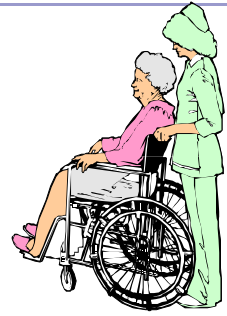


# NURSING FACILITY



## COVERED SERVICES AND LIMITATIONS MODULE



**Nursing Facility  
Covered Services and Limitations Module**

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## Services Included in Per Diem

The following Routine Services and Reserve Bed Days Allowable services are included in nursing facility per diem rates. **Routine services include room, dietary, laundry, nursing services, minor medical, surgical supplies, non-legend pharmaceutical items, the use of equipment and facilities.** Examples of allowable routine services include:

- All general nursing services, including, but not limited to, administration of oxygen and related medication, hand feedings, incontinency care, and tray service.
- Therapy services, including Physical Therapy, Speech Therapy and Occupational Therapy.
- Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans.
- Medical supply and drug items stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities, such as alcohol, applicators, cotton balls, Band-Aids, ostomy supplies, and tongue depressors.
- Oxygen and over-the-counter drugs, which includes insulin.
- Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment.
- Laundry services for routine nursing facility requirements and patients' personal clothing.
- Non-legend nutritional supplements used for tube feeding or oral feeding, even if written as prescription items by a physician.

## Reserve Bed Days

Nursing facilities may receive the per diem rate for reserved bed days during a resident's temporary absence if an appropriate bed is not otherwise available during the time for which reimbursement is sought. "Appropriate bed" is defined as a bed in an empty room or a vacant bed in a room occupied by a person of the same sex as the temporarily absent client.

Reimbursement for temporary absences is limited to fourteen days per calendar year per client.

A provider may not bill a client or the client's family for reserved bed days that are not reimbursed by EqualityCare unless the facility has informed the client, in writing. A client may pay the Nursing Home to hold the bed if the temporary absence exceeds the 14-day annual maximum.

Each NF is to submit to the state or its designed representative a census report of all EqualityCare residents for the previous month. The census report is due the 15th of the month for the previous month's census. Failure to submit a census report would result in EqualityCare withholding payment or a reduction in payment.

## Patient Contribution

Department of Family Services establishes the patient contribution upon admission to the nursing facility. This information is then relayed to ACS on a monthly basis. ACS will only receive the initial patient contribution amount. Any changes that occur must be changed using a DFS 411 form. The DFS will change or pro-rate the patient contribution as needed, then send the DFS 411 to the nursing facility. The nursing facility will then submit an adjustment form along with the DFS 411 to ACS to adjust the patient contribution.

NOTE: You can only adjust a paid claim. Therefore, you must first bill the claim and wait for payment. Once payment have been received, only then is an adjustment considered.

### **Pharmaceutical Services for Residents of Long-Term Care Facilities**

EqualityCare covers prescribed legend drugs for residents of nursing facilities. Drugs must be prescribed by a certified and licensed physician and dispensed by an enrolled licensed retail pharmacy. Legend drugs dispensed by an enrolled licensed retail pharmacy are reimbursable to the dispensing provider outside of the facility's per diem rate. **EXCEPTION:** Total Parenteral Nutrition (legend nutritional products) must be dispensed by a pharmacy enrolled as a licensed retail pharmacy provider and DME provider.

Certain drugs and pharmaceutical products may be dispensed by a long-term care facility and **are included in the facility's per diem rate.** Over-the-counter drugs, products, and medical supplies/equipment ordered by a physician for use by persons residing in a nursing facility **are included in the nursing facility's per diem rate** and cannot be reimbursed separately, including insulin and diabetic supplies. This includes all over-the-counter (OTC) drugs and products. Insulin and diabetic supplies are considered over-the-counter drugs and supplies.

### **Legend Drugs**

EqualityCare will cover all prescriptions, **with the exception** of the following products: Anorexigants, except amphetamines and derivatives which are used for narcolepsy and hyperkinetic states

- Androgenic/Anabolic agents used for weight gain
- Agents used for smoking cessation
- Retin-A for clients 21 years old and over
- Fertility medications
- Products to stimulate hair growth (i.e., Rogaine)
- DESI (Drug Efficacy Study Implementation), **as well as similar, related, or identical** drugs considered to be less than effective by the Food and Drug Administration (FDA); compound prescriptions which include a DESI drug are not covered

**The following items are allowed outside per diem. All must be prior authorized:**

- Ventilators
- Customized wheelchairs and seating systems

### **Over-the-Counter Drugs and Medical Supplies/DME**

Over-the-counter drugs, products, and medical supplies/equipment ordered by a physician for use by persons residing in a nursing facility are included in the nursing facility's per diem rate and cannot be reimbursed separately, including insulin and diabetic supplies. Please refer to Attachment A.

## Evaluations That Must be Completed Prior to Nursing Facility Admissions

### EqualityCare Determination of Medical Necessity (LT101) and Continued Stay Reviews

The LT101 is a functional assessment performed by a Public Health Nurse under contract to the Aging Division. It is a State requirement for the determination of medical necessity for nursing facility level of care. The Department of Family Services (DFS) will deny nursing facility eligibility to any individual who has not scored a minimum of 13 points on the LT101, and EqualityCare will deny payment for nursing facility services for that person.

The LT101 is also a condition of admission to the Long Term Care Home and Community Based Waiver Services program. An LT101 must be completed 45 days prior or 7 days after admission to a nursing home or to the LTC HCBS program.

