

**PREADMISSION SCREEN/MENTAL HEALTH
(PAS/MH)**

**CONTRACTOR'S PROCEDURE
MANUAL**

**Illinois Department of Human Services
Division of Mental Health**

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I. PURPOSE AND SCOPE OF THE PAS/MH MANUAL

The purpose of the PAS/MH Manual is to provide information and instructions to PAS/MH contractors and agents in performing, documenting and completing the terms of its contract with the Illinois Department of Human Services (DHS), Division of Mental Health (DMH).

The PAS/MH Manual establishes a standardized procedural structure and uniform decision criteria for implementing the PAS/MH process in the state of Illinois.

Any questions on the contents of this manual should be addressed to:

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II. DEFINITIONS

Aging, Department on (DoA) – Illinois’ State agency responsible for planning coordination State resources for person who are 60 years of age and over. DoA contracts with community Case Case Coordination Units (CCU’s) to screen persons over 60 referred for an NF or an elderly “waivered” service. These CCU’s also contract with the DHS/Division of Rehabilitation Services in most areas of the State, to provide screening services to persons presented for nursing facility admission who are under 60 and suspected to have a disabling physical disability.

Authorized Entities – Entities authorized to complete the initial Identification Referral” form for a PAS/MH screening. These entities include: Case Coordination Units of DoA, Rehabilitation (DRS) counselors or DRS designated screening agents, PAS/MH contractors/agents authorized by DMH, discharge planning staff in psychiatric hospitals or in general hospitals, state hospital’s, nursing facility staff and community mental health providers funded by DHS.

Appeals process – The due process by which an individual may have the following determinations made during the PAS/MH process reviewed at another level.

- A. The determination that the individual does or does not require specialized services (in patient care).
- B. The determination that the individual does not require the level of care provided by a nursing home.

Centers for Medicaid/Medicare Services (CMMS) – The Federal agency responsible for administering the Federal Medicaid and Medicare programs.

Convalescent Care – The care involved and the gradual return of health after an acute medical condition/illness for a period not to exceed 120 days. This type of admission is exempt from a level II PAS/MH assessment unless there is a reasonable basis to suspect a severe mental illness. In those cases a level I screening should be conducted to ascertain if: further review is

necessary to determine if specialized services are needed or what, if any, rehabilitative psychiatric services should be provided during the convalescent stay.

Human Services, Department of (DHS) – Illinois’ State agency responsible for planning and coordination human services. DHS consists of the following Divisions: Community Health and Prevention; Transitional Services; Rehabilitation Services; Human Capital Development; Community Health and Prevention; Developmental Disabilities; Mental Health; and Alcohol and Substance Abuse.

Determination Process – This is the final phase of the PAS/MH process whereby the findings of the comprehensive mental health evaluation are used to make either a determination for (1) Need for Specialized Services (in-patient psychiatric care) or (2) Nursing Facility Level of Care.

Institute for Mental Disease (IMD) - This is a federal designation applied to state operated mental hospitals, free-standing private psychiatric hospitals and some nursing facilities. A determination of some nursing facilities as IMD licensed intermediate care facility. Determination of the IMD status of a nursing facility is based on whether 50% or more of residents with mental illness (broadly defined) have another medical diagnosis that requires a nursing facility level of care. If more than 50% do not have such a "medical override," the nursing facility meets federal IMD criteria. The facility's IMD status only relates to the inability of HFS to claim Medicaid re-imburement on behalf of services provided in the facilities to persons older than 21 and less than 65 years of age in IMD facilities.

Initial Identification/Referral Form – Previously referred to as the OBRA 1. This document is used by “authorized entities” to identify and refer individuals for further PAS mental health review. The Level I ID screen is conducted to determine if there is a reasonable basis for suspecting that an individual has a severe mental illness. Completion of this form is required as part of the PAS process.

In-Patient psychiatric treatment (Specialized Services) – Specialized services are defined in Illinois as those services provided to individuals who are experiencing an acute episode of severe mental illness, which necessitates 24-hour supervision by trained mental health medical personnel. The purpose of inpatient psychiatric treatment is to diagnose or reduce the individual’s psychotic and/or disabling symptoms, which necessitated admission, to improve their functioning.

Intermediate Care Facility (ICF) – A licensed facility that provides basic nursing care and other restorative services under periodic medical direction. These facilities are licensed by the Illinois Department of Public Health (DPH) and may be certified for Medicaid participation.

Level I Screen – This is the first phase of the Pre-admission Screening process. It is the initial identification and documentation of individuals for whom there is a reasonable basis to suspect a severe mental illness. Based upon the outcome of the Level I screen, individuals may be referred for further assessment and determinations (Level II). This activity may be billable when conducted by a PAS/MH agent and certain determinations/dispositions are completed and documented. The “Initial ID/Referral” document may be completed by any authorized entity (above) including the MH/PAS agent but this is never billable. Only when the MH/PAS agent conducts a desk review completing the “Determination and Disposition” portion of the Level I is the activity billable.

Level II Screen – The second phase in the Pre-Admission Screening process. Based on the completed assessments, determinations are made that: substantiates the presence of a severe mental illness per state and federal guidelines, including substantial role functioning impairments, not attributable to a primary substance abuse disorder, the individual’s need for a nursing facility level of care, and need for specialized services (in-patient psychiatric care). There are two types of Level II reviews: “Re-assessment” (partial) and “Full” Assessment” (complete.) These assessments vary according to the amount of assessment information available during the review and the level of evaluations required and provided by the PAS agent. If there is no valid “psychiatric/medical” exam available (less than one year old), the pas agent may purchase a new psych/med. exam and be reimbursed an additional \$100.

Medicare (Title XVIII) – Coverage under both parts A and B of Title XVIII of the Social Security Act.

Medicaid (Title XIX) – Health care benefits provided under Title XIX of the Social Security Act.

“PAS Mental Health Level II Assessment/Re-Assessment” – Although all services must be reported and billed electronically through the DHS Unified Health System reporting system, this document outlines the demographic and clinical information necessary to complete the level II assessment and make the necessary assessment determinations and dispositions for the Level II PAS evaluation.

PAS Mental Health Re-Assessment – The Level II re-assessment (partial) is required when an individual is referred for another PAS screening after receiving a full or partial Level II previously that year, as long as the psychiatric and/or medical information is current (less than one year old). This re-screening is to be utilized to update the clinical information from the previous PAS evaluation. It must include a face-to-face assessment and required Level II determination, disposition and referral decisions. A re-assessment should be completed when the previous PAS screening is more than 3 months (90) days old and less than one year old.

Mental Health Rehabilitative Services – These services are considered a nursing facility service and are included within the scope of facility services. These services are considered to cover all services less than “specialized services” (psychiatric inpatient care). They refer to those mental health services, which are to be implemented by all levels of nursing facilities that admit a resident with mental illness. The individual’s “plan of care” should specify how the facility will integrate relevant activities throughout all hours of the individual’s day at the nursing facility. There should be competent interaction by staff at all times, in both formal and informal settings in accordance with the individual’s needs. Mental health rehabilitative services may include, but are not limited to:

- Consistent implementation during the resident’s daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors;
- Pharmacotherapy including administration and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;
- Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal);
- Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more

independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of the living environment;

- Crisis intervention services;
- Individual, group, and family psychotherapy;
- Development of appropriate personal support networks; and
- Formal behavior modification programs.

Nursing Facility (NF) – A long-term care setting that provides a level of care for individuals who have a disability, are infirm or in need of convalescent care. Nursing facility refers to ICF (Intermediate Care Facility) or SNF (Skilled Nursing Facility). In this state IMD’s are also licensed nursing facilities.

Omnibus Budget Reconciliation Act of 1987 (OBRA-87) – A Federal law which was applicable to all nursing facility residents concerning assessments, services staffing, etc., and in addition it established nursing facility screening requirements for persons with severe mental illness.

Psychiatrist – A Licensed physician who has completed an accredited psychiatric residency-training program.

Psychiatric Evaluation – A psychiatric evaluation is an in-dept evaluation of an individual conducted by a board certified psychiatrist, or by a physician with training in mental health services or one year of clinical experience, under supervision, in treating problems related to mental illness. A current (less than one year old) valid psychiatric exam must be available as part of the Level II assessment. When a current valid psychiatric is not available the PAS agency may “procure” one and be reimbursed.

Psychologist – An individual licensed or registered with the Illinois Department of Professional Regulations as a “clinical psychologist”.

Healthcare and Family Services, Department of (IDHFS) – The State agency responsible for administrating the Federal Medicaid program (Title XIX), and other Federal and State public assistance programs.

Public Health, Department of (DPH) – Illinois’ State agency responsible for the licensure and certification of long term care facilities. The DPH conducts licensure and certification surveys of nursing facilities.

- **Qualified Mental Health Professional (QMHP)** – A certified, registered or licensed mental health professional that meets one of the criteria in the state Medicaid Rule, 132.

Rehabilitation Services, Division of (DRS) – The Division responsible for developing and coordinating resources for the benefit of individuals with disabilities 18 through 59 years of age.

