have assistance and be present during the entire meal time;
5. Physical assistance with going to the bathroom or using a bedpan for elimination;
6. Existing colostomy care;
7. Indwelling catheter for dry care;
8. Changes in bed position;
9. Administration of stabilized dosages of medication;
10. Restorative and supportive nursing care to maintain the individual's skills and prevent deterioration of the individual's condition;
11. Administration of injections during the time licensed personnel are available;
12. Routine administration of oxygen after a regimen of therapy has been established.

An individual shall not be considered to meet patient status criteria if care needs are limited to the following:

1. Verbal or gestural assistance with activities of daily living;
2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch or cane;
3. Limited diet such as low salt, low residue, low-calorie, reducing, or other minor restrictive diet; or
4. Medications that can be self-administered or the individual requires minimal assistance such as set up of medication or simple cuing.

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. Persons who require the level of care provided in a nursing facility have the right to receive those services in the nursing facility they choose. They also have the choice of seeking alternative placement for which they qualify.

Part II: Responsible Parties

2.1 Agencies

The Center for Medicare and Medicaid Services (CMS)

The Federal agency, which administers the Medicare and Medicaid programs, interprets how states comply with the federal regulations for PASRR (42 CFR 483.100-138). They also provide resources for training and technical assistance.

Department for Medicaid Services (DMS)

Medicaid, as the single designated state agency for the administration of the Title XIX program under the Social Security Act, must implement a PASRR program that meets the statutory requirements of 42 CFR 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.

Medicaid's responsibilities include 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:

1. Assuring that the state mental health, developmental and intellectual disability authorities, who are charged with making the required determinations, fulfill their statutory responsibilities;
2. 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, intellectual disability and related conditions. DMS cannot reverse or revoke determinations made by DBHDID in the claims process, utilization review, or state survey;
3. Assuring that the determinations are needs-based for consistent analysis of data;
4. 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;
5. Assuring that the resident assessments conducted by the nursing facility are coordinated with the state's PASRR evaluations, as required by the Social Security Act, Section 1919(b)(3)(E); and
6. Assuring individuals who must be discharged under Section 1919(e)(7)(C) of that act are discharged.

Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)

The DBHDID is contractually 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.

Community Mental Health Centers (CMHC)

The DBHDID subcontracts with the Regional Community Mental Health Center Boards (CMHC) to conduct the PASRR Level II evaluations for persons who have a serious mental illness, intellectual disability and/or related condition. CMHC's are responsible for completing the PASRR evaluation process within the specified time frames, providing technical assistance to the nursing facilities, and providing specialized services, when indicated, for individuals with an intellectual disability or related condition.

Peer Review Organization (PRO)

The designated Peer Review Organization (PRO) provides level of care determination for all non-PASRR individuals applying to or residing in a nursing facility (NF) participating in the Kentucky Medicaid Program. (PRO staff review nursing facility resident's charts for accuracy in use of PASRR related MAP forms, timeliness of referrals, receipt from the CMHC's of the response to referral forms if appropriate, and the completed Level II evaluations when required.)

The Long Term Care Facilities

The federal requirement for PASRR applies to all licensed long-term care nursing facilities that are participating in the Kentucky Medicaid Program, regardless of the individual's funding source. Anyone seeking placement in a nursing facility (NF) participating in the Kentucky Medicaid Program will have a Level I screen prior to admission. Anyone identified by the screen as having a possible serious mental illness, intellectual disability or related condition must also go through the Level II process, or meet all requirements for a provisional admission, before the individual can be admitted to the facility.

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 of the applicant who was not appropriately screened, resulting in the recoupment of funds as well as putting the facility's participation in the Medicaid program in jeopardy.

The PASRR process is not needed for individuals admitted to swing beds or moving into non-medical residential settings of a nursing facility, such as personal care or assisted living.

The Office of Inspector General

The Office of Inspector General (OIG) is the regulatory agency which ensures that nursing facilities comply with the federal and state statutes and regulations. Although Federal money is not used for the provision of specialized services in Kentucky, because PASSR is a Federal program, the Office of Inspector General includes PASRR in their facility surveys and will review the records.

The OIG looks for accuracy in identification of persons who may need Level II evaluations. They also review the implementation of specialized services when identified, and the facility's response to the recommendations identified in the evaluation. The individual's record must contain all required documentation.

2.2 Other Parties

The Individual, Family or Guardian

Individuals who are found to have a potential serious mental illness, intellectual disability, or related condition through the Level I screen must participate in the Level II process in order to be admitted to or remain in a nursing facility (NF) participating in the Kentucky Medicaid Program regardless of payment source. Any medical documentation or psychosocial history must be provided to the evaluator.

Per CFR 42 483.128, the PASRR Level II evaluations **must** involve the individual being evaluated, the individual's legal representative, if one has been designated under state law, and the individual's family if available and the individual or the legal representative agrees to family participation.

As outlined in 907 KAR 1:755 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 enter or remain in the facility using the standards specified 42 U.S.C. 1396r.

PASRR Coordinators

Each region is expected to designate a PASRR coordinator to be responsible for administering and coordinating the PASRR activities for the region. There may be separate coordinators for the mental illness and intellectual disability/related condition evaluations. A PASRR coordinator's duties include, but are not limited to, the following:

1. Assure that all staff who bill for PASRR services are trained and certified in PASRR policies and procedures;
2. Notify DBHDID of any changes in staffing or staffing credentials;
3. Distribute manual revisions and related information in a timely manner, upon receipt of information from the DBHDID and DMS;
4. Regularly review completed evaluations and records for compliance with policies and procedures, including timelines and content;
5. Be available for consultation to the CMHC staff;
6. Coordinate local training for PASRR staff, nursing facilities, and others as needed;
7. Assure that required forms and information are submitted timely to the DBHDID; and
8. Participate in DBHDID sponsored trainings and peer group activities.

The CMHC may have an additional PASRR coordinator to focus on the implementation of specialized services and case management supervision.

The CMHC should notify DBHDID within ten (10) days if there are changes to PASRR evaluator or specialized services coordinators, or their contact information.

PASRR Evaluators

Each region is expected to have certified PASRR evaluator(s) to be responsible for the Level II evaluations. An evaluators duties include, but are not limited to, the following:

1. Conduct professional, individualized and comprehensive clinical evaluations in accordance with state and federal regulatory requirements;
2. Conduct face to face interviews;
3. Gather comprehensive medical, psychosocial, and mental health information including medical records and supporting documents needed to make PASRR decisions;
4. Document the individual's disability status, history, unique needs, and optimal care strategies;
5. Assess all information to determine level of care, the need for specialized services, and to make recommendations;
6. Complete all DBHDID trainings and maintain current knowledge of PASRR requirements and best practices.

Part III: Evaluation Qualifications

3.1 Training Requirements

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

All PASRR coordinators and evaluators who provide PASRR services must complete the PASRR evaluator certification training offered and approved by DBHDID. PASRR evaluators must be certified prior to his/her independent assignment to the PASRR program.

It is required that persons seeking to become PASRR Evaluators shadow an evaluator to become familiar with the process prior to attending the PASRR training. After receiving the PASRR training, the potential evaluator successfully completes an evaluation which is then signed off on by the coordinator. The evaluation is submitted to DBHDID Central Office and reviewed. If approved by the PASRR committee, the trainee becomes a certified evaluator and is given a certification in the type of evaluation they are able to perform (this should be kept in their personnel file).

