8-30

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PERMANENT ADMINISTRATIVE RULES

SPD 12-2007

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Date prior to or same as filing date

Department of Human Services, Seniors and People with Disabilities Division 411

Agency and Division | Administrative Rules Chapter Number

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to become effective September 1, 2007. Rulemaking Notice was published in the June 2007 & July 2007 *Oregon Bulletin.***
Date upon filing or later | Month and Year

RULE CAPTION

Pre-Admission Screening, Pre-Admission Assessment and Pre-Admission Screening and Resident Review

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately, 000-000-0000.

ADOPT: Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

AMEND:
411-070-0005, 411-070-0040, 411-070-0043

REPEAL:

RENUMBER: Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

AMEND & RENUMBER: Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

FILED
AUG 30 2007
ARCHIVES DIVISION
SECRETARY OF STATE

ORS 410.070, 410.535 & 414.065
Stat. Auth.

42 CFR, Part 483, Subpart C-E
Other Authority

ORS 410.070, 410.535 & 414.065
Stats. Implemented

RULE SUMMARY

The Department of Human Services, Seniors and People with Disabilities Division is permanently amending Oregon Administrative Rule (OAR) 411-070-0005, OAR 411-070-0040 and OAR 411-070-0043 to clarify the Pre-Admission Screening, Private Admission Assessment and Pre-Admission Screening and Resident Review processes related to nursing facility admission.

Catherine A Cooper 8/29/07
Authorized Signer | Date

Catherine A. Cooper
Printed name

*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.
**The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday. ARC 930-2005

DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES DIVISION
OREGON ADMINISTRATIVE RULES

CHAPTER 411

DIVISION 070
MEDICAID NURSING FACILITIES

411-070-0005
Definitions
As used in OAR chapter 411, division 070, the definitions in OAR 411-085-0005 and the following definitions apply:
(1) "Accrual Method of Accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.
(2) "Active Treatment" means the implementation of an individualized service plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.
(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition/behavior.
(4) "Alternative Services" means individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.
(5) "AMHD" means the Department of Human Services, Addictions and Mental Health Division.
(6) "Area Agency on Aging (AAA)" means an established public agency designated under the Older Americans Act, 42 USC 3025, and which has a responsibility for local administration of senior and disability programs as described in ORS chapter 410.
(7) "Basic Flat Rate Payment" and "Basic Rate" mean the statewide standard payment rate for all long term care services provided to a Medicaid resident of a nursing facility except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the all-inclusive payment rate unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate).
(8) "Case Manager" means a SPD/AAA employee who assesses the service needs of an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The Case Manager authorizes and implements the service plan and monitors the services delivered.
(9) "Cash Method of Accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.
(10) "Categorical Determination" means the provision in the Code of Federal Regulations {42 CFR 483.130} for creating categories that describe certain diagnoses, severity of illness or the

need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.
(a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate and of sufficient scope.
(b) An individual with Mental Illness or Developmental Disabilities may enter a nursing facility without PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)-(2)(c).
(11) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means that the attending physician has written orders for the individual to receive skilled care services at the nursing facility.
(12) "Certified Program" means a hospital, private agency or an Area Agency on Aging certified by the Department to conduct Private Admission Assessments in accordance with ORS 410.505 through 410.530.
(13) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Events that change ownership include but are not limited to the following:
(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);
(b) The title to the nursing facility enterprise is transferred to another party;
(c) The nursing facility enterprise is leased or an existing lease is terminated;
(d) Where the owner is a partnership, any event occurs which dissolves the partnership;
(e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or
(f) The facility changes management via a management contract. This subsection is not intended to include changes which are merely changes in personnel, e.g., a change of administrators.
(14) "Client" means a resident for whom payment is made under the Medicaid Program.
(15) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator or other employee. They include but are not necessarily limited to the following:
(a) Salaries paid or accrued;
(b) Supplies and services provided for personal use;
(c) Compensation paid by the facility to employees for the sole benefit of the owner;
(d) Fees for consultants, directors, or any other fees paid regardless of the label;
(e) Key man life insurance;
(f) Living expenses, including those paid for related persons; or
(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.
(16) "Complex Medical Add-On Payment" and "Medical Add-On" mean the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose care is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures or rehabilitation services listed in OAR 411-070-0091.
(17) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.
(18) "Costs Not Related to Resident Care" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to

visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.
(19) "Costs Related to Resident Care" means all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.
(20) "CPI" means the Consumer Price Index for all items and all urban consumers.
(21) "Department" means the Department of Human Services.
(22) "Developmental Disabilities" as defined in OAR 411-320-0020, means a disability that originates in childhood that is likely to continue and significantly impacts adaptive behavior. Developmental Disabilities include mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling conditions that require training or support similar to that required by individuals with mental retardation; and the disability:
(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18; and
(b) Originates in the brain and has continued, or can be expected to continue, indefinitely; and
(c) Constitutes a significant impairment in adaptive behavior; and
(d) The condition or impairment must not be primarily attributed to mental illness, substance abuse, an emotional disorder, Attention Deficit Hyperactivity Disorder (ADHD), a learning disability, personality disorder or sensory impairment.
(23) "Direct Costs" means costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. These costs are further defined in these rules. Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.
(24) "DRI Index" means the "HCFA Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw - Hill in the publication Health Care Costs.
(25) "Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).
(26) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department as a Nursing Facility. A Nursing Facility also means a Medicaid Certified Nursing Facility only if identified as such.
(27) "Facility Financial Statement" means Form SPD 35, or Form SPD 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department for reimbursement.
(28) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.
(29) "Generally Accepted Accounting Principles" means accounting principles currently approved by the American Institute of Certified Public Accountants.
(30) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired or the excess of the price paid for an asset over its fair market value.

(31) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. It does not include "start-up costs" as defined in this rule.
(32) "Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.
(33) "Indirect Costs" means the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). These costs are further described in OARs 411-070-0359, 411-070-0428, and 411-070-0465.
(34) "Interrupted-Service Facility" means an established facility recertified by the Department following decertification.
(35) "Level I" means a component of the Federal PASRR requirement. It refers to the identification of individuals who are potential nursing facility admissions who have indicators of Mental Illness or Developmental Disabilities {42 CFR 483.128(a)}.
(36) "Level II" means a component of the Federal PASRR requirement. It refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with Mental Illness or a Developmental Disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service {42 CFR 483.128(a)}. Level II evaluations include assessment of the individual's physical, mental and functional status {42 CFR 483.132}.
(37) "Level of Care Determination" means an evaluation of the intensity of a client's health care needs. The level of care determination may not be used to require that the person receive services in a nursing facility.
(38) "Medical Add-On" or "Complex Medical Needs Additional Payment" has the meaning provided in OAR 411-070-0027.
(39) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders; bipolar (manic-depressive) and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizo-affective disorders or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimers are excluded.
(40) "Mental Retardation" as defined in OAR 411-320-0020, means significantly sub-average general intellectual function defined as IQ's under 70 existing concurrently with significant impairments in adaptive behavior that are manifested during the developmental period, prior to 18 years of age. Individuals of borderline intelligence, IQ's 70-75, may be considered to have Mental Retardation if there is also significant impairment of adaptive behavior. The adaptive behavior must be primarily related to the issues of Mental Retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision. Levels of Mental Retardation are:
(a) Mild Mental Retardation is used to describe the degree of retardation when intelligence test scores are 50-69. Individuals with IQ's in the 70-75 range can be considered as having mental retardation if there is significant impairment in adaptive behavior as defined in OAR 411-320-0020.

(b) Moderate Mental Retardation is used to describe the degree of retardation when intelligence test scores are 35 to 49.
(c) Severe Mental Retardation is used to describe the degree of retardation when intelligence test scores are 20-34.
(d) Profound Mental Retardation is used to describe the degree of retardation when intelligence test scores are below 20.
(41) "Necessary Costs" means costs that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. These costs are usually costs that are common and accepted occurrences in the field of long term care nursing services.
(42) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility or individuals who have returned to a hospital for treatment and are being admitted back to the nursing facility. New admissions are subject to the PASRR process {42 CFR 483.106(b)(1), (3), (4)}.
(43) "New Facility" means a nursing facility commencing to provide services to SPD recipients.
(44) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation program approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.
(45) "Ordinary Costs" means costs incurred that are customary for the normal operation.
(46) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of care, need for care, and quality of care.
(47) "Pediatric Rate" means the statewide standard payment rate for all long term care services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.
(48) "Perquisites" means privileges incidental to regular wages.
(49) "Personal Incidental Funds" means resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.
(50) "Placement" means the location of a specific place where health care services can be adequately provided to meet the care needs.
(51) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community based service settings and the provision of information about community based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the Federal PASRR Level I requirement {42 CFR, Part 483, (C)-(E)}, to identify individuals with Mental Illness or Mental Retardation or Developmental Disabilities.
(52) "Pre-Admission Screening and Resident Review (PASRR)" means the Federal requirement, {42 CFR, Part 483, (C)-(E)}, to identify individuals who have Mental Illness or Developmental Disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.
(53) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid individuals as established by ORS 410.505-410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated and information is provided about long-term care choices. A component of PAA is the

