March 23, 2007

Dear Medicaid Provider:

This letter is to inform you of recent changes to Florida’s Pre-Admission Screening and Resident Review (PASRR) process. Section 1919(e)(7) of the Social Security Act and Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138 specify the requirements for mental illness and mental retardation pre-admission screening of all individuals before they enter a nursing home, regardless of payment source. Federal regulations require that PASRR screenings take place prior to admission in order for a state to receive federal financial participation for Medicaid reimbursement of nursing home care.

Enclosed are the revised forms recently approved for use in Florida by the Centers for Medicare and Medicaid Services: Level I PASRR Screen and Level II PASRR Evaluation and Determination. To ensure pre-admission screening is conducted prior to nursing home admission, it will be necessary for hospitals to initiate completion of the PASRR screening as part of their discharge planning process. PASRR screening for nursing home admissions from other community settings will continue to be coordinated by nursing home staff.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff from the Department of Elder Affairs (DOEA) will contact you in the near future about upcoming training sessions on the revised PASRR process and forms. CARES will be coordinating these training sessions with the appropriate agencies that participate in the PASRR process. If you have any questions, the enclosed chart provides local contact information for these agencies.

We appreciate your continued support of the Florida Medicaid Program.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid

TWA/sr
Enclosures
FLORIDA’S PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) PROCESS

CONTACT INFORMATION

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<th>LEVEL I SCREENING</th>
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<tr>
<td><strong>ADULTS</strong>&lt;br&gt;Age: 21 years &amp; older</td>
<td>For information on Level I screening process for individuals age 21 and older, please contact your local Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff from the Department of Elder Affairs (DOEA).&lt;br&gt;A list of local CARES staff and their contact information can be found at: <a href="http://elderaffairs.state.fl.us/english/cares.html">http://elderaffairs.state.fl.us/english/cares.html</a>.</td>
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<tr>
<td><strong>CHILDREN</strong>&lt;br&gt;Age: 20 years &amp; under</td>
<td>For information on the Level I screening process for individuals under the age of 21, please contact your regional Children’s Multidisciplinary Assessment Team (CMAT) staff for assistance.&lt;br&gt;A listing of regional CMAT staff and their contact information can be found at <a href="http://www.cms-kids.com/CMSNcmat.htm">http://www.cms-kids.com/CMSNcmat.htm</a>.</td>
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<th>LEVEL II EVALUATION</th>
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<td><strong>MENTAL ILLNESS</strong>&lt;br&gt;Ages: all</td>
<td>Questions concerning individuals with mental illness should be directed to the Department of Children and Families (DCF) Substance Abuse and Mental Health Program (SAMH).&lt;br&gt;A listing of local SAMH staff and their contact information can be found at: <a href="http://www.dcf.state.fl.us/mentalhealth/contacts.shtml">http://www.dcf.state.fl.us/mentalhealth/contacts.shtml</a>.</td>
</tr>
<tr>
<td><strong>CHILDREN</strong>&lt;br&gt;Age: birth to 36 months</td>
<td>Questions concerning children birth to age three should be directed to Early Steps, Children’s Medical Services (CMS).&lt;br&gt;A listing of local Early Steps staff and their contact information can be found at <a href="http://www.cms-kids.com/ContactUs/EIPdir.pdf">http://www.cms-kids.com/ContactUs/EIPdir.pdf</a>.</td>
</tr>
<tr>
<td><strong>DEVELOPMENTAL DISABILITIES</strong>&lt;br&gt;Age: 3 years and older</td>
<td>Questions concerning individuals with developmental disabilities age three years and older should be directed to the Agency for Persons with Disabilities (APD).&lt;br&gt;A listing of local APD staff and their contact information can be found at: <a href="http://apd.myflorida.com/about/contact.htm">http://apd.myflorida.com/about/contact.htm</a>.</td>
</tr>
<tr>
<td>Medicaid Area Offices</td>
<td>Local Medicaid Area Offices and their contact information can be found at: <a href="http://ahca.myflorida.com/Medicaid/Areas/index.shtml">http://ahca.myflorida.com/Medicaid/Areas/index.shtml</a>.</td>
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Level I PASRR Screen

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

Date of admission: ___________________________________________________________________________________________________

Admitting diagnosis:
Primary: _____________________________________________________________________________________________________________
Secondary: ___________________________________________________________________________________________________________
Others: _______________________________________________________________________________________________________________

SECTION I: DANGER

Is the individual a danger to self and/or others? _____Yes _____No

If Yes, this individual cannot be admitted or retained in a NF pursuant to federal regulations. Appropriate treatment and placement must be sought. Upon stabilization, the case can be reviewed. Documentation must be secured from the attending physician or psychiatrist that indicates the individual is no longer a danger to self and/or others.