Severe Mental Illness or Serious Mental Illness (SMI) – The presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), excluding alcohol and substance abuse, Alzheimer’s disease, and other forms of dementia

based upon organic or physical disorder. A severe mental illness is determined by all of the following areas:

1. A diagnosis of schizophrenia; delusional disorder; schizoid-affective disorder; psychotic disorder not otherwise specified; bipolar disorder I – mixed, manic, and depressed; bipolar disorder II; bipolar disorder not otherwise specified; major depression, recurrent.
2. The diagnosis must have been present for at least one year.
3. Self-maintenance: physical functioning; personal care and hygiene, dressing; grooming; toileting; nutrition; speech and language; eating habits; maintenance of personal space or possessions; health maintenance; use of medication; and self-medication.
4. Social Functioning: interaction and involvement with family/significant others; social skills and relationships with friends; peer group involvement; ability to pursue leisure/recreational activities.
5. Community Living Activities: homemaking responsibilities (i.e., cleaning, laundry, meal preparation and service, shopping, financial management, and using telephone); use of transportation; traveling from residence independently.
6. It has been determined that the person's functional abilities are not impaired primarily due to substance abuse problems.
7. The functional disability must be of an extended duration expected to be present for at least a year, which results in substantial limitation in major life activities.

Sheltered Care – A non-medical setting for maintenance and personal care licensed by the Department of Public Health (DPH). This type of setting typically consists of room and board and intermittent personal care.

Skilled Nursing Facility (SNF) – A facility, which provides skilled nursing care, continuous skilled nursing observation, restorative nursing, and other services under professional direction with frequent medical supervision.

Specialized Services – A level of services needed for individuals experiencing an acute episode of severe mental illness and is associated with the level of care provided in a state hospital or an in-patient psychiatric hospital.

Supportive Living Facility (SLF) – Facilities certified by the Illinois Department of Healthcare and Family Services (IDHFS). These are independent apartments within existing nursing facilities or free standing. They are available to persons between the ages of 22 and 64 and physically disable or 65 plus. However, a facility cannot mix this age group within the same facility and persons believed to have severe mental illness (SMI) or a Developmental Disability is *ineligible*. Those persons suspected of having a severe an appropriate PAS specialist prior to admission into a SLF to determine if the SLF can meet their needs must screen mental illness or a developmental disability. Referrals for an MH/PAS screening should be forwarded to the PAS Coordinator of PAS Services for consultation.

III. INTRODUCTION AND BACKGROUND

A. Federal Requirements Pre-Admission Screening Process (PAS)

The **PAS/MH** process is Illinois' response to the Federal requirements associated with the 1987 Omnibus Budget Reconciliation Act (**OBRA '87**). Effective January 1989, the OBRA legislation revised statutory provisions governing certifications standards and enforcement procedures applicable to nursing homes. OBRA '87 contains detailed requirements that established nursing facility screening requirements for persons with severe mental illness and annual resident review (**PASARR**). This legislation specified that individuals with severe mental illness who apply for admission to a Medicaid certified nursing facility are required to receive a pre-admission screening (PAS). Thus, nursing facilities (NFs) are prohibited from admitting any individual with severe mental illness unless the PAS/MH process has determined that the individual requires a nursing facility level of care, and that the individual does not require specialized services (in-patient psychiatric are). In the area of mental health, the specific concerns regarding the mentally ill were: inappropriate placement in NFs, occupancy of beds needed by the frail elderly, and failure to receive needed psychiatric treatment.

In October 1996, Public Law 104-315 repealed the annual Resident Review (**RR**) portion of the requirement stating that states are **required** to perform a Resident Review only if there is a **significant change in the resident's condition**. The PAS/MH process applies to all individuals requesting admission into a nursing facility suspected of having a severe mental illness, or in some situations individuals suspected of having a severe mental illness who are already a resident of a nursing facility. The Federal agency responsible for monitoring states' compliance with the pre-admission screening (PAS) requirements is the Centers for Medicaid and Medicare Services (**CMMS**).

B. PAS/MH Process

Federal regulations require a two-phase screening process that is defined as PAS Level I and PAS Level II.

1. The screening process is detailed as follows:
 - a) Level I: Must be conducted on all persons referred for admission to a licensed nursing facility who are suspected of having a serious mental illness. This evaluation is the initial, pre-admission screen for the purpose of identification of individuals suspected of having a serious mental illness (SMI) or developmental disabilities.
 - b) Level II: For individuals identified as meeting the criteria for a suspected severe mental illness (SMI) through the Level I screening, a Level II evaluation is required to determine if, as a result of their mental illness:
 - The individual is eligible for specialized services (i.e., in-patient psychiatric hospitalization), or
 - The individual is eligible for the level of services provided by a nursing facility and psychiatric rehabilitation services on a 24-hour basis.
2. Level II Activities: When completing the Level II process, the following activities are required by the PAS/MH agent:

- a) The review must confirm the SMI diagnosis including the duration, (chronicity) previous treatment history, response to treatment, the level of role functioning impairments (disability), and the level of care that is required. (medical necessity).
- b) The assessment must evaluate persons for a primary or co-occurring substance abuse disorder and determine risk of non-compliance, self-harm or aggression toward others.
- c) The report must identify any mental health services that the nursing facility (NF) needs to provide of a lesser intensity than specialized services. The report must contain detailed information about the individual's mental health needs in order to explain why nursing facility placement is or is not appropriate.
- d) The report must provide sufficient information to assist the receiving facility in the development of an interim treatment plan for the individual.
- e) The nursing facilities must perform a comprehensive assessment of the individual within 14 days of admission in order to develop a care plan for each individual. The facility may use the PAS evaluation to enrich the care planning process in the nursing facility.

C. PAS/MH Service Elements

The required PAS/MH service elements are as follows :

- 1. Level I evaluations identify whether there is a reasonable basis to suspect the individual has a severe mental illness and what additional PAS Assessments if any are required.
- 2. Level II assessments should include:
 - a) Psychiatric Evaluation
 - b) Physical Examination and Medical History
 - c) Mental Health Assessment, which includes all of the components of the "PAS Mental Health Level II Assessment/Re-assessment" instrument and resulting determinations and dispositions which record the results of the evaluation and placement decisions.
- 3. The history and physical information elicited during a psychiatric exam or psychiatric hospitalization may be used to satisfy the requirements in 2 b) above.

D. Time Frames for Completion of the PAS/MH Process

The following time frames must be met by the PAS contractor:

- 1. The initial face-to-face screening will occur within three (3) business days on a usual basis. Contractors must have staffing levels that support this flexibility in response time.
- 2. The assessments must be scheduled, completed, and determination made of the nursing facility level within ten (10) calendar days from the date the individual was referred by the PAS agent who completes the Level I screen.
- 3. In an emergency or priority situations, the PAS contractor will respond more quickly than the required ten (10) calendar days.
- 4. In cases where additional time is necessary to arrange and complete required assessments (e.g., psychiatric/medical exams), the PAS contractor shall notify the referral source of the progress of the assessment.

E. PAS/MH Service Standards

Services must be provided in accordance with this PAS/MH Procedures Manual, including but not limited to the following:

1. Complying with time frames for completing the evaluation and determination process;
2. Gathering, arranging for, or completing all evaluation components;
3. Completing all necessary determinations regarding placement and level of care needed. (This includes deflection and linkage activity for persons who do not require nursing facility level of care but required some additional mental health services);
4. Completing all required PAS/MH forms; and
5. Providing the receiving nursing facility with a copy of all evaluations, and PAS/MH forms along with the “Transmittal Letter”. This information should be sufficient to assist the receiving facility in the development of an interim treatment plan.

F. Geographic Responsibility for PAS/MH Process

1. The PAS/MH contractor/agent is responsible for the geographic service area defined by the terms of their contract.
2. For the purposes of PAS screening activity, an individual’s residence is defined in the following manner:
 - a) If an individual is residing in a non-hospital setting, the individual’s residence is considered the home address.
 - b) If an individual is in a hospital, a state hospital or institutional setting, the PAS/MH agent serving the local geographic area of the hospital or institutional setting is responsible for completing the PAS/MH assessment.
 - c) For the purposes of **reporting and billing** PAS screening activities, the provider will designate the location (geocode) where billable services were conducted. These services must be provided in the PAS agent’s area of responsibility as identified in the PAS contract.

Guidance

The service geocode should be where the screening took place. If an individual resides in one geocode but is hospitalized (placed) in a different setting, that setting will be used to designate the geocode of service. If that setting e.g., hospital, community residential facility, jail, etc., is in the PAS agent’s geographic area of responsibility, the PAS agent would be responsible for PAS activities using the address of the facility to report those PAS activities. Billable Level I activity should also be coded where they occur, which is typically their own agencies. However, if a face-to-face contract has occurred, the geocode would default to the location of the screening. If the individual being screened is actively treated by another mental health provider, that provider should be notified of the screen and any outcomes/determinations.

