Level One Nursing Facility Pre-Admission Screening for Mental Illness/ Intellectual Disability or Related Condition

DHSS/COMRU

October 2021

Key Points

- The new process is now automated – the link to complete the application will be located on COMRU's webpage: https://health.mo.gov/seniors/nursinghomes/pasrr.php
- The Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability, or Related Condition (Level One Form) replaces the current DA 124 C form.
- This new application will be required for any individual seeking admission into a Medicaid certified bed in a nursing facility on or after October 31, 2021.
- The automated system will give the submitter a Return Code that is unique to each individual application. Please ensure the submitter writes down this code as it will be utilized throughout the process.

Section A. Individual Identifying Information

Missouri Department of Health & Senior Services

Section A. Individual Identifying Information

Last Name:		**First Name:**	
Middle Initial:		**Suffix**	
DCN (Medicaid Number):	12345678 8 characters remaining	**SSN Number:**	xxx-xx-xxxx (must include dashes)
Date of Birth:	mm-dd-yyyy M-D-Y	**Race:**	
Gender:		**Education Level:**	
Occupation:	Prior to Retired or Disabled		

- Individual's First and Last Name
  This should be the individual's **legal name**

- Suffix
  Examples include: "Sr.", "Jr.," or "I, II, III"

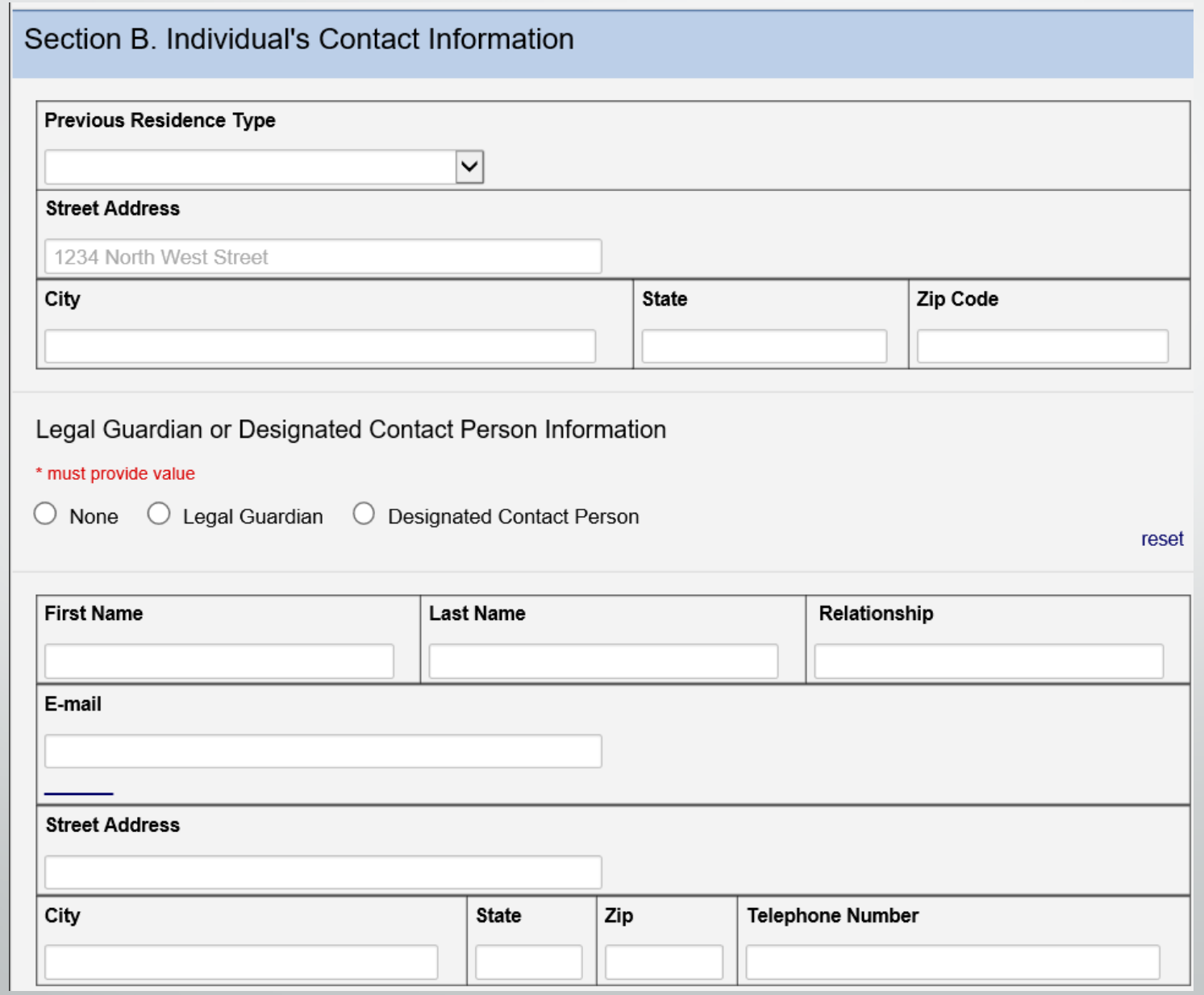
- DCN (aka Medicaid Number)
  This is an eight digit number
  If the individual has not yet applied for Medicaid, this field should be left blank.

- Date of Birth
  This is entered in a "mm-dd-yyyy" format

- SSN Number
  Dashes must be entered between numbers "XXX- XX-XXXX"

- Occupation
  This would be the occupation prior to the individual becoming disabled or retired
  If the individual never worked indicate "never worked"

Section B. Individual's Contact Information



Section B. Individual's Contact Information

Previous Residence Type

Street Address

1234 North West Street

City | State | Zip Code

Legal Guardian or Designated Contact Person Information

* must provide value

None | Legal Guardian | Designated Contact Person

reset

First Name | Last Name | Relationship

E-mail

Street Address

City | State | Zip | Telephone Number

- Previous Residence Type

  What type of setting was the Individual residing **prior** to this admission?

