Appendix B

Request for Proposal
PRI Audit and Hotline
PRI, H/C PRI and Screen Training

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSYTEMS MANAGEMENT
DIVISION OF HEALTH CARE FINANCING
BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT

PATIENT REVIEW INSTRUMENT (PRI) AUDIT AND HOTLINE
PRI, H/C PRI AND SCREEN TRAINING
REQUEST FOR PROPOSAL (RFP)
RFP NO. 0608071010

Bid Opening: DECEMBER 1, 2006

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k,the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

Mr. Terrence P. Cullen
Health Care Finance Program Manager 2
Bureau of Financial Management and Information Support
Room 984 Corning Tower
Empire State Plaza
Albany, New York 12237-0719

Mr. Robert Loftus
Principal Health Care Fiscal Analyst
Bureau of Financial Management and Information Support
Room 984 Corning Tower
Empire State Plaza
Albany, New York 12237-0719

Permissible Subject Matter Contacts:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health also identifies the following allowable contacts for communications related to the following subjects:

Submission of written proposals or bids:
Submission of Written Questions:
Participation in the Pre-Bid Conference:
Debriefings:
Negotiation of Contract Terms after Award:

Mr. Frank A. Czernicki
Associate Health Care Fiscal Analyst
Bureau of Financial Management and Information Support
Room 984 Corning Tower
Empire State Plaza
Albany, New York 12237-0719

For further information regarding these statutory provisions, see the Lobbying Statute summary in Section E, 10 of this solicitation

September 18, 2006

Dear Potential Bidder:

Re: Request for Proposal
PRI Audit and Hotline
PRI, H/C PRI and Screen Training

The reimbursement system for Residential Health Care Facilities in New York State utilizes a resident classification system known as Resource Utilization Groups (RUGs) II. The classification of each resident is based on responses provided on the Patient Review Instrument (PRI), as submitted by each nursing facility. This direct connection between the PRI and reimbursement makes it necessary to audit the PRI. Furthermore, to assist facilities in completing the PRI, a clinical hotline must be maintained.

Both the PRI and the Hospital/Community (H/C) PRI must be completed by a registered nurse who has completed PRI training and been granted an assessor number. The Screen must be completed by a person who has completed a training program and been granted a screener number. To ensure that these forms are completed correctly, training must be provided.

The New York State Department of Health and Health Research Incorporated are seeking a contractor with the necessary clinical and administrative expertise to provide the PRI audit, the hotline and the training functions. The Request for Proposal (RFP), issued by the Bureau of Financial Management and Information Support, which details the required activities, will be posted on the Department of Health's website at www.health.state.ny.us/funding/ on September 18, 2006. Bidders wishing to receive these documents via mail must send a request, in writing, to the Department at the address provided at the bottom of this letter. Any qualified organization is invited to submit a proposal.

A bidder's conference will be held on October 10, 2006, from 11:00 am to 2:00 pm in room 915 of the Corning Tower at the Empire State Plaza. Questions regarding this RFP will be answered only at this time, and may be submitted in writing prior to the date of the conference. Because of building security, you will need to enter the building on the Concourse level and receive a building pass. You must let us know in advance the names of anyone who will be attending the conference from your organization. Please call Ms. Lynne Ryan, at (518) 486-1371, by 4:00 pm on October 2, 2006, to register.

Potential bidders that submit a letter of intent to file a proposal will automatically receive questions and answers, minutes of the bidder's conference, and any updates/amendments to the RFP. This letter should be received by October 30, 2006, and may be faxed to (518) 473-8825 in advance of the original letter.

Proposals in response to this RFP must be received at the address below by 2:00 P.M. on December 1, 2006. The successful bidder must be ready to assume all functions beginning on April 1, 2007.

Requests to receive the RFP via mail, questions for the bidder's conference, the letter of intent, and the proposal itself should be sent to:

PRI Audit & Hotline, PRI, H/C PRI & Screen Request for Proposal
Mr. Robert Loftus, Principal Health Care Fiscal Analyst
New York State Department of Health
Bureau of Financial Management and Information Support
Room 984, Corning Tower, Empire State Plaza
Albany, New York 12237-0719

Thank you in advance for your interest in this project. We look forward to seeing you at the bidder's conference and receiving your proposal.

Sincerely,

Richard Pellegrini
Director
Bureau of Financial Management
and Information Support

TABLE OF CONTENTS

SECTION	PAGE
A. Introduction	1
B. Background	1
C. Detailed Specifications	2
1. Scope of Work	2
1.1 General	2
1.2 Prices to Provide Services	2
1.3 Estimated Volume	3
1.4 Project Manager	4
1.5 Quality Control	4
1.6 Utilization Reports	5
1.7 Continuing Education Credits	5
1.8 Dry Run Training Sessions	5
2. PRI On-Site Review	5
2.1 Background	5
2.2 Administrative Tasks	6
2.3 On-Site Reviewer Tasks	6
3. Hotline	7
3.1 Background	7
3.2 Administrative Tasks	7
3.3 Hotline Tasks	8
4. PRI and H/C PRI Training and Certification	8
4.1 Background	8
4.2 Administrative Tasks	8
4.3 Training Tasks	8
5. Screen Training and Certification	9
5.1 Background	9
5.2 Administrative Tasks	9
5.3 Training Tasks	10
D. Proposal Requirements	10
1. Proposal Format and Content	10
1.1 General Information	10
2. Proposal Requirements	11
2.1 Table of Contents	11
2.2 Overall Project Manager/Assistant Project Manager	11
2.3 Audit and Hotline	11
2.4 Training	13
3. Evaluation of Proposals	14
3.1 Method of Award	14
3.2 Evaluation Criteria for Technical Proposals	14
3.3 Evaluation Criteria for Financial (Cost) Proposals	15
3.4 Final Score	15

E. Administrative 15
1. Issuing Agencies 15
2. Inquires 15
2.1 Questions/Updates 15
2.2 Bidders' Conference 16
3. Letter of Intent 16
4. Submission of Proposals 16
5. State/HRI Reserved Rights 17
6. Payment 17
6.1 Submission of Invoices 17
6.2 Billing Guidelines 17
7. Term of Contracts 19
8. Debriefing 19
9. Vendor Responsibility Questionnaire 19
10. State Consultant Services Reporting 19
11. Lobbying Statute 20
12. Additional Terms and Conditions 21
12.1 Cost Liability 21
12.2 Acceptance of Proposal Content 21
12.3 Oral Presentation 21
12.4 Prime Contractor Responsibilities 22
12.5 Price Changes 22
12.6 Press Releases 22
12.7 Ownership of Products 22
12.8 Meeting Between Contractor and DOH and/or HRI 22
12.9 Confidentiality 22
12.10 Posting Performance Bond 23
12.11 Changes in Scope of Contract 23

F. Appendices 23

Appendix A – Standard Clauses for New York State Contracts
Appendix B – PRI Audit & Hotline, PRI, H/C PRI & Screen Training RFP
Appendix C – Contractor Proposal
Appendix D – General Specifications
Appendix E – Worker's Compensation/Disability Benefits
Appendix H – Federal Health Insurance Portability & Accountability Act (HIPAA) Business Associate Agreement
Appendix X – Modification Agreement Form
Appendix G – Attachments

G. Attachments 25

Attachment 1 – Generic Sample Training Contract
Attachment 2 – Current Versions of Forms- PRI, H/C PRI, & Screen
Attachment 3 – PRI Instructions, PRI Clarification Sheets, & H/C PRI Instructions

Attachment 4 – Screen Instructions
Attachment 5 – Text of PRI Audit Areas
Attachment 6 – New York State Department of Health Bid Form
Attachment 7– N.Y. S. Office of the State Comptroller Vendor Responsibility Questionnaire
Attachment 8 – N.Y.S. Taxation and Finance Contractor Certification Form ST-220
Attachment 9 - State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term
Attachment 10- State Consultant Services Form B, Contractor's Annual Employment Report

Request for Proposal
PRI Audit and Hotline
Training Program for PRI, H/C PRI and Screen

A. Introduction

The New York State Department of Health, hereinafter referred to as DOH, is seeking a sole contractor to provide the State mandated on-site review, or audit, of the Patient Review Instrument (PRI) submitted to DOH for reimbursement purposes, and to provide a hotline to answer questions regarding the completion of the PRI, the Hospital/Community PRI and the Screen.

Health Research, Incorporated, hereinafter referred to as HRI, a domestic not-for-profit corporation, is seeking a sole contractor to provide training programs to health care professionals in long term care, home health care and acute care hospitals for the purposes of meeting the State/Federally mandated requirements for the PRI, the Hospital/Community PRI (H/C PRI) and the Screen.

While the same sole contractor will be expected to provide both functions, the determination will result in the award of two contracts.

The contract for audit and hotline functions will be administered by DOH. The Bureau of Financial Management and Information Support (BFMIS), part of the Division of Health Care Financing in the Office of Health Systems Management, will be responsible for monitoring and approving the services provided under this contract.

The contract for training will be administered by HRI. The Division of Health Care Financing and the Division of Quality Assurance and Surveillance, also in the Office of Health Systems Management, will be responsible for monitoring and approving service provided under this contract. A sample generic contract is included as Attachment 1. The actual contract may vary.

The RFP has been prepared by BFMIS, and consists of seven sections: introduction; background; detailed specifications; proposal requirements; administration; appendices; and attachments.

Copies of the current version of the PRI, the H/C PRI, and the Screen are attached as Attachment 2.

B. Background

The reimbursement system for Residential Health Care Facilities in New York State utilizes a resident classification of each resident based on the responses provided on the PRI, as submitted by each facility. Due to their reimbursement implications, it is necessary that the PRI submissions receive periodic on-site reviews. The PRI audit ensures that the form has been completed accurately and in compliance with the instructions.

To help interpret the instructions for PRI completion, and to help maintain the reliability of the data, a hotline must be maintained. This hotline will also address questions relating to both the H/C PRI and the Screen.

The H/C PRI is utilized for preadmission review of persons in a hospital or living in community based residences who apply for admission to a nursing facility.

The Screen is utilized for the Preadmission Screening and Resident Review (PASSAR), a review of individuals with possible mental illness (MI) and/or mental retardation (MR) or related conditions. The Screen is also utilized to determine a person's potential to be cared for outside a nursing facility setting.

To foster uniformity in completing the forms, training leading to either an assessor or screener number is required.

Recently enacted statutory provisions contained in Chapter 109 of the Laws of 2006 delete the requirement that nursing homes submit PRIs in 2007 and 2008. Nursing homes are, however, authorized to submit full house PRIs if they have a case-mix increase greater than .05. Upon doing so, they are then required to submit full house PRIs for the remainder of 2007 and 2008. Effective 2009, no new PRI submissions will be required and the State will transition reimbursement to the Minimum Data Set (MDS). There has been no change to the filing requirements for PRI submissions for 2006.

It is unclear at this time how much these statutory changes will decrease PRI audit volume over the course of the contract, but it must be mentioned that the backlog in unprocessed PRIs that have yet to be selected for audit will mitigate the decrease in the near term. The effect of these statutory changes on the need for PRI training in 2007 and 2008 are also unclear, but it is important to note that training in the HC/PRI and Screen are not affected.

C. Detailed Specifications

1. Scope of Work

1.1 General

The tasks to be performed under these contracts include PRI audit, PRI hotline, PRI and H/C PRI training, and Screen training. The RFP and resulting contracts require that the contractor perform all activities related to all four of these activities.

1.2 Prices to Provide Services

The prices to provide the services required under this RFP must include all associated costs to the contractor.

For the audit program, the prices must be divided into a fixed price and variable prices. In determining a fixed price, bidders should include costs related to fulfilling administrative and hotline functions. These would include, but not be limited to, office expenses, salary and fringe benefits for the project supervisor and hotline nurse, and secretarial support. In determining the variable prices, bidders should include costs related to the actual performance of the on-site review. These would include, but not be limited to, salary and fringe benefits and travel

expenses for the auditor.

Bidders are reminded to take into account the costs of physically handling the audits. Currently, the audits are printed by DOH. They are then mailed to the contractor for distribution to the reviewers. Upon completion, each audit packet must be mailed back to DOH for processing. In addition, a listing of the residents to be reviewed must be sent to each facility, via facsimile, three (3) business days prior to the scheduled audit.

For the training programs, the contractor will propose a participant registration fee for each program. The registration fee may vary with program costs and volume. Registration fees may also vary with location. The registration fee will cover 100% of the contractors costs in meeting the terms and conditions of the training contract. Bidders should consider the following costs: administrative overhead, trainers' compensation, travel to Albany for meetings with HRI/DOH staff, travel to training sites, and training costs such as lunch for participants, meeting room fees, audio-visual equipment rental or purchase, and printing and mailing of training materials, inflation, and fees associated with the awarding of continuing education credits (see Section C-1.7).

