

ARIZONA LONG TERM CARE SYSTEM

APPENDIX 10 A

PREADMISSION SCREENING MANUAL

FOR

ELDERLY AND PHYSICALLY DISABLED (EPD)

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INTRODUCTION

Legislation

The Arizona State Legislature passed legislation in 1987 expanding the federally funded AHCCCS services (Title XIX) to include long term care (LTC). As a result, the Arizona Long Term Care System (ALTCS) was established with an initial implementation date of January 1, 1989 for the elderly/physically disabled population (EPD). To receive federal Medicaid funds for an individual, AHCCCS Administration must demonstrate that an ALTCS customer has a medical need for these services and is at immediate risk of institutionalization in a nursing facility (NF). For more information on Medicaid see Arizona's Eligibility Policy Manual for MA, NA and CA.

On September 1, 1995, federally funded LTC services were expanded to include the ALTCS Transitional Program. This program allows currently eligible ALTCS customers who have improved and are no longer at immediate risk of institutionalization but still require some LTC services, to receive HCBS services at a lower level of care. For more information on the Transitional Program see Arizona's Eligibility Policy Manual for MA, NA and CA.

LONG TERM CARE (LTC)

Long Term Care refers to ongoing services required by individuals who are in need of care comparable to that received in a nursing facility (NF). These services represent a wide range of health related services above the level of room and board and offer professional services directed towards the maintenance, improvement, or protection of health or lessening of illness, disability or pain. These professional level services include but are not limited to:

1. 24 hour licensed nurse supervision;
2. All care is under direction of a physician who must make routine visits at intervals of at least 30 to 90 days or more often;
3. Development of a care plan by a multidisciplinary team of professionals (e.g., nursing, social services, registered therapists, registered dietitian) who frequently assess medical progress.

HOME and COMMUNITY BASED SERVICES (HCBS)

These long term care services may include home and community based services (HCBS) that offer an alternative to institutional care. ALTCS offers the alternatives in order to ensure that the customer in need of institutional level of care may be treated in the least restrictive environment. HCBS is appropriate for customers who would require institutionalization, but who can retain a more independent lifestyle with services provided in the home and community setting where the absence of 24 hour licensed nurse supervision will not endanger their health or safety.

Preadmission Screening (PAS)

The EPD PAS tool is used to assess the functional, medical, nursing and social needs of the customer. Meeting or exceeding a threshold score on this screening tool establishes initial eligibility for institutional level services (Arizona Revised Statutes §36-2936). A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The threshold score, or point at which a customer becomes eligible, is determined by a formula utilizing those scores. The purpose of the functional/medical threshold is to ensure that customers deemed eligible for ALTCS require a Nursing Facility (NF) level of care.

The eligible customer needs long term care at a level of care comparable to that provided in a nursing facility, but **below** an acute care setting (hospitalization or intense rehabilitation) and **above** a supervisory/personal care setting, intermittent outpatient medical intervention, or benevolent oversight. A customer, already enrolled with an AHCCCS acute health plan, and who needs less than 90 days of convalescent care may be ineligible for ALTCS. A customer who does NOT have a non-psychiatric medical condition or developmental disability that impacts the need for LTC also may be ineligible. For more information see Section IV Medical Assessment.

MEDICARE PART D

As of January 1, 2006, state Medicaid agencies were no longer allowed to pay for prescription medications for individuals eligible for Medicare and Medicaid. Medicare eligible individuals will choose a Medicare drug plan to enroll in to obtain their medications. The financial eligibility specialist, also known as the Program Services Evaluator (PSE) will be attempting to determine an individual's eligibility for and enrollment in a Medicare Part D prescription drug plan. The PAS Assessor may be required to obtain information from the individual regarding Medicare Part D if at the time of the PAS this information has not been obtained. The Medicare Part D status must be reported at the beginning of the PAS summary (see page 43). If the customer is already enrolled with a Medicare Part D plan, this information can be found on the RP214.

Customer Profiles

In the aggregate, the eligible ALTCS customer will have a functional and/or medical condition that impairs functioning to a degree that interferes substantially with the capacity to remain in the community, and results in long term limitation of capacity for self care. A customer who meets ALTCS criteria for Title XIX eligibility will present with a combination of the following needs or impairments:

1. requires nursing care by or under the supervision of a nurse on a daily basis;
2. requires regular medical monitoring;
3. impaired cognitive functioning;
4. impaired self care with activities of daily living;
5. impaired continence;
6. psychosocial deficits.

Eligibility Review

When a customer's medical eligibility for Title XIX services is not adequately defined by the scoring criteria, but in the PAS assessor's professional opinion the customer's overall condition is correlated with the needs or impairments as outlined above, the case may be referred for eligibility review to a consultant physician or an administrative review.

It is important to remember that there is no single definition for the level of care for ALTCS medical eligibility. An entry level of care encompasses a combination of factors. These factors evaluate the differences between individuals in manifestations and severity of a given disease/condition and the impact on functional ability. **An eligible customer should have a combination of factors that impact functional ability and medical need for services.**

Population Assessed

The population assessed with the EPD PAS Tool includes the elderly (age 65 and older), the physically disabled (age 6 and over) and also the developmentally disabled residing in a nursing facility. A separate tool is used to assess children under age 6 and persons with developmental disabilities (DD). The PAS tool may also be used to determine whether customers not applying would be medically eligible before spending down resources. These customers will be assessed upon request.

Assessment Team

The tool is completed by a registered nurse or a social worker who will use professional judgment based on education, experience and ongoing in-service training to describe the customer's functional ability and current medical status. If the customer is ventilator dependent, the assessment will be conducted by a registered nurse. If a customer is hospitalized the assessment will be conducted by a registered nurse if at all possible. A thorough assessment will include a personal interview with the customer and caregiver, and a review of pertinent medical records or information as applicable.

Client Issue Referral (CIR)

When situations are identified that pose immediate and/or serious threat to the customer's well being (e.g., suicidal threats, environmental hazard, or suspected physical abuse or neglect), appropriate health providers and/or authorities (Adult/Child Protective Services, police, paramedics, guardians) as well as the PAS assessor's supervisor, should be notified as soon as possible. Documentation of the referral (person notified, date and description of the incident) should be entered into the PAS case notes and/or an AHCCCS Client Issue Referral Form completed. For more information on CIR, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1000, section 1008.

PASRR

The PAS assessor should be aware that all nursing facility (NF) residents and applicants to Medicaid certified nursing facilities must be assessed through the Preadmission Screening and Resident Review (PASRR) process. The PASRR is a two-level screening process for mental illness/mental retardation and mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) as a portion of NF reform measures. The purpose of the PASRR is to avoid inappropriate placement for persons with mental illness and/or mental retardation. For further information regarding PASRR, see Arizona's Eligibility Policy Manual for MA, NA and CA, Chapter 1000, section 1009.

PAS Tool Sections

The ALTCS Preadmission Screening tool consists of five sections. These sections are:

- I Intake Information
- II Functional Assessment
- III Emotional and Cognitive Functioning
- IV Medical Assessment
- V Physician Review

This manual provides instructions for completing the PAS tool and guidelines for making assessment decisions. For more information regarding PAS, see AHCCCS Eligibility Policy Manual, Chapter 1000.

ACE

The information obtained will be entered into the computerized AHCCCS Customer Eligibility (ACE) system, which is the management information system supporting the PAS.

FORTIS

The medical and financial case documentation obtained is stored by converting paper documents into an electronic database called Fortis. All applicable information obtained will be scanned into this computerized AHCCCS database using the ACE barcode separator sheets.

I. INTAKE INFORMATION

A. ASSESSMENT

The Assessment tab of the EPD PAS window in ACE includes the following fields: (these fields are automatically populated by the system).

Applicant list

This list includes the customer's name along with other persons registered in the same group.

Assessor

The PAS assessor who has created the PAS.

Assessment

This list includes the current PAS date and all previous PAS dates.

Applicant Age

This is the customer's age at the time of the PAS.

DD Status

This field is populated by ACE as a result of the DD Status chosen when the application was originally registered.

Tool Used

This field is populated by ACE as a result of the DD Status chosen when the application was originally registered and at the time the PAS is created.

Assessor

This field is automatically populated by the system when the assessor creates the PAS.

Assessor

This field is usually blank but if a second assessor assisted with the PAS, the name is selected from the drop down list.

Location at time of assessment

This is the setting where the PAS interview was conducted. The assessor selects the appropriate setting from a drop down list in ACE.

Telephone

This is the telephone number at the location where the PAS interview was conducted. This is a required field and must have a number entered into it before the PAS can be completed.

Usual Living Arrangement (Select the applicable setting)

'Usual' refers to the customer's living arrangement for approximately the last six months or if there is no planned discharge or relocation from the present living arrangement.

Community refers to a customer who lives in a private home, mobile home or apartment.

Hospice refers to a medical institution for customers with a terminal illness.

Nursing facility may be a certified or uncertified facility.

Other supervised setting refers to board and care homes, adult foster homes, adult care homes, supervisory care homes, group homes, apartments for assisted living, etc.

Residential Treatment Center is a facility that provides behavioral health services (mental health and substance abuse) to individuals who are under age 21, or under age 22 if admitted prior to age 21.

Usual Living Situation (Select the usual living situation that applies)

Usual living situation refers to with whom the customer has resided for approximately the last six months. If the customer has been in a living situation for less than 6 months and there are no plans to make a change, consider that the usual living situation. If a customer resides in a nursing facility or assisted living setting where a spouse or other family member also resides, "with non-relatives" should be indicated rather than living with spouse or other relative.