3.2 PASRR Evaluator Qualifications

As a Medicaid program, PASRR evaluator requirements are determined by federal PASRR regulations and in accordance with the Medicaid state plan. Kentucky's state plan designates the individuals who are qualified to provide Medicaid services through a CMHC as indicated below, either independently or under supervision. These qualifications apply to all Medicaid funded programs and is not specific to PASRR program; therefore, it is the agency's responsibility to ensure that the service being provided is within the scope of the provider's qualifying credentials.

Evaluator qualifications to perform MI evaluations are based on the Kentucky Medicaid State Plan agreement.

A. Professionals qualified to independently perform PASRR Level II MI evaluations:

- Licensed Psychologist **(LP)**
- Licensed Psychological Practitioner **(LPP)**
- Licensed Clinical Social Worker **(LCSW)**
- Licensed Professional Clinical Counselor **(LPCC)**
- Licensed Marriage and Family Therapist **(LMFT)**
- Psychiatrist
- Physician
- Licensed Professional Art Therapist **(LPAT)**
- Licensed Behavior Analyst **(LBA)**
- An RN licensed in the Commonwealth of Kentucky with one of the following combinations of education and experience:
  - **i.** Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
  - **ii.** Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
  - **iii.** A graduate of a three-year educational program with 2 years of experience in a mental health setting.
  - **iv.** A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
- Licensed Alcohol and Drug Counselor **(LADC)**
- Licensed Alcohol and Drug Counselor Associates* **(LADCA)**

  * Requires Supervision

B. The following professionals may perform the Level II MI evaluations with appropriate supervision:

A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services field under supervision of a professional qualified to independently perform evaluations as outlined in section A above. (Must be signed off by someone with the credentials in section A above).

C. The following professionals may perform the Level II MI evaluations with the appropriate licensing supervision:

- A licensed psychological associate;
- A licensed professional counselor associate;
- A certified social worker, Master Level;
- A marriage and family therapy associate;
- A physician assistant working under the supervision of a physician;
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA;
- A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a LPATA 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 center;
- A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, or a LBA.

Evaluator qualifications to perform ID/RC evaluations are in accordance with 42 C.F.R. 483.430.

A. Professionals qualified to independently perform PASRR Level II ID/RC evaluations shall:
Have at least one year of experience working with persons with ID or other developmental disabilities; and is one of the following:

- A doctor of medicine or osteopathy.
- A registered nurse.
- An individual who holds at least a bachelor's degree in a human service field (including but not limited to: sociology, special education, rehabilitation counseling, and psychology).

Part IV: Referrals and Timeframes

4.1 Level I Screening (MAP 409)

The Level I (MAP 409) must be completed for all applicants to a nursing facility (NF) participating in the Kentucky Medicaid Program, regardless of payer source, before a resident can be admitted into the nursing facility. The nursing facility must complete this screening. NF staff should be thorough when determining answers to the questions on the Level I to ensure that individuals are being properly screened for a potential serious mental illness, intellectual disability, or related condition. The Level I screener should access information from the individual's current history and physical, psychosocial report, other supporting documentation, and/or family members, etc. All of the information gathered will assist in identifying the most appropriate placement, supports, and discharge planning options.

This form is used to determine if the individual should be referred to the Community Mental Health Center (CMHC) for a PASRR Level II evaluation. The instructions on the Level I form and the corresponding instruction sheet provide directions for determining the referral designation. When the Level I is referred to the CMHC, they will begin the Level II process.

4.2 Significant Change (MAP 4095)

This form is used for any individual who has not been discharged or received a lower level of care, who:

- Previously did not meet PASRR criteria but now does due to a newly diagnosed or newly discovered/confirmed PASRR condition; or
- Was previously identified as meeting PASRR criteria and whose mental or physical condition has changed in a manner that affects his/her need for specialized services, nursing facility level of care, or recommended services of lesser intensity; or
- To notify CMHC's of a PASRR individual's discharge or death.

The type of change is noted on the form, and sent to the local Community Mental Health Center within fourteen (14) calendar days. The CMHC, upon receipt of the significant change that is not for discharge or death, will begin the Level II process.

4.3 Out of Region

The CMHC in the region where the individual is located is responsible for completing the Level II evaluation even when the individual is located in a region other than where the facility requesting the PASRR is located.

The CMHC, upon receiving the initial referral from the nursing facility, will contact the CMHC 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 CMHCs.

4.4 Out of State

New admissions from out of state are subject to the same PASRR requirements as in state admissions. The state where the individual resides at the time of referral should complete a Level II evaluation unless a reciprocal agreement between the two states has been made and documented. 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 evaluation.

Different states may have different criteria and/or evaluation forms. Therefore, when a CMHC receives a form completed by another state, they will take the information and complete the appropriate Kentucky PASRR forms. Final determinations for placement and services will be made by the CMHC based on Kentucky's criteria.

4.5 Timeframes

Regardless of the date of admission, type of admission, or type of referral; once the CMHC receives a referral from the nursing facility, the PASRR process including the written determination must be completed within nine (9) business days. If the CMHC goes beyond the nine days, they must submit to DBHDID a written explanation for the delay. The CMHC should maintain an adequate number of trained evaluators to ensure timeframes are met.

Part V: Admissions

5.1 Re-Admission

A re-admission is the designation of an individual who has had a Level II evaluation and:

- Was in the nursing facility but went to the hospital, and is returning to the facility from that hospital admission; or
- Is transferring from one nursing facility to another without a break in their nursing facility care status.

An additional evaluation is not needed unless there has been a significant change that would impact their level of care or utilization of specialized services.

5.2 New Admission

A new admission is an evaluation at a site other than the nursing facility. If someone in a nursing facility is discharged home, or to a lower level of care (regardless of how brief a time they were away) prior to their return to the nursing facility, the PASRR process for them starts from the beginning. They would be considered a new admission and would get a new Level l, and a new Level II if they meet criteria.

A person is considered a new admission for PASRR when the person meets the criteria for a Level I referral and is:

- Requesting admission to a nursing facility for the first time or does not qualify for a re-admission;
- Currently residing in the community;
- Residing in a lower level of care (family care or community placement); or
- Residing in a lower level of care within the same facility (personal care).

These individuals must have the Level II evaluation prior to the nursing facility admission. New admission Level II evaluations must be completed and forwarded to the appropriate parties within nine (9) business days of the referral.

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. In most instances, only a nursing facility with an available bed (vacancy) will request a PASRR evaluation for a new or provisional admission. However, to facilitate the placement of persons with a serious mental illness or an intellectual disability/related condition who would be difficult to place within the confines of the routine PASRR placement procedures, an exception can be made:

- A nursing facility without a vacancy can request a PASRR Level II evaluation upon the completion of a positive MAP 409 (Level I screening) as long as there is a reasonable expectation that the person will be admitted when a vacancy occurs. The Level II evaluation, however, should only be completed when admission to a nursing facility is expected to take place within three (3) business days.

The referral source is expected to be reasonably sure that the individual, if a Medicaid recipient, will meet the nursing facility level of care criteria and is expected to provide the information needed.

5.3 Provisional Admission: Exempted Hospital Discharge (MAP 4092)

An exempted hospital discharge can be used for an individual with a diagnosis of a serious mental illness, intellectual disability, or related condition who meets the following criteria for NF level of care:

1. Is admitted to any nursing facility directly from a hospital after receiving acute in-patient care at the hospital; and
2. Requires nursing facility care for the condition for which he/she received care in the hospital; and
3. 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.

The MAP 4092 is a physician certification of need for nursing facility services for individuals who meet the criteria outlined above. It is used to explain why/how an individual was admitted without the Level II Evaluation. The nursing facility is responsible for the MAP 4092.