#### A new LT101 is **required for an EqualityCare client:**

- Upon application for nursing facility admission. "Nursing facility" includes hospital swing bed units. It does not include Medicare-only Skilled Nursing Facilities (SNF) that do not participate in EqualityCare.
- Upon transfer to another nursing facility.
- Upon re-admission to a nursing facility after previous discharge. "Discharge" does not include temporary absence from the facility for treatment in a hospital, home visits or a trial community stay, provided such temporary absence is not longer than thirty consecutive days.
- Upon redetermination of EqualityCare eligibility following a loss of eligibility for any reason.
- Upon referral for PASRR Level II evaluation for MR or MI.
- Upon admission to a nursing home after participating in the LTC HCBS program.
- DFS shall not grant EqualityCare eligibility to a nursing facility resident unless the resident has an LT101 less than 45 days old.

### Continued Stay Reviews

Nursing facility residents shall receive continued stay reviews as follows:

- During the sixth month, the twelfth month and annually after admission to the nursing facility; **EXCEPTION:** A determination may be made by the Public Health Nurse to discontinue annual reviews when a resident's condition is such that discharge is unlikely.
- When a resident's condition has or is expected to change substantially.

#### A new LT101 is **required for a non-EqualityCare individual:**

- Upon application for EqualityCare eligibility for nursing facility benefits.
- Upon referral for PASRR Level II evaluation for MR or MI.

**A new LT101 is not required when:**

- An LT101 has been performed within the previous 45 days. The PHN may issue a copy of a current LT101 (no more than 45 days old) to a nursing facility in lieu of performing another LT101, providing the PHN believes the information is still accurate and there have been no significant changes in the individual's condition or circumstances. Such a current LT101, regardless of its original purpose, will be considered valid for nursing facility admission or transfer, PASRR Level II evaluations, or EqualityCare eligibility application; it may also be considered valid for admission to the LTC HCBS Waiver.
- The individual is entering the nursing facility as private pay; however, EqualityCare will pay for a non-binding LT101 for any private pay individual and we encourage nursing facilities to make these referrals regardless of payment source. If the individual subsequently applies for EqualityCare, the LT101 will be considered valid if it is less than 45 days old at the time application is made to DFS; if more than 45 days have elapsed, a new LT101 must be performed.

**Pre-Admission Screening and Resident Review (PASRR)**

Federal law requires that all individuals, regardless of payment source, who apply as new admissions to EqualityCare nursing facilities on or after January 1, 1989, must be screened **PRIOR TO ADMISSION** for mental illness and mental retardation. Federal law further requires that any individual whose Level I screening indicates the presence or probability of MI or MR must be referred to the State Mental Health Authority or the State Mental Retardation Authority for a Level II Pre-Admission Screening (PAS) and must be determined **PRIOR TO ADMISSION** to be appropriate for NF placement. If the individual is appropriate for NF placement, the need for specialized services will also be determined.

If an individual seeking admission to a nursing facility has MI or MR and is found to be inappropriate for NF placement, the nursing facility may not admit the individual. If an individual already residing in a nursing facility has MI or MR and is found to be inappropriate for NF placement, the State must arrange for the resident's orderly discharge from the facility. Adverse determinations carry the right of appeal for the resident.

**Individuals for whom respite care is provided under the Long Term Care HCBS Waiver or the DD HCBS Waivers are considered to be admitted to the NF and are subject to PASRR.**

**EqualityCare Reimbursement:**

EqualityCare will not reimburse a nursing facility for services provided to any individual who has not been screened at Level I. Payment will commence as of the Level I date or admission date, whichever is later. **No retroactive payment will be made.**

EqualityCare will not reimburse a nursing facility for services provided to any individual with MI or MR who is admitted prior to completion of a Pre-Admission Screening (PAS). Payment will commence upon the date of determination of appropriate placement. No retroactive payment will be made. The nursing facility may be subject to withdrawal of EqualityCare certification if such a person is admitted to the facility before a PAS determination is rendered.

EqualityCare will not reimburse a nursing facility for services provided to any individual who has previously been found to be inappropriate for nursing facility placement due to the need for specialized services. Any individual who has received such a determination must be re-evaluated and determined to be appropriate before any placement will be allowed.

### **PASRR Level I Screening**

The purpose of the Level I screening is to identify for further screening those individuals for whom it appears that a diagnosis of mental illness or mental retardation is likely, regardless of known diagnosis. No NF may admit any individual for whom the Level I screening indicates a reason to refer the individual to Level II until the Level II evaluation is completed and a determination is rendered by the State.

**Nursing Home.** The Level I screening is performed by qualified staff of the nursing facility to which the individual is applying for admission. "Qualified staff" refers to personnel who, by education, professional status or administrative authority, are able to discern the possibility or probability of mental illness or mental retardation from medical records, observation of presenting evidence, or other sources.

**Hospital or other.** Level I screenings may also be performed by hospital discharge planners, or by qualified staff of mental institutions, ICF-MRs or community service providers when a Level II is being requested in advance of actual application for admission to a NF.

**A Level I screening is required PRIOR TO ADMISSION** for all **new** nursing facility admissions, regardless of payment source. "New admission" is defined as the admission of any individual who has not previously resided in any nursing facility. If the Level I results in a referral to Level II for MI or MR, the NF may not admit the resident until the Level II (PAS) is completed and the placement is determined to be appropriate.

A re-admission following a discharge, hospitalization or therapeutic home leave is not considered a "new admission" for PASRR purposes and does not require Level I screening unless a new diagnosis indicates the presence of MI or MR. An individual with MI or MR who was Level II in the past and is being re-admitted following hospitalization or therapeutic home leave is not considered a new admission.

A Level I is required upon transfer from one facility to another facility or institution if the Resident Assessment (RA) performed on admission indicates the presence or possibility of MR or MI. An inter-facility transfer is not considered a "new admission" for PASRR purposes. In the case of a transfer of a resident with MI or MR from the NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the most recent PASRR and resident assessment reports accompany the transferring resident.

