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GOVERNOR

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SECRETARY

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Dear Medicaid Provider:

This letter is to inform you that the revised Pre-Admission Screening and Resident Review Level I Screen and Determination form (AHCA MedServ Form 004, Part A), and the Level II Request for Evaluation and Determination or Resident Review form (AHCA MedServ Form 004, Part B) are now available on the Department of Elder Affairs (DOEA) website. Both forms are also attached to this letter. Go to <http://elderaffairs.state.fl.us>; select DOEA Programs and Services; select CARES; select Pre-Admission Screening and Resident Review (PASRR). The PASRR forms are in form-fillable pdf files that can be saved. PASRR forms cannot be electronically transmitted to DOEA at this time.

There has been no change in the PASRR process itself. The new PASRR forms have been modified to make it easier to complete the Level I screening in an accurate manner and to clarify which documents must be submitted with a Level II evaluation or resident review request. Updated PASRR training materials are available on the DOEA website, including a recorded training presentation.

A nursing facility is only eligible for Medicaid reimbursement after the PASRR process has determined an individual appropriate for the nursing home setting [42 CFR 483.122(b)]. A Medicaid-certified nursing facility may not admit an applicant with serious mental illness (MI), mental retardation (MR), or a related condition, unless the individual is properly screened, thoroughly evaluated, found to be appropriate for nursing facility placement, and will receive all specialized services necessary to meet the individual's unique MI/MR needs [Section 1919(e)(7) of the Social Security Act and Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138]. Nursing facility residents with MI or MR must have a Resident Review when there is a significant change in their physical or mental condition.

To ensure pre-admission screening is conducted prior to nursing home admission, hospitals complete the PASRR screening as part of their discharge planning. Nursing facilities are required to complete resident reviews and to coordinate PASRR screenings prior to admission from community settings.



Please contact your local CARES office if you have any questions about the PASRR process or the new PASRR forms. Contact information for your local CARES office is available on the DOEA website: <http://elderaffairs.state.fl.us>. Select CARES and then CARES Directory.

We appreciate your continued support of the Florida Medicaid program.

Sincerely,

A handwritten signature in black ink, appearing to read "Beth Kidder". The signature is fluid and cursive, with a large initial "B" and "K".

Beth Kidder  
Chief, Bureau of Medicaid Services

BK/sr  
Enclosures



# Level I Pre-Admission Screen and Resident Review (PASRR) Screen and Determination

The Level I PASRR Screen and Determination is a 3 page form and answers to the applicable questions in Sections I-VI are mandatory. This screen is to be completed prior to admission to a nursing facility (NF). Failure to complete this form accurately may result in disallowance of Medicaid payment.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Is this the applicant's first admission to any NF?  Yes  No  Unknown

Admitting diagnosis to NF: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Others: \_\_\_\_\_

## **SECTION I: GUIDE FOR DETERMINING AN INDICATION OF, OR A DIAGNOSIS OF, A SERIOUS MENTAL ILLNESS (MI), MENTAL RETARDATION (MR), OR RELATED CONDITION**

**Indicators of MI/MR may be found on medical information including, but not limited to the Medical Certification for Nursing Facility/Home- and Community-Based Services Form AHCA MedServ-3008, DOEA Assessment Instrument (701B), CMAT Assessment or any other medical information provided. The review and answering of questions in this section will help determine whether the individual has an indication of, or a diagnosis of, a serious mental illness and/or mental retardation or related condition.**

If any item in 1A or 1B is checked **and** any item in numbers 2, 3, or 4 in the guide below is checked **Yes**, then the individual is suspected to have an indication of, or a diagnosis of, a serious mental illness or mental retardation, or related condition. Part A and/or Part B in Section II below must also be checked **Yes**.