If an individual who enters the nursing facility as an exempted hospital discharge is later found to require more than thirty (30) days of nursing facility care, the nursing facility must refer the individual for a PASRR Level II evaluation as soon as it is known, but no later than 30 days from the date of admission. The referral is

made by submitting a copy of the MAP 409 and MAP 4092 to the CMHC. The nursing facility will not be eligible for reimbursement after the 40th day of admission until a PASRR determination is made authorizing nursing facility level of care.
Once the referral is made, the CMHC must initiate a PASRR Level II evaluation. The PASRR process including the written determination must be completed within nine (9) business days. It is the responsibility of the nursing facility to make the referral timely to allow for the evaluation to be completed within the 9 day time frame and still meet the 40 day requirement outlined above.

5.4 Provisional Admission: Delirium (MAP 4093)

A diagnosis of delirium as defined in the DSM is a rapid disturbance in attention, awareness, and cognition, which could fluctuate throughout the day, and may be the consequences of another condition. A provisional admission allows for a fourteen (14) day admission pending further assessment when an accurate diagnosis cannot be made until the delirium clears.

If a PASRR individual is not discharged within 14 days from this provisional admission, the nursing facility must refer for a PASRR Level II evaluation. The referral is made by submitting a copy of the MAP 409 and MAP 4093 to the CMHC. Once the referral is made, the CMHC must initiate a PASRR Level II evaluation. The PASRR process including the written determination must be completed within nine (9) business days.

The nursing facility will not be eligible for reimbursement after the 14th day of admission until a PASRR determination is made authorizing nursing facility level of care.

5.5 Provisional Admission: Respite (MAP 4093)

Respite is allowed to in-home caregivers to whom the person with a serious mental illness or an intellectual disability/related condition is expected to return following a stay of no more than fourteen (14) days.

If a PASRR individual is not discharged within 14 days from this provisional admission, the nursing facility must refer for a PASRR Level II evaluation. The referral is made by submitting a copy of the MAP 409 and MAP 4093 to the CMHC. Once the referral is made, the CMHC must initiate a PASRR Level II evaluation. The PASRR process including the written determination must be completed within nine (9) business days.

The nursing facility will not be eligible for reimbursement after the 14th day of admission until a PASRR determination is made.

Part VI: Diagnosis and Validation Criteria

6.1 Serious Mental Illness (SMI)

An individual is considered to have a serious mental illness if the following three (3) criteria are met:

1. **Diagnosis**
   The individual has a major mental disorder, as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which includes, but is not limited to: psychotic disorder, mood disorder paranoia, panic, or other severe anxiety disorder, post-traumatic stress disorder (PTSD), or other mental disorder that may lead to chronic disability; and
2. **Level of Impairment**
   The disorder results in functional limitations in major life activities, such as interpersonal functioning, concentration, persistence and pace, and ability to adapt to change. These functional limitations must be evident within the last six months and must be appropriate for the person's developmental stage; and

3. **Recent Treatment/Duration of Illness**
   The individual has experienced at least one of the following in the past two (2) years:
   a) Required intensive psychiatric treatment (more intensive than outpatient care) in order to maintain or restore functioning such as psychiatric hospitalization, partial hospitalization/day treatment, residential treatment; or
   b) 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.

6.2 Intellectual Disability (ID)

Intellectual Disability diagnosis requires intellectual impairment and deficits in adaptive functioning with onset prior to the age of 18.

The following three (3) criteria must be met:

1. Deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experiences confirmed by both clinical assessment and individualized standardized intelligence testing.
2. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life such as communication, social participation, and independent living across multiple environments, such as home, school, work, and community.
3. Onset of intellectual and adaptive deficits during the developmental period (before age 18).

6.3 Related Condition (RC)

Related condition is a severe, chronic disability closely related to intellectual disability which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability that requires similar supports. The condition must have manifested prior to the age of 22.

The following four (4) criteria must be met:

1. The disability is attributable to:
   a) Cerebral Palsy or epilepsy; or
   b) 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.
2. Has manifested before the person reaches age 22;
3. is likely to continue indefinitely; and
4. Results in substantial functional limitations in three (3) or more of the following areas of major life activities:
   a) Self-care;
   b) Understanding and the use of language;
   c) Learning;
   d) Mobility;
   e) Self-direction; or
   f) Capacity for independent living.

<u>A physical disability alone will not meet criteria.</u>

6.4 Dual Diagnosis

For purposes of PASRR, a person is considered dually diagnosed if they meet the criteria for a serious mental illness and for an intellectual disability/related condition.

6.5 Arranging for Additional Exams

A determination must be made based on the information available at the time of the Level II and within the appropriate timeframes. If more information is located later, an updated Level II can be submitted. There will also be times when it is appropriate to request additional evaluations in an attempt to validate a diagnosis. Due to time constraints, this would likely be after the determination for LOC.
If the evaluator can't get the supporting documentation to make a determination and they feel an individual meets criteria for ID/RC and would benefit from SS; then the CMHC should arrange for a complete psychological assessment (to include onset, IQ, and an adaptive behavior assessment).

CMHC's may use state general funds to cover psychological assessments (when no other resources are available to validate a diagnosis) for the PASRR assessment. This testing is billed to SGF under service code 020 Psychological Testing.

Part VII: Level II Evaluation

7.1 Overview

Based on the Level I screening, persons who appear to have a serious mental illness and/or intellectual disability/related condition, shall be referred for a Level II comprehensive evaluation. The purpose of the Level II evaluation is to:

1. Confirm the presence of MI/ID/RC;
2. Assess if applicant meets nursing facility level of care; and
3. Assess whether the applicant requires specialized services and/or services of lesser intensity.

An individual applying for admission to, or requesting a continued stay in, a nursing facility (NF) participating in the Kentucky Medicaid Program shall be deemed to have given consent for the department to evaluate and determine the above listed criteria. HIPAA regulations stipulate that any information collected through the process of identification of a complete plan of care for a patient does not need permission for re-disclosure of additional records collected during this process.

The Department has a comprehensive Level II form that is used for MI, ID/RC, and dual diagnosis evaluations. Using the information from interviews, documentation, and records; the evaluator completes each applicable section with as much detail as possible.

Per CFR 42 483.128, the PASRR Level II evaluations must involve:

1. The individual being evaluated;
2. The individual's legal representative, if one has been designated under state law; and
3. The individual's family if available and the individual or the legal representative agrees to family participation.

If any of the above required individuals are unable to contribute to the interview, the reason must be documented on the evaluation form.

7.2 Information to be Collected

Specific data that is required to make any determination (including response to referral):

- A comprehensive history and physical examination (to include a complete medical history, review of all body systems, and neurological system evaluation) – required by federal regulation to be part of all evaluations including response to referrals.
- Current medications and a comprehensive drug history.

Specific data that should be gathered and used as applicable for evaluations include:

- A current and valid diagnosis, including supporting documentation to validate the diagnosis and age of onset.
- Any additional evaluations conducted by appropriate specialists.
- A comprehensive psychiatric evaluation.
- Documentation of psychiatric treatment and/or hospitalization.
- A psychosocial evaluation (incorporated into the Level II).
- A functional assessment of activities of daily living.
- A specific description of the individual's adaptive functioning deficits and types of support needs (type of supports needed, frequency and intensity of supports).
- School records including the individual education program (IEP) documentation, IQ scores, and assessment of adaptive functioning.
- Psychological evaluation with diagnosis based on IQ testing and adaptive behavior assessment (when the evaluation itself cannot be located, then treatment records which provide review of psychological evaluations and key information from the assessment such as when the testing was done, who it was conducted by, tests and scores obtained, diagnosis given).
- The results of a psychological assessment submitted during the course of guardianship proceedings.
- Onset of ID/RC may be supported through a comprehensive developmental history (records or information from parent/guardian, other close relative who can provide first person account of individuals developmental history) that contains specific information about the onset of any medical conditions or injuries that resulted in intellectual impairment, information about the nature of those impairments (delays or regression in key developmental milestones such as speech, gross and fine motor skills, learning, etc.).
- Records from prior community supports.
- Historical medical or treatment records that provide information on evaluations, diagnosis, and/or functional impairments.
- For ID/RC, assessment and documentation that rules out other factors or conditions that may have contributed to diminished cognitive and adaptive functioning such as severe mental illness, chronic substance abuse, or medical conditions. This can be accomplished by documentation in which the trained professional indicates that these conditions are not present, or if documentation of ID/RC exists prior to the onset of the other conditions, or can demonstrate that the impairments are more consistent with ID/RC than other factors.
- Any other information that is necessary to determine if it is appropriate for the individual with SMI, ID/RC to be placed in a nursing facility.