Exempt hospital discharge: An exemption may be made for an individual (a) who is admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital; and (b) who requires NF services for the condition for which he or she received care in the hospital; and (c) whose attending physician certified before admission to the facility that the individual is likely to require less than thirty days nursing facility services. If the individual is later found to require more than thirty days of NF care, a Level I must be initiated no later than thirty days after admission.

Routine annual Level I screenings are no longer required by EqualityCare. If the Level I does not result in a referral to Level II, it need never be performed again unless a significant change in the resident's condition indicates that a Level II evaluation is advisable.

Dementia, including Alzheimer's Disease and other dementias, is excluded from the definition of serious mental illness for PASRR purposes. An individual is considered to have dementia if he or she has a primary diagnosis of dementia as described in the DSM (current edition), or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. A primary diagnosis of a serious mental illness supersedes a secondary diagnosis of dementia and the individual must be referred for Level II evaluation.

Also excluded from the definition of serious mental illness are those individuals experiencing anxiety or depressive reactions to a terminal or chronic debilitating condition for which admission to the Wyoming State Hospital (specialized services) would not be appropriate, but for which other mental health services may be required based on physician evaluation and recommendation. Transitory or situational depression or anxiety, or adjustment disorders related to physical illness, medication, or relocation to a nursing facility, need not be referred for a Level II. Depression of longer duration or severity, which meets the criteria for a major depressive disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), should be referred.

Mental Illness diagnoses (per DSM IV) that meet the criteria for referral include:

- 295.10 Schizophrenia, Disorganized type
- 295.20 Schizophrenia, Catatonic type
- 295.30 Schizophrenia, Paranoid type
- 295.60 Schizophrenia, Residual
- 295.70 Schizoaffective Disorder
- 295.90 Schizophrenia, Undifferentiated type
- 296.3 Major depressive disorder, current episode
- 296.4 Bipolar disorder, manic
- 296.5 Bipolar disorder, depressed
- 296.6 Bipolar disorder, mixed
- 296.7 Bipolar disorder, unspecified
- 296.8 Bipolar disorder, NOS
- 297.1 Delusional disorder
- 298.9 Psychotic disorder, NOS

### Categorical determinations at Level I

Pursuant to federal guidelines, the State of Wyoming has defined certain categories of conditions that automatically constitute appropriateness for NF placement. These categorical determinations apply to individuals with a known diagnosis or presenting evidence of MI or MR and may be made at the Level I screening stage by nursing facility or hospital personnel; however, the State reserves the right to override the categorical determination and refer the individual to Level II where appropriate. Please note that a categorical determination is not an exemption from PASRR.

*Appropriate due to terminal illness, verified in writing by a physician.* This constitutes a Level II determination of "appropriate, specialized services not required".

*Appropriate due to severe medical conditions.* In Wyoming, this determination may only be applied to an individual with MI or MR who is comatose, ventilator dependent, functions at the brain stem level, OR has a diagnosis such as COPD, severe Parkinson's disease, amyotrophic lateral sclerosis, congestive heart failure (CHF), cardiovascular accident (CVA), Huntington's Disease, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The condition must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This constitutes a Level II determination of "appropriate, specialized services not required."

*Convalescent care for an acute physical illness.* This determination applies only to an individual with MI or MR who has an acute physical illness which (a) required hospitalization; and (b) does not meet all the criteria for an exempt hospital discharge (defined above). This categorical determination is limited to 120 days. When it becomes apparent the individual will require NF placement longer than 120 days, the NF must refer the individual to Level II. A Level II determination must be rendered before permanent NF placement can be made.

*Provisional placements* pending further assessment in cases of delirium, where an accurate diagnosis cannot be made until the delirium clears, or for respite of caregivers. This categorical determination is limited to fourteen days. A Level II determination must be rendered before permanent NF placement can be made.

*Emergency placement* for an individual with MI or MR for the individual's protection. This categorical determination is limited to seven days, at which time the NF must refer the individual to Level II. A Level II determination must be rendered before permanent NF placement can be made.

**NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE**

<b>CODES</b>	<b>MODIFIERS</b>	<b>DESCRIPTION</b>
T1023		LT101
T2011	HI	PASRR LEVEL II
T2011	HP	PASRR LEVEL II PSYCHIATRIST
T2011	HE	PASRR LEVEL II - CMHC

<b>Modifier</b>	
HI	Multi-disciplinary team
HP	Doctoral level
HE	Mental Health Program

**Billing**

All EqualityCare certified facilities are required to bill electronically using the UB92 form. For additional information on forms and billing processes, contact ACS Provider Relations at 1-800-251-1268.

**Attachment A**

ABD Pads  
Adhesive Tape  
Aerosol, Other Types  
Air Mattresses, Air P.R. Mattresses  
Airway-Oral  
Alcohol Plaster  
Alcohol Sponges  
Alternating Pressure Pads  
Applicators, Cotton-tipped  
Applicators, Swab-eez  
Aquamatic K Pads (Water-Heated Pad)  
Arm Slings  
Asepto Syringes  
Baby Powder  
Bandages  
Bandages-Elastic or Cohesive  
Band-aids  
Basins  
Bed Frame Equipment (for certain immobilized bed patients)  
Bed Rails  
Bedpans, all types  
Beds; manual, electric, clinitron  
Bedside Tissues  
Bibs  
Blood Infusion Sets  
Bottle, Specimen  
Canes, all types  
Cannula-Nasal  
Catheter-Indwelling  
Catheter Plugs  
Catheter Trays  
Catheter (Any Size)  
Colostomy Bags  
Combs  
Commodes, all types  
Composite Pads  
Cotton Balls  
Crutches, all types  
Decubitus Ulcer Pads/Dressings  
Denture cleaner/soak  
Denture cups  
Deodorants  
Diapers  
Disposal Underpads  
Donuts  
Douche Bags  
Drain Tubing  
Drainage Bags  
Drainage Sets