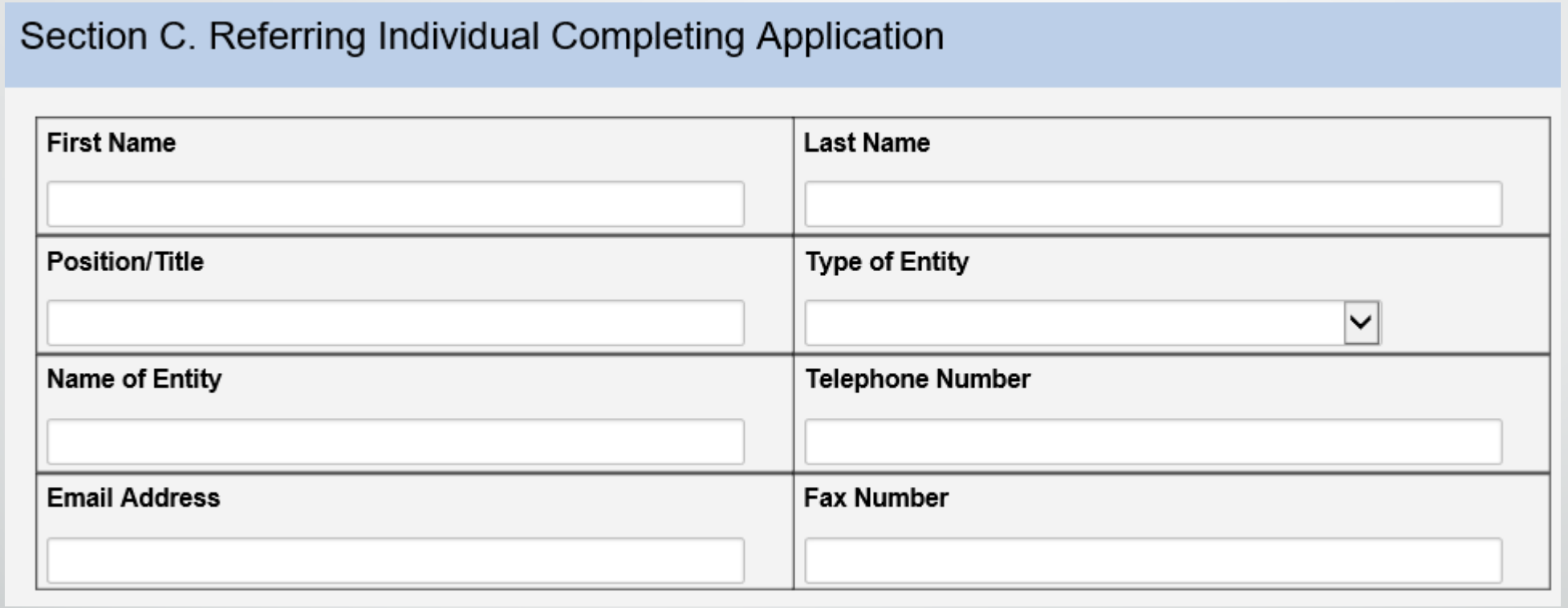
  There is a drop down menu with the following options:

  - Home / Facility Residence
  - RCF (Residential Care Facility)
  - ICF (Intermediate Care Facility)
  - SNF (Skilled Nursing Facility)
  - ALF (Assisted Living Facility)
  - ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disability)
  - DMH Group Home / Individualized Supported Living
  - DMH Psychiatric Hospital and Facilities
  - Homeless / Shelter
  - Incarcerated

- Provide Address of the Previous Residence Type

- Legal Guardian or Designated Contact Person Information
  - If “None” is marked, the requested fields for the Legal/Guardian or Designated Contact information will disappear
  - If the individual has a Legal Guardian or Designated Contact Person, please provide the requested information. This email will be used as the primary mode of providing letters and reports to the legal guardian. These records will be sent via an encrypted email. The email address is a required field on the application.

Section C. Referring Individual Completing Application

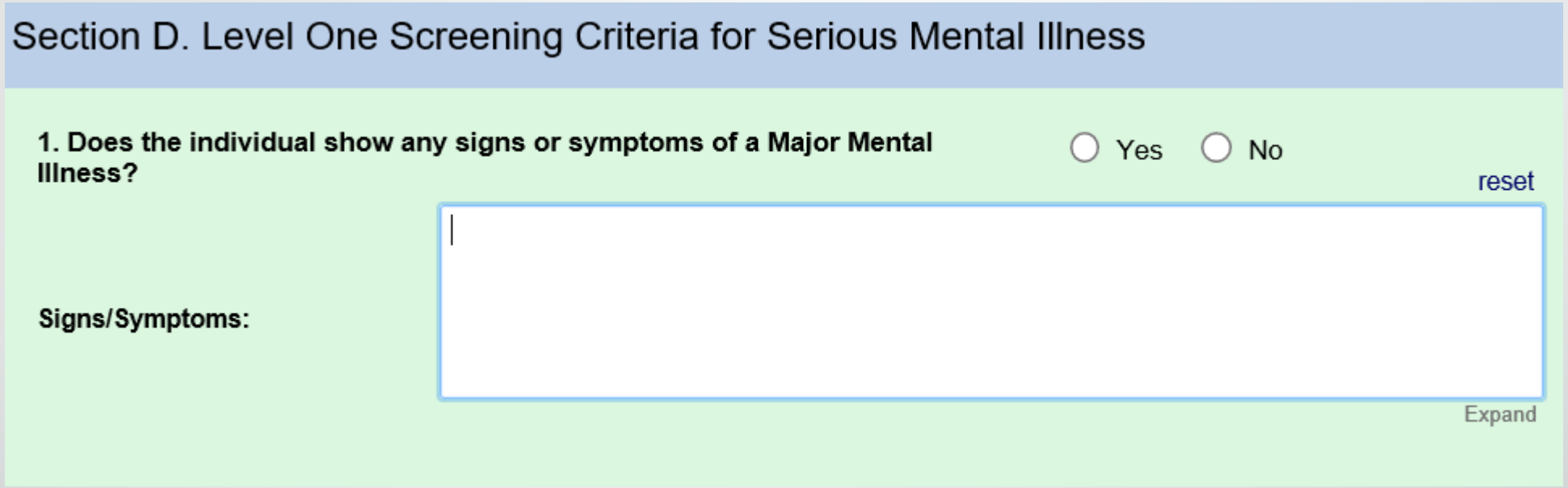


Section C. Referring Individual Completing Application

First Name	Last Name
Position/Title	Type of Entity
Name of Entity	Telephone Number
Email Address	Fax Number

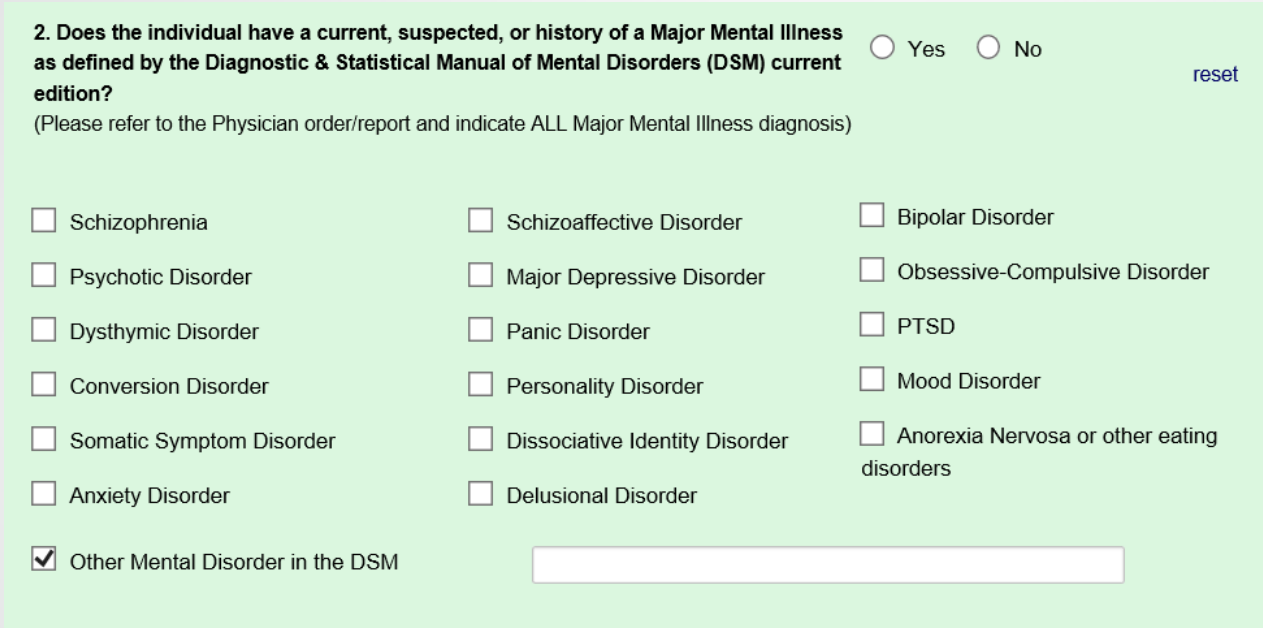
- This is the identifying information of the person completing the application prior to the physician's signature.