The evaluator is responsible for gathering any available supporting documentation. It is important that evaluators interview the family and gather as much information as they can about the individual. Gathering documentation from the family is important, but evaluators should also make every effort to gather documentation from all sources when not available from the family. All attempts should be documented on the Level II, or in the case record if a Level II is found to not be needed.

7.3 The Level II Evaluation

Level II evaluations are completed on a comprehensive form that reviews multiple aspects of an individual's life to identify areas of strengths, needs, and choice. The evaluation is divided into seven (7) parts. It is essential that each section is filled out in detail.

Part one – Referral Information
Captures information on the individual, type and reason for the evaluation, the facility contacts, and dates of the referral and admission. If the evaluator is unable to interview the individual, guardian, or other family, it must be explained here.

Part Two – Diagnosis and Testing
Collects data on all available diagnosis for Mental Health, Intellectual Disabilities, Related Conditions, and medical diagnoses. This section is also used to list and describes previous testing for mental health, IQ, adaptive functioning, or other applicable tests. Information should include documentation of known testing including if it was never done, and documentation of efforts to obtain testing.

Part Three – Medication History
Captures current and historic medications, allergies, medication administration needs, and substance use.

Part Four – Mental Health Status/Psychiatric Assessment
Comprehensive evaluation for mental illness, mental status assessment, previous treatment, and detailed support needs.

Part Five – Activities of Daily Living
An all-inclusive assessment of activities of daily living including physical, sensory, and communication strengths/weaknesses, and therapy support needs.

Part Six – Psychosocial Evaluation
Comprehensive evaluation that captures information on reason for placement, social development, cognitive functioning, treatment, developmental history, education, and work history.

Part Seven – Review of Findings
Based on the evaluation and documentation, the evaluator will make determinations of placement and services. The review of findings includes:

- The level of care assessment.
- Nursing facility and behavioral health service needs.
- Specialized service needs (important to/for the person):
    - If a specific service is not available in the NF, then specialized services are recommended. Identify the specific ID/RC or mental health services required to meet the individual's needs. Include the basis for this conclusion.
    - If a specific service is available in the NF, then specialized services are not recommended. Identify any services of lesser intensity needed. Include the basis for this conclusion.
- Recommendations based on a comprehensive review of the findings. The determinations related to the need for nursing facility level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data concerning the individual. Findings of each evaluation must correspond to the person's current functional status as documented in the evaluation and records.
- Client Signature and Interpretation – Federal regulations mandate that the findings of the PASRR evaluation be interpreted to the applicant, and where applicable, to a legal representative. This is documented by signature on the evaluation form. For persons with an intellectual disability/related

condition, the findings cannot be made known until the final determination is made by the Division of Developmental and Intellectual Disability (DDID) PASRR review committee.

7.4 Discontinuation/Level II not Indicated

PASRR regulations permit Level II evaluations to be terminated at any point during the Level II process when the Level II evaluator finds that the individual:

- Does not have MI/ID/RC;
- Does not have sufficient evidence to support a diagnosis of MI/ID/RC; or
- Has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

Clinical validation of a primary dementia diagnosis should be made by a QMHP through personal interview, unless existing records or interview of caregiving staff sufficiently documents primary dementia.

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.

The decision to stop the Level II process should be based on an evaluation of all available supporting documentation. It is important that evaluators interview the family and gather as much information as they can about the individual. The evaluators should also make every effort to gather applicable documentation from all sources when not available from the family. All attempts should be documented in the case record if a Level II is found to not be needed.

When the evaluation is stopped or discontinued, a response to referral form (PASRR 4) noting the reason is completed and sent to the referring NF.

Part VIII: Specialized Services

8.1 Overview

Specialized services shall be provided in accordance with: 42 CFR 483.120, 42 CFR 483.134, 42 CFR 483.136 and 42 CFR 483.440; and in the state regulation 907 KAR 1:755.

Specialized services are not Medicaid waiver services. An individual cannot receive waiver services while a resident in a facility. The service providers must meet the department requirements to provide the services. The department requires all providers, including subcontracted services, must comply with the personnel requirements in the most current version of the Department for Medicaid Services Supports for Community Living Regulation 907 KAR 12:010 as it pertains to the following, to be applied to all service areas providing supports to individuals with intellectual and/or related conditions:

1. Incident reporting requirements;
2. Staff training requirements;
3. TB risk assessment, negative tuberculosis testing, or, for staff or volunteers with a positive TB test, valid documentation ensuring no active disease symptoms are present;
4. Criminal record, drug test, and registry checks for each potential employee and volunteer performing a supervisory or direct care service;
5. Employment or placement of an individual based on criminal record and registry checks;
6. Annual criminal record checks; and
7. Annual drug tests.

The services and supports that are being provided as specialized services cannot be diversional in nature. When it is determined that the individual's objectives have been obtained or are unable to be obtained, the plan should be modified or discontinued.

Specialized services must meet current CMHC contract requirements.

8.2 Serious Mental Illness

Based on the individual's needs and the services provided at the nursing facility, the evaluator will recommend mental health services for the individual. It is vital for each evaluator to specifically identify which services the nursing facility needs to provide or obtain in order to meet the individual's mental health needs.

The evaluator will complete the recommended services form (PASRR 5), and include those recommendations in the determination letter to the facility. The evaluator should explain the recommendations and provide information on resources to the facility staff that make up the individual's services and treatment team. Evaluators should follow up with nursing facility staff to ensure the individual's recommendations are included in the individual's plan of care.

If the individual's needs cannot be met through services of lesser intensity in a nursing facility, the evaluator may consider referring the individual for specialized services through inpatient psychiatric care.

8.3 Intellectual Disability/Related Condition

For individuals with intellectual disabilities or related conditions (ID/RC), specialized services means the continuous, aggressive and consistent implementation of a program of specialized and generic training, treatment, and health and related services, which are comparable to those provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or in a community-based waiver program that provides services to persons with intellectual or other developmental disabilities.

Specialized services exceed the services ordinarily provided by the NF under its per diem rate. These services are provided in the NF or off-site and are directed toward:

1. The acquisition of the skills necessary for the individual to function with as much self-determination, and independence as possible;
2. The prevention or deceleration of regression or loss of current optimal functional status; and
3. 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 program plan objectives for the individual.

The need and intensity of specialized services are based on determining an individual's inability to:

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

In addition to the above criteria, demonstrated severe maladaptive behavior(s) that place the person's or others' health and safety in jeopardy would necessitate the availability of trained ID/RC personnel to teach the person functional skills.

Specialized services shall not be provided to individuals who are generally independent and are able to function with either minimal supervision or in the absence of a continuous active treatment program.