IV. LEVEL I SCREEN – INITIAL IDENTIFICATION AND REFERRAL PROCESS

A. Purpose of the Level I Screen

The purpose of the Level I identification screen is:

1. To ensure that applicants who may have a severe mental illness are identified for admission to nursing facilities.
2. To identify the correct screening agent (Department on Aging, Division of Rehabilitation Services, Division of Mental Health, Division of Developmental Disability) to assess the applicant's eligibility for long term care.

B. Individuals Who Must Have a Level I Screen

1. Anyone referred for admission into a NF who is suspected of having a severe mental illness regardless of payer status.
2. Persons already admitted into an NF who are later suspected of having a severe mental illness.

C. Entities Authorized to Complete the Mental Health Level I Initial Identification Referral Screen

Entities authorized to perform the "initial identification/referral" screen for a mental health assessment are:

1. Case coordination units of DoA (Appendix);
2. Rehabilitation (DRS) counselors or DRS designated screening agents (Appendix);
3. PAS/MH contractors/agents authorized by DMH (Appendix);
4. DHS/DD pas agents (Appendix)
5. Discharge planning staff in psychiatric hospitals or in general hospitals;
6. State hospital community placement staff;
7. Nursing facility staff;
8. Community mental health providers funded by DHS.

Note: If a referral is received from a private source (individual, family member) or another agency that is not an authorized entity, the PAS/MH agent should complete all sections of the "Initial ID/Referral".

D. General Responsibilities of Level I Screening Agents

1. Department on Aging (DoA) screeners are responsible for screening individuals age 60 and older regardless of payment source if the Level I screen where there is no reasonable basis to suspect a severe mental illness.
2. Division of Rehabilitation Services (DRS) counselors are responsible for completing the Level I screen for individuals 18 through 59 years of age if the Level I screen does not indicate suspicion of a severe mental illness. (Much of the PAS screening activity has been subcontracted to the local area on aging agencies under the auspices of the Department on Aging.)
3. PAS/MH agents have primary responsibility for screening individuals who are seeking admission to a nursing facility, and who have been identified as having or are suspected of having a severe mental illness (SMI), unless there is reason to suspect a dual diagnosis with developmental disability. Anyone suspected of having SMI and a developmental disability should be referred to the appropriate PAS/DD screener for a DD Level II evaluation.
4. Only PAS/MH agents can complete the Level I evaluation including the determination and disposition sections.

Guidance

This manual provides information and instructions for PAS/MH. Other PAS specialists have their own policies and procedures and corresponding documents. If during the initial identification process one of the non-mental health entities discovers information that an individual may have a severe mental illness, a referral to the responsible PAS/MH agent should be made. The PAS/MH agent should review the initial identification information and any supporting documentation making a determination (1) whether a condition exists that requires further mental health assessments, (2) a condition does not exist and thus the referring entity should continue their PAS evaluation, or (3) whether another PAS entity should be involved

E. Level I PAS/MH Procedures

1. The PAS/MH agent is responsible for determining if there is a reasonable basis to suspect that the referred individual has a severe mental illness. The “Mental Health Identification/Referral” form is the vehicle by which PAS/MH agents should accept referrals. (It may be completed by the PAS/MH agent or any of the authorized entities, but it is strongly encouraged that these referral sources complete the “Initial ID/Referral” form.) The Level I process includes completing the “Initial Identification/Referral” form as well as obtaining and reviewing appropriate records or documents and completing the “Level I Determination and Disposition”. This may be done via telephone discussions with the referral source (e.g., a doctor, a nurse, hospital discharge planner, the individual’s guardian or family) who would be able to provide sufficient information that will allow the PAS/MH agent to make a responsible Level I determination.
2. The PAS/MH agent may receive referrals from a variety of sources. It is expected that authorized entities or other PAS agents (listed above) will complete and forward or at least provide the Initial ID Screening information.
3. The PAS/MH agent is responsible for completing, reviewing, and/or correcting the information in the “Initial ID/Referral” form. If the information is incomplete or invalid the PAS agent is responsible for amending/gathering the information for the “Initial ID/Referral”.
4. The PAS/MH agent must report the results of their findings in the “Level I Determination and Disposition” section of the UHS PAS data system. When the review determines that further Level II assessments are not necessary, this may be a billable activity as long as these findings and dispositions are recorded and billed in the UHS PAS data application. All supporting materials/documentation should be maintained by the responsible PAS agency.
 - **Only authorized PAS/MH contractors may bill for these services.**
 - When a Level II assessment is completed, these activities are billed as part of the level II rate.
 - Completion of the “Initial ID/Referral” form without the determination and disposition sections **are never billable.**

F. Individuals Exempt from the PAS/MH Level II Process

If there is no evidence of severe mental illness, those individuals who are diagnosed with one of the following conditions are exempt from a PAS/MH Level II screening:

1. Primary diagnosis of senile or pre-senile dementia. (Includes Alzheimer’s or related disorders). This also applies to persons with a traumatic brain injury or other neurological disorders. This should be based on the criteria

in DSM-IV and confirmed by a physician's diagnosis where there is no evidence of a severe mental illness.

2. Transitory or situational depression, anxiety, or adjustment disorders related to a debilitating physical illness (e.g., someone on psychotropic medications secondary to that condition). This applies to persons who suffer a primary health problem that may manifest some behavioral symptoms, which require psychiatric attention, but does not have a primary severe mental illness or a criterion diagnosis.

Guidance

When any of the above-listed conditions are present without a "primary" diagnosis of severe mental illness, a PAS/MH Level II screening is not required. "Primary" refers to the condition that is creating the clinical picture resulting in the decision to place the individual in the nursing facility.

If an individual has, or is suspected to have a history of severe mental illness and one of the above conditions, the screener (if non-mental health) should ask the MH/PAS agent to review the relevant materials to determine if sufficient evidence exists to warrant a Level II mental health evaluation.

The information suggesting mental illness should be objective and provided by someone qualified to make such judgments (e.g., treatment notes from a psychiatrist, hospital discharge summaries), etc. The PAS/MH agent should be available to offer consultation, technical support regarding these types of cases.

G. Exceptional Circumstance for Categorical Eligibility

A subset of the above exemptions, are certain "exceptional circumstance" where individuals are found to be "categorically eligible" for nursing facility level of care when documented by a physician. In the case of categorical eligibility, it is assumed that the individual's physical illness is so severe that any mental health diagnosis would be "secondary" to the client's medical condition. It is highly unlikely that this individual would benefit from psychiatric rehabilitation services. If the initial screener has doubts about which condition is "primary", the screener should contact the PAS/MH screener. The PAS/MH screener will then review the materials and share their findings with the referral source. If properly documented by a physician, the following situations are considered "categorically eligible":

1. Terminal illness (hospice care) with life expectancy of six months or less (should be verified by physician statement).
2. Severe physical illnesses, such as: coma, ventilator dependence, obstructive pulmonary disease, Parkinson's disease, Huntington's disease. (This list is an illustration not exhaustive).
3. A discharge from a non-psychiatric acute hospital inpatient stay for a medically prescribed period of recovery. The convalescent period should not exceed 120 days. This is time limited and should be for medical recuperation. If a longer stay is required, the nursing facility should refer the client for additional PAS assessments. If the individual is *known* to have a serious mental illness, an MH PAS agent should conduct a Level I assessment to determine if specialized services are needed, or if a Level II should be conducted to determine what if any psychiatric rehabilitation services are needed during the convalescent stay.

Guidance

If an individual with one of the above conditions is referred for a PAS/MH screening, the PAS agent should conduct a Level I evaluation to determine if the individual is in need of specialized services or if there is a reasonable basis to suspect a severe mental illness. If insufficient information is available to determine whether there is a co-existing severe mental illness or which presenting condition is primary, the PAS agent should conduct a Level II screen to determine if the person is in need of specialized services, requires NF level of care based on their mental health needs and any treatment recommendations. The NF is responsible for providing all mental health psychiatric rehabilitation services less than specialized services to any resident admitted to their facility.

H. Individuals Who Do Not Require a Repeat PAS/MH

Nursing facility residents who were screened previously for a nursing facility admission in accordance with the pre-admission screening rules do not require a repeat pre-admission screen upon readmission or inter-facility transfers. Specifically, repeat PAS/MH screening are not required for individuals if the following conditions exists:

1. Acute Care Transfer. An individual who is transferred to a hospital for acute care services (including psychiatric care) and returned to the nursing facility does not require a new PAS screening.
2. Inter-Facility Transfers. An inter-facility transfer occurs when an individual is transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. The transferring nursing facility is responsible for ensuring that copies of the resident's most recent PAS and resident assessment reports accompany the resident). It is the responsibility of the transferring nursing facility to ensure that copies of the resident' most recent PAS documents, care plan, resident assessments, and copies of the most recent "Interagency Certification of Screening Results" (IDHFS 2536 form) accompany the transferring resident. If a nursing facility resident is not expected to return to the same nursing facility following a hospital stay, it is the responsibility of the nursing facility to ensure that copies of those documents accompany the resident to the hospital. The hospital is responsible to forward copies of those documents to the admitting nursing facility post-hospital discharge.
3. Re-admission. A person who has resided in a nursing facility *for at least 60 days*, and is returning to a facility *after an absence of not more than 60 days*, may be readmitted without a PAS screen.
4. A Level II screen has been completed within the past three months. If the individual has received any type of Level II assessment; re-assessment, within the past three months (90 days) an additional Level II assessment is not required, as long as in the previous review they were determined to be eligible for nursing facility (NF) level of care.