Section D. Level One Screening Criteria for Serious Mental Illness



- Please provide the signs and symptoms that the individual is displaying. Diagnoses are not accepted.

Section D. Level One Screening Criteria for Serious Mental Illness



2. Does the individual have a current, suspected, or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition? ○ Yes ○ No reset

(Please refer to the Physician order/report and indicate ALL Major Mental Illness diagnosis)

☐ Schizophrenia	☐ Schizoaffective Disorder	☐ Bipolar Disorder
☐ Psychotic Disorder	☐ Major Depressive Disorder	☐ Obsessive-Compulsive Disorder
☐ Dysthymic Disorder	☐ Panic Disorder	☐ PTSD
☐ Conversion Disorder	☐ Personality Disorder	☐ Mood Disorder
☐ Somatic Symptom Disorder	☐ Dissociative Identity Disorder	☐ Anorexia Nervosa or other eating disorders
☐ Anxiety Disorder	☐ Delusional Disorder	

☑ Other Mental Disorder in the DSM

- Please refer to the Physician's orders, History and Physical, and other supporting documentation to ensure that all the individual diagnoses are indicated on the application.
- The submitter is able to mark more than one diagnosis.
- If the diagnosis is not listed, mark the "Other Mental Disorder in the DSM" box and list the diagnosis in the box. Please list **only** Major Mental Illness diagnoses.
- A Level 2 screening is **not** automatically indicated if an individual has a Major Mental Illness diagnosis.

Section D. Level One Screening Criteria for Serious Mental Illness

3. Does the individual have any area of impairment due to serious mental illness? ○ Yes ○ No

(Record YES if any of the subcategories below are checked) reset

- ☐ **None**
- ☐ **Interpersonal Functioning:**

  The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationship and social isolation.
- ☐ **Adaptation to Change:**

  The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (ideation, gestures, threats, or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention by mental health or judicial system.
- ☐ **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, 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.

- The submitter must choose at least one of the four categories.
- The submitter can choose more than 1 of the 3 categories (Interpersonal Functioning, Adaptation to Change and Concentration/Persistence and Pace) if applicable.

- Adaptation to Change:
  Requires intervention by mental health or judicial system

  Is the individual currently receiving services in the community through Comprehensive Psychiatric Services (CPS – DMH)? If the individual is receiving services, this category would be marked.

- A Level 2 screening would be indicated if any of the three categories are marked and Dementia is **not** the primary mental illness diagnosis

Section D. Level One Screening Criteria for Serious Mental Illness

4. Within the last 2 years, has the individual: ○ Yes ○ No reset

(Record YES if Either/Both of the two subcategories below are checked)

☐ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g. had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

☐ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials?

Check yes, if treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider individual positive for serious mental illness.

Section D. Level One Screening Criteria for Serious Mental Illness

- If treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the individual is positive for serious mental illness. Examples might include (not an exclusive list):
  - The individual went to the hospital and no psychiatric beds were available so the individual was not admitted to the psychiatric unit even though the client was having an episode. Instead, the individual stabilized on the medical floor.
  - The facility does not know whether or not the individual has had an inpatient stay due to the individual being a poor historian.
- A Level 2 screening would be indicated if this question is marked "Yes" and Dementia is **not** the primary mental illness diagnosis

Section D. Level One Screening Criteria for Serious Mental Illness

5. Does the individual have a substance related disorder? ○ Yes ○ No reset

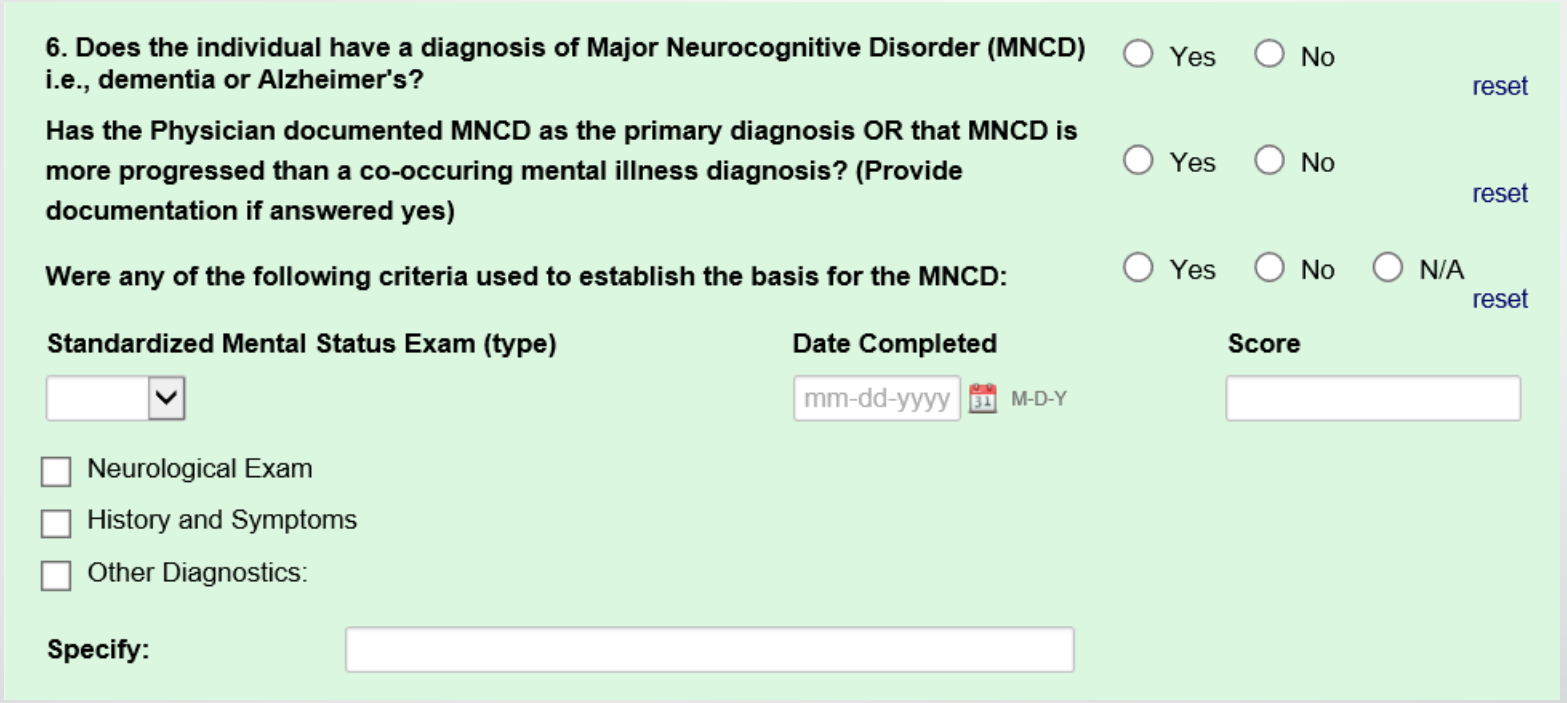
Is the need for a skilled nursing facility placement associated with substance abuse? ○ Yes ○ No reset

When did the most recent substance abuse occur?