If No, proceed to Section II.

SECTION II: 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 major mental illness? _____Yes _____No

If Yes, this individual can be admitted or retained in a NF pursuant to federal regulations. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen.

If No, proceed to next question.

Does the individual have a dementia that exists in combination with MR or a related condition? _____Yes _____No

If Yes, this individual can be admitted or retained in a NF pursuant to federal regulations. A Level II Evaluation is not needed. Level I screener can sign and date Level I Screen.

If No, proceed to Section III.

SECTION III: MI/MR

*Look for indicators of MI/MR on the Patient Transfer and Continuity of Care Form (3008), DOEA Assessment Instrument (701B), CMAT Assessment and any other medical information provided.

Part A - Mental Illness

Does the individual have a diagnosis of a major 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? _____Yes _____No

*Questions on the back of this page will assist in making a determination as to whether the individual has a diagnosis or possible diagnosis of mental illness.

Part B - Mental Retardation

Does the individual have 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 435.1009) which manifested prior to the age of 22? _____Yes _____No

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

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

AHCA-Med Serv Form 004, Part A, November 2006
Part C - Individualized Evaluations

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. 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

Proceed to Section IV.

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, this individual can be admitted to a NF pursuant to federal regulations. 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.

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, this individual can be admitted to a NF pursuant to federal regulations. 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.

If all answers in Section V are No, a Level II Evaluation is needed. The Level II Evaluation and Determination must be received prior to NF admission.

SECTION VI: Level I Screener

Signature: ___________________________________________  Date Completed: ________________________

Title: __________________________________________________

Agency: _________________________________________________

Date of Mental Health Evaluation, if applicable: ______________

Date referred for Level II, if applicable: _________________________

Level II Agency: ___________________________________________
Guide for Determining a Diagnosis or Possible Diagnosis of a Serious Mental Illness, Mental Retardation, or a Related Condition

Does the Level I Screen indicate Alzheimer's Disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in the DSM-IVR?  ____Yes  ____No

Does the Level I Screen indicate the individual has a diagnosis or indication of (check those that apply):

- Severe Anxiety/Panic Disorder____
- Bipolar Disorder____
- Schizoaffective Disorder____
- Major Depression____
- Psychotic Disorder____
- Somatoform Disorder____
- Dysthymia____
- Cyclothymia____
- Schizophrenia____
- Personality Disorder (specify)_______________________
- Prader-Willi Syndrome____
- Spina Bifida____
- Autism __________
- Cerebral Palsy________
- Epilepsy________
- Mental Retardation with an IQ lower than 70 ________
- Childhood and Adolescent Disorder (specify)_______________________
- Other______________________________

Does the Level I Screen indicate that this 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

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

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

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
PREADMISSION SCREEN AND RESIDENT REVIEW (PASRR)
REQUEST FOR LEVEL II PASRR EVALUATION AND DETERMINATION

Section I: Request Information

Date: _______________________________
From: ______________________________ Agency: ____________ Phone: ___________________
To: ________________________________ Agency: ____________ Phone: ___________________

This request for a Level II PASRR Evaluation and Determination is being made based on the Level I PASRR Screen, which shows a diagnosis or possible diagnosis of a major mental illness or mental retardation with no categorical or advanced group determination being met. The Level II Evaluation and Determination should be completed within 7 to 9 days and returned to CARES or CMAT. 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 (Mental Illness)       ____ MR (Mental Retardation)        ____ Both (MI and MR)

Section III: Attachments

Check documents that are attached to this request:

_____ Level I PASRR Screen
_____ Comprehensive Assessment (701B)
_____ Patient Transfer / Continuity of Care (3008)
_____ Psychiatric Evaluation (1911A and B)
_____ Informed Consent (2040)
_____ HIPAA Form
_____ Other medical documentation
_____ Relevant case notes/records of treatment
_____ CMAT Assessment

Section IV: Level II Reviewer

Signature: _________________________________________ Title: ___________________________
Date of Level II Determination: _________________________

Disposition:
1. Are Specialized Services needed?     ____Yes  ____No
2. If yes, can these Specialized Services be provided in a nursing facility? ____Yes  ____No
3. If Specialized Services are needed, attach the care plan of services that are required.
4. 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

AHCA-Med Serv Form 004, Part B, November 2006