Federal PASRR Level I requirement, {42 CFR, Part 483.128(a)}, to identify individuals with Mental Illness or Developmental Disabilities.
(54) "Provider" means an organization that has entered into an agreement with the Department to provide services for Department clients.
(55) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.
(56) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has five percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.
(57) "Resident" or "Individual" means those for whom payment is made under the Medicaid Program.
(58) "Resident Review" means a review conducted by the Addictions and Mental Health Division (AMHD) for individuals with Mental Illness or by Seniors and People with Disabilities Division (SPD) for individuals with Developmental Disabilities who are residents of nursing facilities. The findings of the Resident Review may result in referral to PASRR Level II {42 CFR 483.114}.
(59) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with or direction by the donor to a specific purpose. Restricted Fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.
(60) "SPD" means the Department of Human Services, Seniors and People with Disabilities Division.
(61) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.
(62) "Specialized Services for Mental Retardation/Developmental Disabilities" means:
(a) For individuals with Mental Retardation/Developmental Disabilities under age 21, specialized services are equal to school services; and
(b) For individuals with Mental Retardation/Developmental Disabilities over age 21, specialized services means:
(A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function; and
(B) Promotes the acquisition of function, skills and behaviors necessary to increase independence and productivity; and
(C) Is delivered in community-based care or vocational settings at a minimum of 25 hours a week.
(63) "Start-up Costs" means one-time costs incurred prior to the first resident being admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. They do not include such costs as feasibility studies, engineering studies, architect's fees or other fees that are part of the historical cost of the facility.
(64) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean that the supervisor is physically present when the work is performed.
(65) "Title XVIII" and "Medicare" mean Title XVIII of the Social Security Act.

(66) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.
(67) "Uniform Chart of Accounts (Form SPD 35)" means a list of account titles identified by code numbers established by the Department for providers to use in reporting their costs.
[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0040
Client Screening, Assessment and Review
(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service needs, preferences and must receive information about community based, alternative services and resources that can meet the individual's service needs and are safe, least restrictive and potentially less costly than comparable nursing facility services.
(2) PRE-ADMISSION SCREENING. A Pre-Admission Screening (PAS) as described in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.
(a) PAS includes:
(A) An assessment;
(B) The determination of an individual's service eligibility for Medicaid-paid long term care or post-hospital extended care services in a nursing facility;
(C) The identification of individuals who can transition to community based service settings;
(D) The provision of information about community based services and resources to meet the individual's needs; and
(E) Transition planning assistance as needed.
(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.
(c) The PAS assessment will be conducted by a case manager or other qualified SPD or AAA representative using SPD's Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.
(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.
(e) Payment for nursing facility services will not be authorized by SPD until PAS has established that nursing facility services are required based on the individual's service needs and Medicaid financial eligibility has been established.
(3) PRIVATE ADMISSION ASSESSMENT. A Private Admission Assessment (PAA) is required for individuals with private funding who are referred to Medicaid-certified nursing facilities established by ORS 410.505 through ORS 410.545 and OAR chapter 411, division 071.
(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A Pre-Admission Screening and Resident Review (PASRR) as described in OAR 411-070-0043 is required for individuals

regardless of payment source, with either Mental Illness or Developmental Disabilities who need nursing facility services.
(5) CLIENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:
(a) Staff associated with SPD are required to maintain service plans on all SPD clients in nursing facilities. The frequency of their service plan update will vary depending on such factors as the resident's potential for transition to home or community based care and federal or state requirements for Resident Review;
(b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care or alleged abuse. The SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities;
(c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities; and
(d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.
Stat. Auth.: ORS 410.070, 410.535 & 414.065
Stats. Implemented: ORS 410.070, 410.535 & 414.065