○ N/A ○ 1-30 days ○ 31-90 days ○ Unknown reset

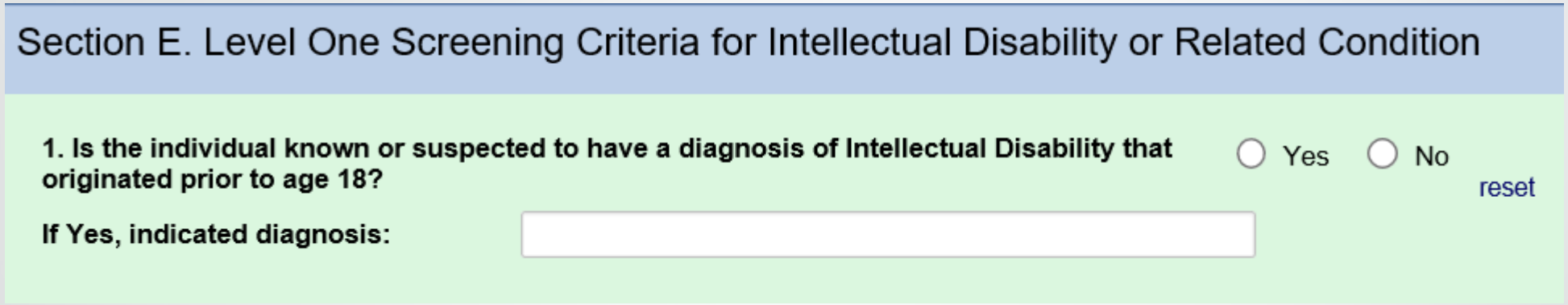
- Must be a documented diagnosis of current substance use **or** history of substance abuse
- A Level 2 screening is not automatically indicated if an individual has a substance related disorder

Section D. Level One Screening Criteria for Serious Mental Illness



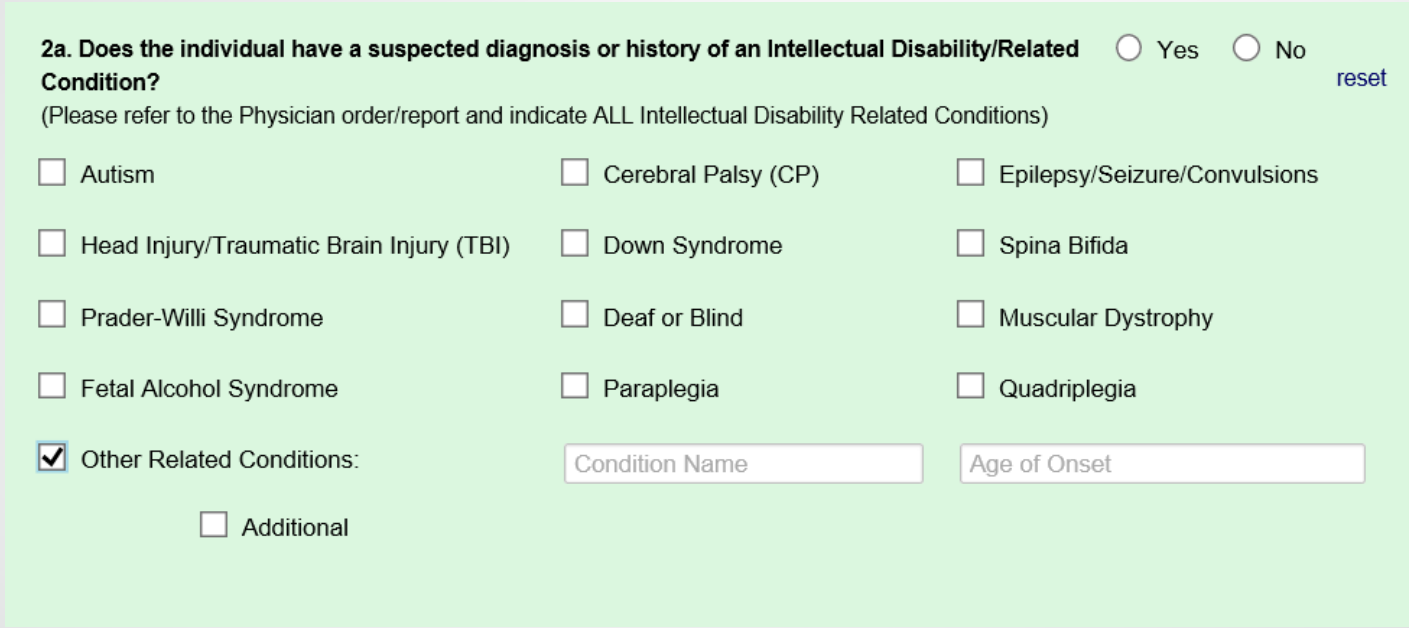
- If the individual does not have a diagnosis of Major Neurocognitive Disorder (MNCD) the additional questions in this section will disappear when answered "No".
- If the individual does have a diagnosis MNCD, then the following questions are required and should be completed to support the primary mental illness diagnosis.

Section E. Level One Screening Criteria for Intellectual Disability or Related Condition



- If "Yes", does the individual have a Mild, Moderate, Severe, Profound, or Unspecified Intellectual Disability
- Related Conditions are not listed in this field

Section E. Level One Screening Criteria for Intellectual Disability or Related Condition



2a. Does the individual have a suspected diagnosis or history of an Intellectual Disability/Related Condition? ○ Yes ○ No reset

(Please refer to the Physician order/report and indicate ALL Intellectual Disability Related Conditions)

☐ Autism	☐ Cerebral Palsy (CP)	☐ Epilepsy/Seizure/Convulsions
☐ Head Injury/Traumatic Brain Injury (TBI)	☐ Down Syndrome	☐ Spina Bifida
☐ Prader-Willi Syndrome	☐ Deaf or Blind	☐ Muscular Dystrophy
☐ Fetal Alcohol Syndrome	☐ Paraplegia	☐ Quadriplegia

☑ Other Related Conditions: Condition Name | Age of Onset

☐ Additional

- Does the individual have a diagnosis or history of a Related Condition?
  If "No" is indicated questions 2b thru 2d will disappear.

