MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-05

Distribution: Inpatient Hospitals (Provider Type 30)
Nursing Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally ill (Provider Type 72)
Hospice (Provider Type 15)

Issued: January 28, 2007

Subject: Revision of PASARR Forms DCH-3877 and DCH-3878

Effective: March 1, 2007

Programs Affected: Medicaid

The Preadmission Screening (PAS) / Annual Resident Review (ARR) form (DCH-3877) and the Mental Illness/Developmental Disability Exemption Criteria Certification form (DCH-3878) have been revised to conform with federal regulations, to conform with Michigan's Public Act 61 of 2004, and to incorporate technical changes.

Revisions to the form include:

- The removal of the words “developmental disability” in the title of the form, etc., which are replaced with the words “mental retardation/related condition”. This change is consistent with federal regulations.
- The removal of the words “certified or registered” social worker, which are replaced with the words “licensed bachelor or master social worker, licensed professional counselor”. This change is consistent with Michigan’s Public Act 61 of 2004.
- Technical changes (e.g., change in the name of the “Significant Changes” box to “Change in Condition”; replaced the word “guardian” with “legal representative”, transfer of form instructions from the form to the instruction sheet).

The attached revised forms are to be used beginning March 1, 2007. Previous versions of the form will not be accepted.

These forms are available on-line at: www.michigan.gov/mdch >> Providers >> Information for Medicaid Providers >> Medicaid Provider Forms and Other Resources.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness / Mental Retardation / Related Conditions Identification)

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**

SECTION I – Patient, Legal Representative, and Agency Information:

Patient Name (First, MI, Last)			Date of Birth (M,D,Y)	Gender ☐ **Male** ☐ **Female**
Address (Number and Street)			County of Residence	Social Security Number
City	State	ZIP Code	MEDICAID Beneficiary ID Number	MEDICARE ID Number
Does this patient have a court-appointed guardian or other legal representative? ☐ **NO** ☐ **YES** ▶			If YES, Give Name of Legal Representative	
County in which the Legal Representative was Appointed			Address (Number, Street, Apt. Number or Suite Number)	
Legal Representative Telephone Number ( ) -			City	State / ZIP Code
Referring Agency Name			Telephone Number ( ) -	Admission Date (Actual or Proposed)
Nursing Facility Name (Proposed or Actual)			County Name	
Nursing Facility Address (Number and Street)			City	State / ZIP Code

Sections II & III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or a physician.

SECTION II – Screening Criteria: All 6 items must be completed

1. ☐ NO ☐ YES..... The person has a current diagnosis of **MENTAL ILLNESS** or **DEMENTIA**. ***(Circle One)***
2. ☐ NO ☐ YES..... The person has received treatment for **MENTAL ILLNESS** or **DEMENTIA** within the past 24 months. ***(Circle One).***
3. ☐ NO ☐ YES..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ NO ☐ YES..... There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment.
5. ☐ NO ☐ YES..... The person has a diagnosis of mental retardation or a related condition, including but not limited to epilepsy, autism, or cerebral palsy.
6. ☐ NO ☐ YES..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have mental retardation or a related condition.

Note: If you check "YES" to items 1 and/or 2, circle the word "**mental illness**" or "**dementia.**"

Explain any "YES"

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if <u>any</u> of the above items are "YES" UNLESS a physician certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature / Date			Name (Typed or Printed) / Degree / License
Address (Number, Street, Apt. Number or Suite Number)			
City	State	ZIP Code	Telephone Number ( ) -

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but if NOT completed, Medicaid will not reimburse the nursing facility.

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DISTRIBUTION: If any answer to questions 1 – 6 in SECTION II is "YES":
Send **ONE copy** to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested.
The nursing facility must retain the original in the patient record and see that a copy goes to the patient or legal representative.

Mental Illness / Mental Retardation / Related Condition Identification Criteria

Instructions for DCH-3877

The DCH-3877 is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or mental retardation, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or physician.

Preadmission Screening: The DCH-3877 must be completed by hospitals as part of the discharge planning process or by physicians seeking to admit an individual to a nursing facility from other than an acute care setting. **Check the PAS box.**

Annual resident review: The DCH-3877 must be completed by the nursing facility. **Check the ARR box.**

Section II – Screening Criteria – All 6 items on the form must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revised (DSM-IV-TR™).
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past twenty-four (24) months. Do NOT mark "YES" for an individual cited as having a diagnosis "by history" only.
2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.
3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.
4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations.
5. **Mental Retardation / Related Condition:** An individual is considered to have a severe, chronic disability that meets **ALL** four (4) of the following conditions:
   a) It is manifested before the person reaches **age 22**.
   b) It is likely to continue indefinitely.
   c) It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d) It is attributable to:
      - mental retardation such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to mental retardation because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine presence of a developmental disability, causal factors, and treatment recommendations.

NOTE: When there is one or more "YES" answers to questions 1 – 6 under SECTION II, a Mental Illness / Mental Retardation / Related Condition Exemption Criteria Certification, DCH-3878 must be completed only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

Michigan Department of Community Health

MENTAL ILLNESS / MENTAL RETARDATION / RELATED CONDITION

EXEMPTION CRITERIA CERTIFICATION

(For Use in Claiming Exemption Only)

INSTRUCTIONS:

- This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant or physician **and signed and dated by a physician**.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS either of the exemption criteria below is met and certified by a physician. **Indicate which one applies.**

Patient Name		Date of Birth	
Name of Referring Agency		Referring Agency Telephone No. ( ) -	
Referring Agency Address (Number, Street, Building, Suite No., etc.)	City	State	ZIP Code

Exemption Criteria:

☐ **COMA:** **YES,** I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA:** **YES**, I certify the patient under consideration has a dementia as established by clinical examination and evidence of meeting ALL 5 criteria below and does **NOT** have mental retardation/related condition or another primary psychiatric diagnosis of mental illness.

Specify the type of dementia: _____

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
   - Impaired judgment as indicated by inability to make reasonable plans to deal with interpersonal, family and job related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.
5. **EITHER:**
   a) Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance **OR**
   b) An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **HOSPITAL EXEMPTED DISCHARGE:**

YES, I certify that the patient under consideration is:

1) being admitted after a hospital stay, **AND**
2) requires nursing facility services for the condition for which she/he received hospital care, **AND**
3) is likely to require less than 30 days of nursing services.

Physician Signature	Date Signed	Name (Typed or Printed)
		Telephone Number ( ) -

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but if NOT completed, Medicaid will not reimburse the nursing facility.

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COPY DISTRIBUTION: **ORIGINAL**- Nursing Facility retains in Patient File
COPY - Attach to form DCH-3877 and send to Local CMHSP
COPY - Patient Copy or Legal Representative

MENTAL ILLNESS / MENTAL RETARDATION / RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

Instructions for DCH-3878

- The **DCH-3878** is to be used ONLY when a person identified on a **DCH-3877** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II evaluation. If the individual under consideration meets one of the following exemptions, she/he may be admitted (under preadmission evaluation) or retained (under annual resident review) at a nursing facility without additional evaluation. However, a completed copy of the **DCH-3878** must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

- This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or physician, **and signed and dated by a physician.**

- Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

- Use an "**X**" to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption **unless** the individual meets all 5 criteria. Any individual who meets some, but not all five (5), criteria will be subject to a LEVEL II evaluation. If the person under consideration meets this exemption category, please specify the type of dementia.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type,
2. Vascular Dementia,
3. Dementia due to Other General Medical Conditions,
4. Substance - Induced Persisting Dementia, **or**
5. Dementia Not Otherwise Specified.