# Massachusetts Executive Office of Health and Human Services

## PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL I SCREENING

### SCREENING TYPE/CORRECTIONS

☐ Preadmission ☐ Expiration of Exempted Hospital Discharge/Categorical Determination (Section G) ☐ Resident review

### SUBMISSION / RESUBMISSION DATES

Initial submission date

If this form is being resubmitted due to an error and/or to add information, please indicate the section(s) and item(s) changed.

| Section(s) | Item(s) | Resubmission date |
|---|---|---|
| Section(s) | Item(s) | Resubmission date |

### IDENTIFICATION & BACKGROUND INFORMATION (Complete all items.)

#### NURSING FACILITY APPLICANT

| Name | ☐ Male ☐ Female | Date of birth |
|---|---|---|
| Home address | Phone | Cell |

| Marital Status | Coverage Information | Accommodations or interpreter needed? |
|---|---|---|
| ☐ Married<br>☐ Divorced<br>☐ Single<br>☐ Widowed | ☐ MassHealth<br>☐ MassHealth pending<br>☐ Medicare<br>☐ Private insurance<br>☐ Self (Private pay) | ☐ No ☐ Yes ☐ Unknown<br>Specify accommodations and/or interpreter needs |

| Current Location | | Name of current facility |
|---|---|---|
| ☐ Acute hospital | ☐ Nursing facility | |
| ☐ Chronic disease and rehabilitation hospital | ☐ Emergency room | |
| ☐ Psychiatric hospital or unit | ☐ Home/community | |

#### AUTHORIZED REPRESENTATIVE

| Name | Phone | Cell |
|---|---|---|
| Address | Email | |

Relationship to applicant (Check all that apply.)

☐ Son/daughter
☐ Spouse
☐ Legal guardian
☐ Decision maker per advance directive (Living will, power of attorney for health care, health care proxy)
☐ Other

#### ADMITTING NURSING FACILITY (if known)

| Facility name | Phone | Fax |
|---|---|---|
| Address | Contact's name | Professional title<br>☐ RN/LPN<br>☐ Social worker<br>☐ MD |
| Anticipated admission date | Admission date | |

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## SECTION A: SCREEN FOR INTELLECTUAL OR DEVELOPMENTAL DISABILITY (ID/DD)

1. Does the applicant have a documented diagnosis or treatment history of ID with a date of onset **before age 18**?

   ☐ No
   ☐ Yes. List agency that provided services (if known).

Agency

2. Does the applicant have a documented diagnosis or treatment history of DD, also known as Related Condition, with a date of onset **before age 22**?

   ☐ No
   ☐ Yes. List diagnosis and agency that provided services (if known). Skip to Question 4.

Diagnosis

Agency

3. Is there presenting evidence, based on available documentation, observations, interviews, or history of indicators below, that the applicant may have ID that occurred **before age 18** or DD that occurred **before age 22**?

   ☐ No
   ☐ Yes. Check all that apply.

   ☐ Cognitive impairment
   ☐ Adaptive functioning
   ☐ Functional limitations in physical, neurological, sensory, cognitive, or major life activities
   ☐ Services from an agency that serves people with ID or DD

Information source (if known)

### ID/DD SCREENING RESULTS

4. If you answered YES to question 1 or 2 or 3, check "Positive ID/DD screen" below. Otherwise, check "Negative ID/DD screen."

   ☐ Positive ID/DD screen
   ☐ Negative ID/DD screen (Level II PASRR Evaluation is not indicated due to no diagnosis or suspicion of ID or DD.)

## SECTION B: SCREEN FOR SERIOUS MENTAL ILLNESS (SMI)

5. Does the applicant have a documented diagnosis of a mental illness or disorder (MI/D) or substance use disorder (SUD) that may lead to chronic disability?

   ☐ No
   ☐ Unknown
   ☐ Yes. Check all that apply.

   ☐ Schizophrenia (any type)
   ☐ Somatoform disorder
   ☐ Delusional disorder*
   ☐ Mood (i.e., bipolar disorder, major depression)
   ☐ Post-traumatic stress disorder
   ☐ Severe anxiety/panic
   ☐ Schizoaffective disorder
   ☐ Atypical psychosis*
   ☐ Paranoia*
   ☐ Personality disorder
   ☐ Eating disorder
   ☐ Other
   ☐ Substance use disorder
   Substance(s) if known:

   Most recent use occurred?
   ☐ More than 90 days ago
   ☐ Less than 90 days ago
   ☐ Unknown

   *Not medication-induced

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6. Within **the past two years,** is the applicant known to have required one of the treatments or interventions below, that is, or may be, due to mental illness or disorder (MI/D)?