Types of specialized services that can be provided include, but are not limited to:

- Habilitative Services (skills training to increase independence in community life)
- Behavior Support (functional behavior assessment and development of a positive behavior support plan)
- Day Services (participation in a program to acquire skills, build positive social behavior and interpersonal competence, and foster a greater independence and personal choice)
- Miscellaneous Services (any other identified service that that will assist the individual in gaining skills towards achieving a more independent life in the community)

8.4 Services of Lesser Intensity

Nursing facilities are required by OBRA 1990 to provide mental health and intellectual disability/related condition services, which are of a lesser intensity than specialized services, to all residents who need such services. The evaluator may make recommendations for services of lesser intensity that the nursing facility will be required to provide.

These services are within the scope of services provided or arranged by the nursing facility as included in their per diem rate, and are less intensive than specialized services. These services are intended to help residents who have a serious mental illness, intellectual disability, and/or related condition to improve, maintain, or prevent regression of optimal functional status and achieve highest possible level of well-being.

Examples of services of lesser intensity include, but are not limited to:

- For speech therapy – the use of a communication device, PECS system or sign language.
- For occupational therapy – learn or help to maintain daily living skills or fine motor skills so the individual remains as independent as possible.
- For physical therapy – learn or help to maintain large motor skills so they don't become a risk for falls.

The PASRR evaluator is expected, as a part of the evaluation, to specifically identify the services required to meet the individual's needs. The evaluator will complete the recommended services form (PASRR 5) and explain these service recommendations to the appropriate nursing facility staff. The recommendations should also be included in the determination letter submitted to the nursing facility. Evaluators should follow up with nursing facility staff to ensure the recommendations are included in the individual's plan of care.

8.5 Responsibility for Providing Specialized Services

The Regional Community Mental Health Centers are responsible for arranging for or providing specialized services. The contractual agreements between DBHDID and the Regional Community Mental Health Centers specifies this as a requirement under services/deliverables: "Provide PASRR specialized services to individuals as determined by the PASRR Level II evaluation through a person-centered plan".

The PASRR coordinator must ensure that a copy of the Level II evaluation and approval letter is provided to the specialized services coordinator or staff, and the nursing facility without delay. To comply with federal PASRR requirements, the individual's plan of care must be completed and implemented within 30 business

days of approval for specialized services. The individual's plan must include case management (CM) and at least one other service. The plan is considered to be implemented when the individual has received at least one service (other than CM) as indicated on the plan.

For Mental Illness, specialized services means the implementation of an individualized plan of care that:

1. Is developed in conjunction with and supervised by a physician;
2. Is provided by an interdisciplinary team of qualified mental health professionals;
3. Prescribes specific therapies and activities for the treatment of a person who is experiencing an acute episode of serious mental illness that necessitates continuous supervision by trained mental health personnel; and
4. Requires the level of intensity provided in a psychiatric inpatient hospital.

For ID/RC, specialized services are provided through a person-centered plan in accordance with 907 KAR 1:755, 42 CFR 483.120, and CFR 483.440. Specialized services should be initiated by the assignment of a Case Manager who will work with nursing facility staff to build a cohesive plan of care that would include the recommended specialized services and PASRR staff responsibilities.

The plan of care should reflect the needs, wants, and desires of the individual, and include measurable goals and objectives. They should include the individual's health issues, family, friendships, community inclusion, and human service needs. They should be directed at the acquisition of new skills and/or the prevention of regression or loss of current optimal functional status. The individual must actively engage in the specialized service and should have some cognitive awareness of the service. Case managers must be able to convey in a discernable way, a measurable response/outcome to the service, this should be documented in their monthly notes.

The individual recommended for PASRR specialized services shall require and receive a minimum of Case Management plus at least one (1) additional service. Documentation of each contact must be kept in the individual's records.

8.6 Specialized Services in the Individual's Nursing Facility Care Plan

In the nursing facility, specialized services are one of many parts of the overall care plan that addresses all areas of an individual's health and support needs.

When an individual receives specialized services, the case manager and the specialized services staff are part of the individual's treatment and support team. The following are guidelines for establishing and maintaining an effective and professional working relationship with the nursing facility staff:

- When PASRR specialized services are indicated, ensure that the services, plans for implementation, and responsible staff are incorporated into the individual's nursing facility care plan.
- Establish a contact person for each facility.
- 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.
- Notes from specialized service providers must be maintained in the NF charts of individuals who receive specialized services.
- The recommendations for services of lesser intensity are part of the PASRR evaluation, and must be maintained in the individuals chart along with the evaluation.
- Attend care-planning meetings for each person receiving specialized services. During these, continue to educate staff regarding integration of the specialized services treatment plan into the nursing facility care plan. Point out progress toward goals, even slow/small progress.
- Identify and involve nursing facility staff members who work with the individual.

- Get input from the social workers, nursing staff, or any other caregivers who have a relationship with the individual.
- Provide opportunities for nursing facility staff to share their perspectives and make staff contacts at each visit.

8.7 Refusal or Discontinuation of Specialized Services

An individual can refuse part or all of the specialized services identified for them. If this happens, a refusal of service form (PASRR 7) needs to be completed. A copy of this form must be kept in the individual's file and be available for review.

When the individual no longer wants or requires the services; is unable to participate, be actively involved, or derive the intended benefit, the CMHC must ensure the required processes are followed to discontinue specialized services in accordance with 907 KAR 1:755, 42 CFR 483.120 and 483.440 and related instructions on the DBHDID website.

Part IX: Community Options

9.1 Overview

An individual with an intellectual disability or related condition may meet nursing facility level of care and require specialized services but not require frequent direct care or continuous oversight by a nurse. An alternative setting in the community may be less restrictive and recommended, but the decision is with the individual and guardian. The individual has the option of being admitted to, or remaining in, the nursing facility and receiving specialized services, or choosing an alternative community placement. In consultation with the individual's family or legal representative, placement options and supports should be discussed. Full disclosure of all options is required.

9.2 Home and Community Based Waiver (HCB)

This waiver provides services and support to the aged and disabled population to help them to remain in or return to their homes. These services include: Assessment, Re-assessment, Case Management, Minor Home Adaptation, Adult Day Health Care, Homemaker, Personal Care, Attendant Care, and Respite Care.

9.3 Michelle P. Waiver (MPW)

This waiver is a home and community-based waiver program developed as an alternative to institutional care for people with intellectual or developmental disabilities. The waiver allows individuals to remain in their homes with services and supports. These services include: Case Management, Adult Day Training, Supported Employment, Community Living Supports, Behavior Supports, Respite, Homemaker Service, Personal Care, Attendant Care, Environmental/Minor Home Adaptation, and Adult Day Health Care.

9.4 Supports for Community Living (SCL)

This waiver is a home and community-based waiver providing an alternative to institutional care for individuals with intellectual and developmental disabilities. SCL allows individuals to remain in or return to the community in the least restrictive setting. Services include: Residential Support Services, Respite, Shared Living, Adult Day Health Care, Case Management, Community Access Services, Community Guide Services, Community Transition Services, Consultative Clinical and Therapeutic Service, Day Training, Environmental Accessibility, Adaptation Services, Goods and Services, Natural Supports Training, Person-Centered Coaching, Personal Assistance Services, Positive Behavior Supports, Specialized Medical Equipment and Supplies, Supported Employment, Transportation Services, Vehicle Adaptation Services

9.5 Acquired Brain Injury (ABI) or Acquired Brain Injury Long Term Care (ABI LTC)

ABI - This waiver program provides intensive services and support to adults with acquired brain injuries working to re-enter community life. Services are provided exclusively in community settings. These services include: case management, personal care, companion services, respite care, environmental modifications, behavior programming, counseling and training, structured day program, specialized medical equipment and supplies, prevocational services, supported employment, and community residential services (excluding room and board).