Source of Referral

Refers to who referred the customer to AHCCCS. Determine if another agency, nursing facility or a case manager recommended or initiated the referral. Enter comments as appropriate. This information is not required on reassessments.

Who referred you to AHCCCS? (Select appropriate response)

Agency/Case Manager – indicate the name of the agency or person

Nursing Facility – include the name of the NF and/or case worker's name

Self Referral

Other (Specify)

Assistance Being Sought Select appropriate response(s). (Indicate the primary assistance being sought and add others to comments)

Indicate the type of assistance the customer and/or family is seeking. More than one item may apply. Use the comments section to elaborate on what is being sought.

ADLs – Activities of Daily Living – assistance with baths, or other personal care

IADLs – Instrumental Activities of Daily Living – housekeeping, cooking, etc.

Housing – Community housing placements

Medical – Assistance for doctor visits and medications

NF Placement – Nursing Facilities

Transport – Assistance getting to and from medical appointments

Other (Specify)

B. EPD INFORMATION

Physical Measurements

1. Height - Record approximate height if actual is unknown. Respond in feet or inches. If not available in feet or inches, use the metric system.
2. Weight - Record approximate weight if actual is unknown. Respond in pounds. If not available in pounds, use the metric system.

C. Medical Assessment

Is the customer currently hospitalized or in an intensive rehabilitation facility?

Answer yes or no as applicable.

If in an acute facility, is discharge imminent?

If discharge is not anticipated within 7 days, the customer is in need of a higher level of care than received in a Nursing Facility and is not eligible for ALTCS. Record the projected discharge date if discharge is imminent.

Ventilator Dependent

This is defined as being on a ventilator **at least 6 hours a day for 30 consecutive days**. The ventilator worksheet for a customer who is dependent on a ventilator must be conducted by a registered nurse. The registered nurse must research the respiratory therapy/pulmonology records to verify the start date and number of continuous days on the ventilator. This information is recorded on the Ventilator Worksheet and included in the PAS. It may be necessary for this assessor to obtain information from multiple facilities in order to accurately determine when the customer started on the ventilator and if the criteria are met. See page 40 for further discussion regarding ventilator dependency.

Number of emergency room visits in the last six months?

Include approximate dates and reasons for these visits in the PAS summary.

Number of hospitalizations in the past six months:

Include approximate dates and reasons for hospitalizations in the summary.

Number of falls in the last 90 days:

Count all of the falls. If there were any injuries, document in the summary the

approximate date and types of injuries which occurred. If the customer fell and had no injuries, report this in the summary.

II. FUNCTIONAL ASSESSMENT

This portion of the PAS tool is designed to obtain information about the customer's functional abilities regarding Activities of Daily Living, Contingency and Communication/Sensory Patterns. This may be achieved by directly asking questions of the customer, the caregiver and/or by observing the behavior of the customer during the interview process and by reviewing available records. **It is important to include the caregiver or family in the interview** if at all possible.

It is important that the interview be conducted with caregiver(s) or others familiar with the customer. It is required that family or legal guardian(s) be contacted to be present at the PAS interview if they choose. If a family member or legal guardian is not available to attend the PAS, the assessor should contact the appropriate person(s) to go over the information obtained at the interview.

The assessor must ensure the information obtained is as accurate as possible. This is done by using knowledge and skills of assessment in addition to ensuring the customer and others who provide information understand what is being asked. This is referred to as investigative interviewing.

The assessor must acknowledge that the informant does not understand PAS definitions and must explain in detail to ensure accurate information is obtained. PAS definitions are unique to ALTCS eligibility and differ from other assessment tools.

Assessments should be conducted after discharge from acute care facilities, if feasible.

A. ACTIVITIES OF DAILY LIVING (ADLs) (30 days)

To evaluate the best environment for a medically or physically disabled person, it is important to first assess the level at which the customer is performing the activities of daily living. The ability to care for self, or independence, is measured by the degree of self reliance in completing these activities of daily living.

The ADLs include: mobility, transferring, bathing, dressing, grooming, eating and toileting. The customer will be rated on his/her ability to perform these tasks within the **residential environment** or other routine setting. This section is designed to obtain information about the customer's ADLs in the past thirty (30) days with emphasis on current performance. Details of the assistance required should be recorded in the comments or summary. The comments should reflect the reasoning applied for the scores recorded.

If it is clearly evident that a customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (for example, only supervision, not physical assistance, may

be needed to attain a generally acceptable level of hygiene). **A thorough explanation of this need must be documented in the comments and/or summary and indicated as scored based on need. Generally a score based on need would not be higher than one (1).**

Each ADL category contains a set of statements that can be used to describe how well a customer is able to complete the ADL. ADL functions should be rated by selecting the answer most appropriate to the customer's task performance in the current living arrangement. If a major portion of the day is routinely spent in another setting, typical ADL performance in that setting may also be taken into consideration. Since the ADL can be comprised of multiple sub-tasks, all components of the ADL relevant to the customer should be considered in scoring.

Some customers will not perform the ADL exactly as described in the statement, **and a comment should be added to explain why the statement selected was assessed to be the best response.** Do not select more than one response.

If the customer's ADL performance was not consistent throughout the 30 day period, please **score the most typical** ADL performance. Then in the comments section, describe any deviations from typical performance.

Be sure to include in your comments: (1) how often deviations occurred; (2) under what circumstances deviations occurred; and (3) the ADL functioning level of the customer during the period of deviation from typical ADL performance.

Short-term or transient episodes of deviation from typical ADL performance such as having the flu or otherwise being temporarily "under the weather", would **NOT** be scored as typical performance. On the other hand, a customer may regularly have "good days" and "bad days" when ADL performance fluctuates within the month. In these situations the assessor must gather enough information to accurately determine the best score.

A description of each ADL included in the PAS instrument is provided below. The following definitions apply to terms used in the ADL assessment:

Supervision - observing the customer and being readily available to provide assistance, including verbal cues or reminders and set-up activities.

Limited/Occasional - a portion of an entire task or assistance required less than daily.

Physical Participation – This is the customer's active participation, not just being passive or cooperative. This includes the ability to complete a small portion of the task.

Mobility

The extent of the individual's **purposeful movement** within the residence (Note – score based on functionality achieved with assistive device(s) such as walkers, canes, handrails or wheelchairs, along with adjustment of restraint devices, if used). Report specific assistance required from another person.

- NOTE:** ▲ Often an individual with cognitive impairment may require assistance for purposeful movement even though the individual is ambulatory or self propels a wheelchair.
- ▲ Ambulating for therapy purposes only is not necessarily purposeful mobility. This may be scored for therapy or rehabilitative nursing but may not be of significant duration to affect purposeful mobility, (i.e., 15 minutes 3 times a week).
- ▲ Set-up for mobility would include placing the assistive device where the customer can reach, (i.e., placing wheelchair or cane next to bed or chair, ensuring the electric w/c is charged, adjusting restraint devices).

Scoring

- 0) INDEPENDENT – Customer is independent in completing activity safely
- 1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer is mobile within the residence, but may need cueing, set-up or standby assistance OR limited/occasional hands-on assistance (e.g., intermittent or less than daily)
- 2) HANDS-ON – Customer is mobile only with hands-on assistance for safety
- 3) TOTAL DEPENDENCE – Customer is dependent on others for all mobility

Transferring

The ability to move between two surfaces, such as: assistance getting into and out of chair/wheelchair, bed (excluding transfer to toilet, bath or shower) within the residential environment. (Note – score transferring based on functionality achieved with assistive device(s), if used). Report specific assistance required.

- Note:** ▲ Assistance to a sitting position in order to facilitate transfer from bed would be considered in scoring transfer.
- ▲ Set-up would include ensuring assistive devices are in place for transfers and/or brakes are locked on the customer's wheelchair for safe transferring activity.

Scoring

- 0) INDEPENDENT – Customer is independent in completing activity safely, but may require the use of assistive devices

- 1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer transfers with supervision, physical guidance or set-up, OR with limited/occasional hands-on assistance (e.g., intermittent or less than daily)
- 2) HANDS-ON – Customer needs to be physically lifted or moved, but can participate physically (e.g., customer pivots, holds on or braces self to assist caregiver)
- 3) TOTAL DEPENDENCE – Customer must be totally transferred by one or more persons, OR is bedfast

Bathing

This is the process of washing, rinsing and drying all parts of the body. This includes the ability to transfer to shower or bath or take sponge baths for the purpose of maintaining adequate hygiene and skin integrity. (Note – score should be based on functionality achieved with assistive device(s), if used). Report specific assistance required.

- NOTE:**
- ▲ If hair is routinely washed by a beautician due to personal preference exclude from scoring.
 - ▲ Set-up would include gathering equipment, running the water/setting the temperature.

Scoring

- 0) INDEPENDENT – Customer is independent in completing activity safely
- 1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer requires set-up help or reminding – can bathe safely without continuous assistance or supervision OR requires limited/occasional hands-on assistance (e.g., washing back or has a paralyzed limb)
- 2) HANDS-ON – Customer may need assistance transferring and may not be able to get into and out of the tub alone OR requires moderate hands-on help OR requires standby assistance throughout bathing activities in order to maintain safety
- 3) TOTAL DEPENDENCE – Customer is dependent on others to provide a complete bath

Dressing

The ability to dress and undress as necessary, that is, choosing and putting on clean clothes and footwear – including assistive devices such as prostheses, braces, anti-embolism stockings. This also includes fine motor coordination for buttons and zippers; choice of appropriate clothing for the

weather (Note – difficulties with a zipper or buttons at the back of a dress or blouse does not constitute a functional deficit; score based on functionality achieved with assistive device(s), if used). This excludes aesthetic concerns such as matching colors. Report specific assistance required.

