



PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES

State Form 45277 (R2 / 7-02) / Form 450B/PASRR2A - Sections IV and V, Part A

This form is **CONFIDENTIAL** according to IC12-15-2 *et seq.*, IC 12-10-10 *et seq.*, IC 12-21 and 470 IAC 1-3-1.

This form **MUST** be completed for **ALL** persons prior to nursing facility admission in accordance with 42 CFR 483.106. All of the following questions must be answered as indicated.

Name of applicant / resident	Name of facility / city
Current location of applicant <input type="checkbox"/> Residential <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Psychiatric bed <input type="checkbox"/> Acute hospital <input type="checkbox"/> Other:	
Please check any of the following that applies to the applicant / resident:	
<input type="checkbox"/> New admission <input type="checkbox"/> Readmission to NF from psychiatric hospital stay <input type="checkbox"/> Transfer between NF's <input type="checkbox"/> Out-of-state resident <input type="checkbox"/> Transfer from residential to NF <input type="checkbox"/> Other: _____	

SECTION IV

1. Does the individual have a documentable diagnosis of senile or presenile dementia (<i>including Alzheimer's Disease or related disorder</i>) based on criteria in DSM-IV, without a concurrent primary diagnosis of a major mental illness or a diagnosis of mental retardation or developmental disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does the individual have a diagnosis of major mental illness [<i>limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability</i>]?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. a. Does the person have a diagnosis of mental illness not listed above? List diagnosis: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Has the individual been prescribed (<i>within the past 1 year</i>) a major tranquilizer or psychoactive drug on a regular basis for a mental health condition? (<i>If given for another purpose, explain by listing the name of the drug and the purpose of the prescription; for example, Mellaril for dementia. When explained and documented in the individual's medical record, check "No".</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
* A Yes answer to 3a and / or 3b DOES NOT ALONE trigger a Level II.		
4. Has the person had any recent (<i>within the last two years</i>) history of in patient / partial hospitalization care? Explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the individual have a diagnosis of mental retardation, developmental disability (<i>MR / DD</i>) or other related condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is there any history of a MR / DD or related condition in the individual's past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is there any presenting evidence (<i>cognitive or behavior characteristics</i>) that may indicate the person has MR / DD or related condition? (<i>Explain</i>) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of authorized assessor	Title / Position	Date signed

SECTION V - PART A

PASRR Determination Criteria - Level II Exemption: See back of form for explanation. (*Exemption MUST be certified by a physician's signature.*)

NOTE: Exemption applies only to initial nursing facility admission, not to RR or transfers.

EXEMPTED HOSPITAL DISCHARGE: An individual may be admitted to a nursing facility directly from a hospital after receiving acute inpatient care (*non-psychiatric*) at the hospital if: (1) the individual requires nursing facility services for the condition for which he/she received care in the hospital; and (2) the attending physician certifies before the admission that the individual is likely to require less than 30 days nursing facility care.

In accordance with the requirements above, I certify that this individual requires less than 30 days of care in a nursing facility.

Signature of physician	Printed name of physician	Date signed
If applicable, hospital or other affiliation:	City	

NOTE: If the individual requires care beyond the initial 30 day period, the nursing facility must notify the PAS agency prior to the expiration of 30 days and provide a written explanation of the reason continued residence is required and the anticipated length of stay. Admission under the above exemption does not exempt the nursing facility from providing services to an individual who has mental health or MR/DD or related needs and would benefit from services. Refer to II B on back for complete instructions

CERTIFICATION OF LEVEL II REFERRAL

PASRR LEVEL II ASSESSMENT REFERRAL NEEDED		
Signature of PAS agency representative	PAS: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Title / Position	Date signed

INSTRUCTIONS

I. SECTION IV: PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA

Answer all questions as indicated.