  If "Yes" is indicated, choose the diagnosis and provide the age of onset in the blank.
  If the diagnosis is not listed, click on "Other Related Condition" to type the diagnosis

- Mental Illness is **not** considered a "Related Condition"

Section E. Level One Screening Criteria for Intellectual Disability or Related Condition

- Did the Other Related Condition develop before age 22?
  (Review the diagnosis and age of onset checked from question 2A)

  If "No" is indicated questions 2C and 2D will disappear.

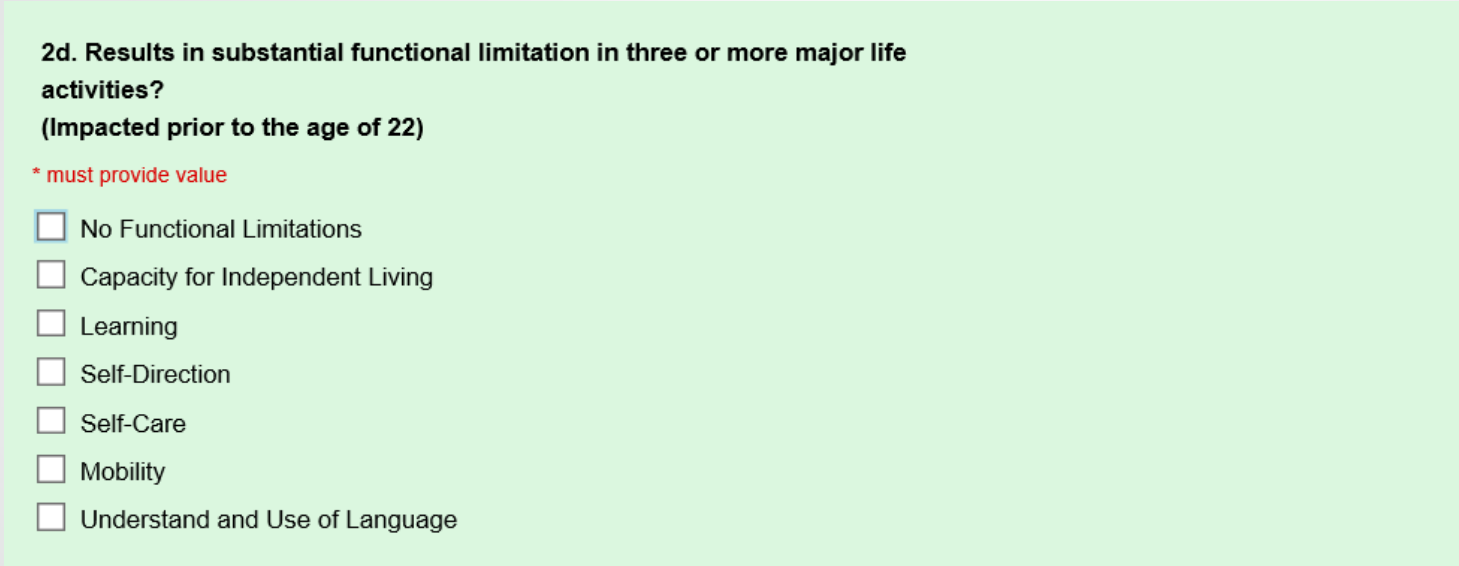
  If "Yes" or "Unknown" is indicated, please answer questions 2C and 2D (see next slides)

Section E. Level One Screening Criteria for Intellectual Disability or Related Condition

2c. Likely to continue indefinitely? ○ Yes ○ No

reset

Section E. Level One Screening Criteria for Intellectual Disability or Related Condition



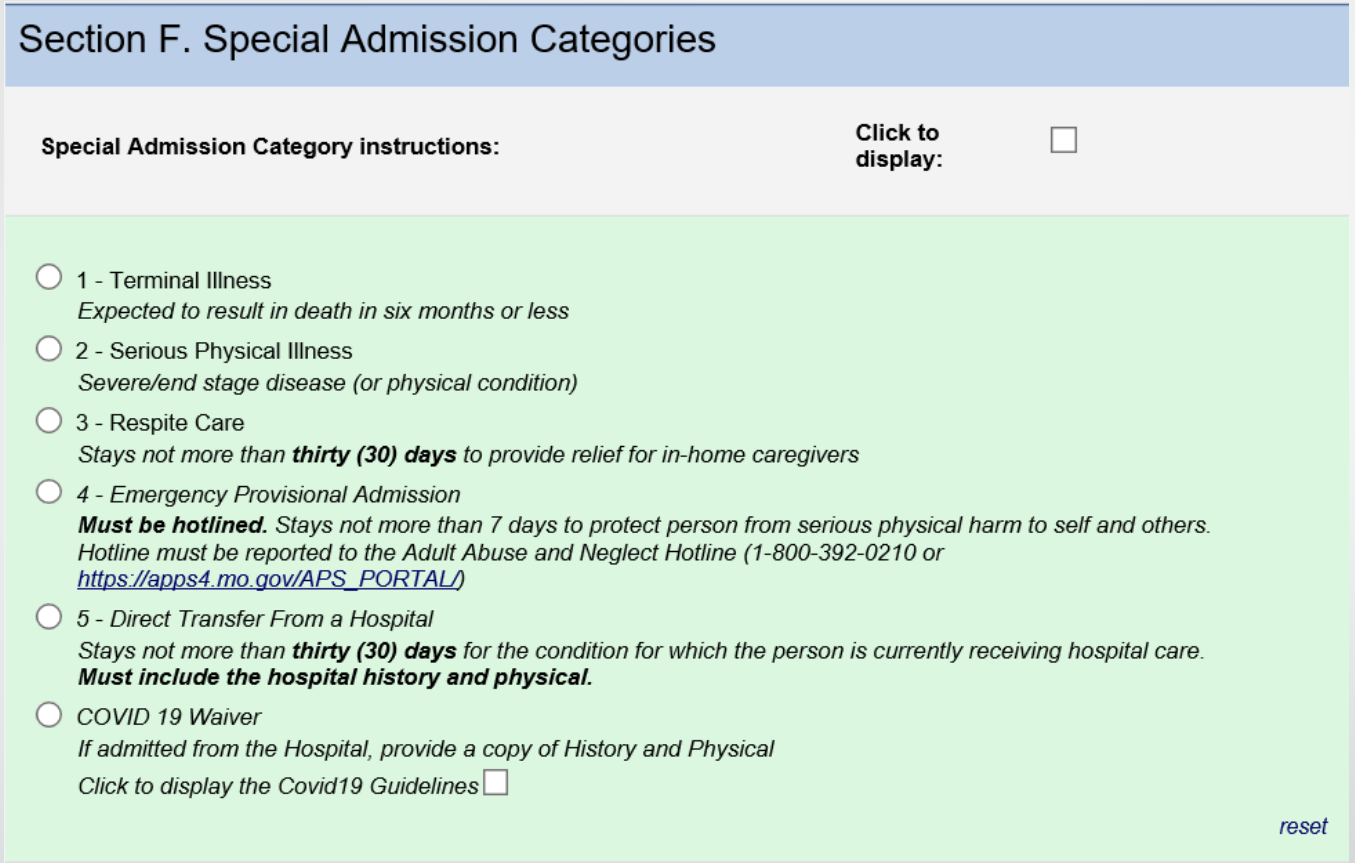
2d. Results in substantial functional limitation in three or more major life activities?
(Impacted prior to the age of 22)

* must provide value

- ☐ No Functional Limitations
- ☐ Capacity for Independent Living
- ☐ Learning
- ☐ Self-Direction
- ☐ Self-Care
- ☐ Mobility
- ☐ Understand and Use of Language

- Results in substantial functional limitations in three or more major life activities?
  - Reminder: The functional limitation must have impacted the individual **prior to the age of 22**.
- A Level 2 screening would be indicated if the individual has a related condition prior to the age of 22 **and** 3 or more functional limitations.
- To assist with answering the questions in Section E, the submitter might have to ask the individual, guardian, or other sources as to whether or not the individual was receiving Developmental Disability Services (DD – DMH) in the community.

