

**PRE-ADMISSION SCREENING/RESIDENT REVIEW
MENTAL HEALTH
(PASRR/MH)**

PROCEDURE MANUAL

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

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I. PURPOSE AND SCOPE OF THE PASRR/MH MANUAL

The purpose of the PASRR/MH Manual is to provide information and instructions to PASRR/MH agents in performing, documenting and completing Pre-Admission Screening assessments for Long-Term Care admissions.

The PASRR/MH Manual establishes a standardized procedural structure and uniform decision criteria for implementing the PASRR/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) – the designated State agency responsible for planning and coordinating resources for individuals who are 60 years of age and over.

Authorized Entities – Entities authorized to complete the initial OBRA I - Identification Referral Form for a PASRR/MH assessment. These entities include: DoA Care Coordination Units (CCU); DRS rehabilitation counselors or DRS screening agents; PASRR/MH agents authorized by DMH; hospital discharge planners/social workers (private psychiatric hospitals, general hospitals and state psychiatric hospitals); nursing facility staff; Specialized Mental Health Rehabilitation Facilities (SMHRF) staff; and DHS/DMH contracted community mental health centers.

Appeals process – The process by which an individual (or representative) may elect to challenge the decision/ determination made as a result of the PASRR/MH assessment.

Care Coordination Units (CCU) - local community agencies contracted by the Department on Aging that provide care coordination services to help older adults and caregivers determine what their specific needs are and what services are available to meet those needs. The care coordinator can discuss community-based services that are funded by the state and federal government and those that an individual can purchase with his or her own resources. The CCUs also conduct Pre-Admission Screening for individuals age 60+ who are seeking

admission to Long Term Care facilities (nursing homes) or who are accessing Medicaid “waiver” services. The CCUs also contract with the DHS/Division of Rehabilitation Services (DRS) (in most areas of the State) to provide Pre-Admission Screening to individuals seeking admission to a Long-Term Care facility and who are under age 60 and suspected to have a disabling physical disability.

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

Convalescent Care – Skilled care involved to facilitate gradual return of health after an acute medical condition/illness for a period not to exceed 120 days. **This type of admission may be exempt from a level II PASRR/MH assessment unless** there is a reasonable basis to suspect a severe mental illness.

Human Services, Department of (DHS) – The Illinois State Department responsible for the planning and coordination human services. DHS consists of the following Divisions: Substance Use, Prevention and Recovery; Developmental Disability; Family & Community Services; Mental Health and Rehabilitation Services.

Determination Process – The final action of a PASRR/MH assessment whereby the finding from the mental health assessment is used to make an eligibility determination for the most appropriate level of care needs, i.e., (1) Inpatient psychiatric hospitalization, (2) Long-Term Care admission, i.e., Skilled Nursing Facility (SNF) or Specialized Mental Health Rehabilitation Facility (SMHRF) or (3) diversion to appropriate community-based mental health service/support and/or diversion to other social service agencies, i.e., substance treatment.

Institute for Mental Disease (IMD) - The Federal CMS designation which applies to state operated psychiatric hospitals, free-standing private psychiatric hospitals and some Long-Term Care facilities where 50% or more of the residents have a diagnosed serious mental illness. Medicaid match cannot be garnered for residents between the ages of 22 and 64 years of age.

Initial Identification/Referral Form – Previously referred to as the OBRA 1. This form is used by “authorized entities” to identify and refer individuals for a more comprehensive PAS assessment. The Level I ID screen is conducted to determine if there is a reasonable basis to suspect a diagnosed Severe/Serious Mental Illness (SMI) or an Intellectual/Developmental Disability (IDD). Completion of this form is a prerequisite to a more comprehensive Level II PAS assessment.

Intermediate Care Facility (ICF) – A licensed nursing home 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 –The first phase of the Pre-Admission Screening process. This is the initial identification and documentation (desk review) to ascertain if there is a reasonable basis to suspect a Severe Mental Illness. Based upon the outcome of the Level I screen an individual may be referred for a more comprehensive assessment and determination (Level II Screen). This activity is billable when conducted by a designated PASRR/MH agent and certain determinations/dispositions are completed and documented. The OBRA I (“Initial ID/Referral”) document is completed by any authorized entity. **This is never billable.**

Level II Screen – The second phase in the Pre-Admission Screening process. Based on a face-to-face interview with the individual (including historical information gathered from ancillary representatives and records), a determination is made that may substantiate (a) the presence of a Severe Mental Illness (per state and federal guidelines) including substantial functioning impairment and/or inability to care for self (not attributable to a primary substance abuse disorder) which requires 24 hour nursing care, or (b) the individual’s need for Long-Term Care could appropriately be addressed in the community with the right mix of community-based services and support (diversion), or (c) the individual requires inpatient psychiatric services for psychiatric stabilization, or (d) the individual does not have a Severe Mental Illness and should be linked/referred to alternate support resources . There are two types of Level II Screens “Re-Assessment” (partial) and “Full Assessment” (complete).

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” - A comprehensive, face-to-face, clinically-based assessment of the mental health service and support needs for individuals seeking admission to Long-Term Care if there is the presence of a severe mental illness. This assessment includes screening for risks, functional level of care scale, substance use history, criminal background and medical/physical health indicators, as well as the capability of the individual to be diverted from admission to Long-Term Care if appropriate community-based support/services or other alternative resources are available.

PAS Mental Health Re-Assessment – The Level II re-assessment (partial) is required when an individual is referred for another PASRR/MH screening after receiving a full or partial Level II previously within a one-year period, as long as the psychiatric and medical information are current (less than one year old). This re-screening is to be utilized to update

clinical information from the previous PASRR/MH evaluation. It must include a face-to-face assessment and requires 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 (MHRS) – Services that are considered within the array of services provided by a Long-Term Care facility to residents who have a diagnosed mental illness, and which are included within the scope of services delivered by the facility, with the exception of “specialized services” (psychiatric inpatient care). MHRS refer to those mental health services which are to be initiated to all individuals admitted to a Long-Term Care facility with a diagnosis of mental illness, as appropriate to meet their treatment needs. The facility’s “plan of care” should specify how the facility will integrate relevant activities throughout all hours of the individual’s day. There should be competent interaction by staff at all times, in both formal and informal settings, in accordance with the individual’s needs. MHRS 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 daily living skills necessary to become 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 24-hour nursing care for individuals who have a disability (medical, physical or psychiatric), who are elderly or

infirm or who need convalescent care. Nursing facility types include ICF (Intermediate Care Facility) and SNF (Skilled Nursing Facility). These facilities fall under the Nursing Home Care Act.