- A. "No" answer to all questions, stop here and return to local PAS agency. [If temporary placement under PAS is authorized by 1. the hospital Discharge Planner (for individuals who are not MI and/or MR/DD), or 2. the physician under the "Exempted Hospital Discharge" this form must accompany the applicant to the nursing facility.]
- B. If question 1 is answered "Yes" and there is also a "Yes" answer to any of questions 2 through 4, the nursing facility **MUST** have adequate documentation of the dementia diagnosis. The PASRR / MI Level II Mental Health Assessment will **NOT** be done. The dementia documentation must be maintained in the active resident record and readily available for federal and state audit. (NOTE: Level II is always required if there is a concurrent diagnosis of a major mental illness specified in Question 2 of the Level I.)
- C. Questions 3b: When an adequate explanation is provided to document that the medication is given for a non-mental illness problem (Question 2) or the serious behavioral problems are due to a non-mental illness or excluded condition (*dementia*), "No" should be checked for that question. If there is no explanation of the medication use or serious behavioral problem, the question should be checked "Yes". For example, the explanation might read: "Haldol for sleep problems", "Mellaril for dementia", etc. * A Yes answer to question 3a and / or 3b DOES NOT ALONE trigger a Level II.
- D. Questions 5 - 7: When any question 5 - 7 is answered "Yes", Form 450B - Section VI - "Physical Examination" must be completed. Send with PASRR Level I to the local PAS agency.

II. SECTION V, Part A: PASRR DETERMINATION CRITERIA - LEVEL II EXEMPTION

- A. Complete Section V only when question 1 is answered "No" and there is a "Yes" answer to any question 2 through 7.
- B. The "Exempted Hospital Discharge" allows only temporary nursing facility admission of less than 30 days without Level II Assessment immediately following a non-psychiatric acute hospital inpatient stay. If the person does not convalesce and requires longer temporary placement, the nursing facility must contact the PAS agency as soon as possible but no later than 30 days following admission for completion of the PASRR Level II Assessment process. At that time the nursing facility must provide to the PAS agency documentation explaining the reason for the request for approval of extended placement. The PASRR Level II Assessment must be received by the nursing facility no later than the 40th day of placement.
- C. Definition of EXEMPTED HOSPITAL DISCHARGE:
CONVALESCENT CARE FOR A PRIMARY ACUTE PHYSICAL DIAGNOSIS: A person may be admitted for short-term recuperative care to a Medicaid-certified nursing facility after release from an acute care hospital stay necessitated by a primary physical diagnosis as long as that person is not a danger to self and/or others. This convalescent period shall **not exceed 30 days and must be part of a medically prescribed period of recovery for the primary physical diagnosis.** The purpose of the convalescent stay is for a short recuperation period with the intention to leave the facility prior to the expiration of the approved time. (Medical documentation must substantiate the need for short-term convalescent care. Whenever possible, attach a copy of the hospital discharge summary to this form when it is sent to the PAS agency.)

CONVALESCENT CARE FOLLOWING AN ACUTE CARE HOSPITAL STAY NECESSITATED FOR TREATMENT OF A PSYCHIATRIC ILLNESS RATHER THAN A PHYSICAL ILLNESS IS NOT INCLUDED.

NOTE: MI and/or MR individuals cannot be temporarily placed in nursing facilities merely because appropriate placements in institutions for mental diseases (*IMD's*), intermediate care facilities for the mentally retarded (*ICF's/MR*), etc. are not available at the time of discharge from an acute care hospital. It is the responsibility of the NF to notify the PAS agency immediately if the resident needs to remain beyond 30 days and explain why continued stay is necessary. The NF will also need to provide a current Form 450B, Physician's Certification. The required Level II assessment(s) must be completed within 40 days of the admission.

NOTE: Medicaid is not allowed to reimburse for more than 40 days unless the individual is found to be appropriately placed in the NF. Further, Medicaid will not reimburse for inappropriate use of this category, such as when the anticipated stay at the time of admission is realistically more than 30 days.

III. CERTIFICATION OF THE LEVEL II REQUIREMENT

- A. ALL Level I forms completed for initial admission or transfer **MUST** be certified by the local PAS agency for the need for Level II Assessment. The PAS agency will check "Yes" or "No" in the section marked "PAS", sign and date the form.