Section F. Special Admission Category



Section F. Special Admission Categories

Special Admission Category instructions: **Click to display:** ☐

- ○ 1 - Terminal Illness
  Expected to result in death in six months or less
- ○ 2 - Serious Physical Illness
  Severe/end stage disease (or physical condition)
- ○ 3 - Respite Care
  *Stays not more than **thirty (30) days** to provide relief for in-home caregivers*
- ○ *4 - Emergency Provisional Admission*
  ***Must be hotlined.** Stays not more than 7 days to protect person from serious physical harm to self and others. Hotline must be reported to the Adult Abuse and Neglect Hotline (1-800-392-0210 or https://apps4.mo.gov/APS_PORTAL/)*
- ○ *5 - Direct Transfer From a Hospital*
  *Stays not more than **thirty (30) days** for the condition for which the person is currently receiving hospital care. **Must include the hospital history and physical.***
- ○ *COVID 19 Waiver*
  If admitted from the Hospital, provide a copy of History and Physical
  Click to display the Covid19 Guidelines ☐

reset

- A Special Admission Category (SAC) is **only** utilized if a individual triggers a Level 2 screening.
- The submitter does not have to choose a SAC for processing.
- SAC numbers 1 thru 5 must be **preapproved** by COMRU prior to admitting to SNF. Failure to preapprove these SACs may result in loss of Medicaid payment.

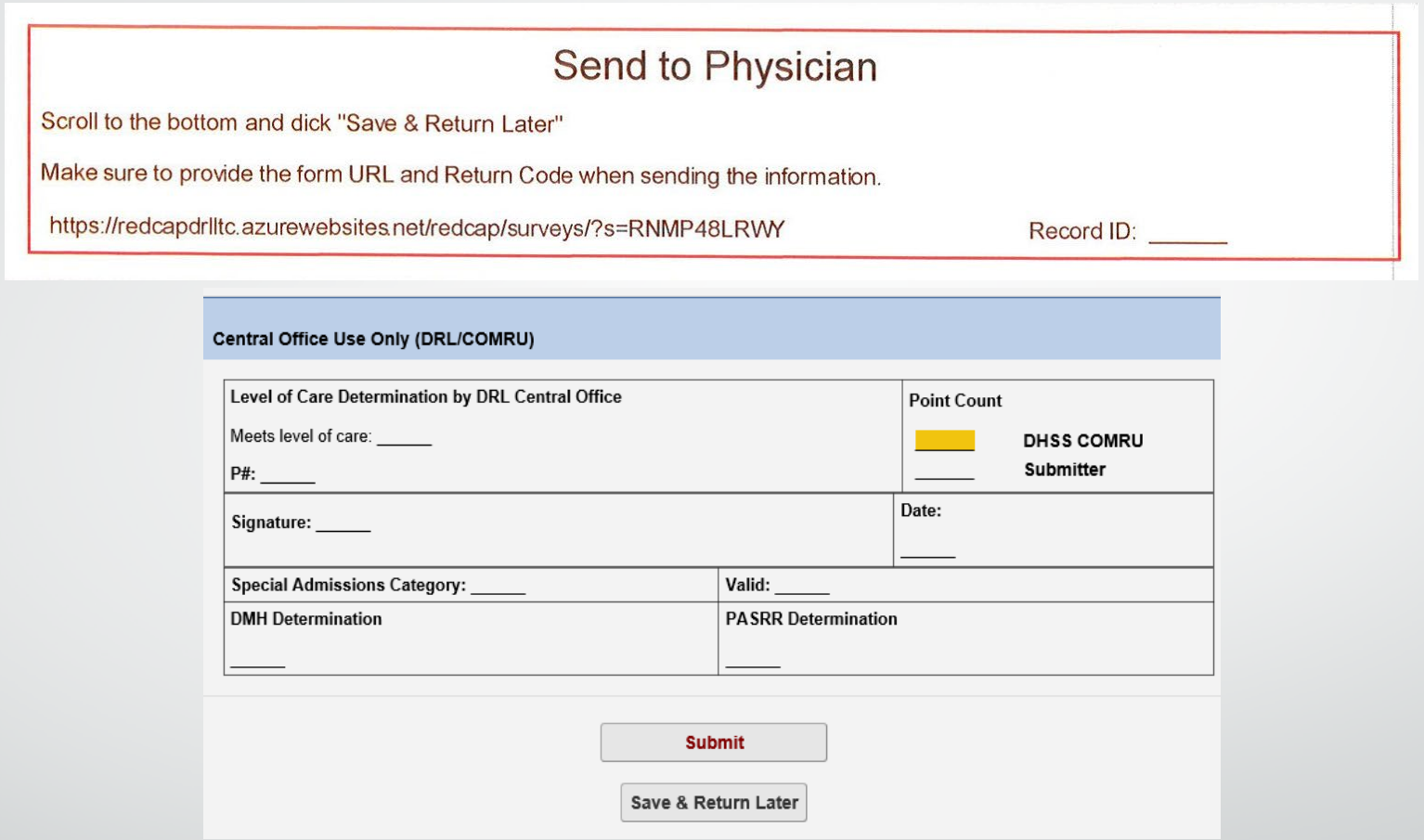
Section F. Special Admission Category

- The submitter will be able to view the determination of the SAC by logging back into the application (using the unique Return code).

- When SAC #3 or #5 is approved, it is the responsibility of the skilled nursing facility to subsequently notify COMRU via email (COMRU@health.mo.gov) if the individual will exceed the thirty-day special admission stay. In order to avoid loss of Medicaid payment, notice must be made to COMRU within the first 14-20 days of the individual's stay to allow time for the processing of the Level 2 screening.

- If the individual discharges, transfers, or leaves the nursing facility for any reason the SAC is considered completed and a new application request will need to be submitted to COMRU prior to the individual's return to any nursing facility.