Omnibus Budget Reconciliation Act of 1987 (OBRA-87) – A Federal law which is applicable to all licensed nursing facility and appropriate SMHRF levels of care, which establishes a pre-admission screening requirement for any individual seeking admission to LTC, across disability populations (including elderly) and regardless of payer source.

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

Psychiatric Evaluation – A comprehensive evaluation of an individual conducted by a board-certified psychiatrist or by a physician with training in mental health services and one year of clinical experience, under supervision, in treating problems related to mental illness or by an Advance Practice (psychiatric) Nurse. A current (less than one year old) valid psychiatric exam may be available as part of the Level II assessment.

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 administering the Federal Medicaid program (Title XIX) and other Federal and State public assistance programs.

Public Health, Department of (DPH) – The State agency responsible for the licensure, certification and regulations of Long-Term Care facilities. The DPH conducts licensure and certification surveys of Long-Term Care facilities and regulate compliance with federal and state standards.

Qualified Mental Health Professional (QMHP) – A certified, registered or licensed mental health professional who meets one of the criteria in the state Medicaid Rule. It is desired (but not mandatory) that PAS agents have a current license.

Rehabilitation Services, Division of (DRS) – The DHS Division responsible for developing and coordinating resources and benefits for individuals who have physical disabilities between the ages of 18 years through 59 years.

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, excluding alcohol and

substance use disorders, Alzheimer’s Disease and other forms of dementia based upon organic or physical disorders. 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
2. depressed; bipolar disorder II; bipolar disorder not otherwise specified; major depression, recurrent.
3. The diagnosis must have been present for at least one year.
4. 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 are grossly impaired.
5. Limited or impaired social functioning: interaction and involvement with family/significant others; social skills and relationships with friends; peer group involvement; ability to pursue leisure/recreational activities.
6. Inability to address basic 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.
7. Determined that the person’s functional limitations are not impaired primarily due to substance abuse problems.
8. 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 24-hour skilled nursing care, continuous skilled nursing observation, restorative nursing, and other services under professional direction with frequent medical supervision.

Specialized Mental Health Rehabilitation Facilities (SMHRF) – The twenty-three pre-identified former nursing facilities, with a Federal Center for Medicaid Services (CMS) categorization as an Institute for Mental Disease (IMD) - implemented and authorized by the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49].

Specialized Services – A level of care - inpatient psychiatric hospitalization (i.e., danger to self or others or unable to care for self)- necessary for an individual who is experiencing an acute episode of severe mental illness.

Supportive Living Programs (SLP) – An alternative to nursing home care for low-income older persons and persons with physical disabilities under Medicaid. Operates under the authority of a 1915 (c) Home and Community Based Services (HCBS) waiver of the Social Security Act. Provides an affordable assisted living model offering limited personal and health services integrated within apartment-style housing. The SLP Waiver has two target

populations, elderly (65 and older) and persons with physical disabilities (22-64), served in two respective types of SLP. The aim is to preserve individual privacy and autonomy, while supporting health and wellness through a combination of medical and non-medical services.

III. INTRODUCTION AND BACKGROUND

A. Federal Requirements Pre-Admission Screening/Mental Health (PAS/MH)

The PASRR/MH process responds to the Federal requirements associated with the 1987 Omnibus Budget Reconciliation Act (**OBRA '87**). Effective January 1989, the OBRA legislation revised statutory provisions governing certification standards and enforcement procedures applicable to nursing homes. OBRA '87 contained detailed requirements that established nursing facility screening mandates for persons with severe mental illness and annual resident review (**PASRR**). 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 PASRR/MH process has determined that the individual requires nursing facility level of care, and that the individual does not require specialized services (psychiatric hospitalization) or can benefit from community alternatives.

The PASRR/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 currently 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 (**CMS**).

B. PASRR/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 who are being referred to or recommended for admission to a licensed Long-Term Care facility or SMHRF if there is a 'suspicion' of a serious mental illness. If SMI is confirmed, then . . .
 - b) Level II: Must be conducted for individuals identified as meeting criteria for a 'suspected' severe mental illness (SMI) through the Level I screen. A Level II PASRR/MH assessment is required to determine if, as a result of the mental illness:

- The individual meets eligibility criteria for specialized services (i.e., inpatient psychiatric hospitalization), or
 - The individual meets eligibility criteria for the level of services and supports provided by a 24-hour staffed skilled nursing facility or SMHRF Recovery and Rehabilitation Unit or
 - The individual may meet criterion for long-term care admission but with appropriate community-based mental health services and supports can be safely diverted and served in a community setting, or
 - The individual does not meet criterion for long term care admission and is referred to alternative community resources.
- c) If SMI is not a clinically, defensible diagnosis, PASRR/MH refers back to the originating referral source.
2. Level II Activities: When completing the Level II process, the PASRR/MH agent must:
- a) Assess the SMI diagnosis including: duration and severity, previous treatment history, response to treatment, the level of role functioning impairments (disability), and the level of care that is required (medical necessity).
 - b) Assess the indicators for a primary or co-occurring substance use disorders, risk of non-compliance, self-harm or aggression toward others.
 - c) Assess to determine if the person's clinical and/or behavioral health needs, due to a mental illness, may be appropriately addressed in a community setting with appropriate community-based mental health services and supports.
 - d) Identify any mental health services that the Long-Term Care facility will need to provide of a lesser intensity than specialized services. The assessment must contain detailed information about the individual's mental health needs to thoroughly explain why Long-Term Care admission is or is not the most appropriate level of care.

- e) Provide sufficient information to assist the receiving facility with their development of an interim treatment plan for the individual.

