

0378

**INSTITUTIONAL CARE**

0378.05

**PURPOSE OF PRIOR AUTHORIZATION**

REV:08/1998

Prior authorization is required for the Rhode Island Medical Assistance Program to provide payment for the care of Categorically and Medically Needy recipients in certain medical facilities. The purpose of prior authorization is to insure that the individual is placed in a facility appropriate to his/her service needs. Therefore the authorization process includes:

- o Evaluating the recipient's needs for institutional care and the type of facility required;
- o Screening potential nursing facility candidates for mental illness and mental retardation (PASRR);
- o Authorizing Medical Assistance and vendor payments;
- o Conducting periodic evaluations of the patient's needs.

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**Authorization Responsibilities**

REV:08/1998

The district office Long Term Care/Adult Service (LTC/AS) units:

- o Determine financial eligibility for MA;
- o Determine patient income to be allocated to the cost of institutional care;
- o Authorize vendor payments to nursing facilities;
- o Assist in the evaluation of medically necessary care;
- o Assist in placement of eligible individuals; and,

- o Provide social services for applicants and recipients of long term care.

The Office of Medical Review (OMR):

- o Establishes the need for nursing facility care by an applicant or recipient prior to authorizing payment; and,
- o Ensures that the PASRR Preadmission Screening requirement is completed.

**0378.10 TYPES OF FACILITIES**

REV:08/1998

The Medical Assistance Program provides payment for the care of MA recipients in the following types of nursing facilities:

- o Nursing Facilities (NF)

A patient qualifies for nursing facility care if s/he requires the services of professional or qualified technical health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, audiologists, or s/he requires assistance with activities of daily living. Activities of daily living include walking, bathing, dressing, feeding and toileting. The facility must provide these services under the supervision of licensed nursing personnel.

- o Intermediate Care Facility for the Mentally Retarded (ICF/MR)

A patient qualifies for an ICF/MR level of care if s/he is mentally retarded, and requires supervision and/or assistance with activities of daily living.

The Medical Assistance Program also provides payment for medically necessary care in the following Public Medical Facility:

- o Eleanor Slater Hospital.

Patients in NFs, ICF/MRs, the Public Medical Facility and certain Waiver programs are considered to be

institutionalized for purposes of determining eligibility for Medical Assistance. The Medical Assistance payment for institutional care is reduced by the amount of the individual's income after certain allowable expenses are deducted.

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**DETERMINING CARE REQUIREMENTS**

REV:08/1998

Procedures for evaluating the type of care required by an individual will vary, depending on whether the individual requests placement from a community setting or while a hospital in-patient.

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**Evaluating Needs, Hospital Patients**

REV:03/1999

This policy section applies to the following individuals seeking nursing facility placement from a hospital:

- o Individuals seeking initial NF placement;
- o Individuals who left a NF to enter assisted living, and are now seeking readmission to a NF;
- o Individuals who left a nursing facility to return to the community for other than short term social or therapeutic stays, and are now seeking readmission to a NF.

Discharge staff at Rhode Island acute care hospitals have been delegated the authority to make preliminary evaluations of the need for nursing facility care. At the time of discharge to a nursing facility, the hospital social worker or nurse:

- o Completes the CP-1 evaluation instrument;
- o Sends the original CP-1 and a copy to LTC/Office of Medical Review unit at C.O., along with the PASRR ID screen (See Section 0378.25), a notification of recipient choice (CP-12) and an Inter-agency Referral form;
- o Sends a copy of the CP-1, the PASRR forms, and

the interagency referral form with the patient to the facility.

Upon approval of the CP-1 evaluation by the Nurse Consultant in the DHS Office of Medical Review (OMR), nursing facility payment is authorized. Copies of the CP-1 and CP-12 are sent to the DHS district office.

Out-of-state hospitals send the PASRR required forms, copies of the medical (72.1) and social worker(70.1) forms, and/or other comprehensive assessments to the DHS Nurse Consultant in the DHS Office of Medical Review. Upon approval, the MA-510 (Authorization for a Level of Care in a Nursing Facility) is completed by the DHS Nurse Consultant and forwarded to the appropriate DHS district office.

When the approved CP-1 or MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in the placement.

The level of care information is entered to the InRhodes system via the STAT/CARE panel.