Section G. Physician Signature



Send to Physician

Scroll to the bottom and dick "Save & Return Later"

Make sure to provide the form URL and Return Code when sending the information.

https://redcapdrlltc.azurewebsites.net/redcap/surveys/?s=RNMP48LRWY Record ID: _____

Central Office Use Only (DRL/COMRU)

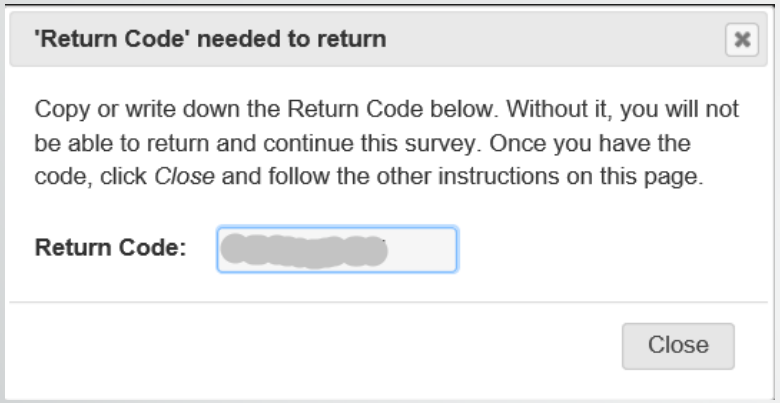
Level of Care Determination by DRL Central Office Meets level of care: _____ P#: _____	**Point Count** _____ DHSS COMRU _____ Submitter
Signature: _____	**Date:** _____
Special Admissions Category: _____	**Valid:** _____
DMH Determination _____	**PASRR Determination** _____

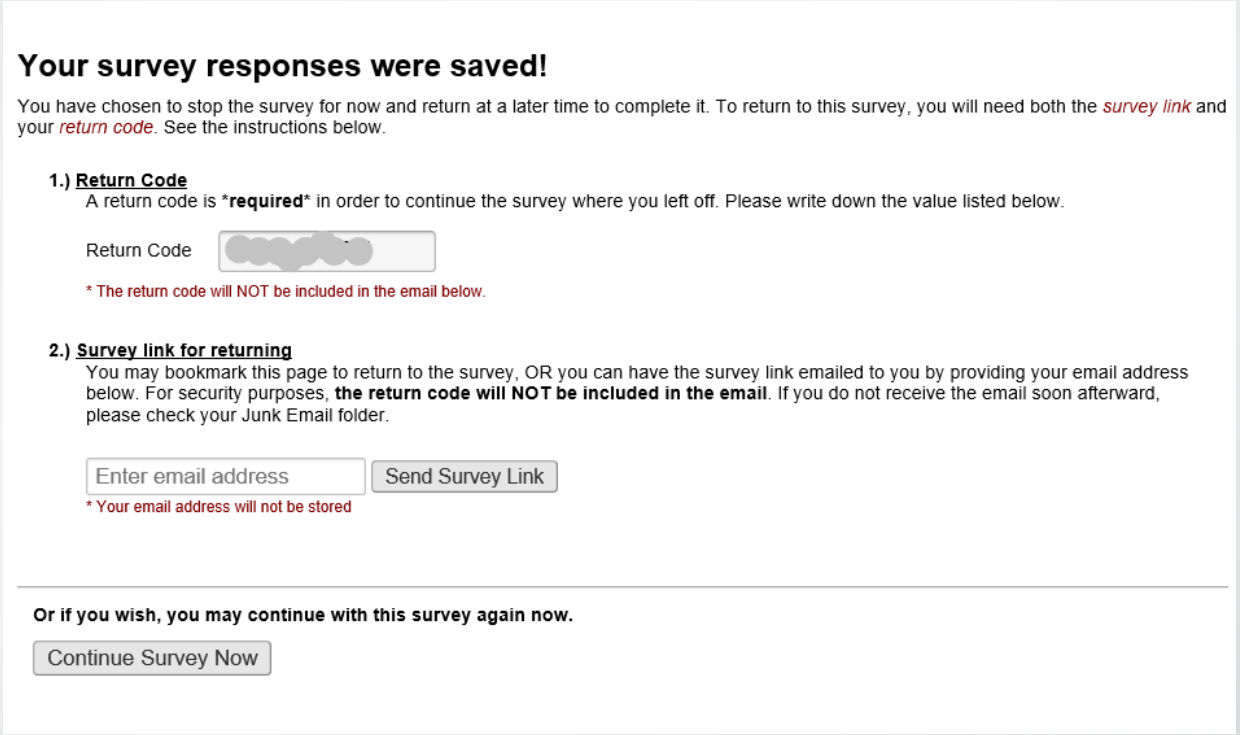
Submit

Save & Return Later

- Once the Level 1 form has been completed, it is then sent to the Physician for their signature.
- The submitter will need to scroll down to the end of the application and click the "Save and Return Later." button.

Section G. Physician Signature



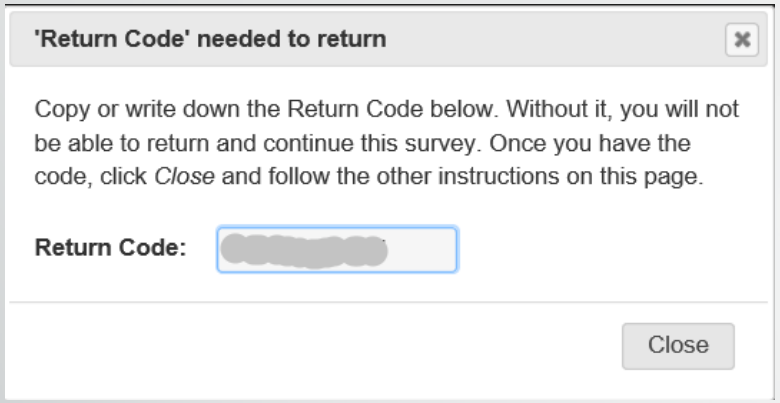


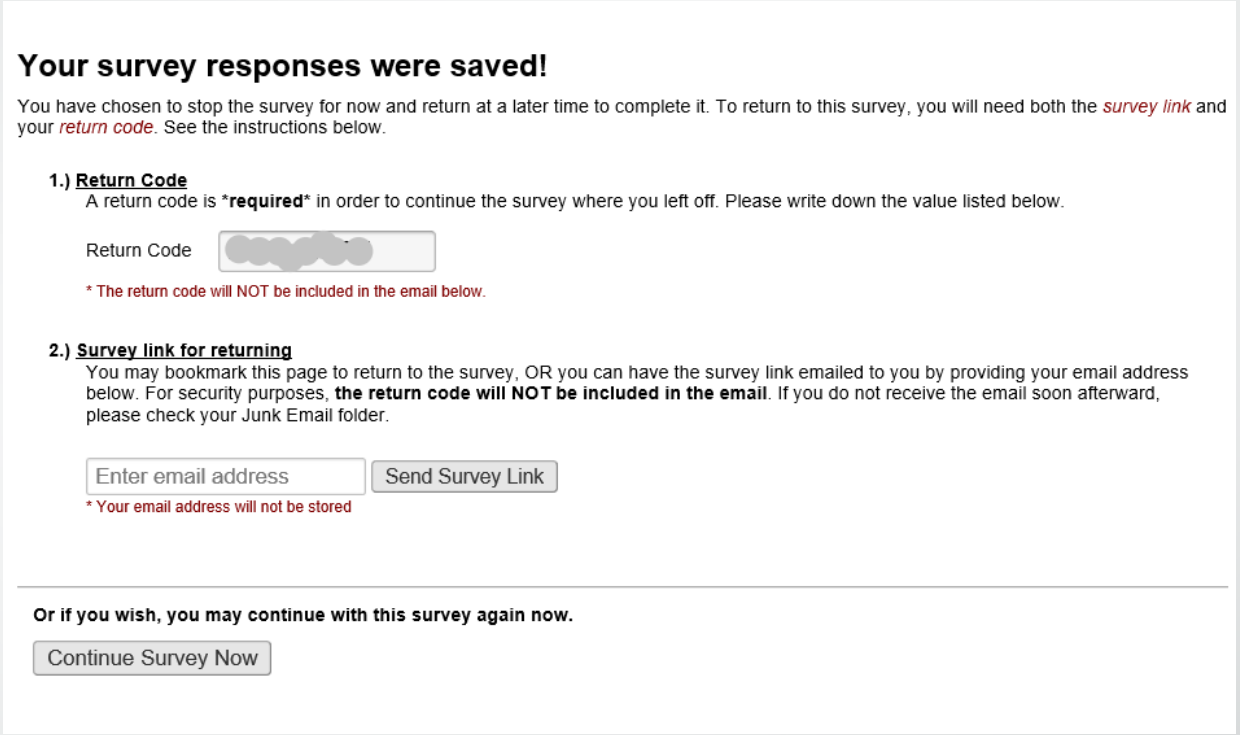
- The submitter will receive a Return Code.