C. PASRR/MH Service Elements:

The required PASRR/MH service elements are as follows:

1. Level I (desk) review identifies whether there is a reasonable basis to suspect that the individual has a severe mental illness and what additional PAS assessments, if any, are required.
2. Level II assessments includes:
 - a) Psychiatric Evaluation (if available)
 - b) Physical Examination and Medical History Mental Health Assessment,
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 PASRR/MH Process

The following time frames must be met by the PASRR/MH screeners:

1. The initial face-to-face assessment must occur no later than 72 hours or three business days after initial contact by the hospital discharge planner or designated contact person. It is highly expected that the response time will be within 24 hours of contact or the next business day.
2. The assessment must be scheduled, completed, and a determination made on the most appropriate level of care or community diversion option by the next business day (optimal) following the face-to-face assessment,
3. In a life safety emergency, the PASRR/MH screener must respond within 12 hours from the initial call or the next business day.
4. In cases where additional time is necessary to arrange and complete required assessments (e.g., psychiatric/medical exams), the PASRR/MH screener shall notify the referral source of the progress with the assessment.

E. PASRR/MH Service Standards

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

1. Comply with time frames for completing the evaluation and determination process;
2. Gather, arrange and complete all evaluation components and accompanying documentation;
3. Complete all necessary determinations regarding recommendations and level of care needed. This includes diversion recommendations and linkage activity for individuals who (1) meet eligibility for Long-Term Care, but who can safely be diverted to appropriate community-based services and supports or (2) do not require nursing facility level of care, including SMHRF, but require some additional mental health services;
4. Complete all necessary documentation, i.e., no fields are blank, all comment areas have sufficient narrative and all required PASRR/MH forms are finalized, and
5. If referred to Long-Term Care, provide the receiving facility with a copy of the Level II assessment and PASRR/MH forms, along with the “Transmittal Letter” and 2536. This information should be detailed, professionally written, justifiable to support 24-hour level of care and sufficiently documented to assist the receiving facility with their development of an interim treatment plan.

F. Geographic Responsibility for PASRR/MH Process

1. The PASRR/MH agent is responsible for conducting PASRR screenings within the geographic service area(s) as identified by DMH.
2. For the purposes of PASRR/MH 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 to be the home address or address of location.
 - b) If an individual is in a private hospital, state psychiatric hospital, free standing psychiatric hospital or public hospital with a psychiatric unit, the PASRR/MH agent serving the local geographic area of the hospital is responsible for completing the PASRR/MH assessment.
 - c) If the individual is in a nursing home or SMHRF, the PAS agent serving the geographical address of the nursing home or SMHRF should be contacted.

Guidance

The service geocode is the location where the actual screening took place. If an individual resides in one geocode area but is currently hospitalized in a different area, the location of that setting will be used to designate the geocode for determining the PASRR/MH screener. 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 PASRR/MH activities using the address of the location to report those PAS activities. Billable Level I activity should also be coded where they occur, which is typically the screening agency. However, if a face-to-face contact 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 (desk review)**

The purpose of the Level I identification screen is:

1. To ensure that individuals who may have a 'suspicion' of a severe mental illness are appropriately identified and referred for a PASRR/MH screening if seeking admission to Long-Term Care level of care.
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 individual's eligibility for Long-Term-Care, if there is no identifiable mental illness diagnosis.

B. Individuals Who Must Have a Level I Screen

1. The individuals who is referred to or seeking admission to a Long-Term Care facility (SNF or SMHRF) who is suspected of having a severe mental illness, regardless of payer status.
2. The individual who is current resident of a SNF or SMHRF and who is later suspected of having a severe mental illness, post admission.

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

Entities authorized to perform the “initial identification/referral” – OBRA I screen are (Appendix):

1. Case Coordination Units of DoA;
2. Rehabilitation (DRS) counselors or DRS designated screening agents;
3. PASRR/MH contractors/agents authorized by DMH;
4. DHS/DD Independent Service Coordination (ISC) centers
5. Psychiatric hospitals (public or private) discharge planners or social workers in State hospital community placement staff;
6. Long-Term Care facility staff;
7. Community Mental Health Centers (CMHC).

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

D. General Responsibilities of OBRA I – Initial ID Screening:

1. The Department on Aging (DoA) – CCUs - screeners are responsible for screening individuals age 60 and older, regardless of payment source, if the OBRA I screen reflects there is no reasonable basis to suspect a severe mental illness.
2. The Division of Rehabilitation Services (DRS) counselors are responsible for completing the OBRA I screen for individuals 18 through 59 years of age if the OBRA I screen does not indicate a suspicion of a severe mental illness. Note: Many of these PAS screening activities have been subcontracted to the local Area on Aging agencies under the auspices of the Department on Aging.)
3. The Division of Developmental Disability (DD), Independent Service Coordination (ISC) centers are responsible for screening individuals who have a documented developmental/intellectual disability prior to 18 years of age.
4. The PASRR/MH agents have primary responsibility for screening individuals (Level I) who are seeking admission to Long-Term Care if there is a suspicion of a severe mental illness (SMI)

5. If there is a suspicion of a dual-diagnosed intellectual/developmental disability and mental illness both PASRR/MH and DD/ISC must screen.
6. If there is a suspicion of a SMI diagnosis and co-occurring medical or physical disability, both the PASRR/MH agent and CCU staff may be requested to screen.

Guidance

This manual provides information and instructions for PASRR/MH. Other PAS specialists have their respective policies, procedures, and corresponding documents. If, during the initial identification process, one of the non-mental health PAS entities discovers information which supports that an individual may have a severe mental illness, a referral to the responsible PASRR/MH agent should be made. The PASRR/MH agent will complete a desk review of the initial identification information and any supporting documentation and make a determination whether: (1) a condition exists that requires further PAS mental health assessment, (2) a condition does not exist that requires a PAS mental health assessment, and, thus, the referring entity should redirect to the appropriate option or (3) identify if another PAS entity should be contacted.

E. Level I PASRR/MH Procedures

PASRR/MH Responsibilities:

1. The PASRR/MH agent is responsible for determining **IF** there is a reasonable basis to suspect that the individual referred has a severe mental illness. The “Mental Health Identification/Referral” form is the vehicle by which PASRR/MH agents should accept referrals. It may be completed by the PASRR/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 (desk review) 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 to allow the PASRR/MH agent to make a responsible Level I determination.

