North Carolina
Medicaid Special Bulletin

An Information Service of the
Division of Medical Assistance

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March 1, 2013

Attention:
Adult Care Homes Licensed under G.S. § 131D-2.4

Update Preadmission Screening and Review (PASRR) Process for Adult Care Homes Licensed Under G.S. 131D, Article 1 and defined in G.S. § 131D-2.1

Preadmission Screening

Beginning January 1, 2013, the Preadmission Screening and Resident Review (PASRR) program is a review of any individual who is being considered for admission into a Licensed Adult Care Home (ACH) regardless of the source of payment. As the N.C. Department of Health and Human Services (NCDHHS) continues to implement the transition to a community living initiative, it has worked towards putting requirements into rule.

As of March 1, 2013, the adoption of temporary rule 10A NCAC 14K .0101 requires that any ACH licensed under G.S. 131D-2.4 must assure that all people admitted to the ACH have had a determination about whether they have a serious mental illness (SMI). This will be accomplished by submitting a pre-admission screening using the N.C. Preadmission Screening and Resident Review (PASRR) Medicaid's Level I screening tool.

Who Is Subject to PASRR Screens

All applicants for admission to ACHs licensed under G.S. 131D; Article 1 must be screened through the PASRR Level I Process.

Level I Screens

NCDHHS provides a Level I screening by an independent screener for all applicants to ACHs licensed under G.S. 131D, Article 1 to identify beneficiaries with serious mental illness (SMI). For individuals with no evidence or diagnosis of SMI, the initial Level I screen remains valid unless there is a significant change in status. The Medicaid Uniform Screening Tool (MUST) for admission to the ACH will generate a PASRR number automatically.

ACHs themselves may not complete the PASRR. However, Adult Care Homes and Department of Social Services are sometimes appointed as guardians, and DSS must substantiate the need for Adult Protective Services. So they wanted to be part of the process. Therefore, NCDHHS has agreed to use a paper process in addition to the web-based screening process to ensure that the Level I screenings are completed expeditiously. It is expected that the online tool will be utilized routinely. **Only** if individuals are having difficulty finding a provider to use the online process should the paper process may be utilized. N.C. Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) staff have been identified to provide technical assistance to screeners or physicians offices with any aspect of completing the PASRR Level I.

Beginning on Friday, March 1, 2013, the following staff persons are available:

- Barbara Flood – EAST - 919-218-3872, barbara.flood@dhhs.nc.gov
- Ed Crotts – WEST - 828-413-2686, ed.crotts@dhhs.nc.gov
- Patricia McNear – CENTRAL – 919-981-2580, patricia.mcnear@dhhs.nc.gov
- Bill Joyce – CENTRAL & FLOATING – 336-312-0212, bill.joyce@dhhs.nc.gov

Getting Started Electronically

If you are currently a registered user of the NC MUST system or Provider Link, there are no further requirements. The tool now has the option to select the ACH Level of Care PASRR form. Please note that the screening form is identical.

If you are not currently registered, follow the steps below.

- To inquire about using the Department's free web based tool or to help assist you in getting started, please refer to our Getting Started page. www.ncmust.com/.
- Technical support is available by contacting the PASARR help desk at **1-800-688-6696**. Choose option 7 from the main menu and then option 2 for the technical help desk.
- One on one or group training is available online. Register Online now. www.ncmust.com/.

Getting Started Paper Process

Below is the process for accessing and using the paper PASRR tool, and instructions for completion of the screening tool.

- Form for printing and completing PASRR Level I can be found at: www.ncmust.com/.

- Health care provider staff, a community member who is not a legal representative of the individual being screened – and is not employed or paid by or affiliated with a licensed ACH – can download and print the PASRR Level I screening form. The person wishing to be admitted to an ACH, who has the paper copy of the screening form, should take it to a health care provider who is familiar with the individual being screened.

- The health care provider who completes the screening must sign and date the form. This signature is an attestation that the person who signs the form has filled it out to the best of his/her ability through either interview or records review.

- The person filling out the form **cannot** fill in the form ahead of time with a legal representative or someone associated with, paid by, or employed by the ACH and then request that a health care provider sign the form.

- Return the completed/signed form to the ACH, County Department of Social Services (when the DSS is the guardian and when the DSS has substantiated the need for Adult Protective Services), or other location that will key the information into an electronic PDF PASRR Level I form.

- The handwritten form, including attestation by the person who completed the screening, is scanned and both the electronic form and the scanned form are submitted to the Division of Medical Assistance at www.ncmust.com/.