Drainage Tubes  
Dressing Tray  
Dressing, all types  
Drugs (Over the counter drugs as designated by the FDA)  
Enema Supplies  
Enema Unit  
Equipment and Supplies for Diabetic Blood and Urine Testing  
Eye Pads  
Feeding Tubes  
Fingernail clipping and cleaning  
Flotation Mattress or Biowave Mattress  
Flotation Pads and/or Turning Frames  
Foot Cradle, all types  
Gastric Feeding Unit, including bags  
Gauze Sponges  
Gloves, Unsterile and Sterile  
Gowns, Hospital  
Green Soap  
Hair Brushes  
Hair Care, Basic  
Hand Feeding  
Heat Cradle  
Heating Pads  
Heel Protector  
Hot Pack Machine  
Hydraulic Patient Lifts  
Hypothermia Blanket  
Ice Bags  
Incontinency Care  
Incontinency Pads and Pants  
Influenza Vaccine  
Infusion Arm Boards  
Infusion Pumps, Enteral and Parenteral  
Inhalation Therapy Supplies  
Irrigation Bulbs  
Irrigation Trays  
I.V. Needles  
I.V. Trays  
Jelly, Lubricating  
Lines, extra  
Lotion, Soap and Oil  
Massages (by facility personnel)  
Mattresses, all types  
Medical Social Services  
Medicine Dropper  
Medicine Cups  
Nasal Catheter  
Nasal Catheter, Insertion and Tube  
Nasal Gastric Tubes  
Nasal Tube Feeding and feeding bags  
Nebulizer and Replacement kit  
Needles (various sizes)  
Needles- Hypodermic, Scalp Vein

Non-Legend Nutritional Products  
Nursing Services (all) regardless of level including the administration of oxygen and restorate nursing care  
Nursing Supplies and Dressing  
Ostomy Supplies: Adhesive, Appliance, Belts, Fact Plates, Flanges, Gaskets, irrigation sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures  
Over-the-Counter Drugs, including insulin  
Overhead Trapeze Equipment  
Oxygen, Gaseous and Liquid  
Oxygen Concentrators  
Oxygen Delivery Systems, Portable or Stationary  
Oxygen Mask  
Pads  
Pitcher  
Plastic Bib  
Pump (Aspiration and Suction)  
Pumps for Alternating Pressure Pads  
Respiratory Equipment: Ambu Bags, Cannulas, Compressors, Humidifier, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, etc.  
Restraints  
Room and Board (Semi-private or private if necessitated by a medical or social condition)  
Sand Bags  
Scalpel  
Shampoo  
Shaves  
Shaving Cream  
Shaving Razors  
Sheepskin  
Side Rails  
Soap  
Special Diets  
Specimen Cups  
Sponges  
Steam Vaporizer  
Sterile Pads  
Sterile Saline for Irrigation  
Sterile Water for Irrigation  
Stomach Tubes  
Suction Catheter  
Suction Machines  
Suction Tube  
Surgical Dressings (including sterile sponges)  
Surgical Pads  
Surgical Tape  
Suture Removal Kit  
Suture Trays  
Syringes (all sizes)  
Syringes, disposable  
Tape-for laboratory tests  
Tape (non-allergic or butterfly)  
Testing Sets and Refills (S&A)  
Therapy Services  
Toenail Clipping and Cleaning

Tongue Depressors  
Toothbrushes  
Toothpaste  
Tracheostomy Sponges  
Trapeze Bars  
Tray Service  
Underpads  
Urinals, male and female  
Urinary Drainage Tube  
Urinary Tube and Bottle  
Urological Solutions  
Walkers, all types  
Water Circulating Pads  
Water Pitchers  
Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining  
Rollabout, Semi-Reclining, Standard, Inc.

**EqualityCare Recipient Death Report Form**

Pursuant to Wyoming Department of Health EqualityCare Rules, providers are required to notify the Department of Health of the death of any EqualityCare recipient in their facility within three working days of the recipient's death.

The form is located on the following page for the provider's use to report this information. Please send it or fax it promptly to the address below:

Debbie Paiz  
Office of Medicaid, Department of Health  
147 Hathaway Building  
Cheyenne, WY 82002  
FAX: (307) 777-6964

**MEDICAID RECIPIENT DEATH REPORT FORM**

Mail to: Debbie Paiz, Office of Medicaid, Department of Health  
147 Hathaway Building, Cheyenne, WY. 82002  
Or FAX: (307) 777-6964

RECIPIENT INFORMATION

NAME:

ADDRESS BEFORE ENTERING NURSING HOME:

SOCIAL SECURITY NUMBER:

RECIPIENT IDENTIFICATION NUMBER:

DATE OF BIRTH:

DATE OF DEATH:

MARITAL STATUS:

GUARDIAN OR NEXT OF KIN:

ADDRESS:

PHONE #:

PROVIDER INFORMATION

NAME:

ADDRESS:

PHONE #:

NAME OF PERSON COMPLETING FORM

DATE:

EXHIBIT 1
LT-101

WYOMING DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING - WYOMING MEDICAID
FORM LT101: ASSESSMENT OF MEDICAL NECESSITY FOR LONG TERM CARE