Note: MA recipients who have been admitted to the hospital from a nursing facility and are being discharged to the same or another NF are considered to be continuously institutionalized and a new evaluation (CP-1) is not required at the time of their readmission to the NF.

#### **0378.15.10                      Evaluating Needs, Community Applicants**

REV:08/1998

When a person residing in the community requests direct placement into a nursing facility, the following documentation is assembled by LTC/AS staff and transmitted to the OMR unit at CO:

- o     A medical evaluation of the applicant by a physician, Form AP-72.1;
  
- o     An evaluation completed by the LTC/AS unit social worker establishing the applicant's functional abilities, living arrangements and service needs, Form AP-70.1;

- o PASRR ID Screen (MA/PAS-1). (See Section 0378.25);

If an emergency placement is indicated, the worker contacts the LTC/OMR Unit for emergency authorization of nursing facility placement. Otherwise, as soon as the documentation is received by the LTC/OMR Unit, the Nurse Consultant reviews the evaluations and determines the need for nursing facility care. The decision is transmitted to the LTC/AS staff on Form MA-510, Authorization for Care in a Nursing Facility.

When the MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in locating a suitable facility. If space is not available, the worker places the individual's name on a waiting list.

The level of care information is entered to the InRHODES system via the STAT/CARE panel.

#### **0378.15.15                      Evaluating Needs, ICF-MR Care**

REV:08/1998

Caseworkers at the Department of Mental Health, Retardation, and Hospitals are authorized to determine an individual's need for ICF/MR level of care. The caseworker completes the CP-1 form, and forwards it and the PASRR ID Screen to the LTC/OMR Unit at C.O. for review and approval.

The level of care information documented on the CP-1 is entered to the InRHODES system via the STAT/CARE panel.

#### **0378.15.20      Re-Evaluation of Needs**

EFF:04/2006

When the Office of Medical Review (OMR) in the Center for Adult Health determines that an individual meets a nursing facility level of care and/or that a full Identification Screen has been received, the OMR Nurse Consultant designates those instances in which the individual's medical information indicates the possibility of significant functional and/or medical improvement within two (2) months. The OMR maintains all records of pending

and completed reviews including all cases requiring future review.

Notification is sent to both the individual, his/her authorized representative and the Nursing Facility by the OMR that a Nursing Facility level of care has been approved, but functional and medical status will be re-reviewed in thirty (30) to sixty (60) days. At the time of the review, the OMR Nurse Consultant must first confirm that the individual remains a resident of the nursing facility. For clients remaining in a nursing facility, the Nurse Consultant reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

1. The individual no longer meets a nursing facility level of care. In this instance , the Long Term Care Office is notified of the Level of Care denial, and the individual, his/her authorized representative if one has been designated, and the nursing facility are sent a discontinuance notice by the Long Term Care Unit. Any fair hearing appeal requests resulting from this Level of Care discontinuance notice will be defended by the Office of Medical Review.
2. The individual continues to meet a level of care, and no action is required.

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**AUTHORIZATION OF MA PAYMENT**

REV:08/1998

Level of care information (and PASRR information for individuals whose authorized level of care is a nursing facility) is entered to InRHODES and maintained via the STAT/CARE panel.

LTC/AS unit staff approve MA eligibility for institutionalized individuals and authorize vendor payments on behalf of the individual via the InRHODES ELIG/AUTH panel, provided a prohibited resource transfer does not prevent Medical Assistance payment for the cost of nursing facility care.

If payment to the nursing facility will be made, the worker determines the amount of the patient's income which must be applied to the cost of nursing facility services. The Medical Assistance payment for care in a nursing facility is reduced by the amount of the patient's applied income. See Section 0392, POST-ELIGIBILITY OF INCOME, for policy regarding allocation of income to the cost of institutional care.

**0378.20.05 Payment for Nursing Facility Services**

REV:08/1998

Special attention must be paid when a recipient who has Medicare coverage is a resident of a nursing facility. If Medicare coverage is authorized, then Medicare payment for the NF services must be utilized before Medical Assistance payment will be made.