Instructions for Completing the Paper PASRR Level I Form

Screening Type

- **Date:** Enter date screening takes place

Screener Information

- **Last Name:** Enter Last Name of individual completing the screening form
- **First Name:** Enter First Name of individual completing the screening form
- **Organization Name:** Enter the Name of the organization with which the screener is affiliated, if applicable
- **Organization Address:** Enter the address of the organization with which the screener is affiliated
- **Organization City, State, Zip:** Complete the rest of the address of the organization with which the screener is affiliated
- **Telephone:** Enter the telephone number of the screener
- **Fax:** Enter the Fax number of the screener
- **Email:** Enter the email address of the screener

Applicant Information

- **Last Name:** Enter Last Name of the individual being screened
- **First Name:** Enter First Name of the individual being screened
- **Middle Name:** Enter Middle Name of the individual being screened
- **Permanent Mailing Address**
    - **Street Address:** Enter permanent mailing address of individual being screened
    - **City:** Enter city of the permanent mailing address of individual being screened
    - **State:** Enter state of the permanent mailing address of individual being screened
    - **Zip Code:** Enter zip code of the permanent mailing address of individual being screened

- **Patient's Current Location**
  - **Specify Location Type:** Indicate where the individual is currently physically located. If it is NOT either the same as screeners organization or the same as the permanent mailing address, check "Other" and then enter the information:
    - **Facility Name:** If the individual is residing in a facility, enter the name of that facility
    - **Street Address:** Enter the street address of the facility
    - **City:** Enter the city of the facility
    - **State:** Enter the state of the facility
    - **Zip Code:** Enter the zip code of the facility address
    - **County of Residence:** Enter the county where the facility is located

Personal Details

- **Social Security Number:** Enter the Social Security number of the individual being screened
  - **Date of Birth:** Enter the birth date of the individual being screened
  - **Applicant's Home of Cell Phone Number:** Enter the phone number of the individual being screened
  - **Gender:** Enter the gender of the individual being screened
  - **Marital Status:** Enter the marital status of the individual being screened
  - **Medicare Number:** If the individual has Medicare, enter the number here
  - **Medicaid ID Number:** If the individual has Medicaid, enter the ID number here
  - **Medicaid Status:** Indicate whether the Medicaid card is Active or Pending
  - **Medicaid County of Residence:** Enter the county from which the individual's Medicaid originates. This is not necessarily the county in which they live. This is critical information so the correct LME/MCO will be informed to plan for services for this individual.
- **Legally Responsible Person:** Complete this section if the person has been adjudicated incompetent and has a legal representative
  - **Name:** Enter the name of the legally responsible person
  - **Street Address:** Enter the address of the legally responsible person
  - **City:** Enter the city of the legally responsible person
  - **State:** Enter the state of the legally responsible person
  - **Zip:** Enter the zip code of the legally responsible person
  - **Home or Cell Phone Number:** Enter the telephone number of the legally responsible person
  - **Work Phone Number:** Enter the work phone number of the legally responsible person if applicable

- **Other Contact Person:** Complete this section if the individual indicates another contact person who is not his/her legal representative
  - **Name:** Enter the name of the contact person
  - **Street Address:** Enter the address of the contact person
  - **City:** Enter the city of the contact person
  - **State:** Enter the state of the contact person
  - **Zip Code:** Enter the zip code of the contact person
- **Attending/Primary Physician**
  - **Physician Name:** Enter the name of the physician of the individual being screened
  - **Street Address:** Enter the street address of the physician of the individual being screened
  - **Mailing Address:** Enter the mailing address of the physician of the individual being screened, if it is different than the street address
  - **City:** Enter the city of the physician of the individual being screened
  - **State:** Enter the state of the physician of the individual being screened
  - **Zip Code:** Enter the zip code of the physician of the individual being screened
  - **Telephone Number:** Enter the telephone number of the physician of the individual being screened

Physical Health Diagnosis

- **Substance Abuse**
  - **Has History of or Currently has a Substance Abuse Problem:** Indicate Yes or No
  - **Date of Last Use:** If answer above is "Yes", indicate date of last use
- **Terminal Prognosis**
  - **Is there a terminal prognosis:** Indicate Yes or No
  - **Has a Doctor Certified a Terminal Prognosis:** Indicate Yes or No
  - **Name of Physician:** If a doctor has certified a terminal prognosis, enter the name of the physician
  - **Date of Physician Certification:** If a doctor has certified a terminal prognosis, enter the date of the certification
- **Cognitive Impairment**
  - **Is there a cognitive impairment diagnosis:** Indicate Yes or No
  - **Cognitive Impairment Diagnosis:** Indicate all cognitive impairment diagnoses that apply. If there is, a cognitive impairment that is not listed check all that apply and check "other".
  - **If other cognitive impairment diagnosis, specify:** If "other" was checked in the previous box, enter the additional diagnosis(es)
  - **Is Dementia the Primary Diagnosis:** Indicate Yes or No