2. The PASRR/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 the Initial ID Screening information to the receiving PASRR/MH agent if there is a “suspicion” of serious mental illness.
3. The PASRR/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 PASRR/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 PASRR/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 PASRR/MH Level II Process

Individuals who are diagnosed with one of the following conditions **are exempt** from a PASRR/MH Level II screening:

1. Primary diagnoses of senile or pre-senile dementia includes Alzheimer’s Disease or related disorders. Exemption from a PASRR/MH screen also applies to individuals with a traumatic brain injury (no psychiatry history prior to the onset of the trauma) or other neurological disorders. The exemption diagnoses must be confirmed by a physician when 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 individuals who suffer a primary health problem that may manifest into behavioral symptoms and

which require psychiatric attention - there is no pre-history of 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 **PASRR/MH Level II screening is not required**. “Primary” refers to the condition that is creating the clinical picture resulting in the decision to refer the individual for nursing facility admission.

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 there is sufficient evidence to warrant a Level II PASRR/MH assessment.

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 PASRR/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 is 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 individual’s medical condition. It is **highly unlikely** that this **individual would benefit from psychiatric rehabilitation services**. If the initial referral source has doubts about which condition is “primary”, the screener should contact the PASRR/MH agent. The PASRR/MH agent 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. Discharged from a non-psychiatric acute hospital inpatient stay for a medically prescribed period of recovery for convalescent care. 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 PASRR/MH assessments. If the individual is *known* to have a serious mental illness, a PASRR/MH 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 PASRR/MH screening, the PAS agent should conduct a Level I (desk review) to determine if the individual needs 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 needs 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 (exception specialized services) to any resident admitted to their facility.

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

Residents of a Long-Term Care facility who had a PASRR/MH screen conducted prior to admission to the facility and was determined to meet eligibility for this level of care do not require a repeat pre-admission screen upon readmission (limited time frame) or inter-facility transfer. Specifically, a repeated PASRR/MH screening is not required for individuals if the following conditions exist:

1. Acute Care Transfer. An individual is transferred to a hospital for acute inpatient services (either medical or psychiatric care) and returns to the same Long-Term Care facility, a new PASRR/MH screen is not required - considered to be continuous care.
2. Inter-Facility Transfers. An inter-facility transfer occurs when an individual is transferred from one Long-Term Care facility to another, with or without an intervening hospital stay. The transferring facility is responsible for ensuring that copies of the resident's most recent PASRR/MH and resident assessment reports accompany the resident. It is the responsibility of the transferring facility to ensure that copies of the resident's most recent PASRR/MH 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 resident is not expected to return to the same facility following a hospital stay, it is the responsibility of the original 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 Long Term Care facility post-hospital discharge.

3. Re-admission. A person who has resided in a Long-Term Care facility *for at least 60 days* and is returning to the same facility *after an absence of no more than 60 days*, may be readmitted without a PASRR/MH assessment.
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 they were determined to be eligible for Long-Term Care in the previous assessment and as long as there has not been a significant change in clinical presentation.

Note: Post Admission Screenings. Illinois Adm. Rule 140.642, Subchapter (d) allows admission to Long Term Care facility without a PAS assessment for: “provisional admissions pending further assessment in cases of delirium when an accurate diagnosis cannot be made until the delirium clears. “Per Federal Rule, a Level II assessment should be conducted by the 40th day of stay.

Out-of-state referrals to LTC may be screened after admission, only with notification to the State PASRR/MH designee and approval to proceed

I. Level I Screen Determinations (options):

1. There is a **reasonable basis to suspect severe mental illness** and a Level II assessment is required. There is objective information, documentation which indicates that the individual has one of the qualifying diagnoses or credible evidence that they “may have” one of the qualifying diagnoses with functional limitations and severity 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. There may be the presence of 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 illness disorder excluding organic conditions.

4. The individual does or does not require specialized services (inpatient psychiatric care), at this time.
5. The individual has received a PASRR/MH screening in the past three months (90 days) with a positive finding for LTC eligibility. The IDHFS 2536 form remains valid and a repeat level II isn't required.
6. There is a reasonable basis to suspect IDD or a dual condition of MI/DD.

J. Level I Disposition (options):

1. The individual does not require a Level II PASRR/MH assessment but has some condition which requires further review from another authorized PAS entity (e.g., age 60+ CCU (DoA), Developmental or Intellectual Disability (DD-ISC) or less than 60 years of age and serious medical condition (DRS). Referral will be made by PAS/MH.
2. The individual requires specialized services (inpatient psychiatric care) and is being referred for hospitalization.
3. A Level II PASRR/MH assessment is required, and the appropriate "tier" of assessments will be completed (e.g., Re-assessment, Full, Psychiatric/Medical Exam).
4. There is a reasonable basis to suspect a dual condition of developmental/intellectual disability and severe mental illness. The individual will be referred to the DD/ISC agent in the geographical area for a concurrent assessment.
5. No follow up is necessary.

Note: If it is determined that no further Level II assessment is 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 assessments 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 (OBRA I) is the documentation form by which authorized entities make referrals to the

PASRR/MH agents if there is evidence that an individual may have a “suspicion” of severe mental illness.

2. The “Initial ID and Referral” form is used to provide initial information for completion of the Level I screen (desk review) process. PASRR/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 PASRR/MH contractor. The determination and disposition sections are used to communicate the results of the Level I (desk review) screen. After completing the review, the PAS agent should share the findings 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 PASRR/MH agent to need a Level II, then the Level I service activity is reported through the Level II assessment and billing procedures.
5. The PASRR/MH agent is responsible for providing a copy of the Level I and Level II information for any individual determined to be eligible for a Long-Term Care facility to the facility where the individual will reside.
6. The PASRR/MH agent is required to keep 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 PASRR/MH provider terminates services with DHS, the records are to be transferred to DHS or its successor contractor.
7. If a referral for a Level I screen is clearly inappropriate, it may be deflected back to the referring entity via telephone communication, without any supporting documentation. This is not a billable activity.