For patients requiring "skilled" services, Federal Medicare helps pay for up to a maximum of 100 days in a participating nursing facility per spell of illness. For persons enrolled in Part A of Medicare, hospital insurance pays for all covered nursing facility services for the first 20 days, if approved. Medically necessary care for the balance of 80 days requires a co-insurance payment. Medical Assistance will pay a recipient's "co-insurance" for approved skilled nursing days if the patient has insufficient income, and no "Medigap" coverage.

**0378.20.05.05 Payment to Long Term Care Facilities**

REV:08/1998

Each nursing facility has a per diem rate established by the Rate Setting Unit within the Division of Medical Services, determined on the basis of the cost of operating the facility. The payment to the facility is made for all persons authorized to receive service in the facility.

Payment is made for the day of admission to the facility, regardless of the hour, but is not made for the day of discharge, regardless of the hour.

**0378.20.05.10 Bed-Hold Days**

REV:08/1998

When a patient goes to the hospital or otherwise temporarily leaves a LTC facility, the Agency makes no payment to retain a bed for the patient's return to the facility.

**0378.20.10                      Notice of Patient Placement or Discharge**

REV:08/1998

When a patient has been placed directly from his/her home into a nursing facility, the LTC/AS worker identifies the facility on the AP-510 or CP-1 form, sends one copy of the AP-510 or CP-1 to the facility, and files a remaining copy in the case record.

**0378.20.10.05                  Facility's Notice of Admission or Discharge**

REV:08/1998

Each facility administrator is required to send a Notice of Admission (MA-602) to the appropriate DHS district office LTC unit whenever a recipient is admitted. The Admission Notice contains identifying data about the person and information pertaining to his/her eligibility for Medicare benefits.

The facility administrator is required to send a Notification of Discharge (MA-603) to the appropriate DHS district office LTC unit when care is no longer required and/or the person is discharged from the facility. Payment is not made to the facility for the day of discharge, regardless of the hour.

**0378.20.15                      Payment to Other Vendors or Facilities**

REV:01/2002

The district office LTC/AS units authorize vendor payments through MMIS to other types of vendors/facilities via InRHODES. Medicare does not provide payment for other than nursing facility services.

**0378.25                              PREAMMISSION SCREEN/RESIDENT REVIEW (PASRR)**

REV:01/2002

All new candidates for admission to a nursing facility (NF) must be screened for mental illness and mental retardation prior to admission. The procedure is known as the Preadmission Screening and Resident Review (PASRR).

PASRR has three major purposes which are:

- o To assure that all candidates for admission to nursing facilities are properly screened for the existence of mental illness or mental retardation;
- o To prevent the inappropriate admission to nursing facilities of patients with mental illness or retardation; and,
- o To assure that proper treatment plans for inpatients in nursing facilities who have mental illness or mental retardation are formulated and adjusted when necessary to meet treatment needs.

Medical Assistance cannot authorize a payment to a facility on behalf of a patient if the PASRR screening is not complete.

An individual cannot be admitted to a nursing facility if it is determined by the Level II evaluation process that the individual's needs for specialized services for mental illness and/or mental retardation cannot be appropriately met in the nursing facility.

**0378.25.05 Preadmission Screen - Levels of Evaluation**

REV:08/1998

Preadmission screening has two levels of evaluation--the Level I PASRR ID Screen and the Level II evaluation.

**0378.25.05.05 PASRR Level I Evaluation - ID Screen**

REV:01/2002

Thirty (30) Day ID Screen Exemption

The Level I PASRR process is required on all nursing facility applicants unless the applicant is an individual:

- a) who is admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital, AND;
- b) who requires NF services for the condition for which the individual received care in the hospital, AND;
- c) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of NF services.

Such individual is EXEMPT from the pre-admission screening aspects of PASRR. It is not necessary to complete either an ID screen or a Level II PASRR on these individuals. Complete page one of the ID screen, including the physician validation section; and return to the Department of Human Services with the appropriate Level of Care determination (i.e., CP-1 or AP-72.1/70.1).

If the patient is found to require longer than 30 days, an ID screen is due on the 25th day after admission. When this ID screen indicates or suggests a serious mental illness, arrangements must be made for an immediate Resident Review (RR).

The PASRR ID Screen is the Level I evaluation instrument to screen for mental illness or mental retardation, and must be completed by a health care professional and signed by a physician for every patient prior to admission to a nursing facility. For patients seeking admission to a nursing facility from a hospital, the PASRR ID Screen accompanies the Interagency Referral Form and the CP-1 for hospital placements. For individuals seeking placement from the community, the PASRR ID Screen is form MA/PAS-1.