IMPORTANT: **Make sure to write the code down as the submitter will need this code to send to the physician. The submitter will utilize this Return Code throughout the process.**

- The code is able to be copied and pasted into a computer document if needed.
  (Using the mouse – highlight the Return Code and right click, then click on the "copy" option)

Section G. Physician Signature

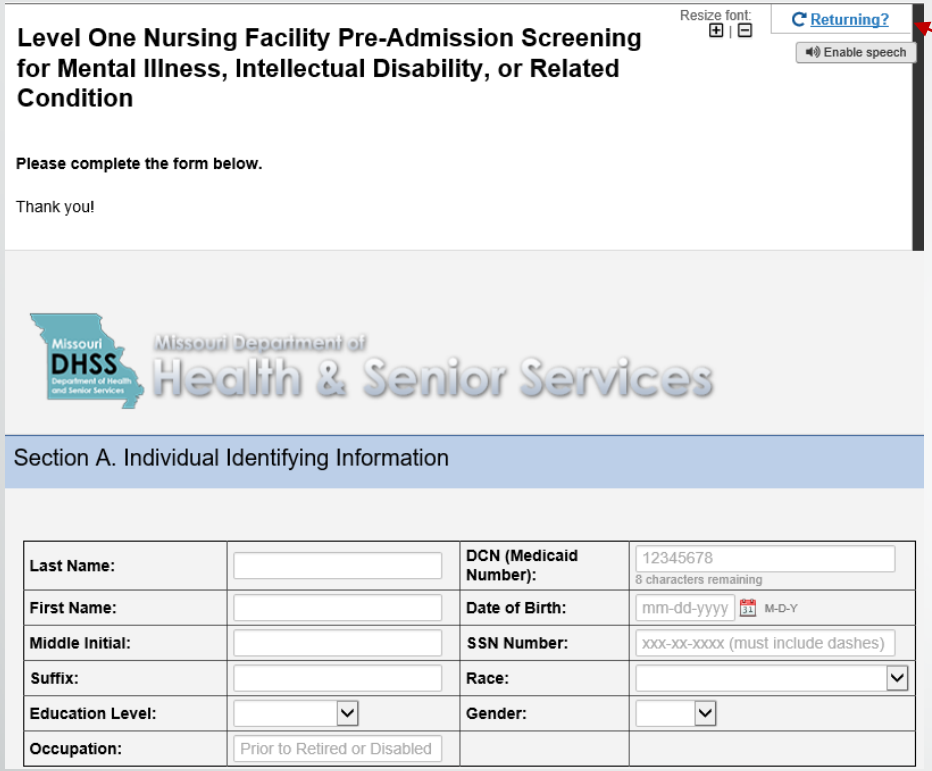


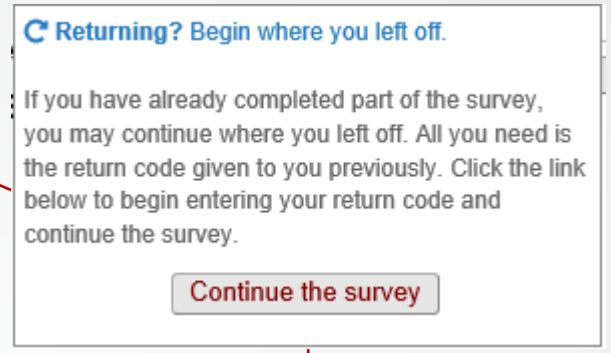


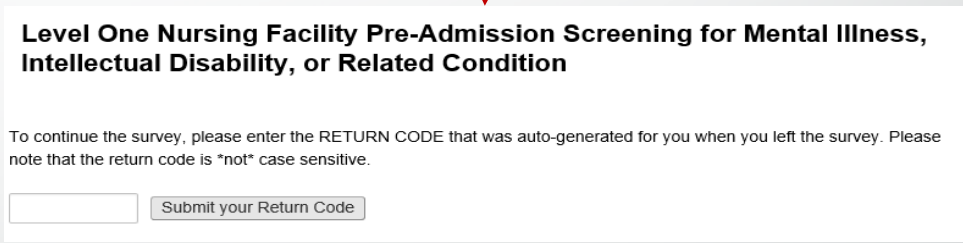
- When emailing the physician, it can be completed 2 ways:
  1. When the screen appears, enter the email address and click survey link.
     A second personal email will need to be sent from the submitter to the physician with the Return Code so they are able to access the application.

     Or
  2. The submitter sends a personal email to the physician with the code and the link to the application.
     The link to the this application will be located on COMRUs webpage.

Other Information







- The physician opens the Application link and clicks on "Returning?". A box will appear and the physician will click on "Continue the survey".
- The physician logs back into the application (using the Return Code).
- When the physician has completed Section G, the physician scrolls to the bottom of the application and clicks "Save and Return Later". The physician can enter the submitter's email address and an email is returned indicating the application has been signed.

- The submitter can also log back into the application (using the Return Code) to verify the Physician has signed/completed the application. This is the same process as the previous slide.

- If the submitter is a hospital and the application **did not trigger** a Level 2 screening, the hospital can email the Return Code and Application link to the SNF for review. The SNF would complete the remainder of the application (Nursing Facility Level of Care Assessment) and submit to COMRU for processing.

- If the submitter is a hospital and the application **triggers** a Level 2 screening, the hospital would continue to complete the rest of the application for submission.

Contact Information

Ammanda Ott
Registered Nurse Specialist/Supervisor
Division of Regulation and Licensure / COMRU

Telephone: 573-522-3092 (option 4)
Email: COMRU@health.mo.gov
Webpage: https://health.mo.gov/seniors/nursinghomes/pasrr.php