NOTE: ▲ The use of mechanical aids (such as zipper pulls, long-handled shoe horns, stocking aids, Velcro fasteners, etc.) and adaptive clothing (elastic waist pants, slip-on shoes or non-tie shoes) would not disqualify the customer from being considered independent.

▲ The use of diapers would not be scored in dressing but would be considered in toileting.

▲ Set-up would include getting out clothes, shoes and assistive devices.

Scoring

0) INDEPENDENT– Customer is independent in completing activity safely in less than 30 minutes

1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer can dress and undress, with or without assistive devices, but needs to be reminded, supervised or given set-up assistance, OR needs limited or occasional hands-on assistance (e.g., putting on socks only or tying shoes) OR needs 30 minutes or more to complete independently due to medical/functional limitation(s)

2) HANDS-ON – Customer needs physical assistance or significant verbal assistance (prompting throughout) to complete dressing or undressing

3) TOTAL DEPENDENCE – Customer is totally dependent on others for dressing and undressing

Grooming

This is the process of tending to one’s appearance. How well does the customer manage grooming activities, including: combing hair, shaving and oral care (**excluding nail care**). Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

NOTE: ▲ This **excludes** aesthetics such as styling hair, skin care and applying make-up.

▲ If shaving is routinely done by barber or beautician, due to personal preference rather than necessity, exclude these from scoring.

Scoring

- 0) INDEPENDENT– Customer can groom without assistance from another person (may use mechanical aids independently)
- 1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer needs supervision or reminding (e.g., setting up grooming implements, giving advice or being available) or limited/occasional hands on assistance (e.g., shaving or brushing hair only; assistance with all tasks less than daily)
- 2) HANDS-ON – Customer needs hands-on physical assistance, but can participate physically
- 3) TOTAL DEPENDENCE – Customer must be totally groomed by another person

Eating

Ability to eat and drink, with or without adaptive utensils; also includes ability to cut, chew and swallow foods (Note – if a person is fed via tube feedings or intravenously, score “0” if the person administers the feeding independently). Otherwise, score based on the amount of assistance required from another person. Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

- NOTE:** ▲ Alteration of food is considered in scoring but preparing food (i.e., cooking) is not scored.
- ▲ Serving food or delivering a meal is not considered in set-up. Set-up is: opening milk cartons, cutting food or otherwise setting up food to facilitate eating, (i.e., clockwise arrangement for visually impaired).

Scoring

- 0) INDEPENDENT– Customer is independent in completing activity safely
- 1) SUPERVISION – Customer can feed self, chew and swallow foods, but may need reminding to maintain adequate intake; may need set-up or food cut up (includes mechanically altered diet)
- 2) HANDS-ON – Customer can feed self, but needs stand-by assistance for frequent gagging, choking, swallowing difficulty, or aspiration OR must be fed some food by mouth by another person
- 3) TOTAL DEPENDENCE – Customer must be totally fed by another person; includes being fed by another person via stomach tube or venous access

Toileting

This is the process of managing the elimination of urine and feces in the appropriate places. Includes the use of commode, bedpan or urinal; transferring on/off toilet, flushing, cleaning self (wiping, washing hands), changing of protective garment; managing an ostomy or catheter and adjusting clothing. Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

NOTE: ▲ Emptying bedpans, commode chairs and urinals are included as set-up activities.

▲ Changing an ostomy bag and/or wafer would be rated under ostomy care.

Scoring

- 0) INDEPENDENT– Customer is independent in completing activity safely (includes with assistive device)
- 1) SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer may need supervision, cueing or limited/occasional hands-on assistance with parts of the task, such as: clothing adjustment, changing protective garment, washing hands, limited/occasional wiping and cleaning self; emptying bedpan/urinal
- 2) HANDS-ON – Customer needs hands-on physical assistance or stand-by (for safety) with toileting OR is unable to keep self clean
- 3) TOTAL DEPENDENCE – Customer is totally dependent on others for the entire toileting process (may include total care of catheter or ostomy); customer may or may not be aware of the situation

B. CONTINENCE (30 days)

The assessor will identify the item that best describes the customer's level of control of bowel and bladder evacuation in the last **30 days**. **These questions do not refer to toileting ability**. An individual who is totally incontinent may still be independent in toileting. Select the appropriate response.

NOTE: ▲ A history of transient incontinence caused by an acute or temporary condition or illness (e.g., acute urinary tract infection or episode of diarrhea) should not be considered for rating.

▲ Incontinence during seizure activity should not be considered unless frequent seizure activity affects overall continency.

▲ Those who willfully toilet in inappropriate places will not necessarily be assessed as being incontinent but these behaviors may be assessed in other parts of this tool (toileting/disruptive behaviors).

- ▲ Incontinence involving minimal amounts (not necessitating an immediate change of clothing) should usually be rated as continent.

The following definitions apply to terms used in this section:

- **Continence** Ability to voluntarily control the discharge of body waste from bladder or bowel.
- **Incontinence** Involuntary loss of bowel or bladder contents.
- **Stress Incontinence** Inability to prevent escape of small amounts of bowel/bladder contents during certain activities such as coughing, lifting or laughing.

· **Bowel Continence**

This is the ability to voluntarily control the discharge of body waste from the bowel.

NOTE: ▲ Those who have no voluntary control and rely upon dilatation or ostomies for evacuation should be rated as totally incontinent of bowel.

Scoring

- 0) Continent. Complete voluntary control
- 1) Incontinent episodes less than weekly
- 2) Incontinent episodes once a week
- 3) Incontinent episodes two or more times a week and/or no voluntary control

· **Bladder Continence**

This is the ability to voluntarily control the discharge of body waste from the bladder.

NOTE: ▲ Those who have no voluntary control and rely upon indwelling catheters, intermittent catheterization, ostomies or condom catheters for evacuation should be rated as totally incontinent of bladder.

▲ Those who receive dialysis **and** do not urinate will be rated as continent.

Scoring

- 0) Continent. Complete voluntary control or minimal stress incontinence/dribbling

- 1) Usually Continent. Incontinent episodes less than weekly
- 2) Occasionally Incontinent. Incontinent episodes one or more times per week, but not daily
- 3) Frequently or Totally Incontinent. Incontinent daily and/or no voluntary control

C. DETERIORATION in OVERALL FUNCTION (ADLs & Continence)

(Consider last 90 days)

This question is used to identify whether significant overall changes occurred in the customer's functional status, skills or abilities related to ADLs and continence as compared to **90** days ago.

Scoring

- 0) No deterioration
- 1) Deteriorated
- 2) Unable to determine

D. COMMUNICATION/SENSORY PATTERNS (30 days)

These questions are used to evaluate hearing, vision and communication abilities in the past **30 days**. The assessor should check the item that best describes the usual level of functioning in each category. Assessment may be made by reviewing available information from the caregiver, customer, medical records and observation.

- NOTE:**
- ▲ If the assessor is unable to assess the ability, this will be scored in the "0" or unimpaired category.
 - ▲ Customers who are unable to respond due to coma will be scored as having maximum impairment.

Hearing

The ability to perceive sounds. If an assistive device is used, hearing should be rated while using the device. Hearing refers to the ability to receive sounds, and does not refer to the ability to mentally comprehend the meaning of the sound.

Scoring

- 0) Hears adequately (e.g., conversations, TV, phone) / Unable to assess
- 1) Minimal difficulty when not in quiet setting (understands conversations when in one-on-one situations)

- 2) Hears in special situations only (e.g., speaker has to adjust tonal quality and speak distinctly or when speaker's face is clearly visible); able to follow only loud conversation
- 3) Highly impaired/absence of useful hearing (e.g., will hear only very loud voice); totally deaf

• **Expressive Communication**

The ability to express information and make self understood by using any means (e.g., verbal, written, signs, etc.). This area may be affected by mental status or physiological conditions.

Scoring

- 0) Understood/Unable to assess
- 1) Usually Understood (e.g., difficulty finding words, finishing thoughts, or enunciating)
- 2) Sometimes Understood -- ability is limited to making concrete requests
- 3) Rarely/Never Understood

• **Vision**

This is the ability to visually perceive visual stimuli. A medical condition or disease affecting the eye that does not affect the ability to see should not be considered in determining adequacy of sight. In this section, the assessor will evaluate the customer's ability to see close objects and those at a distance in adequate lighting, using any usual visual appliances (e.g., glasses, magnifying glass).

NOTE: ▲ A diagnosis of legal blindness does not reflect a specific level of impairment for PAS scoring. For example, an individual may be able to read large print and be legally blind.

Scoring

- 0) Sees adequately (e.g., newsprint, TV, medication labels) / Unable to assess
- 1) Impaired. Difficulty focusing at close (reading) range. Sees large print and obstacles, but not details or has monocular vision
- 2) Highly impaired. Very poor focus at close range (e.g., unable to see large print); field of vision is severely limited (e.g., tunnel vision or central vision loss)
- 3) Severe impairment. No vision or appears to see only light, colors or shapes

- E. Underlying Causes** –Select all items that contribute to limitations in functional ability. This is an important part of the assessment of ADL function and continence. These items do not need to be repeated in comments but may be incorporated into the PAS summary. If the items listed do not apply, indicate “None.” If the customer needs but doesn’t have equipment, include comments to explain.