ABI LTC - This waiver program provides an alternative to institutional care for individuals who have reached a plateau in their rehabilitation and require maintenance services to live safely in the community and avoid institutionalization. These services include: Case Management, Community Living Supports, Respite Care, Adult Day Health Care, Adult Day Training, Environmental Modifications, Behavior Programming, Counseling, Group Counseling, Specialized Medical Equipment and Supplies, Supported Employment, Nursing Supports, Family Training, Assessment and Reassessment, and Supervised Residential Care.

9.6 Model II Waiver (MIIW)

This waiver is a community-based, in-home service for an individual who is dependent on a ventilator 12 hours or greater per day, meets High Intensity nursing care services 24 hours per day and would otherwise require nursing facility level of care in a hospital-based nursing facility. An individual enrolled in MIIW may receive up to 16 hours of Private Duty Nursing (PDN) services per day from a registered nurse, licensed practical nurse or respiratory therapist as determined by assessment, individual ventilator dependency needs and provider staffing.

Part X: Determinations

10.1 Response to Referral

When an evaluation is stopped or discontinued for any reason, the evaluator completes a response to referral form (PASRR 4) and notes the reason. The response to referral form notifies the referring facility that the individual does not meet criteria to complete the Level II evaluation. This may occur when the evaluator determines that the person meets an exception, such as a primary diagnosis of Alzheimer's disease or dementia; or the individual does not meet criteria for a MI, ID, or RC diagnosis. Response to referral shall also be completed for significant change referrals for Level II evaluation when the change is determined to not affect LOC or need for specialized services.

NOTE: When a Level I screening is negative, no response to referral should be completed. Level I's received that don't meet criteria to be referred for a Level II evaluation should be returned to the nursing facility and technical assistance provided. All Level I screenings that do not indicate a referral for a Level II evaluation shall be sent by the NF to the PRO for LOC determination.

10.2 Verbal Determination – for Mental Illness Only

The CMHC evaluator may verbally communicate the MI PASRR determination to the nursing facility within five (5) business days of the evaluation. The evaluator will give the verbal determination form (PASRR 3) to the NF. The written determination is still completed within nine (9) business days of the referral.

10.3 SMI Determinations

Based on the review of records, interviews and comprehensive Level II evaluation, the CMHC PASRR evaluator will make the determinations of appropriate placement and recommended services when an individual with a serious mental illness is seeking nursing facility placement.

The CMHC will then notify the nursing facility and the individual and legal representative (as applicable) of the final determination by sending the completed evaluation along with the appropriate letter explaining the findings and appeal process. A letter is also sent to the discharging hospital and attending physician. In addition, the NF is sent the Notification of Recommended Services (PASRR 5).

The CMHC must notify the applicant and their legal representative (as applicable) within two (2) business days of the determination. Any adverse determination letter must be sent by certified mail with the receipt being maintained in the CMHC PASRR record.

10.4 ID/RC Determinations

Without exception, any applicant for admission to a nursing facility who has an intellectual disability/related condition that is determined to not require NF level of care (per 907 KAR 1:022), regardless of whether specialized services are also needed, are inappropriate for nursing facility placement and must not be admitted.

Based on the review of records, interviews, and comprehensive Level II evaluation, all ID/RC individuals that meet criteria must have their completed evaluation and records **faxed to DBHDID at 502-564-2284** for review by the department PASRR committee. The committee makes a determination and sends a determination letter to the PASRR Coordinator at the CMHC.

The CMHC will then notify the nursing facility and the individual/legal representative of the final determination by sending the completed evaluation along with the appropriate letter explaining the findings and appeal process. A letter is also sent to the discharging hospital and attending physician. In addition, the NF is sent the Notification of Recommended Services (PASRR 5).

The CMHC must notify the applicant and/or their legal representative within two (2) business days of the determination. Any adverse determination letter must be sent by certified mail with the receipt being maintained in the CMHC PASRR record.

10.5 Subsequent Review Determinations

The determination process due to a subsequent review will follow the same steps outlined above in the applicable category. However, for ID/RC, if the CMHC and DBHDID determine the resident no longer meets nursing facility level of care, the CMHC works with the facility to arrange for a safe and orderly discharge of the resident, and prepares and orients the resident for discharge. The CMHC can further assist the individual with obtaining the services that can facilitate a transition to life in the community.

An individual may continue to meet nursing facility level of care and require specialized services but not require frequent direct care or continuous oversight by a nurse. An alternative setting in the community may be less restrictive and recommended, but the decision is with the individual and guardian. The individual has the option of remaining in the nursing facility and receiving specialized services, or choosing an alternative community placement. In consultation with the individual and their family or legal representative, placement options and supports should be discussed. Full disclosure of all options is required.

10.6 Thirty (30) Month Option

Individuals who have been in a nursing facility for thirty (30) months or longer, and require and utilize specialized services will have the option of remaining in the facility or seek community placements when it is determined they no longer meet nursing facility level of care.

To determine length of stay, the evaluator should calculate back to the date the individual first met nursing facility level of care. Temporary absences to the hospital, therapeutic leave, or home visits will be included in determining a continuous stay. When an individual who qualified for the 30 month option and chooses to remain in the facility, may continue that placement unless it is later determined they also no longer require specialized services.

Note: Any NF resident who meets the thirty (30) month option must have a placement option form (PASRR 6) completed. The placement option form should be given to the NF and DBHDID. A copy should also be maintained in the CMHC PASRR record.

10.7 Appeals 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. An individual who is determined not to require NF services or specialized services as a result of a PASRR determination by DBHDID may appeal the denial in accordance with 907 KAR 1:563.

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

1. The CMHC must notify the applicant/resident and his/her legal representative as applicable 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 CMHC 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.
3. 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:

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

Part XI: Records

11.1 Record Keeping for Response to Referrals

The file/folder/record of individual who have had a referral for a PASRR evaluation should include all required documents and supporting information, and be available to DBHDID when requested. The PASRR regulations for retention is 5 years (check your center's policy). Each record should contain the following if applicable:

- The Level I (MAP 409) or significant change form (MAP 4095);
- The hospital exempt (MAP 4092) or provisional admission form (MAP 4093);
- Any part of the Level II evaluation that was completed;
- History and physical;
- Psychological evaluations and/or supporting documents such as school records, MAP 351, etc.;
- Billing validation information;
- Documentation to support the decision including notes;
- All completed MAP and PASRR forms and verifications;
- Response to referral form (PASRR 4).

11.2 Record Keeping for Full Evaluations

The file/folder/record of individuals who have had a PASRR evaluation should include all required documents and supporting information, and be available to DBHDID when requested. The PASRR regulations for retention is 5 years (check your center's policy). Each record should contain the following if applicable:

- The Level I (MAP 409) or significant change form (MAP 4095);
- The hospital exempt (MAP 4092) or provisional admission form (MAP 4093);
- The Level II evaluation;
- History and physical;
- Psychological evaluations and/or supporting documents such as school records, MAP 351, etc.;
- Billing validation information;
- Documentation of services provided;
- DDID letter of determination;
- Recommended services form (PASRR 5);
- Letters sent to the individual, family/guardian, NF, and doctor;
- All completed MAP and PASRR forms and verifications;
- Receipt of certification for sent adverse determination letters.

11.3 Record Keeping for an Ongoing PASRR Client

The file/folder/record of individual who have had a PASRR evaluation should include all required documents and supporting information, and be available to DBHDID when requested. The PASRR regulations for retention is 5 years (check your center's policy) from the date of transfer/discharge/death.

