MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Nursing Facilities 03-06
Hospitals 03-06
Community Mental Health Services Programs 03-02

Issued: July 1, 2003

Subject: PASARR Forms – DCH-3877 and DCH-3878

Effective: Upon Receipt

Programs Affected: Medicaid

This bulletin informs providers of revisions to the Preadmission Screening (PAS)/Annual Resident Review (ARR) form (MSA-3877) and Mental Illness/Developmental Disability Exception Criteria Certification form (MSA-3878).

The MSA-3877 and MSA-3878 have been revised to appropriately reflect that the forms are Department of Community Health (DCH) forms "DCH"-3877 and "DCH"-3878. Additional changes include the name Community Mental Health Board and Mental Health Clinic to Community Mental Health Services Program, the change of Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM III-R) to 4th Edition (DSM IV), the change of the word "exception" to "exemption", the rewording of the Dementia diagnoses on the DCH-3878, and for the dementia exemption on the DCH-3878, the addition of "or another primary psychiatric diagnosis of mental illness."

Copies of the revised DCH-3877 and DCH-3878 are attached to this bulletin.

Ordering Forms

The DCH-3877 and DCH-3878 can be ordered from the Michigan Department of Community Health, Forms Distribution, Lewis Cass Building, 320 S. Walnut Street, Lansing, Michigan 48913. Providers may also download the forms off the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Provider Forms and Other Resources.

Manual Maintenance

Hospitals and Community Mental Health Services Programs: This bulletin may be discarded after noting the changes relayed in this bulletin.

Nursing Facilities: This bulletin should be retained until the Nursing Facility Manual is updated with copies of the new forms.

Hospitals, Community Mental Health Services Programs, and Nursing Facilities: Discard MSA Bulletins 93-10, 93-14, and 94-10.

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 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.

Approval

Paul Reinhart
Deputy Director for
Medical Services Administration

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

(Mental Illness / Developmental Disability Identification)

☐ **PAS**
☐ **ARR**
☐ **Significant Changes**

SECTION I – Patient, Guardian, 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 Guardian or Legal Representative	
County in which the Guardian was Appointed			Address (Number, Street, Apt. Number or Suite Number)	
Guardian or 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	
Facility Address (Number and Street)			City	State / ZIP Code

INSTRUCTIONS:

- Sections II & III of this form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or a physician.
- Answer **ALL SIX (6)** items below.
- The person screened shall be determined to require a comprehensive **Level II OBRA** screening if any of the items 1 thru 6 are answered "YES" **UNLESS** a physician certifies on form DCH-3878 that the person meets at least one of the exemption criteria.
- If you check "YES" to items 1 and/or 2 in **Section II** below, circle the word "**mental illness**" or "**dementia**".

SECTION II – Screening Criteria: *(See the copy distribution in the Instructions.)*

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 a developmental disability including, but not limited to, mental retardation, 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.

Explain any "YES"

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 ( ) –

DCH-3877 (06/03) Replaces form MSA-3877, which is obsolete.

Instructions for completing form DCH-3877
Mental Illness / Developmental Disability Identification Criteria

LEVEL I SCREENING: Completing the DCH-3877

The DCH-3877 is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or developmental disability and who may be in need of mental health services. This form must be completed by a registered nurse, certified or registered social worker, 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.**

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV).
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past 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. **Developmental Disability:** An individual is considered to have a severe, chronic disability that meets **ALL** four 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 **three 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 significantly 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 are one or more "YES" answers to questions 1 – 6 under SECTION II, a DCH-3878 must be completed only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or exempted hospital discharge.

AUTHORITY:	P.A. 280 of 1939	The Department of Community Health is an equal opportunity employer, services, and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	

DISTRIBUTION:

If any answer to questions 1 – 6 in SECTION II is "YES," do the following:

- 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 authorized patient representative.

MENTAL ILLNESS / DEVELOPMENTAL DISABILITY EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

INSTRUCTIONS: **Michigan Department of Community Health**

- This form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant or physician and signed by a physician.
- The patient being screened shall require a comprehensive LEVEL II screening 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 five criteria below and does **NOT** have a developmental disability or another primary psychiatric diagnosis of mental illness.

Specific Diagnosis: _____

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.

☐ **EXEMPTED HOSPITAL 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.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

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

DCH-3878 (06/03) Replaces form MSA-3878, which is Obsolete

Instructions for Completing Form DCH-3878
MENTAL ILLNESS / DEVELOPMENTAL DISABILITY EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

- The **DCH-3878** is to be used ONLY when a person identified on a **DCH-3877** as needing a LEVEL II screening meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, she/he may be admitted (under preadmission screening) or retained (under annual resident review) at a nursing facility without additional screening. 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).

- The nursing facility must retain the facility copy in the patient file and see that the patient copy goes to the patient or authorized patient representative.

- This form may be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician, but must be certified and signed 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 five criteria listed under the dementia exemption category. Do NOT check this exemption **unless** the individual meets all five criteria. Any individual who meets some, but not all five, criteria will be subject to a LEVEL II screening. 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.

COPY DISTRIBUTION:

Original	-	Nursing Facility retains in Patient File
Photocopy	-	Attach to form DCH-3877 and send to Local CMHSP
Photocopy	-	Patient Copy or Authorized Representative