COMRU ONLINE APPLICATION

2022 LONG-TERM CARE PROVIDER MEETING

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

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www.health.mo.gov

OBJECTIVES:

- Participants will be able to locate online applications and where they can access training and updates from COMRU.
- Participants will be able to identify the most common errors in submitting the online application (Level I form and Level of Care form) and how to correct these errors.
- Participants will be able to access the status of the online process, including corrections and completion.

WHEN DOES AN ONLINE APPLICATION NEED TO BE SUBMITTED?

When an individual is seeking placement admission into a Medicaid certified bed in a nursing facility **and** the Level One Form triggers a Level 2 screening or the client is seeking Medicaid Reimbursement.

If the online application does not trigger a Level 2 screening and is not seeking Medicaid Reimbursement, then the SNF would print the Level One Form for the client's record.

The online application is **not** submitted to COMRU for processing.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

DHSS Home » **Senior & Disability Services** » **Nursing Homes and Other Care** » pasrr

The PASRR is a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment. The screening assures appropriate placement of persons known or suspected of having a mental impairment(s) and also that the individual needs of mentally impaired persons can be and are being met in the appropriate placement environment.

The online PASRR training provides the following information: contact information, overview, types of admissions, DA-124 A/B and DA-124C form explanations, special admission categories, assessed needs, and much more.

If you have questions, contact the Central Office Medical Review Unit (COMRU) at 573-522-3092 or **COMRU@health.mo.gov**.

Application for Level One Form and Level of Care Assessment (click here)

COMRU's webpage
https://health.mo.gov/seniors/nursinghomes/pasrr.php

New LOC Process Training - Level One Form
New LOC Process Training - NF Level of Care Assessment
New Online Process - Questions and Answers
New LOC Webex Training

RETURN CODE

- The submitter will receive a **"return code"** the first time the submit button is clicked.
- This "return code" allows the submitter to make changes to the online application at anytime.
- If the submitter is unable to retrieve the "return code" the submitter can request the code via email from COMRU (COMRU@health.mo.gov). The submitter should allow 48 hours for a response.
- The SNF should have the "return code" to view the application (Level I form) prior to admission.

Answers that might trigger a Level 2 screening will turn RED.

WHAT WOULD TRIGGER A LEVEL 2 SCREENING

Level One Form indicates if the application triggers a Level 2 screening

Mental Illness

4. Within the last 2 years, has the individual: (●) Yes ( ) No

(Record YES if Either/Both of the two subcategories below are checked)

☑ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g. had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

☑ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials?

Check yes, if treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider individual positive for serious mental illness.

3. Does the individual have any area of impairment due to serious mental illness? ◉ Yes ○ No

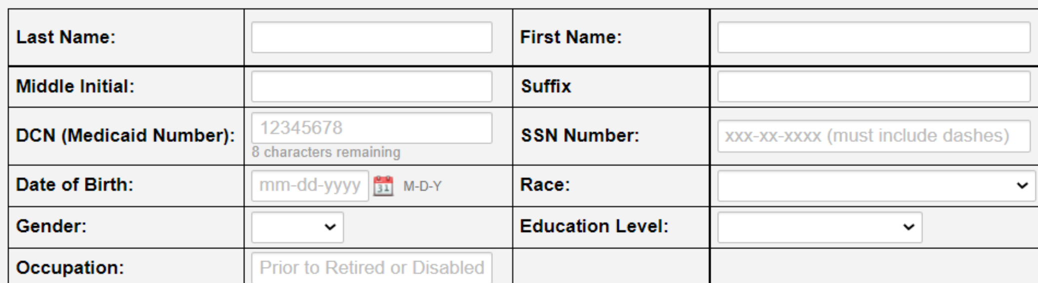
(Record YES if any of the subcategories below are checked)

- [ ] **None**
- [x] **Interpersonal Functioning:**
  The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationship and social isolation.
- [x] **Adaptation to Change:**
  The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (ideation, gestures, threats, or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention by mental health or judicial system.
- [x] **Concentration/Persistence/and Pace:**
  The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors or requires assistance in the completion of these tasks.