NF LTC/WAIVER CASE MANAGER
MEDICAID ID# SSN#
NAME OF RESIDENT (Last) (First) (MI)
HOME ADDRESS
COUNTY OF RESIDENCE PHONE #
BIRTH DATE REFERRAL SOURCE
DATE OF REFERRAL DATE OF REVIEW
COUNTY OF REVIEW NO
DIAGNOSIS

TYPE: ADMIT/ELIGIBILITY LEVEL II 6 MO. HCBS RENEWAL
CONTINUED STAY REVIEW: 3 MO. 6 MO. YEARLY
SITE: HOSP NF RESIDENCE OTHER PHONE
SOURCES: CLIENT PROFESSIONAL CAREGIVER RECORDS
IS RESIDENT EXPECTED TO REMAIN IN A MEDICAL INSTITUTION FOR 30
CONSECUTIVE DAYS OR MORE? YES NO
ENTERING NF FROM: HCBS WAIVER HOME HOSP OTHER
ENTERING HCBS FROM: HOME HOSP NF OTHER
RECEIVING HOME HEALTH SERVICES? YES NO
FACILITY OF RESIDENT
ADMIT DATE PROGNOSIS
IF LESS THAN 13 POINTS OR LTC/HCBS ADMISSION, HAS CARE PLAN BEEN
PREPARED? YES NO IN MAIL

RN SIGNATURE

- 1. EATING/MEAL PREPARATION/DIET
(0) a. Independently feeds self.
(1) b. Independently feeds self but needs someone to prepare meals.
(2) c. Requires supervision or assistance to assure nutritional needs are met.
(2) d. Requires specially prepared diet, i.e. calorie specific diabetic, renal dialysis diet, etc.
(3) e. Swallowing or choking precautions.
(4) f. Requires constant attention and hand feeding by assistant. Tube feedings.
2. MEDICATION MANAGEMENT
(0) a. PRN medication or no medications.
(1) b. Requires minimal (1-4) medications on a regular basis, oral or topical, including vitamins.
(2) c. Requires multiple (5 or more) maintenance medications as a daily regime, or weekly or monthly injections.
(3) d. Requires monitoring for cardiac rate depressors, hypertensives, insulin, anticoagulants, etc. at least once a month.
(4) e. Frequent monitoring is required for need or dosage regulations, e.g., insulin, narcotics, anticoagulants, etc. Requires med box or insulin syringes filled. Oxygen is covered here if required on a regular continuing basis.
3. SKIN CARE, DRESSING, TREATMENT
(0) a. Skin intact.
(1) b. Superficial skin conditions, fragility, rashes or chronic dermatitis.
(2) c. Pressure areas, requires daily peri-care, small skin flap with dressing, or lesions that are not infected.
(4) d. Open skin lesions present (post-op wounds with complications, decubiti, and sterile/special dressing) that can be cared for by non-licensed personnel for a portion of the day.
4. SPEECH, VISION, HEARING
(0) a. Unimpaired or impaired, but not dependent on assistance.
(2) b. Communication impairment that results in the need for assistance.
(3) c. Completely dependent in areas of communications.
5. DRESSING AND PERSONAL GROOMING
(0) a. Appropriate and independent dressing, undressing or grooming with little assistance.
(1) b. Inability to button or zip or choose wardrobe.
(2) c. Significant assistance or cuing needed on a regular basis.
(3) d. Requires total dressing or undressing and grooming.

- 6. BATHING
(0) a. Independent bathing with little assistance.
(1) b. Mobile, but unable to safely bathe without regular assistance and supervision.
(3) c. Cannot bathe without total assistance. (tub, shower, whirlpool or bed bath).
7. CONTINENCE
(0) a. Continent of bowel and bladder.
(2) b. Occasional incontinence or stress incontinence, requires toileting or reminder by another, needs help to clean self.
(3) c. Frequent to total incontinence and unable to participate in a training program; maintenance of colostomies and ileostomies.
(3) d. Requires catheter and catheter care.
8. MOBILITY
(0) a. Independently and appropriately able to transfer and/or ambulate with or without device.
(2) b. Able to transfer and/or ambulate with minimal or stand-by assistance; unstable, weak, frequent falls.
(4) c. Completely dependent, frequent transfers or frequent positioning.
(4) d. Requires two person transfer.
(4) e. Participating in a specialized rehabilitative training in accordance with individual plan of care.
9. BEHAVIOR/MOTIVATION
(0) a. Appropriate behavior, well-motivated to and capable of performing ADLs. Comatose or unresponsive.
(1) b. Intermittently confused and/or agitated; requires occasional reminders as to person, place or time.
(2) c. Potential for substance abuse, including alcohol or prescription drugs, alone or in combination.
(3) d. Frequently aggressive, abusive or disruptive.
(4) e. Forgetful, may wonder, safety concerns. In danger of self-inflicted harm or self-neglect due to depression.
10. SOCIALIZATION
(0) a. Independent participation in social or therapeutic activities by choice. Isolated or reclusive by personal history.
(2) b. Requires special assistance or encouragement for participation in planned social activities because of depression or confusion.
(3) c. Requires one-on-one assistance to maintain contact with reality.
(4) d. Potential for abuse or neglect. Unable to defend self due to confusion, fragility or fear.

- ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT: Any of the following qualifies the individual for nursing facility care as opposed to Home and Community-based care. Circle all that apply.
a. Meets Medicare skilled criteria, or in need of daily professional evaluation for modification of treatment or care.
b. Documented need for rehabilitation training for self-feeding, dressing and grooming, self-administration of medications, bowel and bladder program, validation therapy, behavior modification, blind deaf or aphasic rehabilitation, or special groups necessary five or more days a week in accordance with an individual plan of care and reasonable goals are being reached in a predictable period of time.
c. Unable to be cared for in the community due to unavailability of services or resources or lack of support system, or dependent upon institutional environment to maintain functioning.
d. Intermittently confused and/or agitated and in need of structured environment, wanders extensively, total confusion or total apathy.