The PASRR evaluation stops at the Level I for those patients who do not have either condition.

The Level II PASRR evaluation process must be completed for individuals who have mental illness or mental retardation UNLESS one of the following three conditions exists:

- Delirium - If the individual has delirium to the extent that an accurate diagnosis cannot be made until the delirium clears, or,
- Dementia - If the individual has a PRIMARY diagnosis of dementia according to the DSM IV criteria (including Alzheimer's Disease or related disorders) or this individual has a Primary Diagnosis of an illness other than mental illness and a diagnosis of dementia (including Alzheimer's Disease or related disorder); AND a serious mental illness is not a primary problem. The Dementia exemption does not apply for the MR PASRR process.
- Respite Care - If the individual is admitted for respite care and is projected to require a stay of less than 30 days.

If the delirium exemption applies, a new ID Screen is required when the delirium clears, but no later than the 30th day after NF admission. In the case of a client who was admitted under the delirium exemption and for whom a psychiatric diagnosis could not be initially determined, an ID Screen is required at the point that the delirium clears. If this identifies or suspects serious mental illness, arrangements should be made for an immediate Resident Review (RR). In all cases, the ID screen and RR are required not later than 30 days after admission. In this case, recommendations for medical and psychiatric follow-up at the nursing facility must be made prior to admission.

If the dementia exemption applies, the name of the physician confirming the diagnosis must be on the ID Screen. Supportive documentation to confirm the diagnosis must be included in the ID Screen evaluation packet. This may include a completed Folstein Mini Mental State or Cognitive Capacity Screening Examination (CCSE) or documentation of symptoms or physical findings to support dementia or a related disorder. No further Level II screening for Mental Illness is required.

In addition, some individuals who have either or both conditions will have somatic medical needs which indicate a categorical determination of NF level of care.

The entire Level II PASRR evaluation process as described in Section 0378.25.05.10 must be completed for individuals who have mental illness or mental retardation UNLESS one of the following conditions exists:

- o The patient is being admitted to the nursing facility for care of a terminal illness, and has a life expectancy of less than six (6) months;
- o The patient is being admitted to the nursing facility for care of an illness so severe that active treatment for mental illness or mental retardation is precluded.

If one of the exception conditions exist, a part of the Level II evaluation is necessary prior to nursing facility placement. (As described in Section 0378.25.05.10.)

Completion of the ID Screen ends the PASRR evaluation for those individuals not identified as having mental illness or retardation, and those individuals meeting an exception condition. The following actions must then occur:

- o A copy of the completed PASRR ID Screen is submitted to the Office of Medical Review at C.O. along with the CP-1 (or for community placements, the AP-70.1 and AP-72.1).
- o The ID screen is forwarded by the hospital, LTC unit or placing agent to the nursing facility when the patient is placed.

**0378.25.05.10 PASRR Level II Evaluation**

REV:01/2002

Those patients identified by the Level I evaluation as having mental illness or mental retardation and not meeting one of the exception conditions must be further evaluated to assure that nursing facility placement is appropriate. The Level II PASRR evaluation involves completion of a more detailed patient assessment instrument which is evaluated by staff at the Department of Mental Health, Retardation, and Hospitals (MHRH).

The Division of Integrated Behavioral Health Services (DIBHS) is the state agency charged with making the final determination of whether mental illness exists, and the Division of Developmental Disabilities (DDD) is the state agency responsible for determining if mental retardation exists. DIBHS and DDD also make the final decision regarding placement at a particular facility.

Level II pre-admission requirements must be completed prior to admission unless the individual is admitted under emergency protection services. Individuals who are admitted under emergency protection services must have a PASRR Level II completed within 7 days of admission. In these cases, the nursing facility must have documentation of the need for protective services in addition to the materials required for a routine pre-admission Level II or for an initial Resident Review.