L. Data Submission and Billing:

1. Key data from the Level I screen is to be electronically entered into 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 is to determine if:**

1. The individual has a severe mental illness per the criterion diagnoses, including functionality, severity, duration;
2. The individual's presenting needs require specialized services (inpatient psychiatric care);
3. The individual presenting needs required 24-hour Long-Term Care nursing support (SNF or SMHRF) to address the mental illness or co-occurring mental illness and/other disorders;
4. The individual's presenting needs meet eligibility for 24-hour Long-Term Care, but with the presence of appropriate community diversion services, resources and support, the individual may be diverted to appropriate array of community based-services in lieu of Long-Term Care.

B. Individuals Who Must Have a Level II Assessment:

1. All individuals suspected of having a severe mental illness must be assessed by PASRR/MH before admission to a Long-Term Care facility, **regardless of payment source**.
2. An existing resident of a Long-Term Care facility (SNF or SMHRF) who, subsequent to the admission, is now suspected to have a severe mental illness.

C. Conditions of the Level II Assessment:

1. The PASRR/MH assessments must be adapted to address the culture preference, language, ethnic origin and means of communication used by the individual being evaluated. If assistance is needed with an assessment of an individual with a serious mental illness and a hearing impairment, contact the Coordinator for Deaf and Hearing-Impaired Services, located at Chicago Read Mental Health Center. The number to call is (773) 794-3738 (TTY) or (773) 794-4000 (Voice).
2. The assessments must be conducted by a *qualified* DMH recognized PASRR/MH entity that is ***independent*** of the nursing facility/SMHRF.

3. A PASRR/MH agent may use existing relevant clinical information if available, e.g., psychiatric and 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 PASRR/MH agent is responsible for gathering the required information.

D. Required PASRR/MH Level II Assessments:

- Psychiatric Evaluation (no longer a mandatory requirement – if one is available it is to be used to make a justifiable clinical determination of need)

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 and one year of clinical experience, under supervision, in treating problems related to mental illness; or an Advance Practice Nurse with training in psychiatry. 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 with recommendations for treatment services.
- d) Risk behaviors, if present, with recommendations for treatment, services and proposed interventions for managing risk behaviors.
- e) Current medication needs and any known allergies.

Guidance

Many individuals referred for a PASRR/MH assessment will have recent psychiatric and medical exams available made during a psychiatric hospitalization. It is not necessary to repeat these exams as long as the information outlined above is included. **Ongoing treatment notes or medication reviews do not substitute for complete psychiatric evaluations but may be used to make a determination of need.** If accurate and complete, the psychiatric information is valid for one (1) year.

- Physical Examination and Medical History

A physical exam and medical history are required documents. 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 a psychiatric hospitalization, 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 PASRR/MH agent is responsible for thoroughly 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”, etc.). All documentation must be detailed and clinically justifiable.

The “PAS Mental Health Level II Assessment/Re-assessment” document is a comprehensive review, compilation and summary that 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 a 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. If a situation does apply, a narrative description must be provided that includes 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 evaluation, 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 PASRR/MH file for six (6) years. The Level II assessment review consists of a two-tier approach which is 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.

A. Psychiatric/Medical Exam:

1. Federal CMS no longer requires the inclusion of a psychiatric evaluation as part of the Level II PASRR/MH process. However, if a psychiatric evaluation is available it is to be utilized.
2. Federal CMS does require that a medical exam is provided as part of the Level II process.
3. With the presence of a psychiatric evaluation and/or medical examination, the following must be address:
 - a. The psychiatric section should be performed by a board-certified psychiatrist or psychiatric APN 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. A physician independent of the Long-Term Care facility must complete the psychiatric medical/exam.
- d) When the PAS agent completes either tier of the level II process (full or partial) 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 federal and state eligibility requirements for admission (due to a mental illness or co-occurring disorders) to a Long-Term Care facility (SNF or SMHRF). Once the PASRR/MH agent completes all required assessment, evaluation and determination components, it represents a “full” Level II.

- a. The PAS agent’s responsibilities include the following:
 - 1) A face-to-face contact with the individual within seventy-two (72) hours or three business days from the initial referral contact date.
 - 2) A review of the following written assessments:
 - Psychiatric evaluation (if available) 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 psychiatric advanced practice nurse;
 - The “PAS Mental Health Level II Assessment” has been completed by an authorized screener, based on their review of the above;

- Use of additional available assessments and supporting documentation necessary to make the most appropriate decision on eligibility for admission to a Long-Term Care facilities or appropriateness for community diversion alternatives.

3) Complete all necessary determinations, and supporting documents (e.g., “Notice of Determination”. IDHFS 2536 form, Transmittal letter”).

b. Report determination outcome - Demographic and clinical data should be entered into the *UHS PAS data system* as it is gathered, but no later than 24-hours after the face-to-face screening has been completed.

c. After the screening is completed and entered PASRR/MH agencies may either bill the activities immediately or send the billings in batches.

Billing should not exceed 30 days from 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. Generate final Reports - *The UHS PAS 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 for a PASRR/MH screening after receiving a full or partial Level II assessment, previously within that year. This re-screening is to be utilized to update PASRR/MH information from a previous PASRR/MH assessment. PASRR/MH assessment materials are considered valid for three months (90 days) as long as referral information is updated.

a. The PAS agent’s responsibilities include the following:

- At least one face-to-face contact with the individual within three (3) business days from the initial referral.

- Review all 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 PASRR/MH 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 PASRR/MH agencies may either bill the activities immediately or send the billings in batches. **Billing should not exceed 30 days from 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 PAS 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 are considered valid for one (1) year.
2. The PASRR/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 PASRR/MH Level II screen may remain valid after three months (90) calendar days when the PASRR/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. information, mental status, recent history of treatment, presenting problems, functional impairments, etc.).
 - c. 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.
 - d. 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 PASRR/MH screener reviews all assessments and confers with other assessors, as necessary, i.e., DD/ISC or CCUs or DRS, to make the best clinical determination and recommendation decisions for each individual who receives a Level II assessment.

1. The original assessments must be maintained in the individual’s file at the agency of the PASRR/MH screener. PASRR/MH assessments and forms must remain in the file for a period of at least six (6) years. If the PASRR/MH agency or relationship with DHS/DMH is terminated, all PASRR/MH records are to be secured and transferred according to instructions provided by DHS/DMH.
2. If the outcome determination/recommendation is admission to Long-Term Care, the PASRR/MH shall provide copies of the assessment materials to the receiving facility identified for admission. A copy of the “Release of Information” form should be executed to authorize the release of the assessment materials. This release should conform to all requirements of the Mental Health Confidentiality Act and Federal HIPAA standards.