Physical Impairments

None

Amputation – loss of body part

Balance Problems – inability to maintain equilibrium

Bladder Incontinence – inability to retain urine

Bowel Incontinence – inability to retain feces or stool

Decreased Endurance – lessened ability to withstand prolonged exertion

Fine or Gross Motor Impairment – loss or abnormality of motor function

Fractures – sudden breaking of a bone

Limited Range of Motion – decreased ability to flex or extend a joint

Muscle Tone - degree of tension in a muscle

Neurological Impairment – loss or abnormality of the nervous system

Obesity – an increase in body weight as a result of excessive accumulation of fat

Oxygen Use – administration through a nasal tube or by mask by machine

Pain – sensory and emotional experience associated with tissue damage

Paralysis – loss of function including sensation and voluntary motion

Sensory Impairment - lack of feeling or being unaware of conditions

Shortness of Breath – difficulty exchanging air (inhaling, exhaling)

Swallowing Problems – difficulty moving food or fluids from mouth to stomach

Weakness – lack of physical strength

Supervision Need/Mental Health

None

Behavior Issues – acting or reacting abnormally to the environment

Cognitive Impairment – difficulty thinking, learning, judging or knowing

History of Falls – dropping, sinking or ceasing to be erect in the past

Lack of Awareness – decreased ability to understand or pay attention

Lack of Motivation/Apathy – indifference or without enthusiasm

Memory Impairment – difficulty in recalling past experiences

- F. Assistive Devices** - Select all assistive devices currently used to assist with functional ability. If customer requires but does not have device, list it in comments. Indicate None if customer does not require any of the listed devices.

None	Leg Brace
Commode – bedside	Motorized Scooter
Commode – high rise seat	Overhead Trapeze
Cane - standard	Shower Chair
Cane - quad	Walker – not wheeled
Crutches	Walker – wheeled
Geri Chair	Walker w/seat (trough)
Grab Bars/Side Rails	Wheelchair – standard
Hospital Bed	Wheelchair - motorized

III. **EMOTIONAL AND COGNITIVE FUNCTIONING**

These questions are intended to measure the frequency of specific behaviors and the extent to which these behaviors impose caregiving requirements on others or interfere with self-care. Caregiving can include either supervision or intervention.

A. **ORIENTATION** (Consider last 90 days). **Do not assess for children 6-11**

The following sections are intended to obtain information regarding the customer's orientation. This is achieved through interviewing the customer and asking caregivers for corroborating information.

If there is no caregiver present at the time of assessment every effort should be made to contact a family member or someone familiar with the customer in order to complete this part of the assessment.

Orientation is defined as the individual's awareness of his/her environment in relation to self, place, and time.

The assessor should consider orientation for the last **90** days, placing the most emphasis on recent mental status as well as the ability to reorient self.

- NOTE:** ▲ A customer who is aware of forgetfulness and initiates self reorientation (asking questions, looking at clock/calendar) will usually be considered to be oriented.
- ▲ Temporary disorientation due to an acute condition may not be considered if the customer has recovered (e.g., electrolyte imbalance, intoxication).
 - ▲ Allowances should be made for those persons in cultures/environments where time/place is traditionally measured in general rather than specific terms.
 - ▲ Forgetfulness and confusion does not necessarily indicate disorientation. The ability to re-orient, the frequency and intensity of the forgetfulness and confusion need to be assessed to determine level of orientation.

- ▲ A customer in a coma should be scored as totally disoriented to all three factors.
- ▲ A customer who is aphasic (has difficulty speaking) may need to be assessed using alternate means such as asking multiple choice questions, asking the customer to write or use some other way to communicate. Every attempt to assess orientation should be made.
- ▲ It is best to record the customer's actual responses in comments.

- ▲ Comments need to clearly explain whether scoring is for 'Knows' or 'Unable to assess.' For 'Knows', the exact quote from the customer is sufficient. Unable to assess should be indicated very rarely. An example of when it might be indicated is an individual with a serious mental illness, who is delusional and may respond to their name but not state their name when asked. This may also be used when it appears an individual is just refusing to answer the questions. Explain why unable to assess in the comments.

The assessor should determine the level of orientation to the following dimensions:

- + **Person/Caregiver** – Awareness of current first name, last name and caregiver's name. Assess whether the customer knows or does not know this information at the time of the interview. Unable to assess should not be indicated if at all possible.

Assess the caregiver's judgment of customer's orientation to first name, last name and caregiver's names. Indicate whether the caregiver thinks the customer always knows, usually knows, or seldom/never knows.

If the caregiver is not present at the time of assessment every effort should be made to contact the person to complete this part of the assessment.

Indicate the best response for each section.

Scoring

Does the customer know:

First Name

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Last Name

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Caregiver's Name

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

- + **Place** - Awareness of current location in regard to immediate environment, place of residence, city, and state. Immediate Environment and Residence may be considered accurate if stated in somewhat generalized terms. Immediate Environment may be "the kitchen", "my room", etc. Residence may be "my son's house", "a nursing home", etc. Assess whether the customer knows or does not know at the time of the interview. Unable to assess should not be indicated if at all possible.

Assess the caregiver's judgment of customer's orientation to immediate environment, place of residence, city and state. Indicate whether the caregiver thinks the customer always knows, usually knows, or seldom/never knows.

If the caregiver is not present at the time of assessment every effort should be made to contact the person to complete this part of the assessment.

Indicate the best response for each section.

Scoring

Does the customer know:

Immediate Environment

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Place of Residence

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

City

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

State

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

- + **Time** –This is the awareness of current time frame in regards to day, month, year and time of day). Consideration should be given to those persons in cultures/environments where time passing is traditionally measured in general rather than specific terms (e.g., "winter", "morning", "middle of the week" etc.) Assess whether the customer knows or does not know at the time of the interview. Unable to assess should not be indicated if at all possible.

Assess the caregiver's judgment of customer's orientation to day, month, year and time of day. Indicate whether the caregiver thinks the customer always knows, usually knows, or seldom/never knows.

If the caregiver is not present at the time of assessment every effort should be made to contact the person to complete this part of the assessment.

Indicate the best response for each section.

Scoring

Does the customer know:

Day

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Month

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Year

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Time of Day

Caregiver Judgment

Knows/ Unable to assess

Always knows

Does not know

Usually knows

Seldom/never knows

Indicate No Caregiver if unable to locate or contact any caregiver, family member or person aware of the level of orientation for customer. Explain why unable to locate or contact a caregiver in comments.

B. BEHAVIORS (90 days)

The purpose of this section is to identify the presence of certain inappropriate behaviors that may reflect the level of an individual's emotional and cognitive functioning. Behaviors should be assessed **based on the last 90 days**, except as indicated in self-injurious behavior and aggression. If a particular behavior has been exhibited in the past (more than 90 days ago) but is no longer a problem, then the assessor may indicate a history of the problem by selecting the appropriate response (i.e., zero on frequency of behavior).

Responses are based on both the frequency of the behavior and the intensity of the intervention, that is the amount or degree of intervention required to control the problem behavior. Indicate the most common method of intervention. For example, if verbal redirection is used once or twice a week but chemical restraint is given daily, a score of three should be indicated for intensity of intervention.

- NOTE:**
- ▲ It may be difficult for the customer to discuss behaviors. Assessors need to be sensitive to this and involve caregivers/family separately for collateral information.
 - ▲ It is important to include a description of behaviors and intervention in the comments or summary.

- ▲ **It is possible for the frequency of the behavior to be rated a zero and the intensity of the intervention to be rated a three. An explanation of this should be included.**

The following definitions should be applied when answering questions related to behaviors:

<u>Frequency</u>	number of times a specific behavior occurs within a specific interval;
<u>Intervention</u>	therapeutic treatment, including the use of medication and physical restraints to control the behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior;
<u>Medical Attention</u>	examination by a physician or Primary Care Provider (PCP) and treatment, if necessary.

THE DETAILS OF THE BEHAVIOR AND INTERVENTION MUST BE SPECIFIED IN COMMENTS OR SUMMARY.

+ Wandering

This is defined as moving about with no **rational** purpose, tending to go beyond physical parameters of his/her environment in a manner that may jeopardize safety, as a result of disorientation or memory problems. (This is not leaving without permission.)

- NOTE:**
- ▲ Getting lost in an unfamiliar place or voluntarily leaving against medical advice would not be considered wandering.
 - ▲ Wandering implies an **impaired ability to reorient** one's self to location.
 - ▲ Typically an individual who wanders will be disoriented to some degree.

Frequency of Behavior

0. Behavior has not been observed, or history of wandering behavior; not a current problem (includes if chemically controlled)
1. Occurrences may not pose a safety problem
2. Occurs predictably (in response to particular situations); occurrences pose a threat to the safety of self or others
3. Occurs at least daily, posing a threat to the safety of self or others

Intensity of Intervention (Most Common Method)

0. Customer requires no intervention
1. Customer is easy to verbally redirect
2. Customer can be verbally redirected with difficulty
3. Customer requires physical intervention or restraints (includes chemical restraints)

+ **Self-Injurious Behavior**

Defined as repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body (e.g., slapping, cutting, biting, pica (ingestion of inedible substances), scratching, compulsive water consumption, head banging).

NOTE: ▲ Exclude suicide attempts, accidents (e.g., falling), or risky lifestyle choices (e.g., smoking, drug/alcohol abuse, and non-compliance with medical advice).

▲ Self-injurious behavior may be deliberate or may be irrational.