To meet this requirement for an individual identified or suspected of having a serious mental illness, the facility can either forward the pre-admission Level II directly to the DIBHS for a determination, as long as the Level II is not completed by staff of the nursing facility, or, forward the Notification of Need for Resident Review (MA/PAS-3.2) to the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

The Level II evaluation procedure varies, depending on the individual's diagnosis. Both procedures described below must be followed for persons diagnosed as having mental illness, mental retardation, or both:

- o The Level II evaluation instrument for individuals identified by the ID Screen as having mental illness is the Level II PASRR-MI Evaluation (MA/PAS-2). A copy of the completed MA/PAS-2; along with a copy of MA/PAS-2.1 and MA/PAS-2.2 or equivalent; and a copy of the PASRR ID Screen are forwarded by the MI PASRR contact person to DIBHS for decision;
- o The Level II evaluation instrument for individuals identified by the ID Screen as having mental retardation and/or a developmental disability is the PASRR (MR) Level II Data Sheet. The completed Level II Data Sheet and a copy of

the PASRR ID Screen are forwarded by the MR PASRR contact person to DDD, along with any other appropriate documentation, for decision.

Both DDD and DIBHS may require additional evaluation material prior to making a final determination. When a decision on the diagnosis and placement is made, DOH or DDD will notify the referring agent and the Office of Medical Review at C.O.

For Medical Assistance applicants/recipients pending admission to nursing facilities from hospitals, the PASRR ID Screen and any necessary Level II evaluation is completed by hospital staff. If no Level II evaluation is required, a copy of the ID Screen is forwarded to the Office of Medical Review at C.O. along with the CP-1 and Inter-agency Referral form, for evaluation of the type of care required.

If required, a copy of the Level II evaluations, with a copy of the ID Screen, are forwarded directly to the appropriate division of MHRH, as described above.

For Medical Assistance, applicants/recipients pending admission to nursing facilities from community settings, the physician completing the AP-72.1 completes the ID Screen. If no Level II evaluation is needed, LTC/AS staff forward the screening instrument together with the AP-70.1 and AP-72.1 to the Office of Medical Review at C.O. Any necessary Level II evaluations are forwarded directly to the appropriate division of MHRH as described above. When LTC/AS staff receive either the determination notice from DIBHS or the Level II Screen/PASRR (MR) from DDD, the AP-70.1 and AP-72.1 are then forwarded to the Office of Medical Review at C.O. for approval of nursing facility care.

**0378.25.05.15                      Severe Illness and Serious Mental Illness**

REV:01/2002

Severe Illness Categorical Determination of NF Level of Care and Serious Mental Illness

For patients who are admitted for care of a terminal illness with a life expectancy of less than six months and

who require NF care or for patients who require care for a severe illness which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services only a part of the Level II PASRR is required.

"Severe illness" includes, but is not limited to: comatose, ventilator dependent, functioning at the brain stem level, chronic obstructive pulmonary disease, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis, and congestive heart failure.

Required PASRR paperwork for individuals with a categorical Determination of Level Of Care for severe or terminal illness is as follows:

- a) ID Screen (MA/PAS-1). The ID Screen Update (MA/PAS-1.1) may be used as a supplement to update the ID Screen.
- b) Client Notification of PASRR Level II Screen (MA/PAS 1.2)
- c) Pages 5 and 6 of PASRR Level II Screen (MA/PAS-2)
- d) PASRR Level II Psychiatric Requirements (optional MA/PAS-2.2)

Send the entire PASRR package to the DIBHS prior to discharge for a determination of need for specialized service.

Required documentation to be sent to DHS, Office of Medical Review, 600 New London Avenue, Cranston, RI 02920, for Determination of Level Of Care includes:

- CP-1, an Interagency Form and a completed ID Screen for a patient admitted from a hospital; or,
- 72.1, 70.1 and a completed ID Screen for a patient admitted from the community.

**0378.25.05.20**

**PASRR-MR/DD Process**

REV:08/1998

Though PASRR-MR/DD (Mental Retardation/Developmental Disabilities) shares the overall objectives in the description of the PASRR program in general, there are some differences with respect both to the procedure of completing the PASRR process and the nature of the overall focus of the PASRR-MR/DD program as well.

The Division of Developmental Disabilities (DDD) is responsible for the provision of those services which will enhance the quality of life for persons with developmental disabilities as well as for the maximization of their potential for inclusion and participation in community life. The role of PASRR within the framework of services provided by DDD is to ensure the quality of care of those residing in nursing facilities with the diagnosis of MR/DD and to certify that a nursing facility is the most appropriate and least restrictive residential setting.