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

1. **Client's legal name (Last Name/First Name)**

Section A. Individual Identifying Information



Last Name:		First Name:	
Middle Initial:		Suffix	
DCN (Medicaid Number):	12345678 8 characters remaining	SSN Number:	xxx-xx-xxxx (must include dashes)
Date of Birth:	mm-dd-yyyy M-D-Y	Race:	
Gender:		Education Level:	
Occupation:	Prior to Retired or Disabled		

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

2. **Mental Illness question (Section D #1) -** Does the individual show any signs or symptoms?

1. Does the individual show any signs or symptoms of a Major Mental Illness? ○ Yes ○ No

Signs/Symptoms: Please do not provide diagnosis

Expand

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

3. **Mental Illness question (Section D #2)** based on the client's diagnosis list

   Dementia is **NOT** a Major Mental Illness diagnosis.

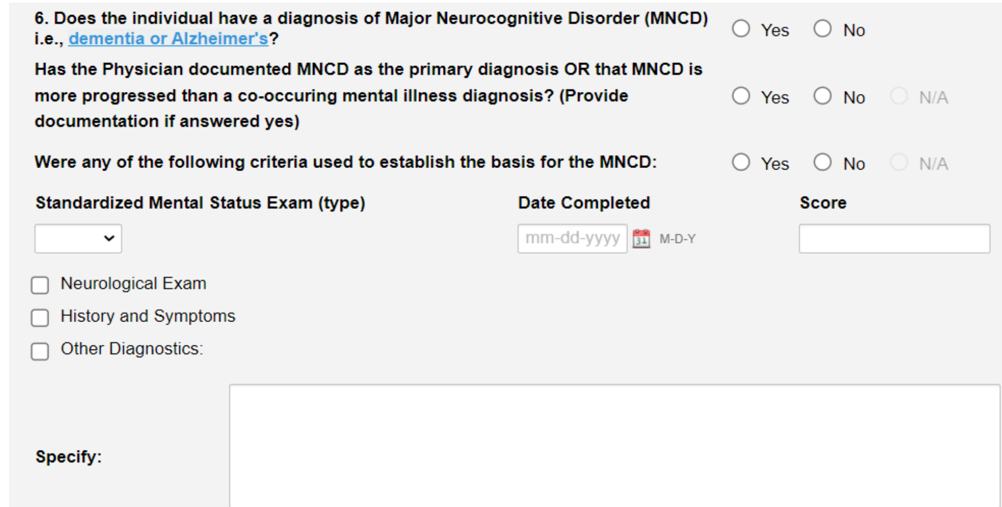
   If "Other Mental Disorder in the DSM" is marked, indicated the diagnosis.

2. Does the individual have a current, suspected, or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition? ○ Yes ○ No
(Please refer to the Physician order/report and indicate ALL Major Mental Illness diagnosis)

☐ Schizophrenia	☐ Schizoaffective Disorder	☐ Bipolar Disorder
☐ Psychotic Disorder	☐ Major Depressive Disorder	☐ Obsessive-Compulsive Disorder
☐ Dysthymic Disorder	☐ Panic Disorder	☐ PTSD
☐ Conversion Disorder	☐ Personality Disorder	☐ Mood Disorder
☐ Somatic Symptom Disorder	☐ Dissociative Identity Disorder	☐ Anorexia Nervosa or other eating disorders
☐ Anxiety Disorder	☐ Delusional Disorder	
☐ Other Mental Disorder in the DSM		

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

4. Dementia (MNCD) question (Section D #6) based on the client's diagnosis list


6. Does the individual have a diagnosis of Major Neurocognitive Disorder (MNCD) i.e., dementia or Alzheimer's? ○ Yes ○ No