Frequency of Behavior

0. No problems in this area or history of injurious behavior; not a current problem (includes if chemically controlled)
1. Incidents occur less than weekly; OR do not pose a threat to health or safety
2. Incidents occur weekly to every other day and MAY pose a threat to health or safety
3. Incidents occur at least once a day; OR has had episode(s) causing serious injury requiring medical attention in the last year

Intensity of Intervention (Most Common Method)

0. Customer requires no intervention
1. Customer is easy to verbally redirect
2. Customer can be verbally redirected with difficulty
3. Customer requires physical intervention or restraints (includes chemical restraints)

+ **Aggression**

Defined as **physically** attacking another; includes throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, and physically threatening behavior. Includes destroying property as part of aggressive behavior, but does not include self-injurious behavior.

Frequency of Behavior

0. No problems in this area or history of aggression; not a current problem (includes if chemically controlled)
1. Incidents occur less than weekly; OR do not pose a threat to health or safety
2. Incidents occur weekly to every other day and MAY pose a threat to health or safety
3. Incidents occur at least once a day; OR has had episode(s) causing serious injury requiring medical attention in the last year

Intensity of Intervention (Most Common Method)

0. Customer requires no intervention
1. Customer is easy to verbally redirect
2. Customer can be verbally redirected with difficulty
3. Customer requires physical intervention or restraints (includes chemical restraints)

+ Resistiveness

This is defined as inappropriately stubborn and uncooperative behaviors, including passive or active obstinate behaviors, refusing to participate in self care or to take necessary medications. Do not include difficulties with auditory processing or reasonable expressions of self-advocacy. Also, do not include verbal threatening or acts of physical aggression to self or others).

Frequency of Behavior

0. Problem does not occur or occurs at a level not requiring intervention (includes if chemically controlled)
1. Behavior occurs less than weekly
2. Behavior occurs weekly to every other day
3. Behavior occurs at least daily

Intensity of Intervention (Most Common Method)

0. Customer requires no intervention

1. Customer is easy to verbally redirect
2. Customer can be verbally redirected with difficulty
3. Customer requires physical intervention or restraints (includes chemical restraints)

+ **Disruptive Behavior**

Defined as **Inappropriate** behavior that **Interferes** with the normal activities of others or self and **usually** requires **Intervention** to stop the behavior. This could include, but is not limited to: putting on or taking off clothing inappropriately; sexual behavior inappropriate to time, place or person; excessive whining or crying; screaming; persistent pestering or teasing; constantly demanding attention; and urinating in inappropriate places. For an individual with dementia, intervention may not be feasible.

NOTE: ▲ Keep in mind that some disruptive behavior may be appropriate, such as: crying from pain, or repeatedly asking for toileting assistance during presence of urinary tract infection. (These would not be scored as disruptive).

Frequency of Behavior

0. Does not occur or occurs at a low level not requiring intervention, or no history of disruptive behavior; not a current problem (includes if chemically controlled)
1. Behavior occurs less than weekly
2. Behavior occurs weekly to every other day
3. Behavior occurs at least daily

Intensity of Intervention (Most Common Method)

0. Customer requires no intervention
1. Customer is easy to verbally redirect
2. Customer can be verbally redirected with difficulty
3. Customer requires physical intervention or restraints (includes chemical restraints)

IV. MEDICAL ASSESSMENT

The assessor reviews the medical status by evaluating the medical condition and the need for medical services. If the customer is hospitalized or resides in a NF, much of this data may be obtained directly from medical records. If a home interview is conducted, accept statements by the customer or caregiver that seem to have clinical validity but verify pertinent facts by consulting with the physician, major health care provider or others who are well-informed regarding the medical condition of the applicant. **This section should give a thorough picture of the customer's current medical condition and immediate medical nursing needs as they pertain to need for long term care services.**

A. MEDICAL CONDITIONS

This section is used to record **only** the diagnoses and specific medical conditions that have a relationship to the customer's current ADL status, cognitive status, mood and behavior status, medical treatments, skilled nursing care or risk of death. The assessor should review each category of conditions listed to ensure that no **significant** diagnoses are omitted.

NOTE: ▲ Include only those diagnoses that have an impact on the customer's current ADL status, cognitive status, mood and behavior status, medical treatments, skilled nursing care or risk of death.

▲ Do **not** indicate inactive or historical diagnoses.

If a specific diagnosis is not found on the tool, but the diagnosis or condition is the same or essentially the same as one of the listed conditions, **select the condition from the list and use the comment section to specify**. For example, if the stated diagnosis is Lou Gehrig's disease, select amyotrophic lateral sclerosis (ALS); if quadriplegia is the stated diagnosis, select paralysis. It is very important to carefully evaluate any condition that may relate to Paralysis, Alzheimer's disease or Dementia, since these conditions affect the score.

It is very important to group diagnoses in the categories listed if at all possible. For more examples of grouping diagnoses, see EPD PAS Manual Supplement Medical Conditions and Associated Related Conditions.

NOTE: Significant historical conditions should be documented in the PAS summary.

ICD-9 (International Classification of Diseases – 9th Revision)

The assessor should identify any other **significant** diagnoses in the ICD-9 section. If you have an ICD-9 code that is not listed, select a miscellaneous ICD-9 code and enter the number code and the specific diagnosis in the comments section. **DO NOT list surgical procedures or V codes as diagnoses. These may be recorded in the summary section.**

***Major Diagnosis**

The assessor should select up to three major diagnoses. The major diagnoses are determined by those that are most resource intensive (e.g., using the most medical/nursing services) and causing significant impact on the need for long-term care. In some cases, there may be only one or two major diagnoses.

By Arizona Revised Statute an eligible person must have a **non-psychiatric** medical condition or developmental disability that by itself or in combination with other medical conditions, places the person at risk of institutionalization in a nursing facility or intermediate care facility for the mentally retarded. **Therefore an eligible person must have a non-psychiatric major diagnosis that impacts the need for long term care.** See page 41 for more information on physician review for cases eligible by score with SMI diagnoses.

***Categories and Related Medical Conditions**

The PAS assessor should verify diagnoses and medical conditions from medical documentation or verbally from provider (by phone or in person) and secure copies of documentation when necessary such as in the event of an eligibility review or hearing.

Some conditions are determined to be predictors for risk of nursing facility placement. They are listed here along with other conditions that are either essentially the same or similar enough they should be marked under that section for scoring purposes. These conditions are bolded below. See page 40 for more information on scoring.

- A1). Hematologic/Oncologic - disorders of the blood and conditions relating to tumors, malignant or benign.
- A2). Cardiovascular - conditions of the heart and blood vessels.
- A3). Musculoskeletal - conditions related to muscles, bones and connective tissue.

PARALYSIS - (Includes but is not limited to the conditions listed below).

Hemiplegia
Paraplegia
Quadriplegia

- A4). Respiratory - conditions related to the act of breathing; involves the nose, trachea, lungs and all air passages.
- A5). Metabolic - conditions that relate to physical and chemical changes in the body, including endocrine disorders and electrolyte imbalances (e.g., hypokalemia, hypernatremia, malnutrition).
- A6). Neurological - conditions related to nerves, nervous tissue or nervous system.
NEUROCOGNITIVE DISORDER, ALZHEIMER'S DISEASE, DEMENTIA - (Includes but is not limited to the conditions listed below).

Alper's disease (grey matter degeneration)
Pre-senile dementia (Pick's disease)
Progressive dementia
Multi-infarct dementia
Arteriosclerotic dementia

Degenerative dementia
Creutzfeldt-Jakob disease (progressive viral disease of CNS)

NOTE: ▲ Cerebellar disorders and cerebral atrophy are NOT indicated here

Score – assign 20 points for patients who have the following documentation:

- Diagnosis of dementia or major NCD: CLINICIAN-verified dementia or major NCD diagnosis that meets criteria, that is:
- Cognitive function/cognitive performance decline: For dementia or major NCD, evidence of significant functional decline from a previous level of performance in one or more neurocognitive domains based on concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function, AND substantial decline in impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment;
- ADLS impact: Dementia or Major NCD impacts ADLs/functional independence;
 - Behaviors: Clinically documented significant behavioral disturbance due to dementia/major NCD diagnosis and interventions.
- Medications or other therapies or interventions (plus or minus): For dementia or major NCD, document related medication (s); other interventions such as physical restraints, locked units; and psychosocial interventions (e.g., supervised day activity programs, nursing home/extended care placement, and caregiver support).
Medications: being on medication by itself should NOT warrant 20 points
- The cognitive deficits are not in the exclusive context of delirium; and are not better explained by a mental disorder, or acute substance/medication-induced intoxication.

A7). Genitourinary - conditions related to the genitals and urinary system and also includes kidneys.

A8). Gastrointestinal - conditions related to the stomach, intestines and related structure such as esophagus, liver, gall bladder and pancreas.

A9). Ophthalmologic/EENT - conditions related to the eyes, ears, nose and throat.

A10). Psychiatric - conditions related to the mind and mind processes.

NOTE: ▲ A non-psychiatric medical condition or developmental disability that impacts the need for long term care is required for ALTCS eligibility per ARS 36-2936.

A11). a. Current Skin Condition(s) – disease/disorders related to the skin on any/all parts of the body. (Indicate all that apply.)

b. History of Resolved Ulcers – select no if the customer has not had any skin ulcers or breakdowns in the past year.

c. If the customer has ulcer(s), indicate pressure ulcer(s) using the following definitions. Indicate all that apply:

Any area of persistent skin redness (without a break in the skin) that does not disappear when pressure is relieved;

Partial loss of skin layers that presents as an abrasion, blister or shallow crater;

A full thickness of skin is lost, exposing the underlying tissue (presents as a deep crater) or the underlying tissue is lost (exposing muscle or bone);

Scab (eschar) over ulcer.