For PRI and H/C PRI training the bidder must allow up to two New York State employees to attend per session, on a space available basis, at no cost to the State. For Screen training the bidder must allow up to five New York State employees to attend per session, on a space available basis, at no cost to the State.

When setting a participant registration fee, bidders should take into account the costs of reproducing or printing the forms and instruction materials. The number of pages in each is shown in the following table:

	PRI	H/C PRI	Screen
Form	4	4	4
Instructions	22	16	67
Clarifications	35		

A limited number of theses materials will be provided to the contractor.

The instructions for both PRIs and the Clarification Sheet are included as Attachment 3. Screen Instructions are included as Attachment 4.

1.3 Estimated Volume

DOH has estimated the annual number of audit days during the contract period. This estimate includes New York City and Long Island in a downstate region, with all other counties considered to be upstate. A total of 1100 annual audit days are projected for the contract period. They are divided as follows:

	Upstate	Downstate
Stage I	320	320
Stage II	200	200
Stage III	30	30
	550	550

While the total amount billed cannot exceed the contract dollar amount, the days to be billed are not required to meet this estimated pattern.

It is estimated that there will be approximately 140 hotline calls per month.

A one day training session will be scheduled every six months in each of the major five regions in New York State, i.e., New York City, Long Island, Albany, Syracuse, and Rochester/Buffalo, for PRI training. It is estimated that there will be 50 participants at each session, for a total of 500 participants annually. Additional sessions may be scheduled as demand warrants.

A one day training session will be scheduled every six months in each of the major five regions in New York State, i.e., New York City, Long Island, Albany, Syracuse, and Rochester/Buffalo, for Screen training. It is estimated that there will be 75 participants at each session, for a total of 750 participants annually. Additional sessions may be scheduled as demand warrants.

Times and places for the training programs and the minimum and maximum number of program participants at each session will be mutually decided by HRI/DOH and the contractor.

The contractor agrees to notify HRI and DOH of scheduled sessions that are cancelled due to lack of registration, such notification to occur at least two weeks prior to the scheduled date.

1.4 Project Manager

A project manager will be appointed by the contractor and approved by DOH and HRI. This manager will have the authority to speak for the contractor. The project manager will be the primary person with whom DOH and HRI conduct day-to-day business relating to the tasks to be performed under these contracts. It is expected that the project manager will have the ability to resolve quickly any problems that arise during the contract period.

1.5 Quality Control

The contractor will have a mechanism to assure quality control.

For the audit and hotline functions this may include, but is not limited to, review of audit reports, review of hotline answers, visiting audit sites, training sessions, and confidentially issues.

For the training programs, the mechanism will include program evaluation by the participants.

The quality control of all printed materials will reside with the contractor. If HRI/DOH determines that materials are not of adequate quality, the contractor will be required to correct the problem and replace inferior materials. All training materials will be free of errors.

The contractor will be responsible for the printing of all materials. The contractor will provide for proofing of camera-ready versions of all material with an accompanying letter of assurance.

1.6 Utilization Reports

The contractor will prepare and provide DOH with monthly utilization reports for the audit and hotline functions. For the Hotline function, these should indicate the name of the caller, as well as the number and general area of the questions. For the audit function, the reports should indicate the facility name, the reviewer name, the audit stage, and a commentary on the review.

The contractor will prepare and provide both HRI and DOH with monthly reports of all the training sessions conducted under this contract. These reports will include the number of people attending, the types of questions received, responses made and concerns of the trainers/attendees. The report will be received by HRI and DOH no more than 30 days following the last day of the month.

1.7 Continuing Education Credits

The contractor will apply to the appropriate professional organizations for permission to award continuing education credits to participants in the training sessions. Participants will include administrators, nurses, dietitians, social workers, physical therapists, physicians, occupational therapists, speech pathologists and other disciplines.

1.8 Dry Run Training Sessions

The contractor will conduct dry run training sessions at the Department's request. The scheduling and order of the dry runs will be negotiated between DOH and the contractor. The dry runs may result in changes to the training programs, which will be implemented for all actual training sessions.

2. PRI On-Site Review

2.1 Background

Because of its use in reimbursement, it is essential that the responses to PRI questions be uniform and accurate. The on-site review process is designed to ensure this.

DOH collects the PRI data submitted by nursing facilities on a scheduled basis for processing. As part of processing, all facilities are occasionally selected for audit. DOH will select the facilities to be audited, the specific residents at those facilities to be reviewed, and the particular questions from the PRI for which answers must be verified.

The audit process is designed in stages. All facilities undergo a Stage I review. Generally forty residents are selected (one audit day), but eighty are selected if the facility has 350 or more beds. The Activities of Daily Living (ADL) area of the PRI is reviewed for all residents selected for audit. Additional areas are reviewed for approximately 40% of the residents selected for audit. All of the review questions follow the PRI questions, verifying especially that selected qualifiers are met. The texts of all the audit areas are attached as Attachment 5. Based on the responses of the auditor, DOH will determine whether the facility has passed or failed the audit. In the case of a failure, there will be a Stage II review, for which generally an additional 80 residents are selected. In the case of a second failure, the remaining residents are selected for a Stage III audit. On Stages II and III, both ADL and hierarchy questions are reviewed for all residents selected. Additionally, at

Stages II and III, the facility is entitled to present evidence to challenge the auditor's findings on the immediately previous stage. If a facility's audit scope does not permit a Stage II or Stage III audit, an exit conference review will be scheduled at which time the facility will have an opportunity to present evidence to challenge the auditor's findings from the failed previous Stage review.

2.2 Administrative Tasks

The contractor must recruit and train a sufficient number of qualified personnel. There must be enough auditors to ensure a timely processing of the audits generated, and to ensure that a different auditor completes each stage review at any given facility. The minimum qualifications for PRI auditor are:

- Must be a registered nurse certified as a PRI assessor
- Must have recent experience in resident chart review, including the completion of Patient Review Instruments or a similar resident assessment form
- Must have a positive attitude and conscientious approach to data review
- Must have strong communication skills

The contractor must develop a work plan and schedule all on-site reviews. This includes notifying both the facility and the reviewer. The audits generated by DOH must be distributed to the reviewer, then returned to DOH after completion of the on-site review.

The contractor must monitor on-site review activities in facilities statewide. This includes review of written reports as well as direct observation in the facilities to ensure that audits are completed in a timely, accurate and consistent fashion. It also includes ensuring that confidentiality of resident and facility information is maintained.

The contractor must respond to inquiries from facility representatives regarding the on-site reviews. The contractor must provide monthly written reports for DOH identifying the status of on-site reviews.

The contractor must maintain continuing liaison with DOH to ensure timely and accurate coordination of functions.

2.3 On-Site Reviewer Tasks

The reviewer must travel to facilities located throughout the state. The reviewer is expected to hold an entrance conference upon arriving at the facility. This would include introductions, statement of purpose, and settling in to the room or area designated for the review. The reviewer must, during a Stage I audit, verify the facility census for the last day of the assessment period.

The reviewer must locate the medical records for each resident to be reviewed. The facility is notified of the time period to be reviewed when the audit is scheduled, but not which residents are to be reviewed until three (3) business days prior to the scheduled audit.

The reviewer must ascertain the accuracy of PRIs prepared and submitted by nurse assessors employed by nursing facilities. To do so reviewers must answer the questions that have been generated by DOH, for the selected residents, exclusively through a review of medical record documentation. Two additional approaches, used in combination with the medical record

review, are acceptable: discussion with direct care staff and resident observation. Information secured through staff discussion and/or resident observation should not result in audit determinations that are not unsupported by the medical record. Review of medical records is the primary review mechanism.

On all Stages of audit, the reviewer is provided with the facility's response to the audit questions.

The reviewer must, on Stages II and III, additionally review those items controverted on the previous stage. The auditor will be aware of which residents were reviewed on the previous stage, as well as the responses of both the facility and the previous reviewer. The facility must notify the auditor on arrival of those responses for which it requests further review, and present documentation to support that request.

The reviewer must, on all Stages, conduct an exit conference with facility personnel to discuss audit findings. On all Stages, the reviewer must prepare a report of the facility visit. This must comment on general findings and observations at the facility. This report must be sufficient to address later facility inquiries regarding the review.

3. Hotline

3.1 Background

The Hotline was established by the State to provide assistance to facility assessors who, having read the instructions, are still unsure of the correct answer to a PRI question. It has been expanded to provide clinical expertise and support for completion of the PRI, the Hospital/Community PRI, the Screen and the PRI on-site review.

3.2 Administrative Tasks

The contractor must recruit and train personnel to answer the Hotline phone. The minimum qualifications are:

- Must be a registered nurse.
- Must have a thorough working knowledge of the PRI, H/C PRI, Screen, and PRI audit.
- Must have strong communication skills to understand the questions posed and convey an accurate response.

The contractor must develop a work plan to ensure a timely and accurate response to queries received. This includes the establishment of a telephone number to be conveyed to the facilities.

The contractor must monitor the responses to the Hotline calls to ensure that calls are handled in a timely, accurate and consistent fashion.

The contractor must prepare monthly written reports for DOH identifying the volume and nature of calls. The contractor must maintain continuing liaison with DOH to ensure timely and accurate coordination of functions.

3.3 Hotline Tasks

The Hotline responder must answer all administrative and clinical questions posed by callers about completion of the PRI, H/C PRI and Screen, or about the audit. The Hotline responder must log all calls received, noting the name or facility association of the caller as well as the question asked and the response given.

4. PRI and H/C PRI Training and Certification

4.1 Background

Both PRI forms must be completed by a registered nurse (RN) who has a PRI assessor number. The purpose of this training is to provide detailed information for completing the forms and issue assessor numbers. The training must address who may complete the forms, when they are completed, and item definitions, all in a one-day training session.

4.2 Administrative Tasks

The contractor must make all arrangements to conduct the training sessions, including providing space for the training, registering participants, and issuing assessor numbers. Training must be conducted with the frequency detailed in Section C-1.3.

At the completion of the training session, participants will be issued certificates of attendance. The contractor will issue and mail a certification card with a five-digit identification number to each participant at a later date after payment has been confirmed. This certification card will allow the participant to complete the PRI and the H/C PRI. Any individual certified to complete the PRI and the H/C PRI must be a registered professional nurse.

The contractor will be responsible for all aspects of updating and maintaining the PRI and H/C PRI Certification File, subject to review and approval by HRI/DOH. The PRI and H/C PRI Certification File will reside with the contractor but will be the property of HRI/DOH. Upon completion or termination of the contract, the PRI and H/C PRI Certification file shall be retained by HRI/DOH.

The contractor must recruit and train a person to provide the training. The minimum qualification for the trainer are:

- Must be a registered nurse
- Must have a PRI assessor number
- Must have strong communication skills

If the forms appended to this RFP are modified during the term of this contract, the training program may also need to be changed. The contractor will make any necessary changes at no cost to HRI or DOH. The contractor will also be responsible for assisting the DOH with any necessary revisions to the form and instructions.

4.3 Training Tasks

The following descriptions of anticipated training program content are provided for initial guidance purposes only. Bidders are expected to provide more substance and detail in their proposals and may add topics to be included in the training as they see fit. At a minimum, the following topics must be addressed:

- **Introduction and Overview**
  This section of the training must provide a history of the RUG II process, reimbursement uses of the PRI, and other uses of the PRI.

- **Detailed Instructions for Each Question**
  This section of the training must provide detailed explanations for the instructions for each question on the PRI. This should include a discussion of the documentation requirements.

- **Determining the RUG-II Assignment from PRI Items**
  This section of the training must address assigning the hierarchy, the ADL index, and the final RUG. It must include scoring exercises. This section must also include the impact of PRI scoring on reimbursement.

- **Questions and Answers**

5. SCREEN Training and Certification

5.1 Background

The Screen must be completed by a person who has a Screener number. The purpose of this training is to provide detailed information for completing the form, and to issue the Screener number. The training must address specific item definitions and who may complete the form and when. This will include particular emphasis on the pre-admission screening and significant change reporting.

5.2 Administrative Tasks

The contractor must make all arrangements to conduct the training sessions, including providing space for training, registering participants, and issuing screener numbers. Training must be conducted with the frequency detailed in Section C-1.3.

At the completion of the training session, participants will be issued certificates of attendance. The contractor will issue and mail a certification card with a six-digit identification number to each participant at a later date after payment has been confirmed. This certification will allow the participant to complete the SCREEN Instrument.

The contractor will be responsible for all aspects of updating and maintaining the SCREEN Certification File, subject to review and approval by HRI/DOH. The SCREEN Certification File will reside with the contractor but will be the property of HRI/DOH. Upon completion or termination of the contract, the SCREEN Certification file shall be retained by HRI/DOH.

The contractor must recruit and train personnel to provide the training. The minimum qualifications for the trainer are:

- Must have a Screener number
- Must have strong communication skills

If the form appended to this RFP is modified during the term of the contract, the training program may also need to be changed. The contractor will make any necessary changes at no cost to HRI or DOH. The contractor will also be responsible for assisting DOH with any necessary revisions to the form and instructions.