Has the Physician documented MNCD as the primary diagnosis OR that MNCD is more progressed than a co-occuring mental illness diagnosis? (Provide documentation if answered yes) ○ Yes ○ No ○ N/A

Were any of the following criteria used to establish the basis for the MNCD: ○ Yes ○ No ○ N/A

Standardized Mental Status Exam (type)	Date Completed	Score
	mm-dd-yyyy M-D-Y	

☐ Neurological Exam

☐ History and Symptoms

☐ Other Diagnostics:

Specify:

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

5. Intellectual question (Section E) based on the client's diagnosis list

The diagnosis listed in this area would be:

Mild, Moderate, Severe, Profound or Unspecified Intellectual Disability

1. Is the individual known or suspected to have a diagnosis of Intellectual Disability that originated prior to age 18? ◉ Yes ○ No

If Yes, indicated diagnosis:

COMMON REASONS FOR RETURNED APPLICATION - LEVEL ONE FORM

6. **Intellectual question (Section E)** based on the client's diagnosis list

Additional diagnosis might include: Multiple Sclerosis and Guillain-Barre Syndrome

2a. Does the individual have a suspected diagnosis or history of an Intellectual Disability/Related Condition? (◉) Yes ( ) No

(Please refer to the Physician order/report and indicate ALL Intellectual Disability Related Conditions)

- [ ] Autism
- [ ] Cerebral Palsy (CP)
- [ ] Epilepsy/Seizure/Convulsions
- [ ] Head Injury/Traumatic Brain Injury (TBI)
- [ ] Down Syndrome
- [ ] Spina Bifida
- [ ] Prader-Willi Syndrome
- [ ] Deaf or Blind
- [ ] Muscular Dystrophy
- [ ] Fetal Alcohol Syndrome
- [ ] Paraplegia
- [ ] Quadriplegia
- [ ] Other Related Conditions:

2b. Did the Other Related Condition develop before age 22? ( ) Unknown (◉) Yes ( ) No

2c. Likely to continue indefinitely? (◉) Yes ( ) No

2d. Results in substantial functional limitation in three or more major life activities?
(Impacted prior to the age of 22)

* must provide value

- [ ] No Functional Limitations
- [x] **Capacity for Independent Living**
- [x] **Learning**
- [x] **Self-Direction**
- [ ] Self-Care
- [ ] Mobility
- [ ] Understanding and Use of Language

The substantial functional limitation must be prior to the age of 22.

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

1. **Provide the Name of Proposed Skilled Nursing Facility (Provide the SNF's full name)**

   If multiple facilities under the same name, provide location.

   The submitter needs to ensure the Facility ID number and Admit Date to NF are accurate

Name of Proposed Skilled Nursing Facility:

(Provide the SNF's full name)

COMRU

Facility ID Number:

12345

5 characters remaining

Facility ID Directory

Admit Date to NF:

M-D-Y

Discharge Date From NF:

M-D-Y

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

2. **Date and Reason for recent hospitalization**

Section C. Recent Medical Incidents (I.E., CVA, Surgery, Fracture, Head Injury, ETC., and Give Dates)

(If the applicant is currently in the hospital or was admitted from the hospital to the SNF, provide the date and reason for hospitalization.)

Expand

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

3. Current list of diagnosis

Upload all pertinent information to this application - the diagnosis list, history and physical, Dementia testing and Psychiatric evaluation.

Indicate the Diagnoses Relevant to Applicant's Functional and/or Skilled Nursing Needs
(Do not list Diagnosis Codes)

- [ ] Diagnosis List Attached Upload file
- [ ] History and Physical Attached Upload file
- [ ] Other Documentation Upload file

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

***** Client must meet a mandated 18 point count for SNF placement *****

4. Behaviors

The date of the last consult completed by a physician or licensed mental health professional.

This is not a Medical Consult, but Psychiatric Consult (Leave date blank if not Psychiatric Consult).