Note: Post Admission Screenings. Illinois Adm. Rule 140.642, Subchapter d, allows admission into an NF without a PAS screening for: "provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears. " Then per Federal Rule, a Level II assessment should be conducted by the 40th day of stay. In this state we require a state sanctioned PAS entity to conduct all pre-admission screening activities so out of state referrals may be screened after admission if the responsible PAS authority receives prior approval of the referral and subsequent admission.

I. Level I Screen Determinations

1. There is a reasonable basis to suspect severe mental illness and a level II assessment is required. There is objective information, documentation that indicates that the individual has one of the qualifying diagnoses or credible evidence that they “may have” which requires further evaluation [e.g., an appropriate level II assessment (re-assessment, partial, complete)].
2. Although there may be some type of psychiatric condition present this individual does not meet the criteria for severe mental illness. The individual may have an axis I diagnosis but it does not reach the threshold for severe mental illness. This may be an individual with some mental health involvement or has one of the “exempted” conditions. They may have behavioral, cognitive or affective symptoms but these are secondary to a primary organic condition.
3. There is no evidence of any type of formal mental disorder excluding organic conditions or substance abuse disorders.
4. The individual does or does not require specialized services (inpatient psychiatric care) at this time.
5. The individual has received a PAS screening in the past three months (90 days) with a positive finding of eligibility. The IDHFS 2536 form remains valid and a repeat level II isn’t required.
6. There is a reasonable basis to suspect DD or a dual condition of MI/DD.

J. Level I Disposition

1. The individual does not require a level II mental health assessment but has some condition which requires further review from another authorized PAS entity (e.g., age 60+ (DoA), developmental disability (DD-PAS), less than 60 and serious medical condition, DRS, and the individual is being referred.
2. The individual requires specialized services (inpatient psychiatric care) and is being referred for follow-up.
3. A Level II Mental Health assessment is required and the appropriate “tier” of assessment will be completed (e.g., Re-assessment, Full, Psychiatric/Medical Exam).
4. There is a reasonable basis to suspect a dual condition of developmental disability and severe mental illness and the individual will be referred to the DD/PAS agent for that area.
5. No follow up is necessary.

Note: If it is determined that no further Level II assessments are necessary the Level I activities are billable if submitted through the UHS Pas Data system. If further Level II assessments are performed, these Level I activities are billed as part of the Level II activities.

K. Reporting and Record Keeping Requirements related to the Level I Screen

1. The “Initial Identification (ID) and Referral” form will be the vehicle by which authorized entities make referrals to the MH/PAS agent if there is evidence that an individual may have a severe mental illness.
2. The “Initial ID and Referral” form is used to provide initial information regarding the Level I screening process. PAS/MH agents are responsible for completing, reviewing and/or amending this document on all individuals who are referred to them.
3. The “Determination and Disposition” of the Level I screen are to be completed only by an authorized PAS/MH contractor. The determination and disposition sections are used to communicate the results of the Level I screen. After completing the review, the PAS agent should share the finds with the referring agency/original screener and maintain a copy in the PAS file with any supporting documentation.
4. If an individual is determined by the PAS/MH agent to be in need of a Level II, then the Level I service activity is reported through the Level II assessment and billing procedures.
5. The PAS/MH agent is responsible for providing a copy of the Level I information for any individual determined to be eligible for a nursing facility in which the individual will reside.
6. The PAS/MH agent is required to keep the supporting data from the completed Initial ID screen including sections determination and dispositions. This should be maintained on file at the PAS/ MH agency. The file should be retained for at least six (6) years. IF the PAS/MH provider’s contract with DHS is terminated, the records are to be transferred to DHS or its successor contractor.
7. If a referral is clearly inappropriate, it may be deflected via telephone without any supporting documentation. However this is not a billable activity.

L. Data Submission and Billing Need Connie’s language here

1. Key data from the Level I screening is to be electronically submitted to DHS utilizing the Unified Health System PAS data system. (see UHS data system manual)
2. Data is to be submitted no later than seven (7) calendar days after completion of the assessment.

V. LEVEL II SCREEN ASSESSMENT PROCESS

A. Purpose of a Level II Assessment

1. The individual has a severe mental illness per the criterion diagnoses,
2. The person needs specialized services (inpatient psychiatric care),
3. There is a need for nursing facility level of care.

B. Individuals Who Must Have a Level II Assessment

1. All individuals suspected of having a severe mental illness must be assessed by PAS/MH before admission into a nursing facility regardless of payment source.
2. A resident of a nursing facility who is suspected to have a severe mental illness.

C. Conditions of the Level II Assessment

1. The PAS/MH assessments must be adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated. If assistance is needed with assessment of an individual with a serious mental illness and a hearing impairment, contact the Deaf and Hearing Impaired Coordinator at Chicago Read Mental Health Center. The number to call is (773) 704-3738 (TTY) or (773) 794-4000 (Voice).
2. The assessments must be conducted by a *qualified* entity that is *independent* of the nursing facility.
3. A PAS/MH agent may use existing relevant clinical information if available, e.g., psychiatric, medical evaluations, discharge summaries, social histories etc. The Level II assessment can use existing data that describes the current functional status of the individual, as long as it reflects accurate data, and is not more than one (1) year old.
4. Temporal information (e.g., current symptoms, level of functioning, mental status, recent treatments and reasons for referral) should be current (less than 90 days old) or must be updated. Other historical data (family history, treatment history, and response) may be valid for at least one (1) year.
5. Where information is not available or where additional assessments will be needed to supplement and verify that the existing data is current and accurate, the PAS/MH agent is responsible for gathering, or completing the assessments.

D. Required PAS/MH Level II Assessments

- Psychiatric Evaluation

A psychiatric evaluation is an in-depth evaluation of an individual conducted by a Board certified psychiatrist, or a physician with training in mental health services or one year of clinical experience, under supervision, in treating problems related to mental illness. The psychiatric evaluation should include:

- a) A complete psychiatric history;
- b) A comprehensive mental status examination, which includes: an evaluation of intellectual functioning, memory functioning, orientation, description of current attitudes and overt behaviors, affect, response to reality testing, suicidal or homicidal ideation, and behaviors that have placed the person or others at risk of serious injury or have resulted in serious injury to self or others;
- c) A diagnostic formulation using the DSM-IV (or most current edition) with recommendations for treatment, services, and proposed interventions for managing risk behaviors if observed or reported; and
- d) If risk behaviors are present, recommendations for treatment, services and proposed interventions for managing risk behaviors.
- e) Current medication needs and any known allergies.

Guidance

Many PAS referrals will have recent psychiatric and medical exams available as the majority of referrals are made during a psychiatric hospitalization. It is unnecessary to repeat these evaluations as long as the information outlined above is included. Ongoing treatment notes or medication reviews do not substitute for complete psychiatric evaluations. If accurate and complete, the psychiatric information is valid for one (1) year. However, DHS will only pay for psychiatric and medical examinations when they are not available and necessary to perform a complete Level II assessment on individuals suspected of having a severe mental illness.

- **Physical Examination and Medical History**
A physical exam and medical history is required. If the information is documented clearly in the record, it is acceptable to use the history and physical information developed during that psychiatric stay. If the physician who completed the exam is not available, then another physician, physician's assistant or advanced practice nurse should review and concur with the conclusions. The information is considered valid for one (1) year.
The following areas must be included:
 - a) Complete medical history
 - b) Complete physical exam
 - c) Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes.

Guidance

It is assumed that persons being discharged from psychiatric care hospitals either public or private will have accompanying medical information. As long as the information is documented clearly in the record, it is acceptable to use the history and physical information developed during that psychiatric stay. This information is also considered valid for one (1) year.

- **"PAS" Mental Health Level II Assessment/Re-assessment"**
The PAS/MH agent is responsible for completing all sections of the "PAS Mental Health Level II Assessment/Re-assessment" screens in the UHS PAS data system and attached components. (E.g. "Level of Care Utilization System", (LOCUS) "Maladaptive Behavior Scale", "Mental Status Exam"). This should be completed by a QMHP. A MHP under the direct supervision of a QMHP may participate in gathering this information but the QMHP must review and concur with the findings.