COMMENTS/REFERRALS:

- PLACEMENT SUMMARY:
Total Points If 13 or more, individual meets medical necessity for Long Term Care.
(1) Has 13 points AND meets Nursing Facility criteria. Client may be served either on LTC/HCBS Waiver or in the Nursing Facility.
(2) Has 13 points but does not meet Nursing Facility criteria. May be served on LTC/HCBS Waiver.
(3) Has 13 points and does not meet Nursing Facility criteria, but CHOOSES Nursing Facility care due to social or geographic isolation, safety concerns, insufficient home support.
(4) Has 13 points AND meets Nursing Facility criteria, but LTC/HCBS Waiver slot is not available. May be served in the Nursing Facility
(5) Does not have 13 points but meets one or more Nursing Facility criteria. May be served in the Nursing Facility only.
(6) Does not have 13 points, but current placement remains medically necessary to maintain optimal functioning and continued safety and welfare of the client. May be served on the LTC/HCBS Waiver (Documentation attached).

I give permission for sharing of information directly related to my health, social, environmental, and economic status with those agencies providing LTC/HCBS Waiver services as necessary to determine if I am appropriate for Waiver services.

Signature: Date:

Witness: Date:

**GUIDELINES FOR COMPLETING THE LT101:** THIS ASSESSMENT MUST BE PERFORMED PRIOR TO NURSING HOME ADMISSION, OR UPON TRANSFER TO A NEW FACILITY, OR UPON APPLICATION FOR TITLE XIX (MEDICAID) BENEFITS FOR NURSING HOME OR LTC/HCBS WAIVER SERVICES. THIS FORM MUST BE COMPLETED BY A PHN WITHIN THREE (3) DAYS OF THE REFERRAL AND MUST BE SUBMITTED WITHIN ONE (1) DAY OF PERFORMANCE.

ALL FIELDS ARE REQUIRED.

WAIVER/NF: Check the service the client is requesting.  
CASE MANAGER: Name of Case Manager chosen for LTC/HCBS Waiver.  
MEDICAID ID#: If known.  
SOCIAL SECURITY #: Required. Form will be returned if SSN is missing.  
NAME OF RESIDENT: Resident's legal name, last name first; no nicknames, please.  
HOME ADDRESS: Client's home address.  
COUNTY OF RESIDENCE: County in which the resident will apply for Medicaid.  
PHONE: Client's home phone number.  
BIRTH DATE: According to SSA or DFS records, if possible.  
REFERRAL SOURCE: Name of nursing home, hospital or agency requesting LT101.  
DATE OF REFERRAL: Date request was received by PHN.  
DATE OF REVIEW: Date review was performed by PHN.  
COUNTY OF REVIEW: County of performance. If by phone, list PHN's county.  
NO.: County code number.  
DIAGNOSIS: List current diagnosis first; include dementia, mental illness or mental retardation where appropriate.

TYPE: Check purpose of review: admission to NF or applying for Medicaid eligibility; or MR/MI Level II screening.  
CONTINUED STAY REVIEW: Check time period that applies. 3 month review is at PHNs discretion.  
SITE: Where the LT101 was performed: hospital, nursing home, residence, or other (Adult Day Care or PHN office), or by telephone.  
SOURCES: How information was obtained. PHN SHOULD SEE THE RESIDENT IN PERSON or Medicaid will not pay for the review. In case of telephone review, a re-review must be done in person at the earliest opportunity.  
IS RESIDENT EXPECTED TO REMAIN IN A MEDICAL INSTITUTION FOR 30 CONSECUTIVE DAYS OR MORE? This includes hospital, inpatient rehab, nursing home or LTC/HCBS Waiver and is part of eligibility determination.  
ENTERING NF FROM: Indicate present location of client.  
ENTERING HCBS FROM: Indicate present location of client.  
FACILITY OF RESIDENT: Name of facility seeking admission.  
ADMIT DATE: Date of admission to facility.  
PROGNOSIS: Current prognosis of client.  
IF LESS THAN 13 POINTS OR LTC/HCBS ADMISSION, HAS CARE PLAN BEEN PREPARED? Check yes or no.  
RN SIGNATURE: Must be performed and signed by Public Health RN only.

**PLACEMENT SUMMARY:**

Add total points from items 1-10 above. Check appropriate box numbered 1-5.

Select (1) if client has 13 or more points in items 1-10 and has at least one of items a-d circled. Client is qualified to be served on either the LTC/HCBS Waiver or in the nursing facility.

Select (2) if client has 13 or more points in items 1-10, but has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT. The client may be served on the LTC/HCBS Waiver.

Select (3) if client has 13 or more points in items 1-10, has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT, but chooses nursing facility care. The client may be served in the nursing facility.

Select (4) if client has 13 or more points in items 1-10, has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT, but there are no LTC/HCBS Waiver slots available. The client may be served in the nursing facility.

Select (5) if client scores less than 13 points in items 1-10, but meets one or more of the ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT. The client may be served in the nursing facility, but not on the LTC/HCBS Waiver.

Select (6) if client is on the LTC/HCBS Waiver and because of the intervention of waiver services no longer meets 13 points but it is anticipated that removal of those services may cause a decline that will result in the need for higher cost services. Documentation of rationale must accompany LT101.

A new LT101 is required for a LTC/HCBS Waiver client with a placement code of (2) or (6) before entering a nursing facility.

SEE LT101 TRAINING MANUAL FOR DETAILS ON COMPLETING THE FORM.