Behavioral:

- **Determine if the applicant or recipient:**
  - Receives monitoring for mental condition
  - Exhibits one of the following mood or behavior symptoms - wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior, or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions - abnormal thoughts, delusions, hallucinations

Date of the last consult completed by a physician or licensed mental health professional (This is not a medical consult):

mm-dd-yyyy M-D-Y

(Blank = None Reported)

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

Behavioral Symptoms: Is the client exhibiting these behaviors?

Behavioral Symptoms:

	None	Min	Mod	Max
Withdrawn/Depressed	☐	☐	☐	☐
Suspicious/Paranoid	☐	☐	☐	☐
Wanders	☐	☐	☐	☐
Hallucinations/Delusions	☐	☐	☐	☐
Abnormal Thought Process	☐	☐	☐	☐
Aggressive(Physical/Verbal)	☐	☐	☐	☐
Suicidal/Homicidal Ideation	☐	☐	☐	☐
Restraints	☐	☐	☐	☐
Sexually Inappropriate	☐	☐	☐	☐
Controlled with Medications	☐	☐	☐	☐

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

5. **Eating -** List what type of diet (a therapeutic diet, would be 3 points)

If client has a tube feeding, this would be 9 points (additional points are assessed under treatment)

Eating:

- **Determine the amount of assistance the applicant or recipient needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or total parenteral nutrition (TPN).**
- **Determine if the participant requires a physician ordered therapeutic diet.**

Diet Ordered by Physician: Must provide an answer

Comment:

Expand

- ◉ 0 pts - No assistance needed **AND** no physician ordered diet
- ○ 3 pts - Physician ordered therapeutic diet **OR** set up, supervision, or limited assistance needed with eating
- ○ 6 pts - Moderate assistance needed with eating, i.e. applicant or recipient performs more than 50% of the task independently
- ○ 9 pts - Maximum assistance needed with eating, i.e. applicant or recipient requires an individual to perform more than 50% for assistance
- ○ 18 pts - TRIGGER: Totally dependent on others

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

6. **Rehabilitation Services -** Add all therapies together to obtain the accurate point count

Rehabilitative Services:

- **Determine if the applicant or recipient has the following medically ordered rehabilitative services:**
  Physical therapy/Occupational therapy/Speech therapy/Cardiac rehabilitation/Audiology

Type of Physician-Ordered Rehabilitative Services: **Frequency (days per week)**

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Cardiac Rehabilitation
- ☐ Audiology

Comment:

Expand

- ◉ **0 pts** - None of the above therapies ordered
- ○ **3 pts** - Any of the above therapies ordered 1 time per week
- ○ **6 pts** - Any of the above therapies ordered 2-3 times per week
- ○ **9 pts** - Any of the above therapies ordered 4 times per week

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

7. **Treatments -** Must be one of the treatments listed below

Skin care, eye drops, oxygen, injections are **NOT** counted as treatments.

Treatments:

- **Determine if the applicant or recipient requires any of the following treatments:**
  - Catheter/Ostomy care
  - Alternate modes of nutrition (tube feeding, TPN)
  - Suctioning
  - Ventilator/respirator
  - Wound care (skin must be broken)

Type of Physician-Ordered Treatment/Comment:

Expand

- ◉ **0 pts** - None of the above treatments were ordered by the physician
- ○ **6 pts** - One or more of the above treatments were ordered by the physician requiring daily attention by a licensed professional

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

8. **Meal Preparation -** What is the client able to complete in this task?

This is not based on the SNF providing general dietary services to all individuals.

Meal Preparation:

- **Determine the amount of assistance the applicant or recipient needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils.**

Comment:

(This is not based on the SNF providing general dietary services to all individuals)

Expand

- (selected) **0 pts** - No assistance needed **OR** only set up or supervision needed
- **3 pts** - Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks
- **6 pts** - Maximum assistance, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

9. **Medication Management -** What is the client able to complete in this task?