The "PAS Mental Health Level II Assessment/Re-assessment" document is a comprehensive review, compilation and summary which includes:
 - Identifying information;
 - Referral information;
 - Pertinent social history;
 - Psychiatric history and response to treatment,
 - Specific functional limitations (Level of Care Utilization System);

- Psychiatric/Medical evaluations;
- Current mental status;
- Diagnostic impression;
- Clinical summary;
- Housing Instability
- Determination and Disposition summary and
- “History of Antisocial/Maladaptive/Risk Behaviors” This is review of the individual’s history of maladaptive behaviors that have placed the person or others at risk of serious injury or have resulted in serious injury to self or others. The review must specify which of the following areas do apply or do not apply to the individual. If a situation does apply, a description must be provided that include time frames of occurrences, and details about the behavior. If applicable, the following areas and or situations should be documented:
 - criminal justice system involvement, self reported information
 - antisocial behavior
 - physical violence towards others
 - self injurious behaviors
 - property damage
 - threatening others with physical or sexual abuse
 - fire setting or arson
 - suicidal gestures or threats
 - suicide attempts
 - self mutilation
 - elopement placing self or others at risk
- When applicable, the PAS agent should share recommendations developed by the referring entity (e.g., hospital, community mental health agency) addressing the individual’s current and future treatment needs in the following areas:
 - Specific proposed interventions for managing risk behaviors observed and/or reported during admission
 - Specific psychosocial rehabilitation needs
 - Specific activity of daily living skills training needs (hygiene, dressing, feeding, etc.)
 - Specific medications required
 - Specific follow-up treatment required

VI. LEVEL II ASSESSMENT REVIEWS

The Level II assessment review is a complex process, which includes: a mixture of clinical data collection, face-to-face evaluations, determinations, and disposition/referral processes. It is the responsibility of the PAS agent to compile evaluation materials using the PASRR assessment screens in the UHS PAS data system as well as hard copies of other pertinent supporting documents. (e.g., psychiatric/medical evaluations, discharge summaries, social histories, medication information, etc.). All records should be maintained in the PAS/MH file for six (6) years. The Level II assessment review consists of two “tiers” which are based upon the availability of current assessment materials, the amount of time and expense related to completing the required evaluation, and state and federal requirements. In addition, a required valid psychiatric/medical exam may or may not be available at the time of the Level II assessment. Thus, the PAS agency may need to “procure” and pay for this psychiatric/medical

exam. When a “Full” (complete) or “Partial” (Re-assessment) is completed a psychiatric/medical exam may be purchased if necessary.

A. Psychiatric/Medical Exam

1. Federal and state rules require that a psychiatric/medical exam be performed as part of the Level II process.
 - a) The psychiatric section should be performed by a board-certified psychiatrist and/or physical exam and medical history should be completed by a licensed physician, physician’s assistant or advanced practice nurse.
 - b) When existing psychiatric/medical evaluation materials are timely, (less than one year old) complete and available, those assessment materials may be used to substantiate the findings in the Level II process.
 - c) Someone independent of the nursing facility must complete the psychiatric medical/exam.
 - d) When the PAS agent completes either tier of the level II process (full or partial) and they arrange and purchase the psychiatric/medical evaluation this service is billable if reported in the UHS PAS data system.

B. Types of Level II Assessments

1. Full or Complete Level II Assessment

The “full” Level II assessment is a screening completed on referred individuals to determine if the individual meets the federal and state eligibility requirements for admission to a nursing facility. If the PAS/MH agent completes all assessment, evaluation and determination components, it represents a “full” Level II.

- a. The PAS agent responsibilities include the following:
 - 1) At least one face-to-face contact with the individual within three (3) business days from the initial referral contact.
 - 2) A review of the following written assessments:
 - Psychiatric evaluation completed within the past year provided by a hospital, attending physician or others;
 - Physical exam and medical history completed within the past year provided by licensed physician, physician’s assistant or advanced practice nurse;
 - “PAS Mental Health Level II Assessment” completed by the staff screener based on their review of the above;
 - Use of additional available assessments to make nursing facility placement eligibility determination, including other available clinical documentation, interviews, of the individual or significant others.
 - 3) The PAS agent must make all necessary determinations, and complete supporting documents (e.g., “Notice of Determination”. IDHFS 2536 form, Transmittal letter”).

- b. Reporting. Demographic and clinical data should be entered into the UHS PAS data system as it gathered, but no later than 48 hours after the face-to-face screening has been completed.
- c. After the screening is completed and entered pas agencies may either bill the activities immediately or send the billings in batches. Billing should not exceed 30 days form the completion date of the screening. The PAS agency should bill at the “full” rate if the contractor completes all the required mental health assessments and required outcome and determination instruments.
- d. Reports: The UHS data system will generate a print packet which includes clinical reports, the #2536, “notice of determination” and the “transmittal letter”.

2. Level II Re-assessment

The Level II Re-assessment is required when an individual is referred to PAS screening after receiving a full or partial Level II previously that year. This re-screening is to be utilized to update PAS information from a previous PAS assessment. PAS assessment materials are considered valid for three months (90 days) as long as referral information is updated.

- a. The PAS agent responsibilities include the following:
 - At least one face-to-face contact with the individual within three (3) business days from the initial referral.
 - Review materials from the previous PAS Level II assessment, assuring accuracy and updating demographic and clinical data.
 - Make all necessary determinations and complete supporting documents (e.g., Notice of Determination, IDHFS 2536 form, Notice of Determination, transmittal letter etc.).
- b. When previous mental health assessment components are available, the PAS agent should review the materials for accuracy updating temporal information such as mental status, history of treatment, LOCUS, and then complete all necessary outcome and determination instruments/functions.
- c. Reporting. Demographic and clinical data should be entered into the UHS PAS data system as it gathered, but no later than 48 hours after the face-to-face screening has been completed.
- d. Billing. After the screening is completed and entered pas agencies may either bill the activities immediately or send the billings in batches. Billing should not exceed 30 days form the completion date of the screening. The PAS agency should bill at the “full” rate if the contractor completes all the required mental health assessments and required outcome and determination instruments.
- e. Reports: The UHS data system will generate a print packet which includes clinical reports, the #2536, “notice of determination” and the “transmittal letter”.

C) Level II Screen Supporting Documentation

1. Medical and psychiatric information is considered valid for one (1) year.
2. The PAS/MH Level II screen is valid for three (3) months (90) calendar days from the date of the determination (the signature date of the “IDHFS 2536”).
3. The PAS/MH Level II screen may remain valid after three months (90) calendar days when the PAS/MH agent updates any of the components of the assessments, which are not current. (Re-assessment/partial)
 - a) If an individual is referred for another PAS screening after 90 days but less than one year, the PAS agent should review the materials for accuracy and completeness and update any necessary components (e.g., referral information, mental status, recent history of treatment, presenting problems, functional impairments, etc)
 - b) If the information is current and credible, the PAS agent should complete the appropriate outcome and determination forms, the “IDHFS 2536” form, “Notice of Determination” and “Transmittal Letter”, and forward to the receiving nursing facility.
 - c) All determination, disposition documents are valid for three months (90 days from the signature date of the “IDHFS 2536”).

D. Record Retention and Release of Information

The QMHP reviews all assessments and confers with other assessors as necessary and makes all determination and outcome decisions for each individual who receives a Level II assessment.

4. The original assessments must be maintained in the individual’s file at the PAS/MH’s Division. PAS/MH’s Division. PAS/MH assessments and forms must remain in the file for a period of at least six (6) years. If the PAS/MH provider’s contract with DHS is terminated, the records are to be transferred to DHS or its successor contractor.
5. The PAS/MH shall provide copies of all of the assessments to the residential setting where the individual will reside. A “Release of Information” form should be executed to authorize the release of the assessments. This release should conform to all requirements of the Mental Health Confidentiality Act and Federal HIPAA standards. This release should allow the PAS agent to gather all necessary supporting documentation to complete the assessment and also release the findings to the receiving nursing facility (see attached releases).
6. The initial face-to-face meeting should occur within three (3) business days and all other assessments must be scheduled, completed, and nursing facility level of care determinations made within ten (10) calendar days from the date the individual was referred.

VII. LEVEL II SCREEN DETERMINATION PROCESS

A. Purpose of Level II Determination Process

The determination process is used to determine the appropriate level of care for an individual, which are identified from the assessment process. The PAS/MH must make two determinations:

1. Determination of Need for Specialized Services (in-patient psychiatric care).
2. Determination of Need for Nursing Facility Level of Care.

B. Criteria for Determining the Need for Specialized Services

Some individuals who have a severe mental illness may be identified as having acute psychiatric treatment needs. When determining if an individual requires specialized services (in-patient psychiatric care), the PAS/MH agent should conclude if:

1. There is a reasonable expectation that the individual will inflict serious physical needs so as to guard self from serious harm upon self or others in the near future; or
2. The individual is unable to provide for basic physical needs so as to guard self from serious harm.

If either of the above-stated indicators is present, PAS/MH shall immediately refer the individual for appropriate specialized services (in-patient psychiatric care).