☐ No
☐ Yes. Check all that apply.

TREATMENT/INTERVENTIONS

☐ One or more inpatient psychiatric hospitalizations
☐ Psychiatric day treatment
☐ Residential treatment
☐ Supportive services to maintain functioning at home
☐ Substance use intervention
☐ Legal intervention
☐ Housing intervention
☐ Association with mental health agency
Specify
☐ Suicide attempt
Specify dates
☐ Other

7. **Currently or within the past six months,** has the applicant had limitation(s) in major life activities in at least one of three areas listed below, that is, or may be, due to mental illness or disorder (MI/D)?

☐ No
☐ Yes. Check all that apply.

MAJOR LIFE ACTIVITY AREAS

☐ Interpersonal functioning – serious difficulty interacting and/or communicating effectively with others: illogical comments, fear of strangers, frequently isolating or avoiding others, excessive irritability, easily upset or anxious, hallucinations, or a possible history of eviction, altercations, or unstable employment.

☐ Concentration, persistence, and pace – difficulty completing age appropriate tasks and/or concentrating, completion timeliness, serious loss of interest, makes frequent errors, or requires assistance with activities/task that the applicant should be capable of accomplishing.

☐ Adaptation to change – significant difficulty adapting to typical change associated with employment, home, family or social interactions, agitation, withdrawal due to adaptation difficulties, self-injurious, self-mutilation, suicidal talks/ideations, physically violent or threatening, judicial intervention, severe appetite disturbance, excessive tearfulness.

## SMI SCREENING RESULTS

8. If you answered YES to question 6 or 7, check "Positive SMI screen" below. Otherwise, check "Negative SMI screen."

☐ Negative SMI screen (Level II PASRR Evaluation is not indicated due to no diagnosis or suspicion of SMI)
**Next step:** If you answered "Positive ID/DD screen" to question 4, then proceed to Section C. Otherwise, complete Section F at the end of this form, file the form in the applicant's medical record, and admit the applicant.
☐ Positive SMI screen
**Next step:** Complete Section C.

## SECTION C: EXEMPTED HOSPITAL DISCHARGE (EHD) (ID/DD AND/OR SMI)

9. Check all that apply.

The applicant is

☐ Being admitted to a nursing facility directly from an acute hospital after receiving inpatient acute medical care
☐ In need of nursing facility services to treat the same medical condition treated in the acute hospital
☐ Not a current risk to self or others, and behavioral symptoms, if present, are stable
☐ Expected to stay in a nursing facility for less than 30 calendar days as certified by the hospital's attending or discharging practitioner

10. Did you check **ALL** of the boxes in Question 9?

☐ No. Go to Question 11.
☐ Yes. If the applicant screened positive for ID/DD, select **Option A** below. If the applicant screened positive for SMI, select **Option B** below. If the applicant screened positive for both ID/DD and SMI, select both **Options A** and **B**.

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☐ **Option A:** Level II PASRR Evaluation for *ID/DD* is *not* indicated *at this time* due to Exempted Hospital Discharge (maximum 30 calendar days).

**Next step:** Complete contact information below and complete Section F; file this form in the person's medical record and admit.

| Contacted DDS PASRR office<br>Date | Form submitted to DDS PASRR office<br>Date | Name of DDS PASRR office staff Contacted |
|---|---|---|

Certifying practitioner's name | Certification date

☐ **Option B:** Level II PASRR Evaluation for *SMI* is *not* indicated *at this time** due to Exempted Hospital Discharge (maximum 30 calendar days).

**Next step:** Complete contact information below and complete Section F; file this form in the person's medical record and admit.

Certifying practitioner's name | Certification date

* If the nursing facility determines that the resident's stay will exceed the 30-day exemption period, the nursing facility must complete Section G in this form and submit the Level I form to the DMH/Designee by no later than the 25th calendar day from admission.

11. Did you answer "Positive ID/DD screen" in Question 4?

☐ No. Go to Question 12.
☐ Yes. Select **Option C** below.

☐ **Option C:** Level II PASRR Evaluation for ID/DD is required and must be completed by DDS before admission.

**Next step:** Complete contact information below and request from DDS an Individualized Preadmission Level II Evaluation. Complete Section F. **Do not admit applicant to a nursing facility until Level II PASRR Evaluation is completed and admission approved.**

| Called/emailed DDS PASRR office<br>Date | Form submitted to DDS PASRR office<br>Date | Contacted DDS PASRR office staff<br>Name |
|---|---|---|

## SECTION D: ADVANCED DEMENTIA EXCLUSION (ADE) (SMI ONLY)

12. Has the applicant screened positive for SMI only and also have a documented diagnosis of Alzheimer's disease and/or related dementias (ADRD) certified by a practitioner?

