Volume 3 No. 42 SEPTEMBER 1993

TO: Nursing Facilities (In-State Only)

SUBJECT: Survey: To Identify Nursing Facility Residents with Mental Illness/Mental Retardation Whose Care Is Reimbursed Through Private Pay, Insurance, or Sources Other Than The New Jersey Medicaid Program

EFFECTIVE: Immediately

PURPOSE: To inform nursing facilities that Federal regulations require the Stat mental illness (MI), mental retardation (MR), or a related condition, regardless of the source of payment for their care.

BACKGROUND: PASARR requirements are established by Federal law - Section 1919(a) and (e) of the Social Security Act, 42 U.S.C. 1396r. These requirements are:

1. Preadmission Screening - Effective January 1, 1989, the State has been required to have a PreAdmission Screening program, for making determinations for individuals with mental illness or mental retardation or a related condition who are admitted to a NF. A NF is prohibited from admitting any new resident who has mental illness or mental retardation or a related condition, unless the State mental health or mental retardation authorities determine, prior to admission, that the individual, because of his/her mental and physical condition, requires the level of services provided by a NF and the need for specialized services.

2. Annual Resident Review - Effective April 1, 1990, the State has been required to have an Annual Resident Review program to determine the appropriateness of continued NF services and the need for specialized services for individuals with mental illness, mental retardation, or a related condition.

The Department of Human Services has been conducting PASARR screening of Medicaid eligible MI/MR individuals. The State must now identify and conduct annual resident reviews on <u>all</u> NF residents in a Medicaid certified NF who have mental illness, mental retardation, or a related condition, regardless of the source of payment for their care. The Division of Medical Assistance and Health Services (DMAHS), in conjunction with the Division of Mental Health and Hospitals

(DMH&H) and the Division of Developmental Disabilities (DDD), has designed the attached survey instrument, PASARR SURVEY OF MI/MR RESIDENTS, to identify those current NF residents with mental illness/mental retardation whose care is reimbursed through private pay, insurance, or sources other than the New Jersey Medicaid program.

ACTION: We are requesting that you assist us in identifying these residents by completing the survey form for each of those residents whose care is reimbursed through sources other than the New Jersey Medicaid program. For your convenience, we have enclosed ten (10) copies of the survey form. If additional forms are needed, please duplicate the form accordingly. The content of the survey form was developed on the basis of PASARR requirements contained in 42 CFR 483.102. Instructions for completing the survey form are enclosed. Also enclosed is a certification letter. Every facility must complete a certification letter whether that facility currently has residents whose care is reimbursed by sources other than the New Jersey Medicaid program who meet the MI/MR PASARR criteria. The certification letter must be signed by the administrator of the facility.

A certification letter and, if applicable, the survey forms must be returned to Jerome Murphy, Assistant Director, Office of Medical Care Administration, Division of Medical Assistance and Health Services, Mail Code #8, CN 712, Trenton, N.J. 08625-0712, by October 15, 1993.

Questions regarding mental retardation issues should be directed to Dennis Hemphill, Division of Developmental Disabilities, at (609) 292-1908. Questions regarding mental illness issues should be directed to Carol Weiss, Division of Mental Health and Hospitals, at (609) 777-0669. General questions regarding this Newsletter should be directed to Eleanor Gray, Division of Medical Assistance and Health Services, at (609) 588-2611.

Enclosures

Instructions for Completing the PASARR SURVEY OF MI/MR RESIDENTS

1. Insert the seven digit nursing facility Medicaid provider billing number.

2. Insert the name of the nursing facility.

3. Insert the resident's last name, first name and middle initial.

4. Insert the resident's date of birth.

5. Insert the resident's social security number.

6. Insert the resident's initial admission date.

7. Identify the main payment source for nursing facility services.

8. Identify the diagnosis category - using examples identified on the survey form.

   NOTE: If the diagnosis in item number 8 is primary dementia, proceed to item number 12.

   NOTE: For the resident identified as having a primary diagnosis of dementia, the nursing facility must have documentation on the resident's clinical record of the history, physical examination, and diagnostic workup to support the diagnosis of dementia, Alzheimer's disease or related dementias.

9. Indicate the appropriate response.

10. Indicate the appropriate response.

11. Indicate the appropriate response.

12. Utilizing the definition of "related condition" on the survey form, identify the appropriate diagnoses for the resident. When specifying age of onset, identify the age in years (e.g. 01, 12.)

13. Utilizing the definition of "related condition" on the survey form, indicate the appropriate response.

The person completing the survey form must sign and date the form and indicate his/her title. The resident's specific survey forms are to be forwarded with the nursing facility administrator's certification letter to Jerome Murphy, Assistant Director, Medical Care Administration, Division of Medical Assistance and Health Services, Mail Code #8, CN 712, Trenton, New Jersey 08625-0712, by October 15, 1993.

TO: Office of Medical Care Administration
Division of Medical Assistance and Health Services
Mail Code #8
CN-712
Trenton, NJ 08625-0712

Certification Letter

Please check the appropriate response:

_____ I CERTIFY that the enclosed resident specific survey forms

_____ I CERTIFY that NONE of the residents in my facility, whose care is reimbursed by sources other than the New Jersey Medicaid program, meet the MI/MR PASARR criteria.

_____
Administrator's Signature/Date

_____
License Number

_____
Nursing Facility Name

_____
Provider Number