C. Criteria for Determining the Need for Nursing Facility Level of Care

There are two types of eligibility determinations for nursing facility care “**Indefinite Stay**” and “**Time Limited**”. The LOCUS will be the primary tool to determine time-limited eligibility, recognizing that other clinical, medical, financial and historical factors may play an important role. Generally persons will be found eligible on a **time limited basis** when they demonstrate the functional abilities or can acquire them within the time frame of a six month stay in a nursing facility to live in more integrated community setting. Key consideration should be given to factors such as such as history of engagement in treatment, significant family/community support and previous housing stability. (see attachment: “Clinical Factors in Determining Time Limited Eligibility”.) With either eligibility determination persons must meet the criteria below.

1. Severe Mental Illness. To meet the criteria for severe mental illness the PAS/MH agent must determine if
 - The individual has an eligible diagnosis of schizophrenia; delusional disorder; schizoaffective disorder; psychotic disorder not otherwise specified; bipolar disorder I – mixed, manic, and depressed; bipolar disorder II; bipolar disorder not otherwise specified; major depression, recurrent.
 - The diagnosis has been present for at least one year.
 - The individual is 18 years of age or older and as a result of the mental illness, exhibit resulting substantial functional limitations in at least two of the following areas:
 - ✓ Self-maintenance
 - ✓ Social Functioning
 - ✓ Community Living Activities
 - It has been determined that the person’s functional abilities are not impaired primarily due to substance abuse problems.

- The functional disability is of an extended duration expected to be present for at least a year, which results in substantial limitation in major life activities.
 - The level of support the individual needs cannot be provided for the individual in an alternative community setting or
 - A nursing facility level of care is appropriate.
 - Mental Health Rehabilitative Services: The PAS/MH agent must determine if the individual needs the availability of mental health rehabilitative services in the form of assessment, monitoring, intervention, and supervision on a 24-hour basis in the following areas:
 - Professional observation for medication monitoring (adjustment and/or stabilization) and
 - Daily supervision and assistance in at least two of the following areas:
 - ✓ Self maintenance – physical functioning; personal care and hygiene; dressing; grooming; toileting; nutrition; speech and language; eating habits; maintenance of personal space of possessions; health maintenance; use of medication; and self-medication program.
 - ✓ Social functioning – interaction and involvement with family/significant others; social skills and relationships with friends; peer group involvement; ability to pursue leisure/recreational activities; and education regarding alcohol and substance abuse.
 - ✓ Community Living Activities – interaction and involvement with family/significant others; social skills and relationships with friends; peer group involvement; ability to pursue leisure/recreational activities; and education regarding alcohol and substance abuse.
2. When making the determination for nursing facility (NF) placements, the PAS/MH agent should note in their review and assessment some of the following characteristics
- A long history of community mental health services including multiple hospitalizations,
 - Poor compliance with follow-up services,
 - Disability has been founded and individual receives social security benefits,
 - As a result of mental illness, individual has difficulty caring for him/herself,
 - Role functioning impairments leave them vulnerable in non-institutional settings,
 - Does not present a long history of antisocial and drug seeking behaviors not directly associated with their mental illness,
 - Persons whose symptoms are not sufficiently stabilized to remain sane in a non-institutional setting.
 - it has been determined that the individual has significant housing instability
 - lacks independent living skills

Guidance

Persons that have been recently diagnosed or just beginning psychiatric treatment should be referred to community treatment agencies or inpatient facilities for further mental health services. Likewise, persons who are acutely ill are not suitable for NF level of care. Nursing facilities are responsible for providing “all services less than specialized”. If further hospitalization is needed to stabilize the patient, such recommendations should be made.

It is common for persons with severe mental illness to have co-occurring substance abuse disorders. However in some cases, severe substance abuse/dependence can mask or mimic the symptoms of severe mental illness. Therefore, it is necessary to differentiate the level of impairment attributable to their mental illness and the role of a substance abuse disorder. Identification of serious substance abuse is also critical to treatment planning and in determining if a nursing home can address the person’s treatment needs. If the substance abuse disorder seems to be primarily responsible for role functioning impairments, the person should be deflected from nursing facility care and referred for inpatient, intensive outpatient or MISA substance abuse

3. The PAS agent must determine if there is a reasonable basis to believe that the individual will benefit from receiving mental health rehabilitative services.
 - Consistent implementation during the resident’s daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors;
 - Pharmacotherapy including administration and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;
 - Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal);
 - Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skill they need to be more independent and self-determining.
 - All services are outlined in Subpart S [Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)] effective February 15, 2002.

Guidance

Due to their symptoms, some individuals may have difficulty coping in a congregate setting and may be at risk to act out against others or self-abuse. These individuals might benefit more from intensive mental health programs or inpatient care. If there is a history of or substantial risk of noncompliant, maladaptive or aggressive behavior, it should be reported clearly in the determination correspondence.

D. Outcomes of the Level II Determination Process

Possible outcomes of the Level II determination process are as follows:

1. **Specialized Services are needed**
If an individual is determined to need specialized services (inpatient psychiatric care), he or she should be referred to a local psychiatric hospital, psychiatric unit of a general hospital, or a state hospital or inpatient/intensive outpatient substance abuse services.

2. **Specialized Services are not needed**
If an individual is determined to **not need** specialized services (in-patient psychiatric care), a determination as to their need for a nursing facility level of care can be made.
3. **Nursing Facility Level of Care is needed**
If an individual is determined to need a nursing facility level of care due to their mental health needs, the individual may seek admission into any licensed nursing facility they choose. The nursing facility is responsible for determining if their facility is capable of meeting the individual's mental health service needs.
4. **Nursing Facility Level of Care is not needed**
If it is determined that an individual does not require a nursing facility level of care because of their mental health needs, the PAS/MH agent shall inform the individual of alternative non-institutional settings capable of meeting his or her needs for services. The PAS/MH agent shall also refer the individual back to the mental health provider which recommended nursing facility care or contact the mental health agency servicing the individual's geographic area to make an appointment for the individual to be assessed for services. Alternative services may include, but are not limited to:
 - a. Supervised/supported residential settings
 - b. Private housing with outpatient mental health services provided by community agencies
 - c. Psycho-social rehabilitation, intensive stabilization or partial psychiatric hospital services
 - d. A combination of outpatient mental health services combined with home support services such as: community integrated living services, assertive community treatment, intensive outpatient etc.

Note: If the individual still wishes to seek admission to a nursing facility for other medical reasons, he or she should be referred to the appropriate screening agency, e.g., DRS or DoA.

E. Required Forms – Determination and Outcomes of the Level II Assessment

1. **“PAS mental Health Level II Assessment/Re-assessment”**
These data elements are included in the UHS PAS data system but can also be acquired by printing the HTML screens or in a separate PDF hard copy. The data elements include information such as: presenting problem, reason for referral, pertinent social history information, history and response to treatment, evaluation of role functioning impairment, mental status, assessment of substance abuse, a review of the individual's history of antisocial/maladaptive/risk behaviors, and necessary outcome determinations and dispositions. This information has been encoded into the UHS PAS Data System.
2. **“Level of Care Utilization Instrument”**
A functional assessment using the LOCUS instrument which indicates the level of role functioning impairment/ability. This assessment will be used to determine whether the level of support is such that nursing facility placement is needed.
3. **PAS/MH “Notice of Determination” Form**

- a. The PAS/MH “Notice of Determination” form must be completed for each individual who completes the PAS/MH Level II process. This notice provides the individual with the following:
 - An interpretation and explanation of the results of their Level II screen.
 - The results of the assessments and determination process as it applies to their need for specialized services and nursing facility level of care.
 - Identifies the services required to meet their assessed needs.
 - Provides a full explanation of their right to appeal the PAS/MH Level II determinations.
- b. A copy of the completed PAS/MH “Notice of Determination” form should be distributed as follows:
 - individual
 - admitting nursing facility
 - discharging hospital
 - original form must be maintained on file at the PAS/MH agency.

F. Additional Required Forms (If the individual is found eligible for nursing facility placement):

1. “Interagency Certification of Screening Results”, IDHFS Form 2536
 - a) The “Interagency certification of Screening Results” (IDHFS 2536) is to be completed by PAS/MH on all individuals PAS/MH has determined to need a nursing facility level of care.
 - b) “IDHFS 2536” form is used by IDHFS to initiate nursing facility payment for eligible clients.
 - c) A copy of the IDHFS 2536 form is to be provided to:
 - The first three pages of the quadruplicate form are to be given to the nursing facility.
 - The last page should be maintained in the individual’s file at the PAS/MH agency.
2. “Transmittal Letter” stating the findings of the Level II review and supporting documentation should be provided to the receiving nursing facility. A template for this is appended to the manual.

All information must be maintained electronically or in hard copy at the PAS/MH Division for a period of at least six (6) years.

VIII. DETERMINATIONS SUBJECT TO APPEAL

An individual or his or her designated representative (guardian, attorney, or any other person acting at his or her request, may appeal determinations by the responsible PAS/MH agent. Determinations that may be considered adverse and may be appealed are as follows:

- ? Individual does or does not require specialized (psychiatric inpatient care) services.
- ? Individual does or does not need the level of care provided by a nursing facility.