☐ No. Go to Section E.
☐ Yes

13. Which of the following were used to establish the Alzheimer's disease and/or related dementias (ADRD)? Check all that apply.

☐ Mental status exam
☐ Neurological exam/testing
☐ History and symptoms
☐ Unknown
☐ Other

14. Has a practitioner documented and certified that Alzheimer's disease and/or related dementias (ADRD) are **both** primary and so advanced that the applicant would be unable to benefit from specialized services?

☐ No ☐ Yes

Name of certifying practitioner | Contact information

**Next step:** Complete Section F, then submit this form and all supporting documentation for an Abbreviated Preadmission Level II Evaluation. **Do not admit to a nursing facility until a Level II PASRR Determination Notice/written report has been received from DMH/Designee.**

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## SECTION E: CATEGORICAL DETERMINATION (CD) (SMI ONLY)

15. Has the applicant screened positive for SMI only and possibly qualify for a categorical determination?

☐ No. Complete Section F. Request a Preadmission Level II Evaluation from DMH/Designee. **Do not admit applicant to a nursing facility until a Level II PASRR Determination Notice/written report has been received from the DMH/Designee.**

☐ Yes. Check only one categorical determination below. Complete Section F. Submit this form and all supporting documentation to DMH/Designee for an Abbreviated Preadmission Level II Evaluation. **Do not admit to a nursing facility until a Level II PASRR Determination Notice/written report has been received from the DMH/Designee.**

CATEGORICAL DETERMINATIONS

☐ Severe Illness:
- ☐ Coma
- ☐ Persistent vegetative state
- ☐ Parkinson's disease (End stage)
- ☐ Huntington's chorea (End stage)
- ☐ Congestive heart failure (CHF) (End stage)
- ☐ Chronic obstructive pulmonary disease (COPD) (End stage)
- ☐ Amyotrophic lateral sclerosis (ALS) (End stage)
- ☐ Chronic respiratory failure, ventilator dependent

☐ Convalescent care (Maximum 30 calendar days)*
☐ Provisional emergency (Maximum 7 calendar days)*
☐ Respite (Maximum 10 calendar days)*
☐ Terminal illness*

* The nursing facility must complete Section G below and resubmit the Level I form to DMH/Designee if the NF determines that the resident's stay will exceed the permitted duration. Requests must be made by no later than the 25th day after admission for convalescent care, the third day after admission for provisional emergency, and fifth day after admission for respite.

## SECTION F. CERTIFICATION: I certify that I am the person who completed this form and did so pursuant to all federal and state rules and regulations, and that the information provided is accurate to the best of my knowledge. I understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

| | | |
|---|---|---|
| Name | Professional title ☐ RN/LPN ☐ Social worker ☐ MD | |
| Organization | Phone | Fax |
| Address | Email | |
| Signature ..... | Date | Time ☐ am ☐ pm |

## SECTION G: EXPIRATION OF EHD/CD (SMI ONLY)

Please select the reason for request.

☐ The nursing facility determined that the resident will not be discharged before the expiration of the **exempted hospital discharge (EHD)** and is requesting a Level II PASRR Evaluation from DMH/Designee.

☐ The nursing facility has determined that the resident will not be discharged before the expiration of the **categorical determination** selected below and is requesting a Level II PASRR Evaluation from the DMH/Designee.

- ☐ Convalescent care
- ☐ Provisional emergency
- ☐ Respite

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## IMPORTANT TERMS — Preadmission Screening and Resident Review (PASRR)

**Abbreviated Preadmission Level II Evaluation (Abbreviated Level II)** — A shortened, individualized Level II preadmission evaluation, completed by the Massachusetts Department of Mental Health or its designee (DMH/Designee) before admission for individuals who have or may have SMI, to determine if the individual is excluded from PASRR due to advanced dementia (Section D) or to confirm that the individual meets the criteria for a categorical determination (Section E).

**Advanced Dementia Exclusion (ADE)** — Applies when a diagnosis of dementia or Alzheimer's disease and/or related disorder (ADRD) co-occurs with a mental illness/disorder diagnosis, and the dementia/ADRD is both primary and so severe that the individual would be unable to benefit from treatment. If ADE applies, an Abbreviated Level II performed by the DMH/Designee is required before admission. If the DMH/Designee determines that ADE applies, the individual does not have SMI for the purposes of PASRR and may be admitted to the nursing facility with no further PASRR involvement.