3. A copy of the Determination Letter (with appeal information) should be made available to the individual and representative, if appropriate.

VII. LEVEL II SCREEN DETERMINATION PROCESS

A. Purpose of Level II Determination Process:

The Level II Determination process is used to determine the most clinically appropriate level of care for an individual, which is based on the outcome of the clinical assessment process. The PASRR/MH must make one of four determinations:

1. Determination for Specialized Services (inpatient psychiatric hospitalization).
2. Determination for admission to Long-Term Care (SNF or SMHRF).
3. [If found appropriate for admission to Long-Term Care] Determination with recommendation (offer) for diversion to a community-based alternative, with the appropriate array of services and supports to meet the individual's clinical and/or functional needs.
4. Determination that the individual is not appropriate for admission to Long-Term Care, with a referral to other community service alternatives.

B. Criteria for Determining the Need for Specialized Services:

Individuals who are experiencing an acute psychiatric episode may require inpatient psychiatric hospitalization, i.e., "specialized services" for stabilization and symptom management. When determining if an individual requires 'specialized services' the PASRR/MH agent should conclude if:

1. There is a reasonable basis (clinical assessment) to conclude that the individual will inflict serious physical harm to self or others in the near future;
or
2. The individual is unable to provide for basic physical needs as to guard self from serious harm.

If either of the above-stated indicators is present, PASRR/MH shall immediately refer the individual for appropriate specialized services (inpatient psychiatric hospitalization or extended hospital stay).

C. Criteria for Determining the Need for Long-Term Care:

There are two types of eligibility determinations for Long-Term Care, “**Indefinite Stay**” and “**Time-Limited**”. The LOCUS is used as the primary tool to determine time-limited eligibility, recognizing that other supporting documentation, i.e., clinical, medical, financial and historical factors, also have contributing roles in decision making. Generally, an individual may be found eligible for Long-Term Care on a **time-limited basis** when they can demonstrate ‘functional capabilities’ (based on clinical need) or can acquire functional capabilities within the time frame of a six month stay (or less) in the facility to move to a less restrictive, more integrated community-based setting. Key considerations should be given to factors such as such as previous levels of independent functioning in the community, history of engagement in treatment, family and community supports and previous housing stability (see attachment: “Clinical Factors in Determining Time Limited Eligibility”). With either eligibility determination the individual must meet criteria below.

1. Have a diagnosed Severe Mental Illness (SMI). To meet the criteria for severe mental illness the PASRR/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 safely provided in an alternative community setting and a Long-Term Care level of care is the most appropriate setting.
 - The individual needs 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 Long-Term Care (SNF or SMHRF) appropriateness, the PASRR/MH screener should document their review and assessment of the following characteristics:
- The individual has a long history of community mental health services, including multiple hospitalizations,
 - The individual has a poor compliance with follow-up services and medication management,
 - The individual’s disability has been substantiated by Social Security Administration and individual receives SSI or SSDI benefits,
 - As a result of mental illness, individual has difficulty caring for self,

- Basic role functioning impairments leaves the individual vulnerable in their immediate environment,
- The individual does not present a history of antisocial, alcohol or drug seeking behaviors not directly associated with the mental illness,
- It has been determined that the individual has significant housing instability, as a result of the mental illness with impaired level of functioning
- Person lacks independent living skills.

Homelessness is not a criterion for referral or admission to LTC

Guidance

If referred to PASRR/MH for an assessment, an individual who has recently been diagnosed with a serious mental illness or one who is just beginning psychiatric treatment should be screened and assessed for the most appropriate, least restrictive setting to meet their recovery, rehabilitation and treatment needs, i.e., community-based diversion alternatives with a mental health center, as clinically indicated. Community-based mental health services should always be the first consideration. An individual who is acutely, psychiatrically symptomatic may not be suitable for admission to Long-Term Care. If hospitalization is warranted to stabilize the individual’s psychiatric presentation, this recommendation and referral should be made.

It is common for individuals with severe mental illness to have co-occurring substance abuse disorders. In some instances, severe substance use/dependence may mask or mimic symptoms of severe mental illness. Therefore, it is necessary to differentiate the level of impairment attributable to the mental illness and the role of a substance use disorder. Identification of serious substance use is also critical to treatment planning and in determining if a facility can adequately address the person’s co-occurring treatment needs. If the substance use seems to be primarily responsible for role functioning impairments, the person should be diverted from admission to Long-Term Care and referred for intensive inpatient or outpatient services to address the substance use disorder.

The PASRR/MH agent must determine if there is a reasonable basis to believe that the individual will benefit from 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 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 community mental health programs or inpatient care. If there is a history of or substantial risk for noncompliant, maladaptive or aggressive behavior, it should be reported clearly in the PASRR/MH determination documentation.

D. Outcomes of the Level II Determination Process

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

1. **Specialized Services - needed**

If the 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.

2. **Specialized Services - not needed**

If the individual is determined **not to need** specialized services (inpatient psychiatric care), a determination is made as to their need for Long-Term Care level of care or appropriateness for diversion to community-based alternatives.

3. **Long Term Care (SNF/SMHRF) - needed**

If it is determined that an individual requires 24-hour skilled care to address impairments in functional capabilities and limitations based on clinical criterion due to their mental illness, the individual may be appropriate for admission to a Long-Term Care facility. The facility is responsible for determining if the facility can adequately and effectively meet the clinical care needs of the individual and to address rehabilitative mental health service needs.

4. **Long-Term Care Level of Care - community diversion offered**

If it is determined that an individual does meet eligibility for 24-hour skilled level of care because of their mental illness (or any co-occurring conditions), but can benefit from a referral for community diversion, the PASRR/MH agent shall inform the individual of community-diversion alternatives, non-institutional settings, capable of meeting his or her needs for services and

supports. The PASRR/MH agent shall refer and link the individual with a community-diversion alternative for an assessment of its ability to provide necessary and appropriate resources and supports. Diversions alternative services may include, but are not limited to:

- a. Supervised/supported residential settings
- b. Private housing/family 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.