In addition to the records required for anyone who received an evaluation, each record should also contain the following:

- Initial and annual plan of care;
- Initial and annual psychosocial assessment;
- At a minimum monthly case management notes that document progress toward goals;
- At a minimum monthly specialized service notes.

Part XII: Forms

12.1 PASRR Forms

PASRR Level II - Comprehensive Evaluation
The PASRR Level II evaluation is designed to capture pertinent, in-depth information and needs assessments for individuals with a serious mental illness, an intellectual disabilities and/or related conditions. Using person centered processes, the evaluators determines if the individual meets nursing facility level of care, and if the individual is in need of specialized services and/or services of lesser intensity. In addition, evaluators make recommendations to address things that are important to and important for the individual.

Verbal Determination Form (PASRR 3)
This form may be used for MI evaluations only to communicate the MI PASRR determination to the PRO and nursing facility. The CMHC evaluator may verbally communicate the MI PASRR determination within five (5) Working days of the evaluation; the evaluator will then fax the verbal determination form. The written determination is still due within nine (9) business days of the referral.

Response to Referral Form (PASRR 4)
Response to referral is used when the evaluation is stopped or discontinued for any reason. It is used to inform the referral source that an individual does not meet criteria to complete the Level II evaluation. This may occur when the evaluator determines that the person meets an exception, such as a primary diagnosis Alzheimer's disease or dementia, or if the individual does not meet criteria for a MI, ID, or RC diagnosis. It is also completed for a significant change referrals for a Level II evaluation when the change does not affect LOC or need for specialized services.

Recommended Services (PASRR 5)
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.

Placement Option Form (PASRR 6)
This form is used for individuals who have been in the nursing facility for 30 months receiving specialized services but no longer meet nursing facility level of care. They have the choice of remaining in the facility or seeking other placements options.

Refusal of Services (PASRR 7)
This form is to be used when a client has a recommendation for specialized services but the client or guardian refuses the service.

Explanation of Billing (PASRR 8)
This form will be used to detail the times and activities required in units/cost to complete each evaluation as well as identifying which evaluations have exceeded one thousand dollars ($1000.00) for a single diagnosis or one thousand five hundred dollars ($1500.00) for a dual diagnosis.

Non Compliance Log (PASRR 9)
This form is used to assist DMS in identifying untimely referrals and recoupment of funds. On the 10th 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 must be noted on the Log.

PASRR Computer Summary (PASRR 10)
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 ID/RC evaluations, do not submit the Computer Summary form to the Department until the letter of determination from the committee is received. The Department will use this form to generate program information for DMS reports.

12.2 Medicaid Forms (Completed by Nursing Facilities)

MAP 409 – Pre-Admission Screening and Resident Review (PASRR) LEVEL I
This form is completed by the nursing facility. Everyone seeking placement in a nursing facility (NF) participating in the Kentucky Medicaid Program must have a Level l screen prior to admission, regardless of payer source. This form is used to determine if an individual potentially has a SMI, an ID, or a RC. Information is collected from the individual, family, guardian, and available medical records.

MAP 4092 – Exempted Hospital Discharge Physician Certification of Need for NF Service
For persons who are admitted to any nursing facility directly from a hospital after receiving acute in-patient care at the hospital, and requires nursing facility care for the condition for which he/she received care in the hospital; and whose attending physician has certified before admission to the facility that the individual is likely to require less than thirty (30) calendar days of nursing facility care. This form is used to document this 30 day exemption from the PASRR process.

MAP 4093 – Provisional Admission to a Nursing Facility
Used when persons are admitted for a time-limited, provisional admissions for delirium or respite for a period of up to 14 days. This form is used to document this 14 day exemption from the PASRR process.

MAP 4094 – Notification of Intent to Refer For Level II PASRR
Notifies the person and/or family/guardian when the individual is being referred for a Level II evaluation for a first time identification of mental illness or intellectual disability/related condition.

MAP 4095 – PASRR Significant Change/Discharge Data
Used to indicate when a PASRR individual's mental or physical condition has changed in a manner that affects his/her need for specialized services, nursing facility level of care, or recommended services of lesser intensity. Also used to identify individuals who previously did not meet PASRR criteria but now may due to a newly diagnosed or newly discovered/confirmed PASRR condition; and to notify the CMHC of an individual's discharge or death.

Part XIII: Financial

13.1 Financial Overview

PASRR expenditures include not only face-to-face contact, but time spent in activities such as travel, record keeping, and collateral contacts. PASRR reimbursement is inclusive of all PASRR costs, however reimbursement for the cost of additional medical/specialty examinations will be provided as appropriate. All associated costs will be accumulated in a separate cost center when preparing the annual cost report.

CMHC PASRR staff are responsible for submitting to DBHDID accurate, complete and timely client, event and human resources data according to the DBHDID performance indicator implementation guide. Specific to the PASRR population, the CMHC will maintain accurate and complete data in all fields related to PASRR in

accordance with the service codes and service definitions in the event data set at: http://dbhdid.ky.gov/DBHDIDReports/CMHCDataGuide.aspx.

P&B and DPR reporting forms shall be submitted in accordance with P&B and DPR reporting schedules.

13.2 Department Periodic Report Form 145

Request for reimbursement shall be submitted quarterly to the BBHDID Division of Administration and Financial Management using Form 145.

PASRR Level II Evaluation Code 004
Unit of service: 15 minutes
A comprehensive Level II evaluation shall be conducted by a certified evaluator for individuals with a mental illness, intellectual disability, or related condition who are seeking admission to or a continued stay in a nursing facility (NF) participating in the Kentucky Medicaid Program, or who requires a subsequent review because of a significant change in condition. The evaluation shall determine: (a) whether the person needs nursing facility level of care and (b) if so, whether the person needs specialized services for mental illness or intellectual disabilities. Services shall be provided in accordance with applicable Kentucky Statute and Regulations.

All activities involved in the evaluation process, from the initial consultation when applicable, to providing final determination letters to the involved parties, are captured as billable units.

Response to Referral Code 006
Unit of service: 15 minutes
When a positive Level I screening is received, but the evaluation is stopped or discontinued without a determination, a response to referral shall be completed by the evaluator. The response to referral form notifies the referring facility that the individual does not meet criteria to complete the Level II evaluation. This may occur when the evaluator determines that the person meets an exception, such as a primary diagnosis Alzheimer's disease or dementia, or the individual does not meet criteria for a MI, ID, or RC diagnosis. Response to referral shall also be completed for significant change referrals for Level II evaluation when the change does not affect LOC or need for specialized services.

13.3 Department Periodic Report Form 140

Accurate reporting shall be submitted quarterly to the BBHDID Division of Administration and Financial Management using Form 140.

PASRR Specialized Services (ID/RC) Code 090
Unit of Service: 15 minutes
The continuous and consistent implementation of training and related services which are comparable to services received in an ICF/IID or in a community-based waiver program where 24-hour supervision is available and are directed toward skills acquisition, maintenance of functional status, and the implementation of specified goals and objectives as determined through a person-centered planning process. Services shall be provided in accordance with applicable Kentucky Statute and Regulations.

Case Management (ID/RC) Code 162
Unit of Service: 1 Month
Case management services for individuals receiving PASRR SS would mirror the expectation for the ID Case Management. Case Management includes a minimum of monthly on site face to face contact, and may include the initiation, coordination, implementation, and monitoring of the assessment, reassessment, evaluation,

intake, and eligibility processes; assisting a person in the identification, coordination, and arrangement of the person centered team; facilitating person centered team meetings that assist a person to develop, update, and monitor the Person Centered Service Plan (PCSP) which shall be designed to meet the needs of the participant; and promotes choice, community experiences, employment, and personal satisfaction. Person-Centered Planning involves assisting the recipient in creating an individualized plan for services, paid and unpaid, needed for maximum independence and integration into the community. The plan is directed by the recipient and shall include other practitioners of the recipient's choosing. Case management shall monitor all services through on site visits, review of records, and conversations with staff, recipient or family. Services shall be provided in accordance with applicable Kentucky Statute and Regulations.