**Categorical Determination (CD)** — Applies to individuals who screen positive for SMI and have characteristics that fall into certain categories determined in advance by the DMH/Designee that nursing facility services are needed on a time-limited basis or indefinitely. If CDs apply, an Abbreviated Level II must be performed by the DMH/Designee before admission to confirm SMI and that the criteria for a CD are met. There are five categorical determinations.

1. ***Convalescent care*** applies when an individual is being directly admitted to a nursing facility after being hospitalized to treat a medical condition (excluding psychiatric care) but the admission does not meet all of the requirements of exempted hospital discharge (EHD). Example: an individual is being admitted to a nursing facility for skilled observation and reconditioning after being hospitalized for treatment of pneumonia (limited to a maximum of 30 calendar days).
2. ***Provisional emergency*** applies in emergency situations where the individual requires protective services or in emergency circumstances on nights, weekends, and holidays (limited to a maximum of seven calendar days).
3. ***Respite*** applies when admission is to provide relief to the family and/or in-home caregiver (limited to a maximum of 10 calendar days).
4. ***Severe illness*** applies if an individual has at least one of the following conditions – coma, persistent vegetative state, end-stage Parkinson's disease, end-stage Huntington's chorea, end-stage congestive heart failure, end-stage chronic obstructive pulmonary disease, end-stage amyotrophic lateral sclerosis, and chronic respiratory failure (ventilator dependent) – and, due to the severity of the illness or condition, the individual would be unable to benefit from specialized services.
5. ***Terminal illness*** applies if a clinician has certified that the individual is terminally ill and the prognosis is six months or less.

Individuals admitted to a nursing facility under convalescent care, provisional emergency, and respite CDs: If a nursing facility determines that the stay is expected to exceed the allowed time period, the nursing facility must (a) complete Section G, (b) check the box "Expiration of Exempted Hospital Discharge / Categorical Determinations" at the top of page 1, and (c) submit the form, along with supporting documentation, to DMH/Designee.

Individuals admitted to a nursing facility under severe illness and terminal illness CDs: If the resident's condition improves or prognosis changes, the nursing facility must (a) check the box "Resident Review" at the top of page 1 and (b) submit the form, along with supporting documentation, to DMH/Designee.

**Exempted Hospital Discharge (EHD)** — Applies when all of the following conditions are met. The individual (1) is admitted to a nursing facility directly from an acute hospital after receiving inpatient acute medical care; (2) requires nursing facility services to treat the same medical condition treated in the hospital; (3) is not a current risk to self or others, and behavioral symptoms, if present, are stable; and (4) stay in the nursing facility is likely to be less than 30 calendar days as certified by the hospital's attending or discharging physician before admission. If all EHD criteria are met the individual may be admitted without PASRR involvement.

Individuals admitted to a nursing facility under EHD: if a nursing facility determines that the stay is expected to exceed 30 days after admission, the nursing facility must complete (a) Section G, (b) check the box "Expiration of Exempted Hospital Discharge / Categorical Determinations" at the top of page 1, and (c) submit the form, along with supporting documentation, to DMH/Designee.

**Resident Review** — A comprehensive Level II evaluation that may be required when a nursing facility resident has experienced a significant change in condition or when a facility newly identifies a condition that may impact that the resident's PASRR disability status, the appropriateness of nursing facility placement and/or specialized services. The nursing facility must (a) check the box "Resident Review" at the top of page 1 and (b) submit the form, along with supporting documentation, to DMH/Designee.

**Serious Mental Illness (SMI)** — An individual is considered to have SMI for the purpose of PASRR if he or she:

1. Has a major mental disorder, such as schizophrenic, paranoid, mood, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability (Diagnosis); **and**
2. Has a treatment history indicating that the individual has received psychiatric treatment more intensive than outpatient care more than once in the past two years; or within the last two years, has 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 (Recent Treatment); **and**
3. Has a level of disability that has resulted in functional limitations in major life activities within the past six months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis: interpersonal functioning; concentration, persistence, and pace; or adaptation to change (Level of Impairment); **and**
4. Does not have a co-occurring diagnosis of dementia or Alzheimer's disease and/or related disorder (ADRD) that is both the primary diagnosis and so severe/advanced that the individual would be unable to benefit from treatment (Advanced Dementia Exclusion).

**NOTE:** ***Keep this form, Level II PASRR determination notices and/or written reports, and all documentation that supports the screening outcome and applicability of advanced dementia exclusion, exempted hospital discharge, or categorical determination permanently in the individual's medical record.***

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