With respect to the PASRR-MR/DD process, the following procedural points should be noted. When an I.D. Screen identifies or suggests MR/DD, a complete pre-admission screen includes:

- o An Identification Screen, which is completed by the referring agency;
- o A PASRR-MR/DD Level II Data Sheet, which is completed by the referring agency and includes the results of cognitive testing and a social history, if available;
- o A PASRR-MR/DD Level II Screen - to be completed by the DDD PASRR representative. It should be noted that in order to complete this form, the PASRR representative from the MHRH Division of MR/DD must meet both with the individual who is in need of nursing facility services as well as thereferring agent.

If a person should require hospitalization after admission to a nursing facility, a new PASRR will not be needed unless the hospital admission is the result of the person's developmental disability.

#### EXEMPTION

There are certain exemptions on the I.D. Screen, that dispense with the need for a Level II PASRR evaluation (see Section 0378.25.05.05). The dementia exemption does not

pertain to the MR/DD PASRR process. A Level II Screen will be necessary for individuals who have this diagnosis.

**0378.25.10**

**RESIDENT REVIEW (PASRR)**

REV:01/2002

When there is a significant change in a resident's physical or mental condition, nursing facilities (NFs) must make a clinical judgment whether the change in the resident's condition warrants a Resident Review (RR).

Formerly, nursing facilities were responsible for arranging for an annual review of their residents with Serious Mental Illness (SMI) or with Mental Retardation/Developmental Disabilities (MR/DD) to assure that a resident had been properly diagnosed regarding the presence of mental illness and/or mental retardation, and to assure that active treatment needs were being met if either condition were present.

Congress amended Section 1919(e)(7)(B) of the Social Security Act to rather require that Resident Reviews (RRs) be conducted promptly after a nursing facility has notified the state authority that a resident has had a "significant change in condition" affecting their physical or mental status.

The change from an annual review to a review upon a "significant change in condition" provides the flexibility to time evaluations and determinations when they are needed. However, RRs are still required by MHRH with certain conditions.

**MR/DD Resident Review**

If there is a question of a significant change in a resident's physical or mental status, the nursing facility is instructed to contact the MHRH Division of DD PASRR representative to determine if a resident review is necessary.

Given the nature of DDD services, significant change has other considerations in addition to a change in an individual's physical or mental status. The purpose of the PASRR MR/DD program is to assure the quality of care of persons with developmental disabilities who reside in nursing facilities. In addition, the program ascertains that nursing facility care is necessary as well as the

choice of the resident. Less restrictive residential options, if appropriate, are offered for consideration. Resident reviews are warranted in order to ensure quality care as well as to determine the need for residential alternatives.

Resident reviews for MR/DD individuals are conducted on a periodic basis. The PASRR MR/DD representative will contact the nursing facility and make arrangements for visitation and consultation. It is the responsibility of the nursing facility to complete the PASRR Level II Resident Assessment Form prior to the visit.

**0378.25.10.05                    Treatment Needs Indicate Significant Change**

REV:08/1998

Treatment is geared to help a resident meet his/her highest practicable level, improve when possible, and prevent avoidable decline.

Treatment needs which may indicate the need for a Level II Resident Review (RR) are listed below.

- o 1 to 1 monitoring;
- o 15 minute checks;
- o Close patient observation, e.g., in the hallway or by the nurses station;
- o Medication holiday which requires 1 to 1, 15 minute checks or close monitoring;
- o Intensive medication review;
- o PRN medication titration monitoring;
- o Introduction or increase in usage of psychotropic medication for behavior control;
- o Introduction or usage of restraints for behavior control;
- o Treatment plan includes repeated use of PRN psychotropic medication and/or restraints for

behavior control;

- o Significant incidence of abusive behavior (such as: sexually inappropriate behavior, assault, suicide attempt);
- o Intensive involvement of nursing facility or mental health professional staff to maintain a behavior plan.