411-070-0043
Pre-Admission Screening and Resident Review (PASRR)
(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with Mental Illness or Mental Retardation or Developmental Disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in sections (2)(a) through (2)(c) of this rule, are groupings of individuals with Mental Illness or Developmental Disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.
(2) CATEGORICAL DETERMINATIONS.
(a) Exempted hospital discharge:
(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or
(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status patient; and
(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and
(D) The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.
(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or SPD staff.
(A) The individual requires nursing facility level of service; and
(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or
(C) Nursing facility admission is the result of protective services action.
(3) PASRR includes three components.
(a) PASRR LEVEL I. This is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual's source of payment. The purpose of the screening is to identify indicators of Mental Illness or Mental Retardation or Developmental Disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in sections (2)(a) through (2)(c) of this rule, which verify that the nursing facility service is required.
(A) PASRR Level I screening is performed by AAA/SPD authorized staff, Private Admission Assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician or by organizations designated by the Department.
(B) Documentation of PASRR Level I screening is completed using an SPD-designated form.
(C) If there are no indicators of Mental Illness or Mental Retardation or Developmental Disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.
(D) Mental Illness Indicators. If PASRR Level I screening determines that an individual has indicators of Mental Illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact the Addictions and Mental Health Division (AMHD) and request a PASRR Level II evaluation.
(E) Mental Retardation or Developmental Disabilities Indicators. If PASRR Level I screening determines that an individual has indicators of Mental Retardation or Developmental Disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact SPD and request a PASRR Level II evaluation.
(F) PASRR Level I Screening Form Requirement. Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual's resident record.
(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or SPD office as required in OAR 411-070-0035.
(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the client record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.
(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the individual's clinical record and must accompany the individual if he or she transfers to another nursing facility.
(b) PASRR LEVEL II. This is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of Mental Illness or Mental Retardation or Developmental Disabilities who does not meet categorical determination criteria {42 CFR 483.128}.

(A) PASRR Level II Referral. Individual's identified with indicators or Mental Illness or Mental Retardation or Developmental Disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.
(B) PASRR Level II Evaluations. PASRR Level II evaluations and determinations are conducted by AMHD for individuals with Mental Illness or by SPD for individuals with Mental Retardation or Developmental Disabilities.
(C) PASRR Level II Determination. PASRR Level II evaluation will result in a determination of an individual's need for nursing facility services and specialized services {42 CFR 483.128-136} consistent with Federal Regulations established by the Social Security Act, Section 1919(e)(7)(C).
(D) Pursuant to 42 CFR 483.130(l) the written determination will include the following findings:
(i) Whether a nursing facility level of services is needed;
(ii) Whether specialized services are needed;
(iii) The placement options that are available to the individual consistent with these determinations; and
(iv) The rights of the individual to appeal the determination.
(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.
(F) Denials of nursing facility service are subject to appeal {OAR 137-003, OAR 461-025 & 42 CFR Subpart E}.
(c) Resident Review. Resident Reviews are conducted by AMHD for individuals with indicators of Mental Illness or SPD for individuals with Mental Retardation or Developmental Disabilities who are residents of nursing facilities. Based on the findings of the Resident Review, a PASRR Level II may be requested. {42 CFR 483.114}.
(A) Mental Illness. All residents of a Medicaid certified nursing facility may be referred for Resident Review when symptoms of Mental Illness develop.
(i) Resident Review for individuals with indicators of Mental Illness that require further evaluation must be referred to the local Community Mental Health Program who will determine eligibility for PASRR Level II evaluations.
(ii) The Resident Review Form, Part A, must be completed by the nursing facility. The Resident Review must be performed in conjunction with the Comprehensive Assessment Form specified by the AMHD, in accordance with OAR 411-086-0060.
(B) Mental Retardation or Developmental Disabilities. All individuals identified as having Mental Retardation or Developmental Disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a Resident Review. A Resident Review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident's needs or desires.
(i) The Resident Review must be completed by SPD or designee.
(ii) The Resident Review must be completed using forms designated by the Department.
(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with Mental Illness are not provided in nursing facilities. Individuals with Mental Illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination, must be referred to another setting.
(b) Specialized services for individuals with Mental Retardation or Developmental Disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.
(c) Specialized services for individuals with Mental Retardation or Developmental Disabilities over age 21 are not provided in nursing facilities. Individuals with Mental Retardation or Developmental Disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.
(5) RESPITE CARE. Respite care in nursing facilities for individuals with Mental Illness, Mental Retardation or Developmental Disabilities is approved under the following conditions:
(a) For individuals with Mental Illness, a nursing facility admission for respite care must be authorized by AMHD and for individuals with Mental Retardation or Developmental Disabilities, a nursing facility admission for respite care must be authorized by SPD Central Office; and
(b) Nursing facility respite stay must be limited to no more than a total of 56 respite days within a calendar year although SPD may grant exceptions to this limit at its discretion; and
(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to Mental Illness, Mental Retardation or Developmental Disabilities; and
(d) There must not be a viable community care setting available that is appropriate to meet the individual's respite care needs as determined by section (5)(a) of this rule.
Stat. Auth.: ORS 410.070, 410.535 & 414.065
Stats. Implemented: ORS 410.070, 410.535 & 414.065