A. Notice of Appeal

1. The individual, his or her designated representative (guardian, attorney,) may appeal the PAS/MH decisions, by sending a written request for a review within 30 calendar days from the date on the *Notice of Determination*.
2. The request must include a copy of the “PAS/MH Notice of Determination” form and should be forwarded to:
Coordinator of PAS Services
Division of Mental Health
319 East Madison, Suite 3B
Springfield, Illinois 62701
3. The coordinator shall contact the parties involved to discuss the facts in dispute and to clarify any other issues. The coordinator may request that the relevant documents be submitted for review in advance. After reviewing the information, the coordinator will forward a written decision and relevant findings, either dismissing or upholding the appeal decision to the individual or designated representative. A copy of this written decision and relevant findings shall also be sent to the PAS/MH agent. This decision is final as it relates to the need for specialized services.
4. If the issue of appeal is the determination for need for nursing facility level of care, the individual or their designee may appeal a negative decision by DHS/DMH to the Illinois Department of Healthcare and Family Services, Bureau of Long Term Care.

B. Second Appeal

1. If the appeal for a determination of nursing facility service is denied, the individual has the right to request that a licensed physician designated by IDHFS review the medical reports and any other evidence the individual wishes to submit, and certify whether there is a need for nursing facility services in the individual’s case.
2. The complaint must be made within 30 days of the denial and be forwarded to:

Illinois Department of Healthcare and Family Services
Bureau of Long Term Care
201 S. Grand Avenue East, 3rd Floor
Springfield, Illinois 62763
Phone Number: (217) 524-7244

IX. RESIDENT REVIEW PROTOCOL

The persons identified for Resident Review will be determined by DHS/DMH, State and Federal policy. Resident Reviews will be conducted under three circumstances: an “Initial Review” following admission of a person to a licensed nursing facility, a “Quality Assurance/Continuing Stay Review” following a period of targeted case management transition services which were unsuccessful, and reviews based on a “significant change” in the resident’s condition. A fourth type of review “Targeted Review” may be implemented at a later date. The goal of Resident Review assessments are to determine if the mental health needs identified in the PAS assessment are integrated into the individual’s facility care plan, to offer the consumer choice in his living arrangement and to determine if the individual could begin the transition to a less institutional setting.

A. (New) Initial Admissions

An initial admission into an NF/NF-IMD will automatically result in a referral for Resident Review. New admissions to nursing facilities are expected to require a Resident Review to be completed after the 30th day of admission and prior to the 60th day of admission. (Note: Persons who are found to be eligible for nursing facility level of care on a time limited basis, based on the clinical findings of the initial PAS screening, will per policy, receive Targeted Case Management services which precludes the need for an “Initial” Resident Review).

1. Resident reviews shall be performed on all persons admitted into a licensed nursing facility after the 30th day of stay and prior to the 60th day of stay. The review shall:
 - Establish that persons are receiving the psychiatric rehabilitation services indicated in the Level II assessment
 - Conduct a re-assessment of the person’s functional abilities to determine if a greater or lesser level of care is necessary to meet the consumer’s clinical needs
 - ascertain consumer choice around treatment issues and living arrangements supported by clinical assessment
 - assure that necessary discharge/linkage planning is being conducted if appropriate including referral for targeted case management if appropriate.
2. The Department will only purchase a maximum of two Resident Reviews per person per year.

B. Change in Condition

The nursing facility shall report in a format established by the applicable State authority or its designee, significant changes in a resident’s condition as required by 42 U.S.C. §1396r(e)(7)(B)(iii)(1999). For the purposes of this subsection, a “significant change” for a resident with severe mental illness will be determined by the Illinois Department of Healthcare and Family Services. This change in condition will result in a referral to DHS/DMH for a

review of the resident's condition. Such a review may be triggered when a substantial change in the individual's status has occurred such as the following conditions:

1. Previously found severely mentally ill, and who has continuously resided in a nursing facility within the last 12 months; who has been referred for admission or been admitted to a psychiatric hospital or psychiatric ward of a general hospital for psychiatric care three (3) or more times within that 12 month period;
2. Previously found to be severely mentally ill, and who is later evaluated by the nursing facility and is found to no longer have a severe mental illness;
3. Not to be severely mentally ill, and who is later evaluated by the nursing facility and is found to have a severe mental illness;
4. To be severely mentally ill, who does not have a medical need for nursing facility level of care, and who meets all of the following:
 - a) No longer receives any intervention programs for mood, behavior or cognitive loss;
 - b) Has successfully completed skills development training or otherwise acquired the functional abilities to return to the community;
 - c) Has expressed an interest in returning to the community.

C. Quality Assurance/Continuing Stay Review

Persons were found eligible for NF level of care on time limited basis (vs. indefinite) will automatically be referred for targeted case management. TCM). If the individual fails to make the transition from the NF into a more independent setting.

1. The TCM worker will make a referral for Quality Assurance/Continuing Stay Review (QA/CSR) to the responsible reviewing agency.
2. The reviewer will conduct a resident review assessment per the guidelines indicated above.
3. Additionally the resident reviewer will indicate the reasons for the persons lack of progress with the transition plan i.e., increase in psychiatric symptoms, deterioration in functional abilities, expressed interest in remaining in the facility, lack of community resources to address the clinical needs, poor compliance with transition plan, etc.
4. The reviewer will complete a new #2536, which constitutes the continuing stay decision.
5. The reviewer will document in the clinical summary his findings regarding the person's lack of progress with the transition plan and any recommendations regarding additional services that may be warranted.
6. If the reviewer finds that the person does not require an NF level of care, DHS/DMH should be notified via e-mail regarding that determination.

D. Dispositions. The resident review determinations should identify one of the following dispositions:

1. If specialized services (in-patient psychiatric care) are needed, he/she should be referred to a local psychiatric hospital, psychiatric unit of a general hospital, or a state hospital.

2. If a nursing facility level of care is needed because of an individual's severe mental illness, he or she may continue to reside in the licensed nursing facility of their choice. The nursing facility is responsible for determining if it has the capability to meet the mental health and medical needs of the individual. However the PAS agent should determine if:
 - a) The current treatment plan is adequate to plan for resident's mental health care and;
 - b) If not, assist by providing information necessary to amend the mental health treatment plan to meet the resident's needs.

3. If a nursing facility level of care is not needed due to their severe mental illness, the PAS/MH agent will do the following
 - a) Inform the individual of alternative non-institutional settings capable of meeting his/her needs for mental health services.
 - b) Provide information on how to contact the local mental health agency serving the individual's geographic area so that they might make an appointment to be assessed for services.
 - c) Refer the individual for targeted case management if appropriate (note: per State Plan each individual may only receive a maximum of 40 hours per year of TCM, see attachment "Targeted Case Management")

E. **Referrals** for resident review will be received in a variety of ways.

1. "Initial Review" referrals will be generated electronically from the UHS PAS data system to the responsible PAS reviewer. When there is a "significant change" in the status of a resident, the referral process is as follows:

2. The nursing facility is responsible for determining a significant change in an individual's status and referral for resident review. The nursing facility will notify DHS/DMH when there is a significant change in the status of a resident. DMH will forward the referral request to the appropriate PAS agent.

3. DHS/DMH Central Office will generate referrals for Quality Assurance/Continuing Stay when an individual has been found eligible on a time-limited basis subsequently assigned targeted case management, which was unsuccessful. The review will focus on the reasons for the lack of progress in transition from the NF and to validate the persons need to continue their stay in the NF by completing a new #2536.

4. The PAS agent is to conduct a resident review within fifteen (15) days of the receipt of the referral from Central Office.

G. Documentation Distribution, Record keeping, and Data Submission

1. The principal document used to conduct Resident Reviews will be the resident review screens in the UHS PAS data system.

2. All resident review data will be submitted electronically using the UHS PAS web based application.

X. Targeted Case Management

A. Description of TCM Services:

Targeted Case Management (TCM) services will assist identified individuals by providing assessment, care planning, referral/ linkage and monitoring activities in support of transition to lesser levels of care. These services will locate and coordinate linkage to needed housing, financial and mental health resources in the community. TCM services will be authorized at some point during the last 180 days of nursing facility stay. These services may be provided through the transition period from discharge to successful linkage with community services. TCM services should be concluded when the individual is linked and successfully engaged in community-based services, including residential, mental health and/or substance abuse and medical services.

TCM services may only be provided based on referrals when authorized by DMH. The following TCM services are focused specifically on facilitating transitions for nursing home residents into non-institutional community settings. These services are limited to re-settlement, linkage and other related issues.