Note the number of current pressure ulcers and **describe the size and location(s) in comments or summary.**

A12). Other Conditions (ICD-9s) - disorders that are not covered in the above categories. The assessor should use this section only when the customer's condition is not covered in categories 1-11. **Enter only those conditions that impact need for long term care.**

B. MEDICATIONS/TREATMENTS/ALLERGIES

B1) MEDICATIONS

This section identifies the medications currently taken by the customer. **If in a facility, medications may be obtained from the physician orders list.** If the interview is in-home, request prescription containers and copy label information. If there is a discrepancy between the verbal report, prescription bottles and/or the medical records, note it as a comment. Also ask if the customer is taking any type of non-prescription medication. The assessor should include dosage, frequency, duration, route and form of each medication. If the applicant receives a PRN medication, note the prescribed frequency as well as the actual frequency taken. Include comments related to blood sugar levels, discontinued medications (taken in last 30 days).

B2) INSULIN – Indicate “Yes” for all that apply.

Does the Customer Take Insulin? Does customer require any assistance drawing up insulin? Does customer require any assistance self-injecting insulin?

This section is designed to collect information for customers who have diabetes and take insulin. If the individual receives assistance with insulin

administration, explain in comments who provides the help for drawing up and/or injecting the medication.

The assessor will need to ask if the customer takes insulin. If the answer is yes, the questions regarding assistance with drawing up and self-injecting insulin will need to be answered. The question regarding assistance with fingersticks must be answered whether the customer takes insulin or not.

Does Customer Require any Assistance with Finger Sticks?

If finger stick blood sugars (FSBS) are done, it is important to document the frequency, the range of blood sugars and who actually performs the testing.

Use the comments section to describe the assistance provided for the customer.

B3) MEDICATION ASSISTANCE

Select yes if the customer needs or receives assistance taking medication. Setting up of a medi-set or similar process would be considered assistance.

Indicate no if the customer completes the process independently.

Use the comments section to describe the assistance provided to the customer.

B4) THERAPEUTIC DIET

A therapeutic diet is prescribed by a physician and based on a customer's medical condition. Select yes and describe the diet in comments if the customer requires a diet that is adjusted to meet special nutritional needs. This may include consistency such as mechanical soft or pureed, level of nutrients (e.g., 1800 calorie ADA), amounts of fluids, number of meals or the elimination of certain foods (no wheat or dairy products).

B5) MEDICATION ALLERGIES

Indicate yes or no. If the customer has allergies to medications, use the comments section to list them.

C. SERVICES AND TREATMENTS

The PAS assessor should identify any services/treatments the customer is currently receiving by selecting from those listed. With information obtained from

PAS sections on Medical Conditions, Medications and Treatments, medical records and contact with health providers, select any of the listed services/treatments. Recent but discontinued services should not be indicated, but if significant can be mentioned in comments or summary. Services and treatments may be provided by professionals, non-professional caregivers, by customer, or others as appropriate.

In evaluating whether or not a service is "**needed**," the assessor must make a professional judgment based on education/experience. He/she will identify the problem and render an opinion as to whether or not it is feasible that the service can resolve or alleviate the medical problem. For example, if the assessor identifies a problem such as incontinence in a severely demented customer, the assessor may decide that bowel/bladder training is not a realistic possibility. If the assessor notes the customer has an open wound that is not being treated, wound care may be appropriate to indicate as a need. When indicating a "**need**" for treatment, it is necessary to provide comments which are to be included in the comments section for Services/Treatments or they may be added to the PAS Summary.

It may be necessary to include comments to clarify the frequency of some treatments in order to help identify the severity of the condition (e.g., dialysis treatment three times weekly for 4 hours).

Select the appropriate response for each service/treatment received:

C1). Injections/IV

a. Intravenous Infusion Therapy

Fluid substance introduced into the body via a vein. This includes intravenous infusions and blood transfusions.

b. Intramuscular/Subcutaneous Injections

Fluid substance injected into the muscle or beneath the skin via a hypodermic syringe.

C2). Medications/Monitoring

a. Drug Regulation - refers to the necessity for close evaluation/monitoring/adjustment of medications to assure effective therapeutic value.

Examples of drug regulation might include:

- Periodic Lab test: blood sugar levels for antidiabetic agents, anticonvulsant blood levels (e.g., Tegretol), clotting time (e.g., Coumadin), cardiac drug levels (e.g., Digoxin), cholesterol lowering medications (e.g., Lipitor);
- Adjustment of medication dosage/schedule in direct relation to diagnostic testing or symptoms: (e.g., Hold Lanoxin if pulse below 60,

hold Procardia if systolic blood pressure below 150, sliding scale for insulin dosage);

- Intense supervision or observation that is needed to evaluate: adverse reactions, interactions, or immediate response to a drug such as response to a pain relieving narcotic such as Demerol, response to chemical restraints or drugs given for behavior control such as Haldol or Mellaril; or
 - Schedule II Narcotics.
- b. Drug regulation is not meant to refer to routine monitoring, evaluation or adjustment that is appropriately and readily accomplished by non-professionals, (e.g., "Aspirin upsets my stomach so I'll take Tylenol instead").

c. Drug Administration

This is the act of giving or applying medication to remedy an illness or condition. This includes self-administration.

C3). Skin Care

a. Pressure/Other Ulcers

Application of various materials or treatments such as Duoderm, Santyl, Collagenase, Betadine, ointments, bandages, heat application, whirlpool and debridement for therapeutic reasons to protect or assist in healing a pressure sore or stasis ulcer. Includes preventive measures ordered by the physician for customers with histories or chronic skin breakdowns which are likely to recur. Use the comments section to describe type, location and description of ulcers as well as treatment provided.

b. Non Bowel/Bladder Ostomy Care

Specific care needs, such as irrigation, cleaning or other bandaging to maintain an artificial opening or stoma. This excludes ostomy care for bowel or bladder ostomies, (covered in C5) or tracheostomies (covered in C6). Examples of Non Bowel/Bladder Ostomies are feeding tubes such as gastrostomies or g-tubes, jejunostomies (j-tubes) and various 'buttons' (e.g., BARD or MIC-KEY buttons).

c. Wound Care

The application of various materials such as medicated solutions, ointments, gauze and bandages to assist in the healing or protection of a wound (incision, skin tears, burns, IV sites, dialysis sites) for therapeutic reasons. This does not include simple first aid measures or medication applied to skin conditions such as ACNE or DRY SKIN. **Use the**

comments section to describe the wound and the treatment provided (may be observation of a dialysis shunt).

C4). Feedings

- a. Parenteral Feeding/TPN - Nutrition administered through a route other than the alimentary canal, usually intravenously.
- b. Tube Feeding - Nutrition administered through a tube (such as nasogastric, gastrostomy or jejunostomy tubes) to the alimentary (GI) tract.

C5). Bladder/Bowel

- a. Catheter Care - Maintenance of urinary catheter patency and hygiene. Includes condom, indwelling and intermittent straight catheterization.
- b. Ostomy Care - Specific care (i.e., changing stoma ring, changing bag) necessary to maintain an artificial opening or stoma for bowel or bladder.
- c. Bowel Dilatation - Expansion of the anal orifice to promote evacuation. This includes the use of suppositories in paralyzed individuals.

C6). Respiratory

- a. Suctioning - The process of removing or withdrawing secretions and waste material.
- b. OXYGEN - Receiving O₂ per nasal prongs, face mask or O₂ tent (for example). Include the rate of liter flow or percentage of oxygen whenever possible.
- c. SVN (Small Volume Nebulizer) - Treatment using a machine that produces a fine spray or mist of a specific prescription for inhalation. **Exclude** hand held atomizers/inhalers (e.g., Metered Dose Inhalers).
- d. Ventilator - A mechanical device for artificial ventilation of the lungs usually administered per tracheostomy (excludes C-PAP and Bi-PAP without a rate setting) There must be a third (3rd) breath rate setting for a bi-level machine to be considered a ventilator.
- e. Trach Care - The process of suctioning and cleaning the stoma and apparatus that provides an artificial airway to the lungs through the trachea.
- f. Chest Physio-therapy - The process of positioning so that gravity will allow drainage from nasal passages, airways and sinuses. Drainage is usually stimulated by percussion to lung areas.
- g. Continuous Positive Airway Pressure (CPAP) – a device which provides the application of constant pressure (e.g., 10-12) throughout the respiratory cycle. No mechanical inspiratory assistance is provided so

CPAP can NEVER be a ventilator. The customer breathes independently with support from the CPAP machine and/or oxygen.

Use this section if the customer uses a **Bi-level Positive Airway Pressure** machine (Bi-PAP) that does not have a set back-up rate (e.g., IPAP 15, EPAP 6) – IPAP, which stands for Inspiratory Positive Airway Pressure and EPAP which stands for Expiratory Positive Airway Pressure. There must be a third breath rate setting for a bi-level machine to be considered a ventilator.

C7). Therapies

- a. Physical - Treatment provided for specific physical problems by or under the direction of a registered physical therapist. Therapies may involve use of physical agents such as hydrotherapy, exercises, electricity, radiation, and training in use of assistive devices.
- b. Occupational - Treatment provided by or under the direction of a registered occupational therapist that will assist the customer in the management of personal care. This therapy helps to improve the customer's functional abilities, teaches adaptive techniques for ADLs and works with upper extremity mobility.
- c. Speech - Treatment provided by or under the direction of a registered speech therapist for various speech and swallowing difficulties. This therapy helps the customer with comprehension and speech difficulties, provides restorative therapy and diagnostic/evaluation services.
- d. Respiratory - Treatment provided by or under the direction of a registered respiratory therapist to restore, maintain and improve respiratory function; includes the use of CPAP which may or may not be under the direction of or provided by a registered respiratory therapist and Bi-PAP which should always be under the direction of a respiratory therapist.
- e. Alcohol/Drug Treatment - Medical or psychological counseling aimed at customers who abuse alcohol and/or mood altering drugs. May include self-help groups.
- f. Vocational Rehabilitation - Therapy directed at developing or redeveloping job-related skills.
- g. Individual/Group Therapy - Psychotherapy or counseling provided by a professional for treatment of mental or emotional disorders or maladjustment.