5. Long Term Care Level of Care – not recommended

If it is determined that the individual does not require 24-hour skilled level of care because of their mental illness (or co-occurring substance use disorder), the PASRR/MH shall inform the individual that this level of care is not supported. The individual will be referred back to the originating referral source for linkage with community mental health services or other community-based social service options, i.e., Catholic Charities, Heartland Alliance, etc.

Note: If there is no indication of a serious mental illness, the PASRR/MH screener will redirect the referral back to the appropriate screening entity, i.e., CCU, DRS or DD/ISC

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 2010”**

A functional assessment using the LOCUS instrument which indicates the level of care needs/role functioning impairment/ability. This tool will be used to determine whether the level of support is such that Long-Term Care admission or community-based service alternatives is supported. The LOCUS is not used in isolation but must be weighed in consideration with other supporting information.

3. **PASRR/MH “Notice of Determination” Form**

- a. The PASRR/MH “Notice of Determination” form must be completed for each individual screened through the PASRR/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 or Long-Term Care admission.
 - Identifies the services and support required to meet their assessed needs.
 - Provides a full explanation of rights to appeal the PASRR/MH Level II determinations.
- b. A copy of the completed PASRR/MH “Notice of Determination” forms should be distributed as follows:
- To the individual
 - To the admitting nursing facility
 - To the discharging hospital
 - The original form must be maintained on file at the PASRR/MH agency.

F. **Additional Required Forms** (If the individual is found eligible for Long-Term Care, then the following additional forms are to be included):

1. **“Interagency Certification of Screening Results”** - IDHFS Form 2536
 - a) The “Interagency certification of Screening Results” (IDHFS 2536) is to be completed by PASRR/MH on all individuals PASRR/MH has determined to meet eligibility requirements for admission to Long - erm 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 Long-Term Care facility.
 - Maintained in the individual’s file at the PASRR/MH agency for six years.
2. **“Transmittal Letter”** - States the findings of the PASRR/MH Level II assessment. The supporting documentation should be provided to the receiving nursing facility.

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

VIII. PASRR/MH specialized assessment – Supportive Living Program (SLP)

- A. The role of PASRR/MH involves screening and assessment of SLP applicants when there is an indication of the presence of a serious mental illness (SMI) regarding the appropriateness of the SLP setting and services to effectively address identified needs and risks.
- B. All SLP applicants must meet the same functional criterion as applied for Nursing Facility Level of Care (NF LOC) determination of need.
- C. In accords with the federally approved SLP Waiver, this determination is based on an evaluation conducted by the Department on Aging (CCUs) or DHS/DRS using a Determination of Need (DON) tool.
- D. PASRR/MH screeners **are not designated** as evaluators of this basic SLP Waiver eligibility determination. PAS/ MH screeners do not complete a Determination of Need (DON) tool nor provide a DON score.

- E. Individuals seeking transfer from a Long-Term Care facility to a SLP are presumed to meet NF LOC criteria based on their existing Long-Term Care residency. They will not require a new DON. However, if there is a suspicion of a serious mental illness, they will require a PASRR/MH specialized assessment.
- F. Individuals residing in the community must meet basic SLP Waiver eligibility via a DON score of 29 or greater. If there is the suspicion of a serious mental illness a PASRR/MH specialized assessment is required.
- G. PAS/MH's specialized assessment for SLPs must be completed prior to SLP admission.
- H. If SMI is not present, the PASRR/MH agent will complete the OBRA 1 and return it to the requesting entity. Note in the Level I the screening is being done as part of the eligibility assessment for SLP.
- I. If SMI is present, PASRR/MH will complete the Level II 'specialized assessment' and enter the assessment information in UHS.
- J. PASRR/MH will document that the individual is being considered for SLP admission and note information relevant to the specialized SLP assessment areas in the appropriate UHS narrative space.
- K. PASRR/MH will complete the documentation, print the Level II and withdraw the assessment from UHS. The Level II material is retained in the system. Do not send out the Level II documentation.
- L. Once the specialized assessment is completed PASRR/MH will fill out the formatted SLP letter (Appendix) and include specific documentation why the person is or is not appropriate for the SLP admission consideration. All documentation should be thorough, clearly written and justifiable.
- M. The PASRR/MH will complete a paper version of the 2536. The 2536 will be given to the SLP with a copy retained in the PASRR/MH file.
- N. A copy of the SLP letter is given to the applicant (representative, if appropriate) and a copy sent to the SLP. PASRR/MH will retain a copy of the letter in the PASRR files. Do not send Level II documentation.
- O. Applicants have full right to appeal a SLP decision. An appeal letter is to be sent within 15 days from the date on the notification letter.

- P. All appeals related to a Supportive Living Program (SLP) should be sent to the attention of:

Patricia Reedy
DHS/Division of Mental Health
401 South Clinton, 2nd floor
Chicago, Illinois 60607

IX. PASRR/MH DETERMINATIONS SUBJECT TO APPEAL

An individual or his/ her representative (guardian, attorney, or any other person acting at his or her request) may appeal the determination by the PASRR/MH screener. Determinations that may be considered adverse and may be appealed are as follows:

- Individual does or does not require specialized (psychiatric hospitalization) services.

- Individual does or does not meet criterion for 24-hour Long-Term Care.

- Individual does or does not meet eligibility for SLP admission.

A. Notice of First Level Appeal (PAS/MH)

1. The individual, his or her designated representative may appeal the PASRR/MH decision, 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 “PASRR/MH Notice of Determination” form and should be forwarded to:
Roberta Allen, PASRR/MH Coordinator
DHS/Division of Mental Health
401 South Clinton, 2nd floor
Chicago, Illinois 60607

The PASRR/MH Coordinator will contact the parties involved to discuss the facts in dispute and to clarify any other issues. The coordinator may request that all relevant documents are 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 representative. A copy of this written decision and relevant findings shall also be sent to the PASRR/MH agent.