5.3 Training Task

The following description of anticipated training program content are provided for initial guidance purposes only. Bidders are expected to provide more substance and detail in their proposals, and may add topics to be included in the training as they see fit. At a minimum the following topics must be addressed:

- Omnibus Reconciliation Act (OBRA) mandates regarding assessing individuals for mental illness and mental retardation and related conditions.
- State requirements for assessing individuals including (a) the Preadmission Screen Process and completion time frames, and (b) Significant Change reviews and completion time frames.
- How to use the SCREEN Instruction Manual and SCREEN Instrument.
- Questions and answers.

D. Proposal Requirements

1. Proposal Format and Content

1.1 General Information

The proposal as prepared and submitted by the bidder is HRI/DOH's sole vehicle for obtaining essential information on which contract award decisions are based.

The information required to be submitted in all proposals has been determined by HRI/DOH to be essential for use by HRI/DOH in the bid evaluation and contract award process. HRI/DOH will use this information as a basis for determining which bidder has offered HRI/DOH the most advantageous bid, price and other factors considered.

Bidders are cautioned that failure to submit at the appropriate level of required information could result in a determination that the bidder's proposal is non-responsive to RFP requirements. Such a determination may deem the proposal ineligible for contract award consideration.

Bidders are advised to thoroughly read and understand the RFP prior to preparing and submitting their bid. Submission of a proposal indicates acceptance by the bidder of all the conditions contained in this RFP. By submitting a proposal, the bidder covenants that he or she will not make any claims for or have any rights to damages because of any misinterpretation or misunderstanding of the specifications.

Proposals must be complete and must meet all RFP terms and conditions at the time of initial submission. Proposals that are incomplete at time of submission will not be considered.

The proposal must be clearly labeled “ORIGINAL”.

The proposal must be bound in four volumes, and properly numbered. Volume One, labeled "Audit and Hotline Technical Approach" must contain no financial information or dollar values for the audit and hotline function (see Section D-2.3). Volume 2, labeled "Audit and Hotline Cost Proposal" must contain all financial and cost information for the audit and hotline function (see Section D-2.3). Volume Three, labeled "Training Technical Approach" must contain no financial information or dollar values for the training function (see Section D-2.4). Volume Four, labeled "Training Cost Proposal" must contain all financial and cost information for the training function (see Section D-2.4). The four volumes must be submitted in four separately sealed packets, clearly marked Audit and Hotline Technical Approach, Audit and Hotline Cost Proposal, Training Technical Approach, and Training Cost Proposal respectively.

2. Proposal Requirements

Proposals must include the following:

2.1 Table of Contents

A detailed Table of Contents must be included in each Volume.

2.2 Overall Project Manager/Assistant Project Manager

The bidder will identify an overall project manager and overall assistant project manager to be assigned to the contracts awarded as a result of this RFP.

2.3 Audit and Hotline – Part 1

- **Volume 1 Technical Approach**

Regarding Volume 1, this volume will describe the bidder's approach and plans for accomplishing the work required under the terms of the audit/hotline contract and must address the technical approach to the audit/hotline project. This part should include:

- An introduction outlining the bidder's technical approach to complete the audit/hotline project and illustrating their understanding of the problem the project is intended to solve.

- The effort and skills necessary to complete this project.

- A detailed task-by task description of how the work will be accomplished. The plans and approaches for each task will be described in sufficient detail to permit the Department to evaluate them fairly with a minimum of possible misinterpretation.

- A section titled "Organizational Support and Experience". This section will document the bidder's capability and competence to fulfill the terms of the audit/hotline contract. This section should include:

  - A chart of the bidder's organization that shows the level of responsibility within that organization for key project members along with a specific chart of the project organization with names.
  - A list of personnel to be assigned, their function on the project and a detailed resume for each person assigned showing quantified

experience which should include at least one year of experience in long term care. For the audit/hotline project, ideally this should include at least one year of experience with the PRI, or similar patient assessment form. Include capabilities for recruitment and training of personnel. Identify procedures for ensuring that a different reviewer does each different audit stage at any facility that proceeds to an Exit Conference Review, Stage II and/or Stage III audit. Include capabilities for obtaining substitute personnel, as required.

- Documentation that clearly shows the bidder's experience in performing similar projects. Include documentation regarding experience in development, scheduling, telephone communication, training, and administration.

- A list of names and addresses of clients including the types of services previously provided which are similar to those requested by this RFP. DOH reserve the right to contact these individuals and/or organizations to verify the services performed as well as the adequacy of these services.

- Position descriptions and vitae for all personnel who will carry out the work required under the contract; DOH may request additional information on these items for clarification purposes.

- **Volume 2 Cost Proposal**

Regarding Volume 2, this volume will contain all information related to prices, fees, and other financial matters addressing the price of the audit and hotline function.

The bidder must prepare fee schedules that state clearly and separately the prices of the two programs – PRI audit, PRI hotline- for the three-year contract period. Further, the bidder must prepare schedules showing the prices for the audit and hotline programs on a combined basis. All price schedules for these programs must clearly differentiate between fixed and variable prices. The bidder must prepare a schedule showing the fixed price for the PRI audit and PRI hotline programs on both a monthly and annual basis. Under this contract, it is expected that payment for the indirect or fixed costs, including such items as office expense and administrative salary and fringe benefits, will be billed at the fixed amount each month. The direct or variable costs, including salary and fringe benefits for on-site reviewers will be paid on a per audit day basis. It is expected that there be separate per diem rates for Downstate which includes New York City and Long Island and Upstate which includes the rest of New York State. Include a certified financial statement or annual report for the bidder's most recent fiscal year.

Bidders should include one page, clearly marked as a summary, which lists individually the following items:

- Audit and hotline function monthly and annual amount of the fixed or indirect price
- The proposed per diem for upstate audits
- The proposed per diem for downstate audits

2.4 Training – Part 2

- **Volume 3 Technical Approach**

Regarding Volume 3, this volume will describe the bidder's approach and plans for accomplishing the work required under the terms of the training contract and must address the technical approach to the training project. This part should include:

- An introduction outlining the bidder's technical approach to complete the training project and illustrating their understanding of the problem the project is intended to solve.

- The effort and skills necessary to complete this project.

- A detailed task-by task description of how the work will be accomplished. The plans and approaches for each task will be described in sufficient detail to permit the Department to evaluate them fairly with a minimum of possible misinterpretation.

- A section titled "Organizational Support and Experience". This section will document the bidder's capability and competence to fulfill the terms of the training contract. This section should include:

  - A chart of the bidder's organization that shows the level of responsibility within that organization for key project members along with a specific chart of the project organization with names.
  - A list of personnel to be assigned, their function on the project and a detailed resume for each person assigned showing quantified experience which should include at least one year of experience in long term care. For the training project, ideally this should include at least one year of experience with the PRI, or similar patient assessment form. Include capabilities for recruitment and training of personnel. For both training programs (PRI, H/C PRI and Screen) this should also include at least one year of teaching or training experience. Include capabilities for obtaining substitute personnel, as required.
  - Documentation that clearly shows the bidder's experience in performing similar projects. Include documentation regarding experience in development, scheduling, telephone communication, training, and administration.

- A description of the distribution process for training program announcement and registration materials and their return, including a mechanism for assurance of delivery and quality control.

- A description of the proposed training program for each of the program areas (PRI, H/C PRI and SCREEN), including course outline(s), visual aides and other media, behavioral objectives, and evaluation design. Merely reiterating course content as outlined in the RFP is not acceptable.

- A list of names and addresses of clients including the types of services previously provided which are similar to those requested by this RFP. DOH and HRI reserve the right to contact these individuals and/or organizations to verify the services performed as well as the adequacy of these services.

- Position descriptions and vitae for all personnel who will carry out the work required under the contract; personnel will be available for interviews by DOH and HRI.

- **Volume 4 Cost Proposal**

Regarding Volume 4, this volume will contain all information related to prices, fees, and other financial matters addressing the price of the training function.

The bidder must prepare fee schedules that state clearly and separately the costs of the two programs – PRI, H/C PRI training, and SCREEN training- for the three-year contract period. Further, a combined annual Cost Schedule for both programs must also be included in the proposal. The bidder must prepare schedules for the training programs, which clearly show the relationship between total program cost and the registration fees described in Section C-1.2 of this RFP. The bidder should be aware that HRI will add a fee to the costs stated by the contractor. This fee will be added to the registration fee proposed by the bidder and will be utilized by HRI to offset its costs to administer the contract. Include a certified financial statement or annual report for the bidder's most recent fiscal year.

Bidders should include one page, clearly marked as a summary, which lists individually the following items:

- The proposed fee for PRI, H/C PRI training
- The proposed fee for SCREEN training

3. Evaluation of Proposals

3.1 Method of Award

All complete and responsive (see Section D-1.1) proposals will be evaluated by DOH/HRI with the assistance of other State agencies as appropriate. At the discretion of the DOH/HRI, all bids may be rejected. The evaluation of the bids will include the following considerations:

3.2 Evaluation Criteria for Technical Proposals

The following general criteria, not necessarily listed in order of significance, will be used to evaluate the overall technical proposal (combining the audit/hotline and training technical approaches). Each proposal will be independently evaluated by three people. A five-point scale

will be used to rate each proposal on each of nine criteria (see a-i below). The score assigned to each criterion will be weighted. The weights are shown in parentheses following each criterion.

a) Proposal organization (1)
b) Proposal completeness (1)
c) Proposal clarity and conciseness (1)
d) The bidder's understanding of the technical tasks associated with the projects (2)
e) The bidder's understanding of the forms and the instructions for completing them (2)
f) The bidder's understanding of the substantive areas to be taught (2)
g) The qualifications and quantified experience of personnel to be assigned as shown on the required staff resumes (2)
h) The bidder's past performance on projects of similar scope and size (2)
i) The appropriateness of both the project's organizational chart and the number of staff assigned to the projects (1)

3.3 Evaluation Criteria for Financial (Cost) Proposals

The financial proposals will be evaluated separately and independently from the Technical proposals. The bidder with the overall lowest total price (combining the audit/hotline and training cost proposals), as determined by the Department, will receive the maximum score. Other bidders will receive a proportionally lower score.

3.4 Final Score

For the Technical proposal, the final weighted scores of the three reviewers will be averaged, and all scores normalized. This technical score will account for 75% of the total final score. The financial proposal will contribute 25% to the final score. The contract will be offered to the bidder with the highest final score. If two or more proposals have the same final score, the proposal with the highest financial score will be offered the contract.

E. Administrative

1. Issuing Agencies

This RFP is a solicitation issued by the New York State DOH and HRI. The Department and HRI are responsible for the requirements specified herein and for the evaluation of all proposals.

2. Inquiries

2.1 Questions/Updates

Any questions concerning this solicitation must be directed to:

PRI Audit & Hotline, PRI, H/C PRI & Screen Request for Proposal
Mr. Robert Loftus, Principal Health Care Fiscal Analyst
New York State Department of Health
Bureau of Financial Management and Information Support
Room 984, Corning Tower Building
Empire State Plaza
Albany, New York 12237-0719

Questions and answers as well as any updates and/or modifications, will be posted on the Department of Health's website at www.health.state.ny.us/funding by November 3, 2006. Bidders wishing to receive these documents via mail must send a request, in writing, to the Department at the address above.

2.2 Bidders' Conference

A bidders conference will be held from 11:00 am to 2:00 pm on October 10, 2006 in the 9th floor conference room 915, of the Corning Tower, at the Empire State Plaza. Prior registration is required to attend. To register, please contact Ms. Lynne Ryan, Bureau of Financial Management and Information Support, (518) 486-1371, by 4:00 p.m. October 2, 2006.

Any bidder wishing to pose a question at the bidders' conference shall send questions in advance for receipt at the address above no later than 4:00 p.m., October 2, 2006. Questions posed verbally during the bidders' conference may not be answered immediately. However, all potential bidders that submit a letter of intent to file a proposal will automatically receive questions and answers, minutes of the bidder's conference, and any updates/amendments to the RFP.

All answers furnished during the bidders' conference will not be official until confirmed in writing.

3. Letter of Intent

All potential bidders that submit a letter of intent, to file a proposal will automatically receive questions and answers, minutes of the bidder's conference, and any updates/amendments to the RFP. The letter of intent should not exceed two pages and should contain the title of the project, name and phone number of the project manager. The letter of intent should be submitted to DOH, at the address in Section E-2.1 above, no later than October 30, 2006.

4. Submission of Proposals

Interested vendors should submit ten signed copies of their Bid proposal not later than 2:00 P.M. on December 1, 2006. Responses to this solicitation should be clearly marked as indicated in Section D-1 directed to:

Mr. Robert Loftus, Principal Health Care Fiscal Analyst
New York State Department of Health
Bureau of Financial Management and Information Support
Room 984, Corning Tower Building
Empire State Plaza
Albany, New York 12237-0719

It is the bidders' responsibility to ensure that bids are delivered to Room 984, Corning Tower Building, prior to the date and time of the bid opening. Late bids due to delay by the carrier or not received in the Department's mail room in time for transmission to Room 984 will not be considered.