**EXHIBIT 2  
PASRR 1 - Page 1**

**PREAMISSION SCREENING  
FOR NURSING FACILITY ADMISSION**

**PASRR LEVEL I**



Public Law 100-203 (OBRA '87) and Public Law 101-508 (OBRA '90) require that all individuals applying for admission to a Medicaid Certified Nursing Facility, regardless of source of payment, be reviewed for mental illness or mental retardation. If a condition of MA or MI is present, the applicant must meet the level of care requirements for nursing facility admission (i.e., has 13 or more points on the LT101) and be reviewed for appropriate placement and need for specialized services. Admission will not be authorized nor Medicaid benefits paid until the Level II determination is completed.

Please complete this Level I review PRIOR TO ADMISSION for ALL initial nursing home admissions. If the initial screening indicates a condition of mental illness or mental retardation, you must:

- 1) Submit a current (within 45 days of this review) LT101 performed by a Public Health Nurse, on which the individual must score 13 or more points; and
- 2) Refer the individual for Level II evaluation of the appropriateness of nursing facility placement and the need for specialized services.

**EXEMPT HOSPITAL DISCHARGE:** Is the individual being admitted to the facility for care not to exceed 30 days, following an acute care hospitalization? If so, no Level I screening is required at this time. Submit the Level I as soon as it is known that the resident will remain longer than 30 days, but no later than the 30th day after admission.

Patient Name: _____ Date of Birth: _____ Sex: M ___ F ___ SSN#: _____ Title 19 (Medicaid) ID#: _____ County of Residence: _____ Payment Source at Admission: T19 _____ SLSC _____ Medicare _____ Private/VA/Other _____	Admitting Facility: _____ Provider #: _____ Date of this Review: _____ Date of Admission: _____ Admitted From: _____ Prior Level II on file: MI _____ MR _____ Both _____ Determination Date: _____
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Please list the current diagnoses from the applicant's medical records **including ICD-9/DSM coding**:

**Primary Psychiatric Diagnosis:**

1. (\_\_\_\_) \_\_\_\_\_ 2. (\_\_\_\_) \_\_\_\_\_

Primary/Secondary Diagnosis of Organic Brain Disease or OBS, Dementia or Alzheimer's disease:

1. (\_\_\_\_) \_\_\_\_\_ 2. (\_\_\_\_) \_\_\_\_\_

Primary/Secondary Diagnosis of Mental Retardation/Developmental Disability:

1. (\_\_\_\_) \_\_\_\_\_ 2. (\_\_\_\_) \_\_\_\_\_

Current Medical Diagnoses (with ICD-9 coding):

1. (\_\_\_\_) \_\_\_\_\_ 2. (\_\_\_\_) \_\_\_\_\_  
 3. (\_\_\_\_) \_\_\_\_\_ 4. (\_\_\_\_) \_\_\_\_\_  
 5. (\_\_\_\_) \_\_\_\_\_ 6. (\_\_\_\_) \_\_\_\_\_  
 7. (\_\_\_\_) \_\_\_\_\_ 8. (\_\_\_\_) \_\_\_\_\_  
 9. ( . ) \_\_\_\_\_ 10. ( . ) \_\_\_\_\_

EXHIBIT 2

PASRR 1 - Page 2

SCREENING CRITERIA FOR MENTAL ILLNESS/MENTAL RETARDATION: Complete both boxes. Refer to Page 4 for a list of diagnosis codes for serious mental illness, mental retardation and developmental disabilities.

Mental Illness Screening (answer all questions):	
1. Does this person have a primary psychiatric diagnosis?	Yes ____ No ____
2. Does this person have any history of mental illness requiring treatment more intensive than outpatient services more than once in the past two years?	Yes ____ No ____
3. Is there any presenting evidence of mental illness including possible disturbance in orientation, affect or mood that is not attributable to dementia or other medical diagnosis listed above?	Yes ____ No ____
Mental Retardation Screening (answer all questions):	
1. Does this person have a primary or secondary diagnosis of mental retardation or developmental disability?	Yes ____ No ____
2. Does this person have any history of mental retardation or developmental disability?	Yes ____ No ____
3. Are there cognition or behavior deficits indicating mental retardation or developmental disability?	Yes ____ No ____
4. Was this person referred by an agency that serves persons with mental retardation and developmental disability, and has this person been eligible for that agency's services?	Yes ____ No ____

If the answer to **any** question is Yes, proceed to Categorical Determination Section below.

If the answer to **all** questions is No, proceed to Level I Screening Summary on Page 3.

CATEGORICAL DETERMINATION FOR MI OR MR INDIVIDUAL: Answer **all** questions for any individual who may have mental illness or mental retardation. A categorical determination is not an exemption from PASARR; you must attach an LT101 and current history and physical to verify determination. The nursing facility must re-review this individual annually on an ARR form.

If this individual has possible or probable MI or MR, does he or she have a terminal illness, verified in writing by a physician?	Yes ____ No ____	If Yes, check Box 4 on Page 3. Do not refer for Level II.
If this individual has possible or probable MI or MR, is he or she comatose, ventilator dependent, functioning at brain stem level, have a diagnosis of COPD, severe Parkinson's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, Huntington's Disease, CVA, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia? (Diagnosis and ICD-9 code must be listed above.) If so, is the condition severe enough that he or she could not participate in evaluation or treatment?	Yes ____ No ____	If Yes check Box 5 on Page 3. Do not refer for Level II.
If this individual has possible or probable MI or MR, does he or she have a medical condition, subsequent to discharge from an acute care hospital, for which convalescent care in excess of 30 days is likely? (This determination is limited to 120 days.)	Yes ____ No ____	If Yes, check Box 6 on Page 3. Do not refer for Level II.
If this individual has possible or probable MI or MR, does he or she require a provisional placement for respite care or due to delirium, not to exceed 14 days?	Yes ____ No ____	If Yes, check Box 7 on Page 3. Do not refer for Level II at this time.
If this individual has possible or probable MI or MR, does he or she require an emergency placement for his or her safety, not to exceed 7 days?	Yes ____ No ____	If Yes, check Box 8 on Page 3. Do not refer for Level II at this time.