1A. Is there an indication the individual has a diagnosis of (check those that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Severe Anxiety/Panic Disorder                     | <input type="checkbox"/> Bipolar Disorder  |
| <input type="checkbox"/> Schizoaffective Disorder                          | <input type="checkbox"/> Major Depression  |
| <input type="checkbox"/> Psychotic Disorder                                | <input type="checkbox"/> Somatoform Disorder   |
| <input type="checkbox"/> Dysthymia   | <input type="checkbox"/> Cyclothymia   |
| <input type="checkbox"/> Schizophrenia                                     | <input type="checkbox"/> Personality Disorder (specify) _____                        |
| <input type="checkbox"/> Prader-Willi Syndrome                             | <input type="checkbox"/> Spina Bifida  |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Cerebral Palsy  |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Mental Retardation with an IQ lower than 70 (specify) _____ |
| <input type="checkbox"/> Childhood and Adolescent Disorder (specify) _____ |  |

1B. Is there an indication the individual has:

- Serious mental illness
- Mental retardation or related condition

2. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage?  Yes  No

3. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.  Yes  No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.  Yes  No

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.  Yes  No

4. Does the Level I Screen indicate the individual has received recent treatment for a mental illness? Does the treatment history indicate that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization).  Yes  No

B. Within the last two years, due to the mental illness, 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.  Yes  No

Once Section I is completed, continue to Section II: MI/MR of the Level I PASRR Screen and Determination (below).

**SECTION II: MI/MR**

**Part A - Mental Illness**

Does the individual have indications of, or a diagnosis of, a serious mental illness as defined in the DSM-IV R, limited to schizophrenia, mood disorder, severe anxiety disorder, or a mental illness that may lead to a chronic disability? **The screener must answer all questions on the guide in Section I (see page 1) to determine a serious mental illness.**

Yes  No

**Part B - Mental Retardation**

Does the individual have indications of, or a diagnosis of, mental retardation as defined in the AAMR Manual on Classification in Mental Retardation or other related conditions such as cerebral palsy, epilepsy, or any other conditions, including autistic disorders, that are closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior (42 CFR 435.1010) which manifested prior to the age of 22? **The screener must answer all questions on the guide in Section I (see page 1) to determine mental retardation or related condition.**

Yes  No

If both answers are **No**, **STOP!** Level I Screener can sign and date Level I Screen.

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

If any answer in Section II, Part A or Part B is **Yes**, proceed to Section III.

**SECTION III: CATEGORICAL DETERMINATION OF DEMENTIA/RELATED DISORDER**

Does the individual have a primary diagnosis of dementia (including Alzheimer's Disease or a related condition) or a non-primary diagnosis of dementia with a primary diagnosis that is not a serious mental illness?  Yes  No

If **Mental Illness only** and answer is **Yes**, **STOP!** Level I Screener can sign and date Level I Screen.

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

If **Mental Illness only** and answer is **No**, proceed to Section IV.

If **Mental Illness and Mental Retardation or Mental Retardation only**, proceed to next question.

Does the individual have a dementia diagnosis that exists in combination with mental retardation or a related condition (i.e. Epilepsy, Cerebral Palsy, Prader-Willi Syndrome, Autism, Spina Bifida)?

Yes  No

If **Mental Retardation only** and answer is **Yes**, **STOP!** This individual can be admitted or retained in a NF. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen.

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

If **Mental Retardation only** and answer is **No**, proceed to Section IV.

If **Mental Illness and Mental Retardation** and any answer is **No**, proceed to Section IV.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### SECTION IV: EXEMPTED HOSPITAL DISCHARGE

Is the individual being admitted from a hospital after receiving acute inpatient care and requires NF services for the condition for which he or she received care in the hospital and whose attending physician has certified before admission that the individual is likely to require less than 30 days NF services?  Yes  No

If **Yes, STOP!** This individual can be admitted to a NF. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen. **If the individual is later found to require more than 30 days of NF care, a resident review must be conducted within 40 calendar days of admission.**

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

If **No**, proceed to Section V.

### SECTION V: ADVANCE GROUP DETERMINATIONS

A provisional admission to a nursing facility can be made under the following time limited categories.

1. Pending further assessment of delirium where an accurate diagnosis cannot be made until the delirium clears, **not to exceed seven days.**  Yes  No
2. Pending further assessment in emergency situations requiring protective services, with placement in a nursing facility, **not to exceed seven days.**  Yes  No
3. Brief respite care for in-home caregivers, with placement in a nursing facility twice a year **not to exceed 14 days.**  Yes  No

If any answer is **Yes, STOP!** This individual can be admitted to a NF. Level I screener can sign and date Level I Screen. **If the individual is later determined to need a longer stay, identified through a resident review, a Level II Evaluation and Determination must be conducted before continuation of the stay may be permitted and payment made for days of NF care beyond the State's time limit.**

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

If all answers in Section V are **No**, proceed to Section VI.