- C8). Rehabilitative Nursing- Professional nursing service that establishes a therapeutic plan of care that is problem oriented, individualized, and has measurable goals. The objective of the care plan is to enable the ill or

disabled person with rehabilitation potential to achieve optimum, practicable **functional efficiency**.

- Provides for **direct** or **indirect** nursing care to restore functional ability or prevent further deterioration in ability.
 - Rehabilitative nursing is **not** monitoring although monitoring may be a component of the teaching/training process.
 - Rehabilitative nursing is **not** activity or exercise carried out for recreation/general health purposes.
- a. **Teaching/Training Program** - To teach a customer or family caregiver routine tasks in relation to customer's medical need due to a new diagnosis (e.g. diabetic testing, ostomy care, catheter care, diet planning, use of prosthesis, self administration of medication, insulin injections).
 - b. **Bowel/Bladder Training** - A formal method of establishing regular evacuation/urination by reflex conditioning.
 - c. **Turning and Positioning** - Moving, turning or repositioning a customer who is not able to move independently. This is done to improve circulation and to avoid decubiti or contractures.
 - d. **Range of Motion** - Active or passive exercise related to the restoration of a specific function or to maintain function. Excludes general exercises to promote overall fitness.
 - e. **Other Rehab Nursing** - Other rehab nursing services deemed appropriate to regain health or strength, under the direction of nurses or therapists that is reasonable and justified. This includes restorative ambulation, restorative feeding, deep breathing exercises, therapeutic splinting, or physical, occupational or speech therapy tasks performed by nursing staff (e.g. RNA or caregiver at the direction of the therapist).

C9. **Other Services and Treatments**

- a. **Peritoneal Dialysis** - Removal of waste products from the body by perfusing prescription solutions through the peritoneal cavity.
- b. **Hemodialysis** - Removal of waste products by circulating the body's blood supply through special dialyzing tubes via a shunt or through a special catheter.
- c. **Chemotherapy/Radiation** - The application of chemical or x-ray agents that have a specific and toxic effect on cancerous cells.
- d. **Restraints** - Devices that hinder or restrict movement to protect an customer from injury.

Mechanical: Physical devices or barriers that restrict normal access to one's body or immediate environment and to protect from injury. May include devices (attached or adjacent

to the body) that cannot be easily removed such as vest, wanderguard, seat belts, gerichair with laptray or barriers to normal, standard movement (e.g., locked rooms or areas). Usually, devices such as side rails, bed or chair alarms or self-removable seat belts will **not** be considered restraints.

Chemical: Prescribed medication used for elimination or modification of **overt physical behaviors** likely to cause physical harm to self or others (e.g., combativeness, constant pacing, or self mutilation).

- A specific drug must be linked with a particular behavior and used to eliminate or control the specific behavior.
 - Verbal reminders/redirection by others, shielding, deflecting, guiding or bracing a body part for completion of a procedure is **not** a restraint.
- e. **Fluid Intake/Output** - Measuring and monitoring the oral and parenteral intake of fluids and/or the fluid output (e.g., IV fluids, tube feedings, parenteral feedings, specific fluid intake or urine output, catheter output, vomitus and other fluid loss). Routine recording of dietary intake or supplements (e.g., percentages) is not I & O.
- f. **Other** - Includes other therapies prescribed for a specific problem e.g., sitz bath, TED hose, TENS unit for pain, special mattress, whirlpool (if used for reasons other than physical therapy or decubiti care, it should be noted here). Any service or treatment received or needed **but not documented elsewhere** should be indicated here. This is essential if a diagnosis is marked as requiring services or treatment. For example, if peripheral vascular disease is indicated because the customer requires treatment with TED hose; then the TED hose should be indicated here if not documented elsewhere.

D. PAS SUMMARY EVALUATION

The personal contact information will be data entered on the Personal Contacts tab of the PAS Summary window.

Personal Contacts / Source of Information

This section is designed to report information about personal contacts and the customer's physician. The personal contact may or may not be the same as the authorized representative who has been identified by the financial eligibility specialist. Include the contact's name, relationship to customer and telephone number(s). Additional contacts may also be added to the PAS summary. Indicate as above for customer's primary physician. If medical records/diagnoses are obtained from other specialists, include the name(s) and telephone number(s).

Informal Supports

1. Does the customer have a primary caregiver?
Indicate yes or no as applicable.
2. If yes, enter name & relationship to applicant;
Same as informant/personal contact? Indicate if the primary caregiver is also the informant.

Include comments in summary to describe who the primary caregiver is and what is done for the customer.

In all cases the customer must be observed and preferably the interview would occur in the usual living arrangement.

PAS SUMMARY

In this section the assessor will summarize the overall medical conditions, functional status and needs of the customer. The assessor should avoid making statements regarding eligibility, the advisability of any particular placement or need for institutionalization. The following factors **must** be included when completing the summary, if applicable:

NOTE: The status of the customer's Medicare Part D coverage must be included at the beginning of the PAS summary for the Program Contractor Case Manager to know whether the customer has medication coverage.

1. A brief description of the customer's current major medical condition and related problems; any conditions which are unstable or requiring significant treatment should be described. Any vital signs, pertinent lab data, and other diagnostic information should be noted if pertinent (i.e., blood sugars, blood pressures, MRI, CT scan);
2. Descriptive information regarding ADL performance, functional limitations and capabilities and who provides assistance; if scores are based on need, include comments to explain the reasons assistance is needed but not received;
3. A description of falls, injuries, hospitalizations and ER visits including dates;
4. Formal and informal support system (e.g., describe formal services received such as meals on wheels, or any informal services or support provided by relatives, neighbors, and friends);
5. Environmental conditions and living situation/arrangement;
6. Psychosocial factors, behaviors, cognitive abilities (describe the impact upon health status and caregiving);
7. Nutritional status (e.g., chewing or swallowing problems, unusual eating patterns, major fluctuations in weight);

8. Sensory status (describe any significant impairment in sense of touch or any other sensory impairments);
9. Any other information the assessor feels is necessary to document including statements made by the customer or caregiver such as what services are desired, any unmet needs observed or described. The assessor should avoid statements which reflect any personal value judgments or biases.

NOTE: ▲ Document that a description of the ALTCS program requirements for nursing facility (NF) level of care and referrals to community resources were provided.

E. PAS Eligibility / Scoring

All medical and functional scores are computed by the ACE system and appear on this window. Physician Review and Override are also located on this window.

Three scores are given for the PAS screening tool:

- a functional score;
- a medical score; and
- a resulting grand total score.

For more details see the flow chart for EPD scoring, Appendix A-3.

No minimum functional or medical score is required for eligibility. A customer must be at risk for institutionalization at the nursing facility level of care.

In order to qualify by score, a grand total score of 60 or higher must be achieved.

On reassessment, a customer must have a score of 40 but less than 60 to be eligible for the ALTCS Transitional program.

Special Status

- This window displays ACUTE, VENTILATOR DEPENDENT or ALTCS Transitional program.

V. Physician Review

Eligibility review is an integral part of the PAS assessment process. It is designed to address those customers whose score outcome is not thought by the assessor to be a complete reflection of the customer's **need for nursing facility level of care**. The assessor should indicate the reason a review is requested when it is for something other than standard review such as SMI scoring eligible, no longer DD eligible.

It is important to remember that there is no single criterion for the entry level of care for ALTCS medical eligibility. An eligible individual might have a combination of factors that impact functional ability and medical need for services. A customer who needs the entry level of care will require care greater than what is considered supervisory care (ARS-36-401 [unskilled nursing care]) and may present a combination of the following needs or impairments:

- 1) requires nursing care by or under the supervision of a nurse on a daily basis;
- 2) requires regular medical monitoring;
- 3) impaired cognitive functioning and psychosocial deficits;
- 4) impairments in ADLs and incontinence.

Eligibility reviews may occur for customers who score either below or above the entry level scoring threshold or have impairments in some aspects (as described above) that "overshadow" their strengths in other areas. These reviews will usually be performed by a physician consultant or an administrative process. A customer cannot be determined ineligible by an administrative process.

Reviews **must** be requested for:

- Ineligible cases scoring 56 or more on an initial PAS;
- Customer meets threshold score but has a psychiatric condition (includes chemical dependence) and **does not have a non-psychiatric condition** or developmental disability that by itself or in combination with the psychiatric condition places the customer at risk of institutionalization;
- Customer meets threshold score on an initial ALTCS application who is already a member of an AHCCCS health plan and appears to need less than 90 days of convalescent care;
- All ALTCS customers who do not meet threshold score for ALTCS or Transitional on reassessment;
- Any ALTCS customer residing in a Nursing Facility who, at the time of reassessment meets the score for transitional but not ALTCS eligibility;
- All ALTCS customers who do not meet threshold score and have a documented diagnosis of autism, autistic-like behavior or pervasive developmental disorder
- All children through age 11.