**0378.25.10.10 Health Status Areas of Significant Change**

REV:08/1998

Significant change usually contains the following conditions:

1. The change is not self-limiting. Self-limiting is defined as:
  - o a change confined to a particular clinical area;
  - o a transient change where intervention(s) are appropriate and timely.
2. There is a major change in more than one area of the Resident's Health Status. Examples of classifications of the Resident's Health Status include:
  - o Communication
  - o Cognition
  - o Behavior
  - o Mood
  - o Physical Symptomology
  - o Activities of Daily Living (ADLs)

This may include more than one change within a particular classification.

3. An interdisciplinary review and/or a revision of the care plan is required.

**0378.25.10.15                      Significant Change, Level II Resident Review**

REV:08/1998

The following describes some, but is not inclusive of all, situations that may require a Resident Review for a significant change in condition.

1. Person does not stabilize, improve, or return to baseline within the expected time frame despite implementation of mental health treatment as identified on previous PASRR.
2. A resident with MI may benefit from mental health Services when there is a significant change in physical condition such as:
  - Deteriorating physical condition.
  - Significant unplanned weight loss, e.g., 5% in the past 30 days or 10% in the past 180 days.
  - Significant deterioration in two (2) or more of the following areas: ADLs, communication, cognitive ability or continence.
  - Deterioration in mood or behavior when daily problems arise and relationships become problematic, if staff conclude that these conditions in the resident's psychosocial status are not likely to improve without staff intervention.
  - Significant overall deterioration of resident's condition.
3. NF readmission when a substantial change in the resident's condition has not responded to hospitalization or has developed after hospitalization. A Resident Assessment (RA) is required within 14 days along with a revision of the treatment plan within 7 days of the RA. An evaluation of the need for a resident review would be indicated

if the resident does not respond to treatment within 21 days of readmission provided that the change in condition has a bearing on his or her mental health needs.

4. Improvement in behavior, mood or functional status to the extent that the plan of care no longer addresses the needs of the resident and the resident may be more appropriate for another community setting.

**0378.25.10.20 Other Conditions Indicating Need for RR**  
REV:01/2002

Other conditions which may indicate a need for a Resident Review (RR) when the ID Screen identifies or suspects serious mental illness are identified below.

1. Any person with either:
  - a. a newly-suspected diagnosis of "Serious Mental Illness" (SMI); or,
  - b. a recurrence of a Serious Mental Illness in an individual whose last PASRR may or may not have specifically identified the individual as having a SMI.

Complete form MA/PAS-3.2 and forward to DIBHS and DOH Within a maximum of 21 days.

2. A Department of Health (DOH) review of "Nursing Facility Patient to Patient Abuse Report" or a Department of Elderly Affairs (DEA) Nursing Facility Ombudsman identifies suspected mental illness or a significant change in condition.
3. An MHRH or DOH request for reevaluation.
4. Any change in condition when a pre-admission 30-day exemption no longer applies.
5. Any change in condition where a terminal or severe illness exemption no longer applies.
6. Any change in condition where a respite admission is expected to be longer than 30 days.

7. When a delirium condition clears, following a delirium exemption lasting not longer than 30 days.
8. A PASRR Level II is required within 7 days of admission for patients who are admitted under emergency protection services. In these cases, the nursing facility must have documentation of the need for protective services in addition to the materials required for a routine pre-admission Level II or for an initial Resident Review (RR).

To meet this requirement, the facility can either forward the pre-admission Level II directly to the DIBHS for a determination, as long as the Level II is not completed by staff of the nursing facility, or, forward the Notification of Need for Resident Review (MA/PAS-3.2) to the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

**0378.25.10.25                      Summary of Assessment Activities**

REV:01/2002

A nursing facility is required to initiate treatment to meet immediate needs and begin a comprehensive reassessment when there is a significant change in a resident's condition. Treatment is geared to help the resident meet his/her highest practicable level, improve when possible and prevent avoidable decline.

The nursing facility is responsible for:

- completing a comprehensive assessment by the 14th day after noting a significant change;
- revising the care plan based on the reassessment within 7 days after its completion;
- assuring that active treatment needs, if any are identified, are met;
- concurrently making a clinical judgment , based on the person's response to treatment and current treatment needs, on whether the change in the resident's physical or mental condition warrants

a Resident Review (RR) by the State within this 21-day time period.

If the facility decides that a State RR might be necessary, the nursing facility must complete:

- a PASRR Level I, "RI DEPARTMENT OF HUMAN SERVICES ID SCREEN UPDATE FOR MI AND MR" (MA/PAS-1.1).