**EXHIBIT 2  
PASRR 1 - Page 3**

PASARR LEVEL I SCREENING SUMMARY: If you answered “Yes” to **any** of the Screening Criteria for Mental Illness or Mental Retardation (at the top of Page 2) and the individual does not meet the criteria for a categorical determination (bottom of Page 2), you **must** refer this individual for Level II evaluation.

Check only ONE box:

<b>0</b>	No evidence of mental illness or mental retardation.	No additional information required.
<b>1</b>	Referred to Level II for evaluation of Mental Illness.	Attach current LT101 I current history and physical, and comprehensive drug history.
<b>2</b>	Referred to Level II for evaluation of Mental Retardation.	Attach current L T1 011 current history and physical, and comprehensive drug history.
<b>3</b>	Referred to Level II for evaluation of both Mental Illness AND Mental Retardation.	Attach current L T1 01, current history and physical, and comprehensive drug history.
<b>4</b>	Categorically appropriate due to terminal illness.	Attach current L T1 01, current history and physical, and comprehensive drug history.
<b>5</b>	Categorically appropriate due to severe medical condition.	Attach current L T1 011 current history and physical, and comprehensive drug history.
<b>6</b>	Categorically appropriate for convalescent care after acute hospital stay, not to exceed 120 days.	Attach current L T1 011 current history and physical, and comprehensive drug history.
<b>7</b>	Categorically appropriate for provisional care, not to exceed 14 days.	Attach current L T1 011 current history and physical, and comprehensive drug history.
<b>8</b>	Categorically appropriate for emergency care, not to exceed 7 days.	Attach current LT101 I current history and physical, and comprehensive drug history.

**FACILITY CERTIFICATION:**

**I have read the definitions and conditions incorporated into this level I screening instrument; and I certify the above information is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record. I have attached all required information.**

\_\_\_\_\_  
Signature and job title of person completing form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of facility, if different from admitting facility

<b>MEDICAID DISPOSITION:</b>
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Photocopy and retain in resident's permanent medical record.

Mail original with attachments to:

Health Care Financing, Long Term Care Unit  
6101 Yellowstone Road, Cheyenne, WY 82002

**EXHIBIT 2**  
**PASRR 1 - Page 4**

**REGULATIONS REGARDING PASARR SCREENING:**

- For an individual's first nursing facility admission, the PASARR Level I must be completed PRIOR TO ADMISSION. Medicaid will not pay for nursing facility services rendered to an individual who has not been screened at Level I.
- If the individual is referred for MI or MR Level II evaluation, the nursing facility MAY NOT admit the individual until the Level II evaluation is completed and the placement found to be appropriate.
- If the individual is referred for MI or MR Level II evaluation, OR has been determined categorically appropriate due to terminal illness or severe medical condition, you must attach the individual's most recent history and physical from nursing facility, hospital or physician records; comprehensive drug history including dose and frequency; and documentation of medical necessity for nursing facility level of care (i.e., an LT101 no more than 45 days old and performed by a Public Health Nurse).
- It is the responsibility of the nursing facility to notify the resident of any Level II referral and all rights of appeal.

**CONDITIONS AND DEFINITIONS FOR PASARR LEVEL I SCREENING:**

1. **Serious Mental Illness:** An individual is considered to have serious mental illness if he or she has a current primary or secondary diagnosis of a major mental disorder as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Acceptable diagnosis codes for serious mental illness are:

295.1	295.2	295.3	295.6	295.7	295.9	296.2
296.3	296.4	296.5	296.6	296.7	296.8	297.1
298.9						

2. **Mental Retardation and Related Conditions:** An individual is considered to be mentally retarded if he or she has a level of retardation (mild, moderate, severe or profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation: "Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." The provisions of PASARR also apply to persons with related conditions as defined by 42 CFR 435.1009. Acceptable diagnosis codes for mental retardation are:

237	299	314.0	314.00	314.01	314.1	314.2
314.8	314.9	315	315.0	315.1	315.2	315.3
315.4	315.5	315.8	315.9	317	318.0	318.1
318.2	319	330	330.0	330.1	330.2	330.3
330.8	330.9	343.0	343.1	343.2	343.3	343.4
343.8	343.9	345	345.0	345.1	345.2	345.3
345.4	345.5	345.6	345.7	345.8	345.9	

3. **Terminal Illness:** An individual is considered to be terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less. For purposes of applying this criterion, the nature and extent of the individual's need for nursing services and medical supervision and treatment shall be considered the determining factor, while the existence of a chronic mental or illness or disability shall be treated as an incidental consideration. Terminal illness must be substantiated in writing in the individual's history and physical records.
4. **Severe Medical Condition:** An individual is considered to have a Severe Medical Condition if he or she is comatose, ventilator dependent, or functioning at a brain stem level, or has a diagnosis of Chronic Obstructive Pulmonary Disease, severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, severe cardiovascular Accident (CVA), quadriplegia, advanced multiple sclerosis, muscular dystrophy, end stage renal disease (ESRD), severe diabetic neuropathy or refractory anemia. The illness must be of a severity that would preclude the individual from participating in a meaningful evaluation of mental illness or mental retardation or from participating in specialized services or treatment for mental illness or mental retardation. Severity of the medical condition must be substantiated in writing in the individual's history and physical records.