### SECTION VI: INDIVIDUALIZED EVALUATION DETERMINATION

A Level II Evaluation is required for individuals with MI or MR who meet one of the following advanced group determinations of the need for NF services (questions 1-3), or for those who do not meet one of the categorical or advanced group determinations in Sections III, IV, or V. The Level II Evaluation and Determination must be received prior to NF admission.

1. Does the individual require convalescent care from an acute physical illness that required hospitalization and does not meet all the criteria for an exempt hospital discharge?  Yes  No
2. Does the individual have a terminal illness as defined for hospice purposes (**life expectancy six months or less**)?  Yes  No
3. Does the individual have a severe physical illness such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Congestive Heart Failure, which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services?  Yes  No

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Typed or Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Date of Mental Health Evaluation, if applicable: \_\_\_\_\_

Date referred for Level II, if applicable: \_\_\_\_\_

Level II Agency: \_\_\_\_\_



# Request for Level II PASRR Evaluation and Determination or Resident Review

## Section I: Request Information

Date: \_\_\_\_\_ Request for:  Initial Level II Evaluation and Determination or  Resident Review

From: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

To: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

An indication of, or a diagnosis of, a serious mental illness or mental retardation or related condition was identified on the Level I Pre-Admission Screen and Resident Review (PASRR) Screen or the Minimum Data Set revealed a significant change in the resident's mental or physical condition. The Level II Evaluation and Determination should be completed within 7 to 9 days and returned to Comprehensive Assessment and Review for Long-Term Care Services (CARES) or Children's Multidisciplinary Assessment Team (CMAT). The Resident Review should be completed within 7 to 9 days and returned to the Nursing Facility and CARES. The Level II Reviewer should notify the individual or legal guardian of the right to appeal the Level II PASRR Determination.

## Section II: Individual Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Location: \_\_\_\_\_

MI/MR Indicator:  MI (Serious Mental Illness)  MR (Mental Retardation)  Both (MI and MR)

## Section III: Required Documents for Level II PASRR Evaluation and Determination or Resident Review (Check box for all documents that are attached)

For Initial Level II for CARES/CMAT:	For Resident Review for Nursing Facility:
<input type="checkbox"/> Level I PASRR Screen (AHCA MedServ Form 004, Part A)	<input type="checkbox"/> Level I PASRR Screen (AHCA MedServ Form 004, Part A)
<input type="checkbox"/> Informed Consent Form ( AHCA MedServ 2040, May 2008)	<input type="checkbox"/> Relevant Case Notes/Records of Treatment and/or Evaluations (including psychiatric)/ Medication Administration Record (MAR)
<input type="checkbox"/> Notice of Privacy Practices (DOEA HIPAA Form)	<input type="checkbox"/> Minimum Data Set (MDS)
<input type="checkbox"/> Medical Certification for Nursing Facility/Home and Community Based Services Form (AHCA MedServ-3008 form)	
<input type="checkbox"/> Other Medical Documentation Including Relevant Case Notes or Records of Treatment/Medication Administration Record (MAR)	
<input type="checkbox"/> Psychiatric Evaluation Forms (DOEA-MH Form 1911-A, Aug 01, and DOEA-MH Form 1911-B, Aug 01)	
<input type="checkbox"/> DOEA Assessment Instrument (DOEA Form 701B, September 2008)	
<input type="checkbox"/> CMAT Assessment	

## Section IV: Level II Reviewer

Date of Level II Determination: \_\_\_\_\_

Disposition:

- Does the individual meet the State definition for mental illness or mental retardation or a related condition?  Yes  No
- Are Specialized Services needed?  Yes  No
- If yes, can these Specialized Services be provided in a nursing facility?  Yes  No
- Can Specialized Services be provided in the community?  Yes  No
- If not, is nursing facility placement appropriate?  Yes  No
- If Specialized Services are needed, attach the care plan of services that are required.
- If Specialized Services are not needed, attach other service recommendations required to meet identified needs.

Date of Distribution of Level II Evaluation and Determination to: \_\_\_\_\_

- Individual  Nursing Facility  Other: \_\_\_\_\_
- Legal Guardian  CARES  Primary Care Physician  CMAT

Signature: \_\_\_\_\_ Title: \_\_\_\_\_