The Bid Form, included as Attachment 6, must be filled out in its entirety.

The responsible corporate officer for contract negotiation must be listed.
This document must be signed by the responsible corporate officer.

All evidence and documentation requested under Section D, Proposal Requirements must be provided at the time the proposal is submitted.

5. State/HRI Reserved Rights

The Department of Health and HRI reserve the right to:

Reject any or all proposals received in response to this RFP.

Waive or modify minor irregularities in proposals received after prior notification to the bidder.

Adjust or correct cost figures with the concurrence of bidder if errors exist and can be documented to the satisfaction of DOH, and the State Comptroller, and HRI.

Negotiate with vendors responding to this RFP within the requirements to serve the best interests of the State or HRI.

Modify the detailed specifications should no bids be received that meet all these requirements.

If the Department of Health and/or HRI are unsuccessful in negotiating a contract with the selected vendor within an acceptable time frame, the Department of Health and/or HRI may begin contract negotiations with next qualified vendor(s) in order to serve and realize the best interests of the State and/or HRI.

6. Payment

6.1 Submission of Invoices

If awarded a contract, the contractor shall submit invoices to the office designated below:

New York State Department of Health
Bureau of Financial Management & Information Support
PRI Analysis Unit, Room 984
Corning Tower, Empire State Plaza
Albany, New York 12237-0719

Payment of such invoices by the Department of Health, for the State Audit contract only, shall be made in accordance with Article XI-A of the New York State Finance Law.

6.2 Billing Guidelines

Contract Audit billing will follow these guidelines:

For billing the following areas are considered DOWNSTATE: New York City and Long Island, all others areas, including Westchester, are considered UPSTATE.

It is estimated that a reviewer will need to be on-site a full 7.5- hour workday for every forty - (40) residents selected for review when the audit is generated. The 7.5- hour workday is

considered sufficient time to complete all audit activities specified in the RFP. These activities include: record reviews, including those for controverted items (CIs) and additional Traumatic Brain Injured (TBI) Extended Care reviews; entrance and exit conferences; observation of residents.

The actual time an auditor will need to be on-site for any given audit may somewhat vary upward or downward from the above described assumptions due to a number of factors, including but not limited to: the availability and adequacy of facility records; the accessibility and helpfulness of facility staff; and the relative number of TBI and CI reviews.

The amount of actual time spent on-site must be sufficient for the auditor to comprehensively and accurately perform all required audit activities.

Travel and lodging expenses are a component of the audit per diem. Therefore, variances in the costs of these items across audits are not a consideration that impacts the number of billable audit days.

For an audit that initially generates reviews of 40 residents or less, the contractor will bill one full time equivalent (FTE) audit day.

For an audit that initially generates reviews of 80 residents, the contractor will bill two FTE audit days, provided that the auditor is actually on-site the second day.

For all other audits that generate reviews in multiples of 40, the contractor will bill the number of FTE audit days that correspond to the preceding two scenarios, provided the auditor is actually on-site the allowable number of billed FTE audit days.

For audits that generate reviews that exceed a multiple of 40, the contractor will bill additional FTE audit days on a pro-rated basis, using the number of additional initially generated reviews, provided the auditor is actually on-site the number of days billed. The following illustrates this:

> There are 58 residents to be reviewed on the initially generated Stage 2 audit. The contractor will bill 1.45 FTE audit days if the auditor is actually on-site the second day. (58/40)= 1.45 FTE audits days.

When the number of resident reviews for an audit is such that multiple audit days will be billed, one auditor or multiple auditors may perform those days. For example, at a Stage 1 of 80 residents, one auditor may spend two days at the facility or two auditors may each spend one day at the facility.

If there are extenuating circumstances, additional time may be billed up to actual time spent at the facility. In these instances, the Department must grant prior approval. The contractor is expected to call the PRI Unit as soon as it is apparent that the review may not be completed within the normal time.

Contract training billing will follow these guidelines:

The contractor will collect all registration fees from program participants and/or their

employers. Checks, money orders or other negotiable instruments for registration fees must be made out to "Health Research, Inc." Credit cards may be used if the contractor agrees to pay all associated processing costs from their proposed fee. All fees collected by the contractor for training services performed in accordance with this proposal will be transferred, in total, by the contractor to HRI.

The contractor will submit to HRI a voucher (bill) for the monies due to the contractor based upon a documented itemized voucher (bill) for the training services provided. HRI, upon verification of the voucher, will authorize/make payment to the contractor of the monies due to the contractor for the services so rendered. The contractor shall remit monies and submit vouchers on forms and in a manner prescribed by HRI.

7. Term of Contracts

These agreements shall be effective upon approval of the New York State Office of the State Comptroller for the State Audit contract and HRI for the Training contract. The contracts awarded as a result of the RFP will cover a 36-month period anticipated to run from April 1, 2007 through March 31, 2010. These contracts may be renewed for up to one additional two-year period, depending on project extension and bidders performance.

These agreements may be canceled at any time by the Department of Health and/or HRI giving to the contractor not less than thirty (30) days written notice that on or after a date therein specified this agreement shall be deemed terminated and canceled.

8. Debriefing

Bidders may request a debriefing of their proposal up to six months from the date of contract award. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals.

9. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors.

Attachment 7 contains the "Vendor Responsibility Questionnaire" that all bidders must complete and submit with their proposal.

In addition to the questionnaire, bidders are required to provide the following with their proposal:

- Proof of financial stability, in the form of audited financial statements, Dunn & Bradstreet Reports, etc.
- Department of State Registration
- Certificate of Incorporation, together with any and all amendments thereto; partnership Agreement; or other relevant business organizational documents, as applicable.
- N.Y.S. Dept. of Taxation and Finance's Contractor Certification Form ST-220 (included as Attachment 8)

10. State Consultant Services Reporting

Chapter 10 of the Laws of 2006 amended certain sections of State Finance Law and Civil Service Law to require disclosure of information regarding contracts for consulting services in New York State.

Winning bidders for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

Winning bidders must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

Both of these forms are included as attachments to this RFP. "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" is included as Attachment 9. "State Consultant Services Form B, Contractor's Annual Employment Report" is included as Attachment 10.

11. Lobbying Statue

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as pertains to development of procurement contracts with governmental entities:

a. makes the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;

b. requires the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;

c. requires governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;

d. authorizes the Temporary State Commission on Lobbying to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;

e. directs the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;

f. requires the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment;

g. expands the definition of lobbying to include attempts to influence

gubernatorial or local Executive Orders, Tribal–State Agreements, and procurement contracts;

h. modifies the governance of the Temporary State Commission on lobbying;

i. provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;

j. increases the monetary threshold which triggers a lobbyists obligations under the Lobbying Act from $2,000 to $5,000; and

k. establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerers. Sections 139-j and 139-k are collectively referred to as "new State Finance Law."

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York Temporary State Commission on Lobbying (Lobbying Commission) regarding procurement lobbying, the Lobbying Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the Lobbying Commission.

12. Additional Terms and Conditions

12.1 Cost Liability

DOH and HRI assume no responsibility and no liability for any costs incurred by bidders for proposal preparation or activities related to the review of this RFP.

12.2 Acceptance of Proposal Content

The contents of the proposal of the successful bidder will become a part of any contracts awarded as a result of this RFP.

12.3 Oral Presentation

Bidders who submit a proposal in response to this RFP may be required to give an oral presentation of their proposals to DOH. This will provide an opportunity for the bidder to clarify or elaborate on his or her proposal and is simply to clarify claims made in the RFP. An oral presentation will in no way change the bidder's original bid, and will not change the scoring of the proposal. DOH will schedule the time and location of these presentations if it is determined that the proposal requires this further clarification.

12.4 Prime Contractor Responsibilities

The selected contractor will be required to assume sole responsibility for the complete effort as required by this RFP. DOH and HRI will consider the selected contractor to be the sole point of contact with regard to contractual matters. All subcontracts entered into by the contractor for any part of this RFP are subject to review and approval by DOH and HRI as appropriate.

12.5 Price Changes

Prices for the audit and hotline service provided will be firm and not subject to any increase during the three-year period of the contract. The prices to provide these services will be segregated into fixed and variable prices. Under this contract, it is expected that payment for the fixed costs will be billed at the fixed amount per month. The variable price, incurred in actually providing the on-site review, will be billed on a per diem basis. The DOH has prepared an estimate of audit days as indicated in Section C-1.3, but does not guarantee that this number of days will be generated. Prices for any renewal (up to 2 additional years) of the audit and hotline contract may be subject to increase based on the Consumer Price Index (CPI). Any requested increase greater than five (5) percent will require approval of the New York State Office of the State Comptroller.

Prices (Registration fees) for SCREEN and PRI training will be firm and not subject to increase during the three-year period of the contract. Prices for any renewal (up to 2 additional years) for the SCREEN and PRI training contract may be subject to increase based on approval of HRI.

12.6 Press Releases

The contractor may not issue a news release regarding this project without prior approval from DOH and/or HRI.

12.7 Ownership of Products

All contractor activities to be performed and all materials to be produced under all parts of these contracts will be accomplished in consultation with and under the direction of DOH and HRI, are subject to final approval by DOH and HRI, and remain the property of DOH and /or HRI.

12.8 Meetings Between Contractor and DOH and/or HRI

All meetings between the contractor and DOH will be held in Albany, New York unless otherwise agreed to in advance by DOH and/or HRI. The contractor agrees to meet with DOH to discuss contractual and programmatic issues at least on a semi-annual basis during the term of this contract, unless otherwise agreed to by DOH and/or HRI.

12.9 Confidentiality

All proposals submitted in response to this RFP will be kept in strict confidence to the

extent permitted by law. Proposals and resulting contracts with the DOH are subject to disclosure under the Freedom of Information Law (FOIL). Confidential, trade secret or proprietary materials as defined by the laws of the State of New York must be clearly marked and identified as such upon submission. Bidders/Contractors intending to seek an exemption from disclosure of these materials under FOIL must request the exemption in writing, setting forth the reasons for the claimed exemption, at the time of submission. Acceptance of the claimed material does not constitute a determination on the exemption request; such determination will be made in accordance with statutory procedures.

12.10 Posting Performance Bond

The contractor will be required to post a performance bond in the amount of $300,000 for the period of the audit and hotline contract and possible contract renewals and an additional $300,000 for the period of the training contract and possible contract renewals

12.11 Changes in Scope of Contract

The contractor agrees that, in the event the State through change in policy, regulation or law, alters the scope or level of required work or reallocates functions, which the State in its sole discretion may do at any time during the term of this agreement, and thereby causes a substantial increase or decrease in the required effort of the contractor, the parties will enter into good faith negotiations in order to reach agreement on the actions, if any, to be taken in order to achieve an equitable adjustment to the agreement terms that will promote the parties' expectations and objectives in entering into this agreement and not alter its fundamental purpose. It is further agreed that both parties will use best efforts to finalize negotiations on these matters within sixty (60) days of notification.

The contractor shall implement changes within the scope of work of this agreement, in accordance with a State approved schedule, including changes in policy, regulation, statute, or judicial interpretation.

The contractor shall recognize and agree that any and all work performed outside the scope of this agreement or without consent of the State shall be deemed by the State to be gratuitous and not subject to charge by the contractor.

Upon approval of the OSC, the State may agree to additional payment for unanticipated changes in the scope of the program. The changes must be approved via a formal amendment to this agreement. The contractor shall not be reimbursed for any unauthorized changes in the scope of this agreement. Verbal agreements regarding changes are not binding. To request a change, the contractor must define the need and the requirements of the change and any associated costs. The contractor shall provide a written explanation concerning how the cost increase was calculated. In addition, the request for change in scope of this agreement must include a discussion of the impact on the project if such change is not approved.

F. Appendices – For State Audit Contract Only

The following will be incorporated as appendices into any contracts resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

- ❑ APPENDIX A – Standard Clauses for All New York State Contracts

- APPENDIX B – Request for Proposal

- APPENDIX C – Proposal. The bidder's proposal (if selected for award), including the Bid Form and all proposal requirements.

- APPENDIX D – General Specifications

- APPENDIX E – Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or Workers' Compensation Board, of coverage for:

    - Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

        - WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
        - WC/DB-101, Affidavit That An OUT-OF-STATE Or FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; OR
        - C-105.2 – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the U-26.3;OR
        - SI-12 - Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.

    - Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

        - WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
        - WC/DB-101, Affidavit That An OUT-OF-STATE Or FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; OR
        - DB-120.1 – Certificate of Disability benefits Insurance OR the DB-820/829 Certificate/Cancellation of Insurance; OR
        - DB-155 – Certificate of Disability Benefits self-Insurance

- APPENDIX H – Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement

- APPENDIX X – Modification Agreement Form

G. Attachments

Attachment 1 – Generic Sample Training Contract
Attachment 2 – Current Versions of Forms- PRI, H/C PRI, & Screen
Attachment 3 – PRI Instructions, PRI Clarification Sheets, & H/C PRI Instructions
Attachment 4 – Screen Instructions
Attachment 5 – Text of PRI Audit Areas
Attachment 6 – New York State Department of Health Bid Form
Attachment 7 – N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire
Attachment 8 – New York State Taxation and Finance Contractor Certification Form ST-220
Attachment 9 - State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term
Attachment 10 – State Consultant Services Form B, Contractor's Annual Employment Report

Appendix A

Standard Clauses for New York State Contracts

STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $15,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain

S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $30,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it not its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor warrants, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further warrants that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of setoff any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance

with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION**.** (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, AESOB, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of

$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St – 7th Floor
Albany, New York 12245
Telephone: 518-292-5220

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
http://www.empire.state.ny.us

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. PROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if

not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

Appendix D

General Specifications

APPENDIX D
GENERAL SPECIFICATIONS

A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:

> All specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specification, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.

B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, telegram, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.

C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety be liable to the State of New York for any excess cost on account thereof.

D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.

E. The Department of Health will make no allowances or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.

F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.

G. The successful bidder will be required to complete the entire work, or any part thereof as the case may be, to the satisfaction of the Department of Health in strict accordance with the specifications and pursuant to a contract therefore.

H. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of

this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

I. Non-Collusive Bidding By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:

a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;

c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or

to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its or its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.

L. Work for Hire Contract Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed or included in the application software provided to the Department as a part of this contract.

M. Technology Purchases Notification -- The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"

1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over $20,000, or of other technology over $50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.

3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.

4. The responses to this RFP must include a solution to effectively handle the turn of the century issues related to the change from the year 1999 to 2000.

N. YEAR 2000 WARRANTY

1. Definitions

For purposes of this warranty, the following definitions shall apply:

a. Product shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data conversion or data entry, the term Product shall include resulting deliverables.

b. Vendor's Product shall include all Product delivered under this Agreement by Vendor other than Third Party Product.

c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: a) corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Warranty Disclosure

At the time of bid, Product order or Product quote, Vendor is required to disclose the following information in writing to Authorized User:

a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's Installed Product) which have been specified to perform as a system: Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and

b. For Third Party Product Not Specified as Part of a System: Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's Year 2000 Warranty, Vendor shall pass through said third party warranty from the third party manufacturer to the Authorized User but shall not be liable for the testing or verification of Third Party's compliance statement.

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the product(s) or system(s) in question with the year 2000 warranty statement set forth below.

3. Warranty Statement

Year 2000 warranty compliance shall be defined in accordance with the following warranty statement:

Vendor warrants that Product(s) furnished pursuant to this Agreement shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, Vendor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to Authorized User's ongoing business processes, time being of the essence, at Vendor's sole cost and expense. This warranty does not extend to correction of Authorized User's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Agreement.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Agreement.

O. No Subcontracting Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health.

P. Superintendence by Contractor The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the Contractor.

Q. Sufficiency of Personnel and Equipment If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.

R. Experience Requirements The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.

S. Contract Amendments This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor

2. If, in the judgement of the Department of Health, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was

engaged in at the time of such termination, subject to audit by the State Comptroller.

U. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and

2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

V. Conflicts

If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT The New York State Department of Health recognizes the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic

background, gender and Federal occupational categories or other appropriate categories specified by the Department.

X. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:

   a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

   b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than $500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than $1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than $500,000 for damages arising out of damage to or destruction or property during any single occurrence and not less than $1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

      i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.

      ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

Y. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

c. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the

prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions.

g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non-procurement Programs.

h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

i. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the

department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

   a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.

   b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Z. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report,

document or other data developed pursuant to this AGREEMENT.

4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.

5. The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

6. All subcontracts shall contain provisions specifying:

   a. that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and

   b. that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

AA. Provision Related to Consultant Disclosure Legislation

1. CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:

   a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and

   b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and

   c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

BB. Provisions Related to New York State Procurement Lobbying Law

1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

Appendix H

Federal Health Insurance Portability and Accountability Act (HIPAA)

Business Associate Agreement

Appendix H

Federal Health Insurance Portability and Accountability Act ("HIPAA")
Business Associate Agreement ("Agreement") Governing Privacy and Security

I. Definitions:

(a) Business Associate shall mean the CONTRACTOR.

(b) Covered Program shall mean the STATE.

(c) Other terms used, but not otherwise defined, in this agreement shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including those at 45 CFR Parts 160 and 164.

II. Obligations and Activities of the Business Associate:

(a) The Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law.

(b) The Business Associate agrees to use the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates receives, maintains or transmits on behalf of the Covered Entity pursuant to this Agreement.

(c) The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Agreement.

(d) The Business Associate agrees to report to the Covered Program, any use or disclosure of the Protected Health Information not provided for by this Agreement, as soon as reasonably practicable of which it becomes aware. The Business Associate also agrees to report to the Covered Entity any security incident of which it becomes aware.

(e) The Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by the Business Associate on behalf of the Covered Program agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.

(f) The Business Associate agrees to provide access, at the request of the Covered Program, and in the time and manner designated by the Covered Program, to Protected Health

Information in a Designated Record Set, to the Covered Program or, as directed by the Covered Program, to an Individual in order to meet the requirements under 45 CFR 164.524, if the business associate has protected health information in a designated record set.

(g) The Business Associate agrees to make any amendment(s) to Protected Health Information in a designated record set that the Covered Program directs or agrees to pursuant to 45 CFR 164.526 at the request of the Covered Program or an Individual, and in the time and manner designated by Covered Program, if the business associate has protected health information in a designated record set.

(h) The Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Covered Program available to the Covered Program, or to the Secretary of Health and Human Services, in a time and manner designated by the Covered Program or the Secretary, for purposes of the Secretary determining the Covered Program's compliance with the Privacy Rule.

(i) The Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(j) The Business Associate agrees to provide to the Covered Program or an Individual, in time and manner designated by Covered Program, information collected in accordance with this Agreement, to permit Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

III. <u>Permitted Uses and Disclosures by Business Associate</u>

(a) General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Program as specified in the Agreement to which this is an addendum, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Program.

(b) Specific Use and Disclosure Provisions:

(1) Except as otherwise limited in this Agreement, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and

the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(2) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the business associate or to carry out its legal responsibilities and to provide Data Aggregation services to Covered Program as permitted by 45 CFR 164.504(e)(2)(i)(B). Data Aggregation includes the combining of protected information created or received by a business associate through its activities under this contract with other information gained from other sources.

(3) The Business Associate may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR '164.502(j)(1).

IV. <u>Obligations of Covered Program</u>

Provisions for the Covered Program To Inform the Business Associate of Privacy Practices and Restrictions

(a) The Covered Program shall notify the Business Associate of any limitation(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.

(b) The Covered Program shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.

(c) The Covered Program shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Program has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.

V. <u>Permissible Requests by Covered Program</u>

The Covered Program shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Program, except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate.

VI. <u>Term and Termination</u>

(a) *Term.* The Term of this Agreement shall be effective during the dates noted on page one

of this agreement, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in The Agreement.

(b) ***Termination for Cause.*** **Upon the Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for the Business Associate to cure the breach and end the violation or may terminate this Agreement and the master Agreement if the Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or the Covered Program may immediately terminate this Agreement and the master Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible.**

(c) ***Effect of Termination.***

(1) Except as provided in paragraph (c)(2) below, upon termination of this Agreement, for any reason, the Business Associate shall return or destroy all Protected Health Information received from the Covered Program, or created or received by the Business Associate on behalf of the Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, the Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VII. <u>Violations</u>

(a) It is further agreed that any violation of this agreement may cause irreparable harm to the State, therefore the State may seek any other remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.

(b) The business associate shall indemnify and hold the State harmless against all claims and costs resulting from acts/omissions of the business associate in connection with the business associate's obligations under this agreement.

Miscellaneous

(a) ***Regulatory References*. A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended, and for which compliance is required.**

(b) ***Amendment*. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Program to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.**

(c) ***Survival*. The respective rights and obligations of the Business Associate under Section VI of this Agreement shall survive the termination of this Agreement.**

(d) ***Interpretation*. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the Covered Program to comply with the HIPAA Privacy Rule.**

(e) If anything in this agreement conflicts with a provision of any other agreement on this matter, this agreement is controlling.

(f) HIV/AIDS. If HIV/AIDS information is to be disclosed under this agreement, the business associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

Attachment 1

Generic Sample Training Contract

AGREEMENT

This Agreement, made this of .2003, by and between **Contractor's Name** existing under the laws of the State of New York, with its principal offices located at Contractors Address, hereinafter referred to as the "Contractor", and Health Research, Inc., a non-profit organization, existing under the laws of the State of New York, with its principal offices located at One University Place, Rensselaer, New York 12144, hereinafter referred to "HRI".

Whereas, HRI in concert with the New York State Department of Health, Office of Health System Management, hereinafter referred to as OHSM, desires to retain Contractor to develop training materials and to provide training programs to health care professionals in long term care, home health care and acute care hospitals for the purposes of meeting State/Federally mandated requirements; and,

Whereas, Contractor has available the personnel, professional expertise, and facilities needed to conduct such work; and,

Whereas, Contractor desires to enter into agreement with HRI for the conduct of the aforementioned work.

Now, therefore in consideration of the promises and mutual covenants hereinafter contained, the parties agree as follows:

1) Scope of Work

The Contractor agrees to provide training programs to health care professionals in long-term care, home health care and acute care hospitals for the purposes of meeting the State/Federally mandated requirements in the following area:

> Patient Review Instrument (PRI) — Utilized for nursing facility reimbursement

> Hospital and Community Patient Review Instrument (H/C PRI) — Utilized for preadmission review of persons in a hospital or living in community based residences and facilities, who apply for admission to a nursing facility.

> Preadmission Screening and Annual Resident Review Process (PASSARR) —Utilized for preadmission screening of individuals for possible mental illness (MI), and/or mental retardation and related conditions (MR).

Contractor agrees to conduct said training programs pursuant to a schedule determined by the OHSM and the Contractor. In developing and conducting the sessions, the Contractor agrees to conduct and carry out in a professional, competent, and timely manner, all the work and services set forth in the Work Plan and payment schedule which are attached hereto as Exhibits A and B, respectively, and made a part of this Agreement.

2) Compensation

The Contractor agrees that persons attending the training session will be charged a registration fee. The Contractor will collect all registration fees from program participants and/or their employers. Checks, money orders or other negotiable instruments for registration fees must be made out to "Health Research, Inc." In the event registrants mistakenly make checks, money orders or other negotiable instruments payable to the Contractor, the Contractor will accept said instruments and will submit to

HRI a check for the total of such instruments along with a copy of the instrument(s) made payable to Contractor. The Contractor will transfer all such fees, collected by the Contractor for services performed in accordance with this proposal, in total to HRI along with a copy of the instrument(s) and an adding machine tape showing the total of said instruments. The Contractor will submit to HRI an itemized invoice for the services provided. HRI, upon verification of the invoice, will authorize/make payment to the Contractor for the monies due to the Contractor for the services so rendered. The Contractor shall remit monies and submit invoice on forms and in a manner prescribed by HRI. HRI, upon receipt of Contractor invoice and in accordance with Exhibit B, will reimburse Contractor for the training session attendees.

Training fee schedule is attached as Exhibit B.

Contractor will assume all costs for providing periodic training sessions, which are to be held at least on a semi-annual basis per year at locations statewide on a schedule agreed to by the Contractor and HRI. Contractor will not be obligated to hold training sessions for less than XXX trainees. No session will be held for more than XXXX trainees.

Contractor will receive compensation as outlined in Exhibit B for each trainee who completes the training sessions and for whom adequate records indicating attendance is submitted. Adequate records of attendance means a list of attendees for each session and certification/assessor number issued, if appropriate.

Contractor will receive the normal fee described above for no shows and cancellations received less than ten (10) business days prior to the program.

Contractor will be responsible for collecting on any checks returned to HRI for insufficient funds. Contractor will charge a $25 fee for returned checks. HRI will be given $10 of that fee.

HRI agrees to reimburse Contractor promptly upon receipt of Contractor invoice with documentation of attendance described above. In no event should reimbursement to Contractor exceed thirty (30) days from receipt of Contractor invoice to HRI.

3) Proprietary Information

It is understood that, in the course of carrying out the purposes of this Agreement either party may wish to provide the other party with proprietary information. Each party agrees not to disclose such information, which is clearly indicated as proprietary to other than its employees and shall use its best efforts to prevent unauthorized disclosure of such information.