- Assistance with securing basic necessities (e.g., food, income, housing, medical care)
- Engagement of consumer in their transition plan.
- Linkage with a continuum of mental health services
- Assessment and planning around independent activities of daily living/community living skills.
- Linkage with entitlements and protective payee if necessary.
- Collaboration with consumer's family/personal support network.
- Critical services for TCM clients to be provided by referral linkage include:
 - Psychiatric services, Medication management, unit dose, ongoing mental health services to maintain the consumer in a community setting

B. Policy and Procedures: Referrals for Targeted Case Management

1. The Central Office, DMH will use management reports to identify persons for referral to TCM services.
2. After initial authorization, the DMH, Central Office will forward a referral for TCM services via electronic e-mail to the responsible PAS agent. (The PAS agency with geographic responsibility for the area where the consumer resides)
3. A copy of this notification will be forwarded to Healthcare and Family Services (HFS).
4. TCM Services will be authorized under two circumstances:
 - a) When the initial PAS screening determination is for time limited eligibility for NF or NF/IMD. Time limited eligibility is based on:
 - services are not expected to be needed beyond 120 days,
 - the individual has a place to return in the community (e.g., family, community residential setting, subsidized apartment, other stable housing, etc.)
 - the individual has demonstrated an ability to live in the community previously with mental health supports

- the individual either possess or can develop within a limited length of stay, self-management skills to live successfully in a non-institutional setting

Or

b) When a Resident Review indicates the consumer is prepared to begin transition from nursing facility level of care to a lesser level of care and the consumer has expressed an interest in moving to a less institutional setting or the review reveals their condition requires a higher level of care. Resident Review services will be provided to those persons previously designated as having a serious mental illness who are currently residing in a nursing facility and

- have been identified as having a “significant change” in their condition which requires less intensive or more intensive care

Or

- who requires such a review per State policy

C. HFS Billing Requirements:

1. PAS providers will use procedure code T1016 with a modifier of HN or HO when billing the targeted case management service. The claims can be submitted electronically or in hard copy paper. For information on electronic billing, please refer to Medical Electronic Data Interchange (MEDI)/Internet Electronic Claims (IEC) at <http://www.myhfs.illinois.gov/>

2. To bill hard copy paper, use the HFS 1443, Provider Invoice. Instructions for completing the HFS 1443 can be found in the CMH-200, Handbook for Providers of SASS Services on the Web site at: <http://www.hfs.illinois.gov/handbooks/chapter200.html#cmh200>

D. Rates/Payment Limits and Conditions:

1. The rates are illustrated in the table below:

HCPCS Code	Modifier(s)		Place of Service	Notes	Unit of Service	Rate per unit of service
	(1)	(2)				
T1016	HN		11	On-site; MHP	1/4 hour	\$ 16.58
T1016	HN		99	Off-site; MHP	1/4 hour	\$ 19.23
T1016	HO		11	On-site; QMHP	1/4 hour	\$ 17.88
T1016	HO		99	Off-site; QMHP	1/4 hour	\$ 20.74

2. TCM services must be provided at a minimum of (2) hours per week and a maximum of (8) hours per week
3. The total number of TCM service hours is not to exceed (40) hours per individual per calendar year without prior authorization
4. These services must be initiated during the last 180 days of stay in an NF-NF/IMD

5. Services must be guided by a transition plan that includes consumer preferences
6. A monthly summary of TCM services must be forwarded to the Central Office, Division of Mental Health

E. Documentation:

1. Using the MH PAS assessment, nursing facility and other medical records and input from the consumer transitional needs plan should be completed within 30 days of initiating TCM services. This plan should include: resident strengths, preferences, and assessment of functional abilities/deficits, re-settlement issues that are the focus of treatment. This plan will be included in the monthly reporting process below.
2. *Monthly Summary of TCM Contacts* must be forwarded to the Central Office, Division of Mental Health at the address below.
3. *Final Disposition Plan* should be completed which identifies the: new living arrangement, how basic needs will be met, mental health and other support services that are in place, any unresolved service needs that require immediate attention. This document should also be forwarded to the address below.

Mail Address:

C/O DMH PAS Coordinator,
Centrum Building, Suite 3B
319 East Madison
Springfield II, 62701

Fax Number: 217-557-8568

Contact Person: Dennis Smith

Phone: 217-557-8568

XI. Quality Improvement

A. Procedures

PAS/MH providers will have in place and maintain its own continuous quality improvement and quality assurance activities, which will be inclusive of PAS/MH services.

B. Review Process/Internal

The review process shall determine:

- a. If all required PAS documentation is complete and accurate,
- b. If the person meets the standards for severe mental illness,
- c. If the documentation supports the determination decisions (i.e., not a risk to self or others) for needed nursing facility level of care.

C. External Review

DHS/DMH may conduct Quality Assurance activities on reported PAS screenings through electronic reports.

XII. BILLABLE SERVICES: SPECIFIC PAYMENT RATES, LIMITS and CONDITIONS

The purchase of service rates is established through the contract negotiation. The DHS, Division of Mental Health will purchase the following screening activities:

A. Level I Determination and Disposition

- a) When the PAS agent receives information on the Initial ID screen that requires further evaluation that results in making a Level I determination and disposition the activity is billable if the following conditions are met:
 - i. The initial screen indicates a reasonable basis to suspect a severe mental illness;
 - ii. The PAS agent examines supporting documentation;
 - iii. This results in completing sections of the Determinations and Disposition form);
 - iv. A Level II assessment is **not** conducted;
 - v. This information is documented and entered electronically

Specific Payment Rate: \$80

Payment Limits/Conditions : May be billed once every 30 days.

b) Inappropriate Referrals

If the information on the Initial reveals no basis to suspect a severe or any mental illness, the PAS agent should stop all evaluation activities and inform the referral source of their finding. This is not billable under the terms of the contract.

B. Psychiatric/Medical Exam

1. A board-certified psychiatrist should perform the psychiatric section. A licensed physician, physician's assistant or advanced practice nurse should complete the physical exam and medical history.
2. When existing psychiatric/medical evaluation materials are timely, (less than one year old) complete and available, those assessment materials may be used to substantiate the findings in the Level II process. No additional psychiatric/medical is needed nor should be billed..
3. When the PAS agent completes either tier of the level II process (full or partial) and they arrange and purchase a psychiatric/medical evaluation his service is billable if reported in the UHS PAS data system.

4. The name of the physician, location of the exam date and the date of the exam as well as justification for purchasing the exam must be documented in the PAS data system
5. The psychiatric/medical exam evaluations must be arranged and provided prospectively for the current PAS assessment. Exams cannot be billed retrospectively.
6. The psychiatric medical/exam must be completed by someone independent of the nursing facility.

Specific Payment Rate: \$100

Payment Limits/Conditions: Can be billed once in a calendar year.

C. Level II Types of Assessments

1. **Full (complete) Level II Assessment**
 - a) This must include at least one face-to-face contact with the individual. When all required mental the PAS agent completes health assessments, evaluations, and determinations. When the PAS/MH agent initiates all assessment, evaluation and determinations.
 - b) When there has never been a previous PAS screening, the screening was conducted more than a year ago, or the evaluation materials are not available to the current PAS screener a Full Level II assessment should be conducted.
 - c) When these services are reported and billed through the UHS PAS data system;

Specific Payment Rate: \$400

Payment Limits/Conditions: Can be billed once in a calendar year.

2. **Partial Level II or Re-assessment**

This is required when an individual presents for another PAS screening after receiving a full or partial Level II previously that year. This re-screening is to be utilized to update PAS information when all the required PAS documentation is available and valid.

 - a) Other PAS assessment materials are considered valid for 90 days as long as the referral information is updated. It requires face-to-face contact, review and update of assessment materials, completion of all necessary documentation in support of the determination and outcome process. The PAS agent must review the materials and determine that they are complete and accurate updating any missing information.
 - b) The PAS agent shall conduct a face-to-face contact and make all necessary determinations and reports these findings via the documents specified above.
 - c) It is the contractor's responsibility to make every effort to ascertain if the individual has been in a nursing facility previously and if they have received prior PAS screenings.

- d) PAS contractors will be able to access a PAS activity database which will give client specific information on previous billable activities provided. The contractor should perform/bill the appropriate assessment necessary given the requirements outlined above;

Specific Payment Rate: \$320

Payment Limits/Conditions: Can be billed every 90 days.

D. PAS/MH Resident Review Activities

1. The persons identified for Resident Review will be determined by DHS/DMH, State and Federal policy. Resident Reviews will be conducted under three circumstances: an “Initial Review” following admission of a person to a licensed nursing facility, a “Quality Assurance/Continuing Stay Review” following a period of targeted case management transition services which were unsuccessful, and reviews based on a “significant change” in the resident’s condition. A fourth type of review “Targeted Review” may be implemented at a later date. The goal of Resident Review assessments are to determine if the mental health needs identified in the PAS assessment are integrated into the individual’s facility care plan, to offer the consumer choice in his living arrangement and to determine if the individual could begin the transition to a less institutional setting.
2. The assessment findings and determinations of the resident review will be documented in the UHS PAS data system Resident Review screens. This will be reported and submitted electronically as are other PAS billable services.

Specific Payment Rate: The payment rates for PAS/MH Resident Review rate is the same as a mental health re-assessment: \$240

Payment Limits/Conditions: The Department will only purchase a maximum of two Resident Reviews per person per year

E. Targeted Case Management. (See section X.)