B. Notice of Second Appeal (PASRR/MH or SLP specialized assessment)

1. If the first appeal for a determination of LTC or SLP admission 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 SLP level of care or alternate care.
2. The complaint must be made within 30 days of the denial and be forwarded to:

Chief, Bureau of Long Term Care
Healthcare and Family Services
201 S. Grand Avenue East
Springfield, Illinois 62763
Phone Number: (217) 782-0545

X. RESIDENT REVIEW PROTOCOL

The goal of the Resident Review assessment is to determine if the mental health needs/ functional impairments identified in the original PASRR/MH assessment are still relevant to warrant continued Long-Term stay in the facility or to assess if the individual's mental health needs can be supported in a transition from Long-Term Care to the least restrictive setting or other appropriate community-based options.

A. (New) Initial Admissions:

An initial admission to a Long-Term Care facility (SNF or SMHRF) will automatically result in a referral for a Resident Review. New admissions to Long-Term Care require that a Resident Review is completed after the 30th day of admission, but prior to the 60th day of admission.

1. The Resident Review assessment shall:
 - Establish that the individual is receiving the appropriate psychiatric rehabilitation services as indicated in the Level II assessment.
 - Re-assess the person's functional abilities to determine if a greater or lesser level of care can be recommended to best meet the individual clinical needs.

- Ascertain consumer choice around treatment issues and living arrangements supported by the clinical assessment.

Ensure that necessary discharge/linkage planning is being conducted, as appropriate

2. The Department will reimburse for two Resident Reviews, per person, per year.

B. Change in Condition:

The Long-Term Care 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 to have a severe mental illness, and who has continuously resided in LTC 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 a 12-month period;
2. Previously determined to have a severe mental illness, but upon re-evaluation by a licensed psychiatrist or physician is subsequently, clinically determined not to have a severe mental illness;
3. Admitted to LTC facility and not initially determined to have a severe mental illness, but upon re-evaluation meets clinical criteria for a diagnosis of severe mental illness;
4. Has a diagnosis of severe mental illness, but no longer meet criteria for continued stay in a Long-Term Care facility and who meet all of the following:
 - a) No longer receives any clinical intervention or rehabilitation services/supports for psychiatric symptoms, including mood disorders, behavior management or cognitive impairments affecting daily functional abilities;

- b) Has successfully completed basic skills development training identified to facilitate transition back to the community;
- c) Has expressed an interest to return to the community.

XI. Quality Improvement

A. Procedures

PASRR/MH entities will have in place and maintain its own continuous quality improvement and quality assurance activities, which will be inclusive of PASRR/MH service requirements.

B. Review Process/Internal

The review process shall determine that:

- a. All required PASRR/MH documentation is complete and accurate,
- b. PASRR/MH determinations for Long-Term Care eligibility meet standard criteria and necessity for the level of care
- c. The PASRR/MH documentation entered is defensible and supports either the determination decisions for Long-Term Care admission or appropriate community diversion.

C. External Review

DHS/DMH may conduct Quality Assurance activities on reported PASRR/MH screening through electronic reports (UHS).

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

A. Level I Determination and Disposition

- a) When the PASRR/MH agent receives referral information on the Initial ID screen (OBRA I) that requires further evaluation which results in a Level I determination (desk review) 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 reviews and examines supporting documentation;
 - iii. The outcome of the review results in completing the appropriate sections of the Determinations and Disposition form);
 - iv. A Level II assessment is **not** triggered;
 - v. This information is documented and entered electronically into UHS.

Specific Payment Rate: \$80

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

b) Inappropriate Referrals

If the information on the Initial ID (OBRA I) reveals no basis to suspect a mental illness or severe mental illness, the PAS agent should STOP any further evaluation activities and inform the referral source of their finding. This is not a billable PASRR/MH activity.

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 assessment) 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 PASRR/MH data system.
3. The psychiatric/medical exam evaluations must be arranged and provided prospectively for the current PAS assessment. Exams cannot be billed retrospectively.
4. The psychiatric medical/exam must be completed by a physician independent of the 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. Level II is a comprehensive assessment that includes the presenting problem, social history, clinical review of previous mental health engagement, treatment and hospitalizations, level of functioning and/or functional impairments, ability to address daily living skills, cognitive functioning, as well as risk factors (behavioral and criminal) and substance use indicators.
- b) A Full Level II assessment should be conducted if there has never been a PASRR/MH screen and the individual is seeking or has been referred for admission to Long Term Care.
- c) When Level II PASRR/MH determinations are entered into UHS these services are reported and billed;

Specific Payment Rate: \$400

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

2. Partial Level II or Re-Assessment

This screening is required when the individual presents for another PASRR/MH assessment after receiving a Full or Partial Level II assessment within the same 12-months period. This “reassessment” is to be utilized to update PASRR/MH information when all the required PAS documentation is available and valid.

- a) PASRR/MH 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 PASRR/MH agent must review the materials and determine that they are complete and accurate, updating any missing information.
- b) It is the PASRR/MH screener’s responsibility to thoroughly search the UHS data base and make every effort to ascertain if the individual being

screened has previously been in a Long-Term Care facility and if they have received a prior PASRR/MH screening.

- c) PASRR/MH agents will be able to access PASRR/MH activity via the UHS database which will provide specific information on the person being screened. The PASRR/MH agent should bill the appropriate assessment necessary given the requirements outlined above.

Specific Payment Rate: \$320

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

D. PASRR/MH Resident Review Activities

1. A PASRR/MH Level II determination for Long Term Care admission will automatically generate a Resident Review due date, once the name of the Long-Term Care facility is entered into the UHS data base. Resident Review is required between 30 days – 60 days, post admission. The purpose of this review is to ascertain if the individual still requires the supports provided in the facility, if the mental health and treatment needs identified in the PAS assessment are integrated into the individual’s facility care plan or to determine if the individual does not require continued stay in Long-Term Care and can begin transition to a less restrictive setting.
2. The assessment findings and determinations of the Resident Review will be documented in the *UHS PAS data system* as Resident Review screens.

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

Payment Limits/Conditions: Only two Resident Reviews assessments are allowed, per person, per year

E. Supportive Living Facility (SLP) Specialized Assessment

1. PASRR/MH specialized assessment for SLP admission determination will be paid at the same rate as a Level II assessment.
2. The specialized assessment documentation and determination will be entered into UHS, as is a Level II.

3. Once entered, this information is printed and action is 'WITHDRAWN'. The content of the screen remains in the system.

Specific Payment Rate: \$400

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