OBH/PASRR Level II
Fax Cover Sheet
Fax to OBH ONLY:
877-652-4995

Date Faxed:

Facility Name:

Facility Contact for PASRR Level 2:

Contact Phone:

Contact Fax:

Contact Email:

Individual Name:

9-Digit SSN (000-00-0000):

DOB (MM/DD/YYYY):

Documents Included (check off what was submitted):

- ☐ CURRENT **Face Sheet** from requesting facility
- ☐ CURRENT **MDS (resident reviews)**
- ☐ CURRENT **Comprehensive history and physica**l with **complete medical history**, and in the case of abnormal findings which are the basis of NF placement, **additional evaluations conducted by appropriate specialists.**
- ☐ CURRENT **comprehensive medication history/record**
- ☐ CURRENT **comprehensive psychiatric evaluation** with **complete psychiatric history**, intellectual functioning, memory functioning, and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence of content of delusions) and hallucinations.
- ☐ Current **Psychosocial Assessment** (includes inpatient and outpatient treatment history for MH and SA issues and social history)
- ☐ CURRENT Documentation that supports the **need for nursing facility placement (i.e. physician letter, progress notes)**
- ☐ **Corroborative testing or other information available to verify the presence of and progression of dementia (ie. CT Scan, MRI, testing results...)**
- ☐ **Any additional documentation to support presence of SMI (social work notes, etc…)**
- ☐ **Any additional documentation that supports presence of functional needs that necessitate NF placement (PT, OT, ST notes, assessments, other unit notes…)**

*****OBH may not be able to process your request without the required Level 2 documents.**

OBH PASRR Level II Request for Resident Review – 8/25/21 rev.

*****OBH PASRR Level II Fax Cover Sheet MUST be sent to OBH with this Resident Review Request. It must be filled out and required documentation attached. OBH may not be able to process your request without the required Level 2 documents**

The Office of Behavioral Health (OBH) PASRR Level II office has developed a set of guidelines for Nursing Facilities (NF) to utilize to determine when a Resident Review is required. Please complete this form for each resident for whom you are seeking a Resident Review. This form should be signed and dated by appropriately credentialed staff (LPN, RN, LPC, or LCSW/LMSW) and should include updated contact information (phone and fax number). This form may be reviewed as part of the resident's chart during a Health Standards survey or Office of Behavioral Health monitoring visit. If not completed correctly, your facility *may* be cited by Health Standards for non-compliance with the Preadmission Screening and Resident Review Critical Element Pathways. *If the resident has an expiring authorization for which an extension is needed, please send the Continued Stay Request Form and required supporting documentation via RightFax to the Office of Aging and Adult Services Nursing Facility Admissions Unit [(225) 389-8198 or (225) 389-8197]. Information should be submitted at least 15 calendar days, and no earlier than 30 calendar days, prior to the expiration of the authorization.*

Resident Name: _____ **SS#:** _____ **DOB:** _____

Has the resident received a Level II evaluation by the Office of Behavioral Health (OBH)*?* ☐ Yes ☐ No
If Yes, please respond to question #1 only. If No, please skip to question #2.

1. **If a resident has received a Level II evaluation by OBH (*do not include those residents who have received a determination of a Level II not required due to dementia*);** please check which of the following applies:
   - ☐ The resident experienced Inpatient Psychiatric Stay due to increased behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment
   - ☐ The resident has a new mental health diagnosis, which will not normally resolve itself once the condition stabilizes
   - ☐ The resident has changes to their physical health, which negatively affects their behavioral, psychiatric, or mood-related symptoms, or cognitive abilities impacting their daily living
   - ☐ The resident has experienced a substantial increase to their psychiatric medication regimen to manage increasing psychiatric symptomology
   - ☐ The resident has experienced substantial improvement or decline in functioning that might trigger a significant change on the MDS

   - **A Resident Review is NOT required if NONE of the boxes above are checked**
     - **Nothing needs to be submitted to OBH though a copy of this form should be maintained on the resident's chart.**
   - **A Resident Review IS required if ANY of the boxes above are checked**
     - **Please follow the instructions on page two (2) for submitting the Resident Review.**

2. **If the resident has not received an OBH PASRR Level II evaluation *(include residents regardless of whether or not they were previously identified by the Level I Screen and Determination as having primary dementia)***; please check which of the following apply:
   - ☐ DIAGNOSIS (tier 1): The resident has a diagnosis of Schizophrenia, Bi-Polar d/o, Major Depressive d/o, Schizoaffective or Other Psychotic d/o
   - ☐ DIAGNOSIS (tier 2): The resident has a diagnosis of Depression, Anxiety/Panic d/o, Obsessive Compulsive d/o, Delusional d/o, Trauma-related disorder/PTSD, Somatoform or Personality d/o DURATION/LEVEL OF
   - ☐ DISABILITY: Psychiatric diagnosis/symptomology is not episodic or situational and the resident has experienced one of the following as a result of their psychiatric condition:
     - ☐ Level of Impairment – disorder resulted in functional impairment of life activities **within the past 3 – 6 months** resulting in limitations in one of the following:
       - ☐ interpersonal functioning (e.g. serious difficulty interacting appropriately and communicating effectively, violent outbursts, unable to control behaviors)

Signature required on Bottom of Page 2

- ☐ concentration, persistence, and pace (e.g. inability to complete tasks independently, needs assistance to complete tasks, unable to maintain focus and follow directions)
- ☐ adaptation to change (e.g. difficulty in adapting to changes which negatively impact ability to function independently)

☐ Recent Treatment – **within the past 2 years**, the disorder has resulted in one of the following:

- ☐ inpatient psychiatric hospitalization, partial hospitalization, or intense psychiatric care
- ☐ significant psychiatric episode which resulted in legal intervention, loss of housing/normal living situation, or the need for in home supports to remain in the community

- **A Resident Review is NOT REQUIRED if the following apply:**
  - **The resident does not have either a Tier 1 or Tier 2 Diagnosis**
  - **The resident has a Tier 2 Diagnosis BUT no box in the Duration/Level of Disability Section was checked**

  Note: If Resident Review is NOT required, then nothing needs to be submitted to OBH though a copy of this form should be maintained on the resident's chart

- **A Resident Review is REQUIRED if the following apply:**
  - **The resident has a Tier 1 Diagnosis**
  - **The resident has a Tier 2 Diagnosis AND any box in the Duration/Level of Disability Section was checked**

  Note: If Resident Review is REQUIRED, then please follow the instructions below for submitting the Resident Review

If a Resident Review is required, please fax this sheet along with current versions of the records below to the OBH ProviderLink Fax Number at (877) 652-4995. Please do not send the person's chart in its entirety. A copy of this form should be maintained in the resident's chart for review by Louisiana Department of Health (LDH) staff in the event of a survey or monitoring review.

Records from inpatient stay	Psychiatric evaluation	Results from testing (if applicable)
History and physical	Psychosocial	Most recent MDS
Progress reports	Medication list	NF progress notes

Please read the form in its entirety, completing all sections as requested. If not fully completed and signed, the request will be rejected and returned for resubmission. If you have any questions, please contact the OBH PASRR Level II Office by phone at (225) 342-4827 or via email at OBHPASRR@LA.GOV.

Printed Name of Staff Completing Form		
Credential (must be LPN, RN, LPC or LCSW/MSW)		
Date Submitted:	Phone Number:	Fax Number:

X

Signature of Staff Completing the Form

Before signing this document, verify that the content you are signing is correct. By signing this form, you attest that the information included within is accurate.

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