PASRR Specialized Goods Purchased (ID/RC) Code 094
Unit of Service: 1 Purchase
Tangible items purchased for maintenance of functional status or for the implementation of specific goals or objectives, determined through person-centered planning process. Specialized goods shall be provided in accordance with applicable Kentucky Statute and Regulations.
Psychological Testing Code 020
Unit of Service: 15 Minutes
Psychological testing is used for diagnostic purposes to determine eligibility for available programs. Testing shall be provided by a licensed psychologist, licensed psychological practitioner, licensed psychological associate, certified psychologist with autonomous functioning, or certified school psychologist within their scope of practice. This includes psychological testing for the purpose of acquiring supporting documentation for PASRR specialized services.

Part XIV: Examples of Letters and Correspondence

14.1 Overview

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.

- All correspondence, including the example letters, if used, must be on the CMHC letterhead.
- Customize the letters to convey only information concerning the individual in question.
- Do not circle, underline, or fill in the blank to individualize the letter.
- The letters should be written with clear understandable language that leaves no question of the letters intent, available appeal processes, and contacts.
- Adverse determinations include appeal rights. Send adverse determinations by certified mail. File the receipt in the resident/applicant's PASRR chart in the PASRR office.
- If an adverse determination letter is going to an individual currently in a Medicaid waiver who does not have a guardian, the case manager should also receive a copy of the letter.

14.2 Example Letter for Individual/Family/Guardian

DATE

INDIVIDUAL'S NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

RE: INDIVIDUAL EVALUATED

Dear INDIVIDUAL:

Federal and state regulations (42 CFR 483.100 and 907 KAR 1:755) require a Preadmission Screening and Resident Review (PASRR) evaluation of each nursing facility applicant who has been identified as potentially meeting the criteria for a serious mental illness, an intellectual disability, or a related condition. The purpose of this evaluation is to determine if PASRR criteria is met; and if so, then to determine your need for nursing facility and specialized services.

Evaluations are completed by the Community Mental Health Centers through a contract with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) who administers the PASRR program for the Department for 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. Please note that your signature of the "Interpretation of Findings" form does not imply agreement with these findings.

Findings & Recommendations

Based on the information reviewed describing medical diagnosis, care needs, functional abilities, and the services and health personnel required to meet those needs, it has been determined that INDIVIDUAL :

- ☐ Does meet, or continues to meet, Nursing Facility Level of Care criteria noted in 907 KAR 1:022;
  AND
  - ☐ Requires specialized services for a serious mental illness, an intellectual disability or a related condition.
  - ☐ Does not require specialized services.

OR

- ☐ Does not meet, or no longer meets, Nursing Facility Level of Care criteria noted in 907 KAR 1:022.
- ☐ After 30 months of placement in the Nursing Facility, no longer meets Nursing Facility Level of care, and no longer is able to benefit from specialized services for an intellectual disability or related condition as described in 907 KAR 1:755.

If the level of care determination was "does not meet, or no longer meets", or if the specialized services determination was "does not require", then you have the right to an 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) days of the date of this letter and may be requested by you, your legal guardian, or other 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. Please preface your request for appeal by noting that denial or adverse determination was based upon PASRR findings or determination.

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 the nursing facility (if already admitted) until the final cabinet level hearing. You, a friend or relative, spokesperson or other authorized representative (including legal counsel) may represent you at the hearing.

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 ( ) ___ - ____ if you have any questions regarding the evaluation, findings, or process.

Sincerely,

EVALUATOR NAME
PASRR Evaluator
CMHC NAME

cc: Nursing Facility

14.3 Example Letter for Nursing Facility

DATE

MEDICAL/NURSING SERVICE/SOCIAL SERVICE DIRECTOR NAME
NURSING FACILITY NAME
NF ADDRESS
CITY, STATE, ZIP CODE

Re: CLIENT NAME

Federal and state regulations (42 CFR 483.100 and 907 KAR 1:755) require a Preadmission Screening Resident Review (PASRR) evaluation of each nursing facility applicant who has been identified (per preadmission screening) as meeting the criteria for a PASRR Level II evaluation. This evaluation is used to determine the presence of a serious mental illness, an intellectual disability or a related condition. The evaluation determines an individual's need for Nursing Facility level of care and identifies the need for specialized services, or services of lesser intensity.

The Department for Behavioral Health, Developmental and Intellectual Disabilities, who administers the PASRR program for the Department of Medicaid Services, has contracted the Community Mental Health Centers to use qualified professionals in the fields of Mental Health and Intellectual Disabilities to conduct the evaluations.

Based on the information reviewed describing medical diagnosis, care needs, functional abilities, and the services and health personnel required to meet those needs, it has been determined that INDIVIDUAL :

- ☐ Does meet, or continues to meet, Nursing Facility Level of Care criteria noted in 907 KAR 1:022;
  AND
  - ☐ Requires specialized services for a serious mental illness, an intellectual disability or a related condition.
  - ☐ Does not require specialized services.

OR

- ☐ Does not meet, or no longer meets, Nursing Facility Level of Care criteria noted in 907 KAR 1:022.
- ☐ After 30 months of placement in the Nursing Facility, no longer meets Nursing Facility Level of care, and no longer is able to benefit from specialized services for an intellectual disability or related condition as described in 907 KAR 1:755.

Sincerely,

EVALUATOR NAME
PASRR Evaluator
CMHC NAME

14.4 Example Letter for Hospital/Attending Physician

DATE

DOCTOR'S NAME
DISCHARGING HOSPITAL
STREET ADDRESS
CITY, STATE, ZIP CODE

RE: INDIVIDUAL

Dear Doctor NAME:

Federal and state regulations (42 CFR 483.100 and 907 KAR 1:755) require a Preadmission Screening Resident Review (PASRR) evaluation of each nursing facility applicant who has been identified (per preadmission screening) as meeting the criteria for a PASRR Level II evaluation. This evaluation is used to determine the presence of a serious mental illness, an intellectual disability or a related condition. The evaluation determines an individual's need for Nursing Facility level of care and identifies the need for specialized services, or services of lesser intensity.

The Department for Behavioral Health, Developmental and Intellectual Disabilities, who administers the PASRR program for the Department of Medicaid Services, has contracted the Community Mental Health Centers to use qualified professionals in the fields of Mental Health and Intellectual Disabilities to conduct the evaluations.

Based on the information reviewed describing medical diagnosis, care needs, functional abilities, and the services and health personnel required to meet those needs, it has been determined that INDIVIDUAL :

- ☐ Does meet, or continues to meet, Nursing Facility Level of Care criteria noted in 907 KAR 1:022;
  AND
  - ☐ Requires specialized services for a serious mental illness, an intellectual disability or a related condition.
  - ☐ Does not require specialized services.

OR

- ☐ Does not meet, or no longer meets, Nursing Facility Level of Care criteria noted in 907 KAR 1:022.
- ☐ After 30 months of placement in the Nursing Facility, no longer meets Nursing Facility Level of care, and no longer is able to benefit from specialized services for an intellectual disability or related condition as described in 907 KAR 1:755.

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

Sincerely,

EVALUATOR NAME
PASRR Evaluator
CMHC NAME

cc: Nursing Facility