4) Use of Name

Under no circumstances are the results of this work completed under this contract to be defined, construed or advertised as an endorsement of a product or material by HRI, the New York State Department of Health or New York State unless specifically authorized to do so, nor are products developed outside the scope of this contract to be advertised as endorsed by HRI, the New York State Department of Health or New York State unless specifically authorized to do so.

5) Ownership of Materials

Title and ownership of all materials developed under the terms of this contract, whether or not subject to copyright will remain the property of HRI. Use of the training materials during the contract period and

thereafter will be subject to approval in writing by HRI. Contractor shall surrender all materials developed by the Contractor or loaned by HRI under this contract within thirty (30) days of the terminated date of this contract.

6) Submission of Financial Records

The Contractor will maintain customary and appropriate records regarding revenue and expenses for activities completed under this contract and will periodically submit records of revenue and expenses at the request of HRI. All revenue and expenses will be subject to audit by HRI.

7) Sole Authorization

Training sessions developed under this contract and presented by the Contractor will represent for the period of the contract the sole source of training approved by the OHSM.

8) Conflict of Interest

The Contractor certifies that any and all subcontractors employed in the completion of the activities identified in Exhibit A will comply with the terms and conditions of Articles 3, 4, 5, 6, and 7 of this contract and will not undertake activities deemed in conflict of interest with HRI, OHSM or the New York State Department of Health.

9) Notices

All notices required or permitted to be given under this Agreement shall be in writing and shall be delivered personally, given by prepaid telegram or sent certified mail prepaid or by prepaid Federal Express to the address set forth above.

10) Waivers

No waiver of any term, provision or condition of this Agreement, whether by conduct or otherwise, in any one or more instances, shall be deemed to be or construed as a further or continuing waiver of any such term, provision or condition or of any other term, provision or condition or, this Agreement.

11) Integration Clause

This Agreement represents and embodies all the agreements and negotiations between the parties hereto and no oral agreements or correspondence prior to the date of the execution of this Agreement shall be held to vary the provisions hereof.

12) Modification and Change

This Agreement may be changed, amended, modified, extended or terminated by mutual consent provided that such consent shall be in writing and executed by the parties hereto prior to the time such change shall take effect.

13) Indemnification

The Contractor shall indemnify and hold HRI, the New York State Department of Health and the State of New York harmless from any and all claims, costs, expenses (including attorney's fees), losses and liabilities of whatsoever nature ("Losses") to the extent such Losses are attributable to the negligent acts

or omissions of the Contractor, its employees, agents or subcontractors arising out of, occasioned by, or in connection with or under this Agreement.

14) Term

The term of this Agreement shall be START DATE to END DATE and shall remain so unless terminated sooner or extended by mutual agreement of the parties hereto expressed in writing in the manner provided in this Agreement or terminated by HRI pursuant to clause 15. No obligation shall be incurred by Contractor to devote any time or effort to this work beyond the stipulated completion date unless deliverable previously agreed upon has not been developed by that date.

15) Termination

HRI may terminate this Agreement by giving thirty (30) days written notice when, in its sole discretion, HRI determines that just cause for termination exists or that termination is in the best interests of HRI.

16) Cancellation of Training

If, for any reasons beyond the control of HRI or the Contractor, the training sessions are canceled or the contract is terminated pursuant to Section 15, the Contractor will be reimbursed for allowable expenditures for conducting the training made up to the time at which they were notified of such cancellation.

17) Situs

Regardless of the place of physical execution, this Agreement shall be construed according to the laws of the State of New York.

18) Project Director Change

In the event that the project director agreed to by HRI and the Contractor as of the date of execution of this Agreement is unable to complete this project, Contractor shall notify HRI within ten (10) days. HRI shall have the option to complete the project with a new project director or terminate the contract pursuant to Article 15.

19) Reports

The Contractor will provide both HRI and DOH with monthly reports for both programs on the programs presented in the previous month, including number of people attending and types of questions received, responses made, as well as concerns of the trainers/attendees. The report should detail the number of training sessions held per-region, the number of canceled sessions, and the number of registrants that forfeited their registration fee due to non-attendance. The report for each month following the month the contract is executed will be received by HRI no more than 30 days following the last day of that month. At the discretion of HRI, quarterly reports may be substituted for monthly reports for one or more of the training programs. The Contractor agrees to notify HRI of scheduled sessions that are canceled due to lack of registration, such notification to occur at least two weeks prior to the scheduled date.

20) Project of Precedence

In the event of any inconsistency between Clauses 1 through 19 of this Agreement, the attached Exhibits

A and B, and Appendix "A", the inconsistency should be resolved by giving precedence to Clauses 1 through 19.

In witness whereof, this Agreement has been duly executed by the parties hereto as of the date written above.

HEALTH RESEARCH, INC.	CONTRACTOR'S NAME
_____	_____
Michael J. Nazarko Executive Director	Name: Title: Fed ID#:

Attachment 2

Current Versions of Forms

PRI
H/C PRI
Screen

RUG-II GROUP OF PATIENT:
(please print name)

New York State Department of Health
DIVISION OF HEALTH CARE FINANCING

PATIENT REVIEW INSTRUMENT (PRI)

Use with separate PRI Instructions and Training Manual

I. ADMINISTRATIVE DATA

1 OPERATING CERTIFICATE NUMBER (1–8)

2 SOCIAL SECURITY NUMBER (9–17)

3 RESIDENT IS LOCATED: (18)
1 = Former HRF Area
2 = Former SNF Area

4 PATIENT NAME (PLEASE PRINT) (30)
LAST F.I. M.I.

5 DATE OF PRI COMPLETION (31-36)
MO DAY YEAR

6 MEDICAL RECORD NUMBER (37-45)

7 ROOM NUMBER (46-50)

8 UNIT NUMBER (Assigned by RUG II Project) (51-52)

9 DATE OF BIRTH (53-60)
MO. DAY YEAR

10 SEX (61)
1 = Male
2 = Female

11 DATE OF **INITIAL** ADMISSION: to this facility (NF) (first admission, not most recent) (62-67)
MO DAY YEAR

12 MEDICAID NUMBER (68-78)

13 MEDICARE NUMBER (79-88)

14 PRIMARY PAYOR. (89)
1 = Medicaid 3 = Other
2 = Medicare

15A REASON FOR PRI COMPLETION: 15A (90)
1 = Biannual Full Facility Cycle
2 = Quarterly New Admission Cycle

15B Was a PRI submitted by your facility (NF) for this patient during a previous full facility or a new admit cycle? 15B (91)
1 = Yes 2 = No

II. MEDICAL EVENTS

16 DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS (92)

17 MEDICAL CONDITIONS: DURING THE PAST FOUR WEEKS. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS. 1 = Yes 2 = No (93-103)

A. Comatose
B. Dehydration
C. Internal Bleeding
D. Stasis Ulcer
E. Terminally Ill
F. Contractures
G. Diabetes Mellitus
H. Urinary Tract Infection
I. HIV Infection Symptomatic
J. Accident
K. Ventilator Dependent

18 MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR QUALIFIERS. 1 = Yes 2 = No (104-116)

A. Tracheostomy Care/Suctioning (Daily — Exclude self care)
B. Suctioning — General (Daily)
C. Oxygen (Daily)
D. Respiratory Care (Daily)
E. Nasal Gastric Feeding
F. Parenteral Feeding
G. Wound Care
H. Chemotherapy
I. Transfusion
J. Dialysis
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS)
L. Catheter (Indwelling or External)
M. Physical Restraints (Daytime Only)

Sample

III. ACTIVITIES OF DAILY LIVING (ADLs)

Answer questions 19-22 according to how each task was completed 60% of the time during the past four weeks or since admission, whichever is shorter (regardless of cause). Read the **Changed Condition Rule** and definitions in the instructions.

19 **EATING:** PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE).

1 = Feeds self without supervision or physical assistance. May use adaptive equipment.

2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3 = Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.

4 = Totally fed by hand; patient does not manually participate.

5 = Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments.)

19 (117) ☐

20 **MOBILITY:** HOW THE PATIENT MOVES ABOUT.

1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.

2 = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.

4 = *Wheels* with *no* supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5 = Is *wheeled*, chairfast or bedfast. Relies on someone else to move about, if at all.

20 (118) ☐

21 **TRANSFER:** PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING. (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).

1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.

2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.

4 = Requires *two* people to provide constant supervision and/or physically lift. May need lifting equipment.

5 = Cannot and is not gotten out of bed.

21 (119) ☐

22 **TOILETING:** PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.

1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

2 = Requires *intermittent* supervision for safety or encouragement; or *minor* physical assistance (for example, clothes adjustment or washing hands).

3 = Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).

4 = Incontinent of bowel *and/or* bladder and is not taken to a bathroom.

5 = Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

22 (120) ☐

IV. BEHAVIORS

23 **VERBAL DISRUPTION:** BY YELLING, BAITING, THREATENING, ETC.

1 = None during the past four weeks. (May have verbal outbursts which are not disruptive.)

2 = Verbal disruption one to three times during the past four weeks.

3 = Short-lived disruption at least once per week during the past four weeks *or predictable* disruption regardless of frequency (for example, during specific care routines, such as bathing).

4 = Unpredictable, recurring verbal disruption *at least once per week* for no foretold reason.

5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

23 (121) ☐

24 **PHYSICAL AGGRESSION:** ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH **INTENT FOR INJURY.** (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR).

1 = None during the past four weeks.

2 = Unpredictable aggression during the past four weeks (whether mild or extreme), *but not at least once per week.*

3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4 = Unpredictable, recurring aggression at least once per week *during the past four weeks for no apparent or* foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5 = Patient is at level#4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

24 (122) ☐

Sample

PATIENT NAME (please print) _____ LAST _____ F.I. _____ M.I.

25 DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL **PHYSICAL** BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS* (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS), EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.

1 = No infantile or socially inappropriate behavior, whether or not disruptive, during the past four weeks.
2 = Displays this behavior, but is not disruptive to others (for example, rocking in place).
3 = Disruptive behavior during the past four weeks, but *not* at least once per week.
4 = Disruptive behavior at least *once per week* during the past four weeks.
5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

25 (123) ☐

26 HALLUCINATIONS: EXPERIENCED AT LEAST ONCE PER WEEK DURING THE PAST FOUR WEEKS, VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.

1 = Yes 2 = No 3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

26 (124) ☐

V. SPECIALIZED SERVICES

27 PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) PER WEEK.

A. Physical Therapy (P.T.) ..... P.T. Level (125) ☐ P.T. Days (126) ☐ P.T. Time (127-130) ☐☐ HOURS ☐☐ MIN/WEEK

B. Occupational Therapy (O.T.) ..... O.T. Level (131) ☐ O.T. Days (132) ☐ O.T. Time (133-136) ☐☐ HOURS ☐☐ MIN/WEEK

LEVEL

1 = Does not receive.
2 = Maintenance Program - Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3 = Restorative Therapy - Requires and is currently receiving physical and/or occupational therapy for four or more consecutive weeks.
4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, restorative therapy given or to be given for only two weeks.)

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) PER WEEK THAT EACH THERAPY IS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28 NUMBER OF PHYSICIAN VISITS: ENTER ONLY THE NUMBER OF VISITS DURING THE PAST FOUR WEEKS THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. EXCLUDE VISITS BY PSYCHIATRISTS.

28 (137-138) ☐☐

29 MEDICATIONS

A. Monthly average number of medications ordered. **29A** (139-140) ☐☐
B. Monthly average number of psychoactive medications ordered. **29B** (141-142) ☐☐

DIAGNOSIS

30 PRIMARY PROBLEM: THE MEDICAL CONDITION (ICD-9 CODE) REQUIRING THE LARGEST AMOUNT OF NURSING TIME. THIS MAY NOT BE THE ADMISSION DIAGNOSIS BY THE PHYSICIAN.