Current Psychiatric Medications

- **Medication Name:** Up to six psychiatric medications being taken by the individual being screened can be entered in this section
- **Type of Medication:** Indicate whether the psychiatric medication is Formulary (Prescription) or Over the Counter
- **If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication:** Enter the purpose of the medication

Mental Health

- **Is there a MH Diagnosis:** Indicate Yes or No
- **If MH Diagnosis, specify Disorders/Diagnoses:** Indicate all mental health diagnoses that apply. If there is, a mental health diagnosis that is not listed check all that apply and check "other".
- **If other mental health diagnosis, specify:** If "other" was checked in the previous box, enter the additional diagnosis(es)
- **Mental Retardation (MR) Diagnosis**
    - **Is there a MR Diagnosis:** Indicate Yes or No
    - **If MR Diagnosis is present/suspected, indicate the severity level:** Indicate severity level
    - **Age at Onset:** If there is a MR diagnoses, enter age at onset
    - **Are MR services being provided:** Indicate Yes or No
- **Conditions Related to Mental Retardation (RC) Diagnoses**
    - **Is there a RC Diagnosis:** Indicate Yes or No
    - **Select All RC Diagnoses:** Indicate all RC diagnoses that apply. If there is, a RC diagnosis that is not listed check all that apply and check "other".
    - **If other RC diagnosis, specify:** If "other" was checked in the previous box, enter the additional diagnosis(es)
    - **Did the Condition Manifest Prior to Age 22**: Indicate Yes or No

Mental Health Behavioral Profile

- **Concentration / Task Limitations within the Past 6 Months:** Indicate all limitations that apply. If there is a limitation that is not listed check any that apply and check "other"
- **Other limitations within the past 6 months:** If "other" was checked in the previous box, enter the additional concentration / task limitations
- **Adapting to Changes within the Past 6 Months:** Indicate adaptations to changes in the past 6 months. If there is an adaptation that is not listed, check any that apply and check "other"
- **Other Adapting to Changes within the Past 6 Months:** If "other was checked in the previous box, enter the additional adaptations to changes

- **Mental Health Treatments**
  - **Treatments Received with the Past 2 Years / Date Treatment was Received:** Indicate treatments(s) received and the most recent date of the treatment(s)
- **Mental Illness Interventions**
  - **Interventions to Prevent Hospitalization / Intervention Treatment Date:** Indicate intervention(s) provided and the intervention treatment date(s). If there was an intervention provided that is not listed, check "other"
  - **If Other MI Intervention, Specify:** If "other was checked in the previous box, enter the additional intervention(s)
- **Orientation**
  - **Oriented to Time:** Indicate Yes or No
  - **Oriented to Person:** Indicate Yes or No
  - **Oriented to Place:** Indicate Yes or No
- **Mood and Behavior:** Based on interview, observation or assessment, check any mood and behavior characteristics that apply to the individual being screened
- **Interpersonal Functioning:** Based on interview, observation or assessment, check any interpersonal functioning characteristics that apply to the individual being screened
- **Categoricals**
  - **Is this a request for a short term nursing facility stay:** Indicate Yes or No
  - **If Yes the indicate the duration of the nursing facility stay:** Enter the duration of the nursing facility stay requested

Communication

- **Makes self understood:** Based on interview, observation or assessment, select one response for how often the individual being screened makes themselves understood
- **Understand/Use of language:** Based on interview, observation or assessment, indicate all descriptions of how the individual being screened understands or uses language

Functional Limitations

- **Does the applicant have any functional limitations:** Indicate Yes or No
- **Select all that apply:** If the answer to the previous question was yes, based on interview, observation or assessment, indicate which areas of functional limitations apply for the individual being screened.

Screener Certification

- **Who supplied the information:** Indicate all informants of information for this screening
- **Screener Name and Signature:** Signature of the person who did the screening and date the screening is signed is required
- **Physicians Name and Signature:** If this screening was completed at a physicians office, signature of the physician and date the screening is signed is required.

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