Reviews **may** be requested for but are not limited to these cases:

- Customer does not meet threshold score but the assessor thinks the customer may be at risk of institutionalization;
- EPD already in a Nursing Facility or very elderly and frail – may have only minimal functional deficit, OR medically involved with multiple hospitalizations over past 6-12 months OR has scores 40-50 in general

- Customer requests a hearing;
- Atypical cases: traumatic brain injuries with behavioral concerns, HIV/AIDS declining function, specialized treatments, e.g., halo brace, body cast, any cases requiring extensive and complex medical care.

When requesting the Physician Review, the assessor completes the following fields in the Physician Review window in ACE:

Requested Date

Date the case is actually sent to review, after medical records have been received, reviewed by the assessor and scanned into Fortis.

Requestor Comments

When requesting an eligibility review, the assessor should provide a brief, specific reason based on the customer's functional and medical conditions. Any information recorded must be factual and objective. **Do not suggest an eligibility decision.** When requesting an eligibility review, the assessor should provide the reviewer with current documentation, if available, and pertinent to the customer's condition. Documentation should be selected for its ability to **CLARIFY** the current medical condition and/or functional needs.

If documentation is NOT available note that in this section and provide a more thorough explanation in the PAS summary.

This documentation may include:

- History and Physical;
- Discharge summary if the customer was hospitalized;
- Consultations by specialists (e.g., psychology, psychiatry, neurology or cardiology reports);
- Therapy notes;
- Nursing notes **only** if addressing a specific incident or condition;
- SIGNIFICANT test results such as laboratory results (HgA1C for diabetics, viral titers, T-cell or CD4 counts for people with AIDS), EEG, EKG or MRI results;
- Physician Progress Notes relating to current condition or need for long term care;
- MDS (Minimum Data Set), if the customer is in NF;

- For reassessments, the case manager notes and Member Change Report, if that is the reason a reassessment is being completed should be included.

Referral

Once the PAS and documentation have been reviewed by the HPM, supporting documents are scanned into Fortis. The local office notifies the physician review coordinator via e-mail when the case is ready to be reviewed. The physician reviewers/PARC are notified and review the case in ACE and Fortis.

■ **Eligibility Reviewer's Summary**

In this section the reviewer determines, independent of score, if the customer is at immediate risk of institutionalization in a NF. The summary will describe significant factors that determined eligibility and may include:

- A brief summary of the significant medical conditions;
- Discussion of the extent of the impact the current medical condition has upon physical/mental functioning;
- A prognosis with an estimate of chances for recovery or satisfactory maintenance of health without ALTCS intervention. For example, the customer may be served adequately through supervisory care facilities, periodic outpatient care, or intermittent hospital stay;
- An opinion about the stability of the medical condition; how likely is it that symptoms will recur or the severity of the condition will become worse or cause significant impairment in mental or physical function, over the course of the next few months.

In conducting the review, the reviewer/s may consider all available information from the PAS as well as any additional documentation provided by the assessor. The reviewer may call and discuss the case with the assessor or the customer's primary care physician for further information. In making the determination, the reviewer may consider several areas such as functional limitations; cognitive deficits; stability of medical conditions; number, frequency and complexity of treatments, to list a few. The reviewer may place a different degree of significance on factors within each individual case. The reviewer must look at the case from the overall perspective of risk of institutionalization, in conjunction with the combination of conditions, impairments and other limitations which may be the deciding factors.

Review Results/Physician's decision

After the review is completed, the reviewer indicates the appropriate decision, eligible or ineligible or Transitional on reassessment.

Reviewer's Signature and Title/Name of Doctor

The reviewer's name and title should be indicated.

Review Date

Date reviewer completed the review.

When the review document is returned from the physician, it is data entered into the remaining fields of the Physician Review window in ACE by the physician review coordinator and assessor or Health Program Manager is notified.

PAS Override

A PAS decision can be overridden based on the following reasons:

- Physician Review;
- Administrative Review;
- Hearing Review;
- Hearing Decision.

VI. POSTHUMOUS PAS AND REASSESSMENTS

A. Posthumous PAS

In some instances an initial PAS may need to be completed after the customer has expired. The customer may have died after the application has been made, or in some cases a representative may have applied for the deceased customer.

If the eligibility interviewer is aware that the customer is deceased, the date of death is entered into the system. In some cases, the customer may die after the PAS referral has been made, and the financial eligibility specialist may be unaware of the death. In that case, **the PAS assessor will be responsible for notifying Financial Eligibility** of the date and place of death and source of this information.

Although the posthumous PAS may be an initial PAS, there are limitations on information availability and applicability. The following items do not require completion on a Posthumous PAS.

- Deterioration in overall function;
- Medications – and whether assistance is required in administration, and allergies to medications;
- Therapeutic diet;
- Number of hospitalizations, ER visits, falls;
- Whether the client is hospitalized or has plans for discharge.

NOTE: No comments are required on the Posthumous PAS. A brief summary should be included. **As of 1/1/2014, a deceased customer no longer must have been placed in a nursing facility/medical institution during the application**

period. A deceased applicant can be in any type of living arrangement and still be assessed on a Posthumous PAS. Title 9 28-401.01 A5.

B. Reassessments

PAS reassessments are required on certain cases to determine continued eligibility for ALTCS. The same basic PAS criteria must be met in order for eligibility to continue. Any changes in score or condition **must** be explained in comments or in the summary. Each reassessment should give a complete description of the customer's current functional and medical status. To insure consistency and to prepare for the interview it is necessary to review the PAS file or PAS windows prior to conducting a reassessment. If at all possible, a reassessment should not be completed on a hospitalized client.

Prior to completing an ineligible reassessment the assessor must have contacted the case manager to obtain collateral information and to discuss the potential ineligibility. Prior to completing a reassessment on a customer that scores into the Transitional Program and resides in a nursing facility, the case manager should be consulted regarding discharge planning. (Reviews must be requested for any ALTCS customer who resides in a nursing facility and meets the score for Transitional but not ALTCS eligibility on reassessment.)

There are a few differences in requirements between the initial PAS and a reassessment that should be noted. The following non-scored item is not to be completed on PAS reassessments:

Whether or not the customer is hospitalized and the plan for discharge;

ACE will not allow entry of these fields on a reassessment.

For more information on Reassessments, see Arizona's Eligibility Policy Manual for MA, NA and CA, chapter 1000.

VII. Prior Quarter and Private Request PAS

A. Prior Quarter

An applicant can request coverage for up to 3 months prior to the date of their application. This time period is called Prior Quarter. In order to be eligible for Prior Quarter coverage, the following must be met:

- Have a medical expense in a Prior Quarter month. The medical expense can be paid or unpaid.
- Meet **all** eligibility requirements in the month the medical expense was incurred.

Coverage in the Prior Quarter month(s) are Fee For Service. ALTCS members eligible for Prior Quarter are not enrolled with a Program Contractor.

For instructions on how to enter a Prior Quarter PAS in ACE, see Arizona's Eligibility Policy Manual for MA, NA and CA, chapter 1313.

B. Private Request PAS

What is a Private Request PAS?

A private request PAS is a courtesy that ALTCS provides to customers not currently applying for ALTCS. These courtesy assessments are completed without a charge to the customer and are not a final determination of medical eligibility.

Why would someone ask for a Private Request PAS?

A customer might ask for a private request PAS if:

- they are planning on moving to Arizona and want to know if there is a likelihood of being medically eligible;
- they already know they are within the financial limits but are not sure about medical eligibility;
- they know they are over the resource limit and before they consider reducing resources, want to know whether potential medical eligibility exists.

As a PAS Assessor, what do I need to do when I am assigned a Private Request PAS?

- If the customer is a resident of Arizona, a private request PAS will be entered into the system. You will make an appointment to do a home visit and complete the PAS just as you would any other PAS. If the customer needs to go to physician review, either by rule or if you feel the customer is at risk of institutionalization, you will send it through PR. You will request medical records as usual.
- If the customer is **not** a resident of Arizona, you will need to complete the PAS on paper. You will contact the customer and any caregivers to obtain PAS information. You will request medical records as usual. These assessments also can go through the PR process; however, if the customer does not have solid plans on moving to Arizona, sending it through PR might not be warranted. You will need to discuss this with your HPM and/or PAS QC.

What do I tell the customer about the PAS outcome?

- If the customer is an Arizona resident and you completed the PAS in the system, you can tell the customer that **at this time**, based on the courtesy assessment, they do/do not meet medical eligibility criteria. You need to make it clear that if/when they apply for ALTCS, a new PAS referral will be completed. The private request PAS information **MAY** be used but is not a guarantee of medical eligibility when they apply for ALTCS.
- If the customer is out of state, you can tell them that it appears they do/do not meet the medical eligibility criteria at this time. You need to tell them that if/when they apply for ALTCS; they **will** need another PAS assessment. The private request PAS is not a guarantee of medical eligibility. If they move here and apply, you will need to schedule a home visit and update the PAS with current information. After this visit, the PAS can be entered into the system.

VIII. PAS Completion

Before completing a PAS, the assessor **must** review the system to ensure accuracy of data entry on all screens. All scores must be reviewed for accuracy and the content of comments and summaries must also be reviewed. **If the assessor assigned the PAS is not available to complete the PAS, whoever completes the PAS is responsible for reviewing and ensuring the accuracy of the information as defined above.**

If the assessor feels the customer's condition may improve (e.g., recent fracture or other acute episode) the case should be referred to his/her supervisor prior to completing as a reassessment in six months may be indicated.

Before completing a PAS that has had a Physician Review completed, the assessor must review the physician's comments.

If the assessor questions the physician review decision, the PAS should be discussed with the supervisor, regional or branch manager, and/or ALTCS Eligibility Manager **prior to completion**. It is important to note that the final dispositioning of the case and eligibility determination is done by Financial Eligibility.