ICD—9 Code of medical problem ..... **30** (143-147) ☐☐☐.☐☐

If code cannot be located, print medical name here:

_____

31 QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS PRI:

☐ Yes ☐ No

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ Signature of Qualified Assessor

Assessor Identification Number **31** (148-152) ☐☐☐☐☐

Sample

38 RACE/ETHNIC GROUP: ENTER THIS CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP.

1 = White
2 = White/Hispanic
3 = Black
4 = Black/Hispanic
5 = Asian or Pacific Islander
6 = Asian or Pacific Islander/Hispanic
7 = American Indian or Alaskan Native
8 = American Indian or Alaskan Native/Hispanic
9 = Other

Sample

Hospital and Community Patient Review Instrument (HC-PRI)

RUG II Group (print name)

RHCF Level of Care:
☐ HRF ☐ SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER (1-8)

2. SOCIAL SECURITY NUMBER (9-17) - -

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)

4B. COUNTY OF RESIDENCE

5. DATE OF PRI COMPLETION

(18-25) - -
MO DAY YEAR

6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34)

7. HOSPITAL ROOM NUMBER (35-39)

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING

9. DATE OF BIRTH

(40-47) - -
MO DAY YEAR

10. SEX (48) 1=Male 2=Female

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT

(49-56) - -
MO DAY YEAR

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)

(57-64) - -
MO DAY YEAR

12. MEDICAID NUMBER (65-75)

13. MEDICARE NUMBER (76-85)

14. PRIMARY PAYOR (86)
1=Medicaid
2=Medicare
3= Other

15. REASON FOR PRI COMPLETION (87)
1. RHCF Application from Hospital
2. RHCF Application from Community
3. Other (Specify:)

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. _____

17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS
1=YES
2=NO

A. Comatose _____
B. Dehydration _____
C. Internal Bleeding _____
D. Stasis Ulcer _____
E. Terminally Ill _____
F. Contractures _____
G. Diabetes Mellitus _____
H. Urinary Tract Infection _____
I. HIV Infection Symptomatic _____
J. Accident _____
K. Ventilator Dependent _____

18. MEDICAL TREATEMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.
1=YES
2=NO

A. Trachesotomy Care/Suctioning (Daily—Exclude self-care) _____
B. Suctioning-General (Daily) _____
C. Oxygen (Daily) _____
D. Respiratory Care (Daily) _____
E. Nasal Gastric Feeding _____
F. Parenteral Feeding _____
G. Wound Care _____
H. Chemotherapy _____
I. Transfusion _____
J. Dialysis _____
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS) _____
L. Catheter (Indwelling or External) _____
M. Physical Restraints (Daytime Only) _____

Sample

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.
2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.
3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
4=Totally fed by hand, patient does not manually participate
5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
3= Walks with *constant* one-to-one supervision and/or constant physical assistance.
4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).
3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).
4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.
5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history
2=Known history or occurrences, but not during the past week (7 days)
3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)
4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.
2=Known history or occurrences, but not during the past week (7 days).
3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

sample

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. 25. (119)

1=No known history
2=Displays this behavior, but is not disruptive to others (for example, rocking in place).
3=Known history or occurrences, but not during the past week (7 days).
4=Occurences of this disruptive behavior at least once during the past week (7 days)
5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. 26. (120)

1=Yes 2=No 3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level (121)

P.T. Days (122)

P.T. Time (123-126) HOURS MIN/WEEK

B. Occupational Therapy (O.T.)

O.T. Level (127)

O.T. Days (128)

O.T. Time (129-132) HOURS MIN/WEEK

LEVEL
1=Does not receive.
2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.
4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. 28. (133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem 29. - (135-139)

If code cannot be located, print medical name here:

Sample

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

30. DIAGNOSES AND PROGNOSES: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1.

Secondary (Include Sensory Impairments)

1.

2.

3.

4.

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP 34.

1=White	4=Black/Hispanic	7=American Indian or Alaskan Native
2=White/Hispanic	5=Asian or Pacific Islander	8=American Indian or Alaskan Native/Hispanic
3=Black	6=Asian or Pacific Islander/Hispanic	9=Other

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

☐YES ☐NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ IDENTIFICATION NO.

SIGNATURE OF QUALIFIED ASSESSOR

Sample

SCREEN

Review completed Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) before beginning the SCREEN, Use with separate PRI or H/C PRI and SCREEN Instructions.

IDENTIFICATION

1. Facility Operating Certificate Number:
2. Patient/Resident/Person Social Security Number: | |
3. Name of person(s) Completing SCREEN:
4. Patient/Resident/Person Name:
5. Date of H/C-PRI or PRI Completion:
6a. Date of SCREEN initiation:
6b. Date of SCREEN completion: | |

DIRECT REFERRAL FACTOR FOR RHCF

	YES	NO	
7.	☐	☐	Person has a home in the community (owns or rents a home, lives in an Adult Care Facility or with family or friends) and that place is still available OR appropriate community based living can be arranged OR the person is eligible for an Adult Care Facility. If NO, explain on a separate sheet of paper and attach to this form.

Guideline: If item 7 is marked NO, explain as indicated above and refer to RHCF. Proceed to REFERRAL DECISION (item 21)
If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT.

DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT

	YES	NO	
8.	☐	☐	Person understands information given and strongly opposes placement/continued stay in a Residential Health Care Facility.
9.	☐	☐	Person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility.
10.	☐	☐	Person has a good informal support system – willing and capable (physically and mentally) of caring for most of the specific needs of the person.
11.	☐	☐	All ADL responses = 1 or 2 (see PRI PART III, 19-22)
12.	☐	☐	Person was independent in ADL prior to most recent acute episode and shows good rate of return of physical and mental functioning.

Guideline: If any direct referral factor (8-12) is marked YES, refer to Home Assessment or Assessment for Adult Care Facility. Proceed to REFERRAL DECISION: Item 21. If all direct referral factors (8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS.

Sample

HOME AND CAREGIVING ARRANGMENTS

Check YES and NO boxes to document each response. For questions on the far right, enter the number of the answer that best applies.

13. a. Estimate the total number of hours per day that informal supports are willing and able to provide supervision or assistance to the person.

b. Estimate the total number of hours per day that the person can be alone.

+ _____

c. Add a and b (a+b=c)

d. Is the number of hours in line c 12 or more?

YES ☐ NO ☐

14. Within six months can the number of hours per day that the person is attended by self or informal supports be increased to12 or more?

YES ☐ NO ☐

15. If NO, enter principal reason (1,2,or 3):

1. Person understands options and has decided to enter/remain home.
2. Person has no informal supports.
3. Informal supports are unable or unwilling to provide additional assistance or person does not want care from informal supports.

16. Is there a need for restorative services which is documented by a physician or rehabilitation specialist?

NO ☐ YES ☐

17. Can the person receive restorative services at home, at adult day care or as an outpatient?

YES ☐ NO ☐

18. If NO, enter principal reason (1, 2 or 3):

1. Restorative services are not available in person's community.
2. Restorative services are too costly or not covered.
3. Person cannot access restorative services.

19. Can the person be placed in the community without causing undue risk to self or others? (only consider reason listed in item 20)

YES ☐ NO ☐

20. If question 19 is NO, enter principal reason (1, 2, 3, or 4):

1. Person has history of unpredictable behaviors and may injure self or others.
2. Comatose or all ADL responses = 4 or 5 (PRI PART III, 19-22).
3. Requires constant monitoring due to health threatening medical problems.
4. Skilled services are needed at least one time per day and cannot be delegated to nonprofessionals or informal supports.

Sample

REFERRAL DECISION

21. Enter principal reason (1, 2, 3, 4 or 5):

1. RHCF: Item 7 is marked NO OR an entry appears in item 15 or 20, OR a home assessment was done by an authorized home care agency and it was determined that the person cannot be cared for in the community. This home assessment represents the person's current status.
2. RHCF for Restorative Services: There is an entry in item 18.
3. Home Assessment or Assessment for Adult Care Facility: One or more of items 8-12 are marked YES or no entries appear in items 15, 18, or 20.
4. Community Based and RHCF care are both being investigated.
5. Referral Decision indicates Home Assessment or Assessment for Adult Care Facility but RHCF care is recommended.

If response 4 or 5 is chosen, explain:

DEMENTIA QUALIFIER

YES	NO	
☐	☐	22. Does the person have a diagnosis of dementia, (including Alzheimer's disease), without a diagnosis of MR/DD?

Guideline: If item 22 is marked YES, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).
If item 22 is marked NO, proceed to LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (item 23).

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

YES	NO	
☐	☐	23. Does the person have a serious mental illness?

Guideline: Proceed to LEVEL I Review for Possible Mental Retardation/Developmental Disability.

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer items 24-27 in order, as soon as an item is marked YES, proceed to Categorical Determinations (items 28-31).

YES	NO	
☐	☐	24. Does the person have a current diagnosis of mental retardation or a developmental disability (cerebral palsy, autism or epilepsy) and did the mental retardation or developmental disability manifest itself prior to age 22 and it is likely to continue indefinitely and result in substantial functional limitations in three or more areas of major life activity?
☐	☐	25. Was this person referred by an agency that serves persons with MR/DD or has this person ever been deemed eligible AND received MR/DD services current or past?
☐	☐	26. Is there a documented history of mental retardation or developmental disability in the person's past?
☐	☐	27. Does the person present evidence (cognitive or behavioral functions) that may indicate the presence of mental retardation or developmental disability?

Guideline: If items 23-27 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).
If any of items 23-27 are marked YES, proceed to Categorical Determinations (items 28-31).

CATEGORICAL DETERMINATIONS

Guidelines: All items must be answered.

YES	NO	
☐	☐	28. Does the person qualify for convalescent care?
☐	☐	29. Is the person seriously ill?
☐	☐	30. Is the person terminally ill?
☐	☐	31. Is the person admitted for a very brief and finite stay or a provisional emergency admission?

Guideline: If any of the items 28-31 are marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 32). If all are marked NO, proceed to LEVEL II REFERRALS (item 34).

DANGER TO SELF OR OTHERS QUALIFIERS

YES	NO	
☐	☐	32. Based on your interview of the person (and/or available informants), and/or a review of the person's medical record, is there any evidence to suggest that the person has or may have had homicidal or suicidal thinking or behavior during the past two years?

Guideline: If item 32 is marked YES, proceed to item 33. If NO, proceed to Patient/Resident/Person Disposition (item 36).

☐	☐	33. Based on a current mental health consultation, has the person been deemed homicidal or suicidal by a qualified mental health specialist?

Guideline: If item 33 is marked YES, proceed to LEVEL II REFERRALS (item 34). If NO, proceed to Patient/Resident/Person Disposition (item 36).

Sample

LEVEL II REFERRALS

34. Enter the Level II Referral decision (1, 2, or 3)

1. Level II mental illness assessment.
2. Level II assessment and determination by the Office of Mental Retardation and Developmental Disabilities.
3. Both 1 and 2

Complete item 35 only after obtaining the Level II determination(s) from the appropriate Office of Mental Health (OMH) and /or Office of Mental Retardation and Developmental Disabilities (OMR/DD) designee.

LEVEL II DETERMINATIONS

YES ☐ NO ☐ 35. Based upon the Level II determination(s), specialized services are required.

Guideline: If item 35 is marked YES, complete item 38. If item 35 is marked NO, proceed to Patient/Resident/Person Disposition (item 36).

PATIENT/RESIDENT/PERSON DISPOSITION

36. Enter one response (1, 2, 3, 4, 5, 6, 7 or 8):

1. Home
2. Home with home care services
3. Adult Care Facility
4. Adult Care Facility with home care services
5. RHCF for restorative services
6. RHCF for other services
7. Person died
8. Other (specify) _____

PATIENT/RESIDENT/PERSON OR REPRESENTATIVE ACKNOWLEDGEMENT

Guideline: Check the appropriate box(es)

37. ☐ a. I have had the opportunity to participate in decisions regarding the arrangements for my continuing care and I have received verbal and written information regarding the range of services in my community.

☐ b. I have been informed in writing that: (please check the appropriate office(s))

☐ Office of Mental Health
☐ Office of Mental Retardation and Developmental Disabilities

will now be involved in determining my appropriate service/placement.

_____

Patient/Resident/Person or Representatives signature

QUALIFIED SCREENER

38. I have personally observed/interviews this person and completed the SCREEN: I certify that I am a trained and qualified Screener and the information contained herein is a true abstract of the person's condition and circumstances. YES ☐ NO ☐

_____ Signature of Qualified Screener

_____ SCREENER IDENTIFIFCATION NUMBER (Assigned by NYS DOH)

UPDATE

39. The information contained herein has not changed and is a true abstract of the person's condition and circumstances.

_____

Signature of Trained and Qualified Screener

Review Date | Review Date | Screener Identification Number:

_____

Signature of Trained and Qualified Screener

Month / Day / Year — HC-PRI or PRI: - -

Month / Day / Year — Screen: - -

_____

Signature of Trained and Qualified Screener

Month / Day / Year — HC-PRI or PRI: - -

Month / Day / Year — Screen: - -

_____

Signature of Trained and Qualified Screener

Month / Day / Year — HC-PRI or PRI: - -

Month / Day / Year — Screen: - -

sample

Attachment 3

PRI Instructions
PRI Clarification Sheets
H/C PRI Instructions

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

I. USING THESE INSTRUCTIONS: These instructions and the training manual should be read before completing the PRI. These instructions should be kept with the PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE PRI ACCURATELY.

2. ANSWER ALL QUESTIONS: Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number should be entered: / /9 /6 /2 /1 /0 /. If there are unused boxes, they should be on the left side of the number as shown in the example.

3. QUALIFIERS: Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered yes. These qualifiers take the following forms:

o TIME PERIOD - The time period for the questions is the past four weeks, unless stated otherwise. For patients who have been in the facility less than four weeks (that is, new admissions or readmissions), use the time from admission to PRI completion as the time frame.

o FREQUENCY - The frequency specifies how often something needs to occur to meet the qualifier. For example, respiratory care needs to occur daily for four weeks or the PRI cannot be checked for this patient as receiving this care.

o DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered Ayes@ for the patient.

o EXCLUSIONS - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from respiratory care.

