



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 20 No. 25

October 2010

TO: Hospitals and Long-Term Care Nursing Facilities

SUBJECT: Pre-Admission Screening and Resident Review (PASRR)

EFFECTIVE: Immediately

PURPOSE: To Advise of Recent Changes to New Jersey's Pre-Admission Screening and Resident Review (PASRR) Process

ACTION: Section 1919(e)(7) of the Social Security Act and Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138, specifies the requirement that before entering a Medicaid-certified nursing home, all individuals, regardless of payment source, must have a pre-admission Level 1 screening for mental illness and mental retardation. 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.

Attached is the revised Level I PASRR Screening Tool (LTC-26). It can also be found on the Department of Health and Senior Services' (DHSS) website at <http://web.doh.state.nj.us/apps2/forms/>. To ensure pre-admission screening is conducted prior to nursing home admission, it will be necessary for hospitals to initiate the 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.

The DHSS, Division of Aging and Community Services (DACS) has already begun training nursing home staff on the new PASRR process. DACS will contact both hospital and nursing home staff in the near future about upcoming training sessions on the revised PASRR process and forms. DACS will be coordinating these training sessions with the appropriate agencies that participate in the PASRR process.

If you or your staff have questions or concerns regarding this information, please contact DACS at 609-633-8604.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

**New Jersey Department of Health and Senior Services
New Jersey Department of Human Services
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL**

This form must be completed for all applicants prior to nursing facility admission in accordance with Federal Regulations 42 CFR 483.106.

• PLEASE PRINT •

Name of Applicant (Last Name, First Name)	Social Security Number
Current Location of Applicant	Date of Birth
Residence Prior to NF Placement: <input type="checkbox"/> Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Boarding Home <input type="checkbox"/> Other (specify): _____	County
MENTAL ILLNESS	
<p>1. a. Does the individual have a documented primary diagnosis of dementia (including Alzheimer's Disease or related disorder) based on criteria in the DSM-IV? <input type="checkbox"/> Yes <input type="checkbox"/> No DSM-IV Code: _____</p> <p>b. The diagnosis was made on the basis of (check all that apply): <input type="checkbox"/> Mental Status Exam <input type="checkbox"/> Neurological Exam <input type="checkbox"/> History and Symptoms <input type="checkbox"/> Other Diagnostics (specify): _____</p>	
<p>2. a. Does the individual have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, 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 chronic disability? <input type="checkbox"/> Yes <input type="checkbox"/> No (Based on the DSM-IV) Psychiatric Diagnosis</p> <p>b. Current Psychiatric Medications and Dosages:</p>	
<p>3. Within the past 6 months, has the individual had a significant impairment in functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check all that apply):</p> <p><input type="checkbox"/> Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history or allegations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation.</p> <p><input type="checkbox"/> Concentration, persistence, and pace. The individual's ability to pay attention long enough to complete tasks appropriately and on time, including tasks commonly found in work settings. Marked limitations means that the individual cannot complete simple tasks accurately and consistently: 1.) without extra help or supervision; 2.) without too many rest periods; or 3.) without too many interruptions or distractions.</p> <p><input type="checkbox"/> 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.</p>	
<p>4. Within the last 2 years, has the individual had any history of inpatient or partial care/partial hospitalization treatment or has had two or more visits to a Community Mental Health Screening Center? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the individual been involved with PACT or Integrated Case Management Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain and provide dates:</p>	
MENTAL RETARDATION/DEVELOPMENTAL DISABILITY	
<p>5. Does the individual have a diagnosis of mental retardation (mild, moderate, severe or profound)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6. Does the individual have a severe, chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior (for example, related conditions such as autism, seizure disorder, cerebral palsy, epilepsy, spina bifida, or head injury)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>7. Is there a history of MR/DD or related condition in the individual's past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

**PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL, CONTINUED**

MENTAL RETARDATION/DEVELOPMENTAL DISABILITY, CONTINUED			
8. Is there any presenting evidence (cognitive or behavior characteristics) that may indicate the person has MR/DD or related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
9. Does the individual currently receive services paid through the Division of Developmental Disabilities? (For example, day habilitation, group home, case management, Community Care Waiver, Real Life Choices, Family Support, or Self Determination)..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
CERTIFICATION OF MEDICAL PROFESSIONAL COMPLETING LEVEL I FORM			
Name and Title of Medical Professional Completing Form (<i>Print</i>)		Signature of Medical Professional Completing Form	
Name of Alternate Level I Screener Contact	Phone No.	Fax No.	Date
INSTRUCTIONS			
Place check in <u>only one box</u> beside outcome:			
<input type="checkbox"/> If ALL Questions 1 through 9 are answered NO = NEGATIVE SCREEN: Stop here. Individual may be admitted to a Nursing Facility without referral to DMHS and/or DDD for a Level II Evaluation. Original copy of Level I Form must be placed in NF chart.			
<input type="checkbox"/> If Question 1 is YES but Questions 2 through 9 are NO = NEGATIVE SCREEN: Stop here. Individual may be admitted to a Nursing Facility without referral to DMHS and/or DDD for a Level II Evaluation. Original copy of Level I Form must be placed in NF chart.			
<input type="checkbox"/> If Question 1 is YES and if any of Questions 2 through 4 are YES = NEGATIVE SCREEN: Stop here. Individual may be admitted to a Nursing Facility without referral to DMHS for a Level II Evaluation. Original copy of Level I Form must be placed in NF chart.			
<input type="checkbox"/> If Question 1 is YES and if any of Question 5 through 9 are YES = POSITIVE SCREEN: Make simultaneous referrals to DDD for Level II Evaluation and OCCO for Level of Care Determination. Screener will give a copy of the Notice of Referral for a Level II Evaluation Letter to the NF Applicant or Legal Representative.			
<input type="checkbox"/> If Question 1 is NO and if ANY of Questions 2 through 9 are answered YES = POSITIVE SCREEN:			
1. Refer to DMHS for ANY of Questions 2 through 4 that were answered YES.			
2. Refer to DDD for ANY of Questions 5 through 9 that were answered YES.			
3. Refer to <u>both</u> DMHS and DDD simultaneously for any of Questions 2 through 4 AND any of Questions 5 though 9 that are answered YES.			
4. NOTE: In addition to referral(s) for Level II Evaluation(s), make a simultaneous referral to OCCO for a Level of Care Determination. Screener will give a copy of the Notice of Referral for a Level II Evaluation Letter to the NF Applicant or Legal Representative.			
PASRR DETERMINATION CRITERIA – LEVEL II EXEMPTED HOSPITAL DISCHARGE FOR LEVEL I POSITIVE SCREENS			
NOTE: Hospital Discharge Exemption applies only to initial nursing facility admission, not resident review, nursing facility readmission or inter-facility transfer. Complete this section if any YES responses are noted in Questions 2 through 9.			
EXEMPTED HOSPITAL DISCHARGE – An individual may be admitted to a skilled nursing facility directly from the hospital after receiving inpatient care (non-psychiatric) at the hospital if:			
1. The individual requires skilled 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 skilled nursing facility care.			
3. NOTE: If the individual requires care beyond the initial 30 day period, the nursing facility must notify DMHS and/or DDD 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.			
Name of Physician (<i>Print</i>)		Signature of Physician	Date
CONTACT INFORMATION: DIVISION OF MENTAL HEALTH SERVICES AND DIVISION OF DEVELOPMENTAL DISABILITIES			
Division of Mental Health Services Statewide PASRR Coordinator Phone 609-777-0725; Fax 609-777-0662		Division of Developmental Disabilities Regional Offices, Cont'd: Lower Central Region – Ocean and Monmouth Phone 732-863-4500; Fax 732-863-4406 Lower Central Region – Hunterdon, Mercer and Middlesex Phone 609-588-2727; fax 609-584-1402 Southern Region – Camden and Burlington Phone 856-770-5900; Fax 856-770-5935 Southern Region – Atlantic and Cape May Phone 609-476-5200; Fax 609-909-0656 Southern Region – Cumberland, Salem and Gloucester Phone 856-696-6000; Fax 856-690-5277	
Division of Developmental Disabilities Regional Offices: Northern Region – Morris, Sussex and Warren Counties Phone 973-927-2600; Fax 973-927-2683 Northern Region – Bergen, Hudson and Passaic Counties Phone 973-977-4004; Fax 973-977-2120 Upper Central Region – Somerset, Union and Essex Counties Phone 908-226-7800; Fax 908-412-7900			