This is not based on the SNF providing general medication management to all individuals.

Medication Management:

- **Determine the amount of assistance the applicant or recipient needs to safely manage their medications. Assistance may be needed due to a physical or mental disability.**

Comment

(This is not based on the SNF providing general medication management services to all individuals)

Expand

- (selected) **0 pts** - No assistance needed
- **3 pts** - Set up help needed **OR** supervision needed **OR** limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks
- **6 pts** - Maximum assistance needed, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

10. Safety - Preliminary score (Falls, Balance and Vision) additional points for Age and Institutionalization.

Safety:

- **Determine if the individual exhibits any of the following risk factors:**
  - Vision Impairment
  - Falling
  - Problems with balance. Balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait.
- **After determination of preliminary score, history of institutionalization and age will be considered to determine final score.**
  - Institutionalization in the last 5 years - long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities.
  - Aged - 75 years and over

Date of last fall:

mm-dd-yyyy M-D-Y

(Blank = None Reported)

Type of Institutionalization:

(Do not include current SNF admission)

Timeframe or Date Admitted to Institution:

Blank = None Reported)

COMMON REASONS FOR RETURNED APPLICATION - LEVEL OF CARE FORM

Safety - Preliminary score (Falls, Balance and Vision) additional points for Age and Institutionalization

Comment:

Expand

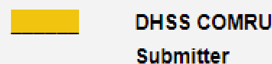
Individual's DoB: ______

Individual's Age:

- **0 pts** - No difficulty or some difficulty with vision **AND** no falls in last 90 days **AND** no recent problems with balance
- **3 pts** - Severe difficulty with vision (sees only lights and shapes) **OR** has fallen in the last 90 days **OR** has current problems with balance **OR** preliminary score of 0 **AND** Age **OR** Institutionalization
- **6 pts** - No vision **OR** has fallen in last 90 days **AND** has current problems with balance **OR** preliminary score of 0 **AND** age **AND** Institutionalization **OR** preliminary score of 3 **AND** Age **OR** Institutionalization
- **9 pts** - Preliminary score of 6 **AND** Institutionalization
- **18 pts** - TRIGGER: Preliminary score of 6 **AND** Age **OR** Preliminary score of 3 **AND** Age **AND** Institutionalization

CHECKING STATUS OF THE ONLINE APPLICATION

Central Office Use Only (DRL/COMRU)

Level of Care Determination by DRL Central Office (COMRU) Application Submitted to COMRU: Complete or Incomplete Application Accepted:Yes/No | Correction: There will be a PDF upload if corrections are needed Meets level of care: Yes/No Application Type: Level I or Level 2 or Special Admission Category	Point Count There is a mandated 18 point count for SNF placement  DHSS COMRU ______ Submitter Signature: ______ Date: ______

CHECKING STATUS OF THE ONLINE APPLICATION

- **If the application triggers a Level 2 screening**

  The submitter can view if the Special Admission Category is Valid after the Level of Care is assigned.

  The submitter can view the timeframe for the Level 2 screening to be completed (Date sent to DMH/Date due from DMH).

  The determination letter is uploaded (This will be transitioning from DHSS to DMH/Bock Associates).

  The Level 2 screening from Bock Associates is uploaded.

If Level 2 indicated above: Special Admissions Category: ______ | Valid: ______ Date Referred to DMH for Level 2 Screening: ______ Date Due from DMH: ______	DHSS Determination: ______
Level 2 Determination (DMH)	DMH Determination ______ Level 2 Evaluation/Determination ______

THANK YOU

FOR MORE INFORMATION CONTACT

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
AMMANDA OTT
COMRU@HEALTH.MO.GOV
573-522-3092 (OPTION #4)

HTTPS://HEALTH.MO.GOV/SENIORS/NURSINGHOMES/PASRR.PHP