If a "serious mental illness" (SMI) is identified or suspected as a result of the PASRR screen, the nursing facility must also:

- complete a "NOTIFICATION OF NEED FOR RESIDENT REVIEW" (MA/PAS-3.2); and,
- forward a copy of the MA/PAS-3.2 to the State Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

**0378.25.10.30 Department of Health Notified of Need for RR**

REV:08/1998

Upon receipt of a "Notification of Need for Resident Review" (MA/PAS-3.2), the Department of Mental Health, Retardation and Hospitals (MHRH) is responsible for determining the need for:

- additional information updates in collaboration with the Department of Health (DOH);
- an immediate full Resident Review (RR);
- a delayed RR; or,
- an abbreviated RR; and,
- notifying the nursing facility accordingly.

**0378.25.10.35 Client in Crisis**

REV:01/2002

In addition to the Resident Review (RR), an intensified level of psychiatric services may be indicated. If,

however, a client is in a crisis situation that needs more care than the nursing facility can provide, it is the nursing facility's responsibility to transfer the client to a more appropriate setting. The receiving facility sends a notification of need for Resident Review (MA/PAS-3.2) to the DIBHS and DOH and the Resident Review (RR) is conducted in the receiving nursing facility.

**0378.25.10.40                    Conditions Requiring an Annual Review**

REV:08/1998

Conditions which require at least an annual Resident Review (RR) when the ID Screen identifies or suspects "Serious Mental Illness" (SMI) are:

1. Any usage of physical restraints for symptoms of an SMI.
  
2. Residents with SMI whose condition has not changed since the last PASRR and whose psychiatric condition exhibits frequent fluctuation, is not responsive to, or counter-indicates traditional treatments. These residents may be significantly withdrawn or have frequent episodes of symptoms or behaviors that require Nursing Facility (NF) psychiatric services. These symptoms related to a "Serious Mental Illness" may include episodes of continued use of psychotropic PRNs for behavior control; episodes of extensive supportive treatment for significant disruptions; and episodes of cyclical mental illness manifesting themselves as episodic periods of screaming, demanding, intrusive, or aggressive behavior, which result in intensive or ongoing need for NF psychiatric services.

This requirement for a PASRR on an annual basis is differentiated from the requirement for an immediate PASRR for a significant change in condition in that the client's symptoms are well established, predictable cyclical patterns of clinical signs and symptoms associated with a previously diagnosed condition which was described on a previous PASRR. In addition, the treatment plan documents appropriate treatment and this condition is appropriately managed with ongoing NF psychiatric services. The condition is not severe enough to

require specialized services.

3. Residents who have made a competent decision to refuse treatment and have not had a recent significant deterioration in condition. Although these residents refuse treatment, they may significantly benefit from additional medical or psychiatric services.

This requirement for a PASRR on an annual basis is differentiated from the requirement for an immediate PASRR for a significant change in condition in that the condition is appropriately managed with ongoing NF psychiatric services. A previous PASRR along with the current treatment plan documents appropriate follow-up treatment. However, it is likely that increased mental health or medical services may significantly improve the quality of life.

**0378.25.10.45                      Quality Assurance Survey Program**

REV:08/1998

A quality assurance survey program is geared to assure the quality of services for nursing facility (NF) residents with mental illness. A survey of 10-100% of residents previously determined to have or suspected of having, a "Serious Mental Illness" will review the MDS Assessment, Plan of Care and services provided. The program will provide consultation and limited technical assistance aimed to assure that treatment is geared to reduce psychiatric symptoms and behaviors, improve level of functioning, and prevent regression and loss of functioning.

This may include:

- a) Survey of MDS assessments, treatment plans and need for additional Resident Assessment Instruments for any Significant Change in Condition. Review for appropriateness and timeliness.
- b) Survey the implementation of treatment recommendations identified in previous Preadmission Screening and Resident Review (PASRR) evaluation.
- c) Survey of treatment regarding:
  - o Provision of opportunity for client choice and

self-management.

- o Participation of all relevant staff in implementation of an individualized treatment plan.
  - o Implementation of habilitation services in formal and informal settings across disciplines to support the achievement of objectives in the plan of care.
- d) Review of policy, procedures and standards for treatment provision.