4. ACTIVITIES OF DAILY LIVING: The approach to measuring ADLs is slightly different from the other PRI questions. Measure the ADLs according to how the activity was completed 60% or more of the time during the past four weeks. Read the specific instructions for ADLs to understand the CHANGED CONDITION RULE and other details. PERFORMANCE: Measure what the patient does, rather than what the patient might be capable of doing.

5. CORRECTIONS: Cross out any responses which you wish to change and re-enter clearly to the right of the original response. Example: /3/ 4.

6. Use pen, not pencil.

INSTRUCTIONS: PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the 8 character identifier (7 numbers followed by the letter "N") stated on the facility's operating certificate. The last character "N" indicates Nursing Facility.

2. SOCIAL SECURITY NUMBER: Your PRIs can not be processed unless this question is accurately entered. Do not leave this question blank, do not enter zero if there is no social security number. Only use the Social Security number that has been specifically designated for the patient and not the spouse of the patient. Only use the number that has been assigned by the federal Social Security Administration. If there is no such number for a patient, a NEW SYSTEM has been developed to enable all facilities in the State to assign a unique ID number to those patients without a Social Security number. If a patient was assigned a computer generated number by the Department, that number should no longer be used. If the patient has no Social Security number, use this method: Enter the first three (3) letters of the patient's last name (starting to the far left), and then enter the six digits of the patient's date of birth. Omit the century in the birth date, which will be either a "19" or "18" as in 1930 or 1896. As an example, if a patient named Cheryl Brant has no social security number and was born on May 8, 1913, you would enter:/B/R/A/0/5/0/8/1/3 on the PRI.

3. RESIDENT IS LOCATED: Former HRF Area or Former SNF Area. This question has been revised to reflect the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). It is imperative that nursing facilities formerly deemed "dual level" complete this section properly.

4. PATIENT NAME: Enter the patient's name, last name first, in the boxes provided. Enter up to the first 10 letters of the patient's last name.

6. MEDICAL RECORD NUMBER: Enter the unique number assigned by the facility to identify each patient. It is not the Medicaid, Medicare or Social Security number unless that is the number used by the facility to identify each of its patients.

7 ROOM NUMBER: Enter the numbers and/or letters which identify the patient's room in the facility.

8. UNIT NUMBER: Enter the one or the two digit number (01-12) assigned by your facility to each nursing unit for the purpose of this data collection.

11. DATE OF INITIAL ADMISSION: Enter the month, day and year the patient (1) entered the present nursing facility. Use the date of the patient's first admission and not the most recent. If the patient were transferred from another facility, it would be an initial admission to your facility. As another example, consider a patient that was admitted to a hospital from your facility and subsequently loses bed hold. If this patient is eventually readmitted to your facility at the original level of care, use the original admission date to complete this item.

12. MEDICAID NUMBER: Enter these numbers if patient has the coverage available, whether

13. MEDICARE NUMBER: or not the coverage is being used. If not, enter only one zero in the
far right box.

14. PRIMARY PAYOR: Enter the one source of coverage which pays for most of the patient's current nursing home stay. Code "Other" only if the primary payor is not Medicaid or Medicare. (Do not code "Other" for a patient with Medicaid coverage supplemented by Medicare Part B Code Medicaid.) Medicaid pending is to be coded as "Medicaid", if there is no other primary coverage being used for the patient's present stay.

15A. REASON FOR PRI COMPLETION: Select the one reason why the PRI is being completed. Responses 3, 4, and 5 under Utilization Review have been eliminated.

REIMBURSEMENT ASSESSMENT CYCLE:

Indicate whether this assessment is being completed as a part of a full facility assessment or as part of a quality assessment cycle for new admissions only.

1. Biannual Full Facility Cycle - The data collection during which all the patients residing in the facility are assessed. These PRI assessments include patients who were assessed during your previous PRI data collection and any new admissions.

2. Quarterly New Admission Cycle - The "new admission only data collection," involving only patients who were not assessed at their present level of care during your previous full facility data collection are reviewed. This specific PRI data collection occurs three months after your full facility PRI data collection. A new admission may be a new patient from the hospital, community or another nursing facility; or was hospitalized during your previous full facility assessment (regardless of bedhold).

15B. WAS A PRI SUBMITTED BY YOUR FACILITY FOR THIS PATIENT DURING A PREVIOUS FULL FACILITY AND/OR NEW ADMIT CYCLE: Review your facility's records to determine whether a PRI for reimbursement purposes was ever completed for this patient.

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

Documentation-	For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components: o A description of the patient's decubitus. o Circumstance or medical condition which led to the decubitus. o An active treatment plan.
Definition LEVELS:	#0 No reddened skin or breakdown. #1 Reddened skin, potential breakdown. #2 Blushed skin, dusty colored, superficial layer of broken or blistered skin. #3 Subcutaneous skin is broken down. #4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone. #5 Patient is a level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a AYES@ to be answered for any of these conditions, all of the following qualifiers must be met:	
Time Period-	Condition must have existed during the past four weeks. (The only exception is to use the past twelve weeks for question 17H, urinary tract infection.
Documentation-	Written support exists that the patient has the condition.
Definitions-	See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17A.	COMATOSE: Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days.	Brain insult Hepatic encephalopathy Cerebral vascular accident	Total ADL Care Intake and output Parenteral feeding
17B.	DEHYDRATION: Excessive loss of body fluids requiring	Fever Acute urinary tract	Intake & output Electrolyte lab tests

	immediate medical treatment and ADL care.	infections Pneumonia Vomiting Unstable diabetes	Parenteral hydration Nasal Feedings
17C.	INTERNAL BLEEDING: Blood loss stemming from a subacute or chronic condition (*e.g.*, gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood likely to be needed every 60 days
17D.	STASIS ULCER: Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.	Severe edema Diabetes PVD	Sterile dressing Compresses Whirlpool Leg elevation
17E.	TERMINALLY ILL: Professional prognosis (judgement) is that patient is rapidly deteriorating and will likely die within three months.	End stages of: Carcinoma, Renal disease, and Cardiac diseases	ADL Care Social/emotional support
17F.	CONTRACTURES: Shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to spasticity, paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.		
	To qualify as AYES@ on the PRI the following qualifiers must be met:		
	1. The contracture must be documented by a physician, physical therapist or occupational therapist.		

	2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis. There does not need to be an active treatment plan to enter AYES@ to contractures.		
17G.	DIABETES MELLITUS: A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.	Destruction/malfunction of the pancreas Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus	Special diet Oral agents Insulin Exercise
17H.	URINARY TRACT INFECTION: During the past twelve weeks symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q.29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (*e.g.*, mentally confused or incontinent patients).	Exclude if symptoms are present, but the lab values are negative	Antibiotics Fluids

17I.	HIV INFECTION SYMPTOMATIC: HIV (Human Immunodeficiency Virus) Infection, Symptomatic: Includes Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection AND a positive finding is documented AND the patient has had symptoms, documented by a physician, nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant as related to the HIV infection. Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.		
17J.	ACCIDENT: An event resulting in serious bodily harm, such as a fracture, a laceration which requires closure, a second or third degree burn or an injury requiring admission to a hospital.		
	To qualify as AYES@ on the PRI the following qualifier must be met: 1. During the past six months serious bodily harm occurred as the result of one or more		

	accidents.		
17K.	VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.		
	All services shall be Provided in accordance with Sections 416.13, 711.5 and 713.21 of Chapter V of Title 10 of the *Official Compilation of Codes Rules and Regulations* of the State of New York.		

18. MEDICAL TREATMENTS: For a AYES@ to be answered for any of these, the following qualifiers must be met:	
Time Period-	Treatment must have been given during the past four weeks in conformance with the frequency requirements cited below and-still be required. For medical treatments having a daily frequency requirement, treatment must be provided every day of the four week period, except for residents newly admitted during the period. For residents newly admitted during the four week period, treatments required daily must have been provided each day from admission to the end of the four week period and documentation must support the seriousness of the condition and the probability that treatment will continue for at least four weeks.
Frequency-	As specified in the chart below. (The only exception is to

	use the past twelve weeks for question 18L, catheter.)
Documentation-	Physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order specifies that treatment should be given and includes frequency as cited below, where appropriate.
Exclusions-	See chart on next page.

	DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18A.	TRACHEOSTOMY CARE: Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.	Daily	Self-care patients
18B.	SUCTIONING: Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.	Daily	Any tracheostomy Suctioning
18C.	OXYGEN THERAPY: Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (*e.g.*, cardiopulmonary condition).	Daily	Inhalators Oxygen in room, but not in use
18D.	RESPIRATORY CARE: Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.	Daily	Suctioning
18E.	NASAL GASTRIC FEEDING: Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.	None	None Gastrostomy not applicable
18F.	PARENTERAL FEEDING: Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (*e.g.*, comatose, damaged stomach).	None	None Gastrostomy not applicable
18G.	WOUND CARE: Subcutaneous lesion(s) resulting from surgery, trauma,	Care has been provided or is	Decubiti Stasis ulcers

	or open cancerous ulcers.	professionally judged to be needed for at least 3 consecutive weeks	Skin tears Feeding tubes
18H.	CHEMOTHERAPY: Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician, nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant when the physician assistant's order is appropriately cosigned. (Patient may have to go to a hospital for treatment.)	None	None
18I.	TRANSFUSIONS: Introduction of whole blood or blood components directly into the blood stream. (Patients may have to go to a hospital for treatment.)	None	None
18J.	DIALYSIS: The process of separating components, as in kidney dialysis (*e.g.*, renal failures, leukemia, blood dyscrasia). Patient may have to go to a hospital for treatment.	None	None
18K.	BOWEL AND/OR BLADDER REHABILITATION: The goal of this treatment is to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (i.e., usually not longer than six weeks). NOT all patients at level 5 under Toileting Q.22 may be a "YES@ with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:	Very specific And unique for each patient	Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions

	Bladder rehabilitation: Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental and physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.		
	Bowl rehabilitation: A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (*e.g.*, bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.		Exclude a bowel maintenance program which controls bowel intinence by development of a routine bowel schedule
18L.	CATHETER: During the past twelve weeks, an indwelling or external catheter has been needed. Indwelling catheter has been used for any duration during the past twelve weeks. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past twelve weeks. A physician order is required for an indwelling catheter; for an external catheter a physician order is not required.		Exclude catheters used to empty the bladder once, secure a specimen or instill medication
18M.	PHYSICAL RESTRAINTS: A physical device used to restrict resident movement. Physical restraints include belts, vests, cuffs, mitts, jackets, harnesses and geriatric chairs.	At least two continuous Daytime hours for at least 14 days during the past four weeks.	Exclude all of following: o Medication use for the sole purpose of modifying residents behavior

			o Application only at night o Application for less than two continuous daytime hours for 14 days o Devices which residents can release/remove such as, velcro seatbelts on wheelchairs o Residents who are bed bound o Side rails, locked doors/gates, domes
	To Qualify as AYES@ on the PRI the following qualifiers must be met: 1. The restraint must have been applied for at least two continuous daytime hours for at least 14 days during the past four weeks. Daytime includes the time from when the resident gets up in the morning to when the resident goes to bed at night. 2. An assessment of need for the physical restraint must be written by an M.D. or R.N. 3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint.		
	NEW ADMISSIONS: If a patient is a new admission and will require the use of a physical restraint for at least two continuous daytime hours for at least 14 days as specified by the physician order, then enter AYES@ on the PRI.		

III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING Use the following qualifiers in answering	

each ADL question:	
Time Period-	Past four weeks.
Frequency-	Asses how the patient completed each ADL 60% or more of the time performed (since ADL status may fluctuate during the day or over the past four weeks.) CHANGED CONDITION RULE: When a patient's ADL has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.
Definitions-	SUPERVISION means verbal encouragement and observation, not physical hands-on care. ASSISTANCE means physical hands-on care. INTERMITTENT means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis. CONSTANT means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity. Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

CLARIFICATION OF ADL RESPONSES

19. EATING:

#3 ARequires continual help...@ means that the patient requires a staff person=s continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

#5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.

20. MOBILITY:

#3 AWalks with constant supervision and/or assistance...@ may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient needs the help of two people to transfer.

#5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 "Continent... Requires no or intermittent supervision" and #2 "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 "Continent...Requires constant supervision/total assistance... " refers to a patient who may not be able to balance him/herself and transfer, has contractures, has fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, as documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A Patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel

incontinence.

Example 2: The patient requires intermittent supervision for bowel function (level 2) and is taken to the toilet every two hours as part of a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

IV. BEHAVIORS - VERBAL DISRUPTION; PHYSICAL AGGRESSION; DISRUPTIVE, INFANTILE/SOCIALLY INAPPROPRIATE BEHAVIOR; AND HALLUCINATIONS

The following qualifiers must be met:

Time Period-	Past four weeks.
Frequency-	As stated in the responses to each behavioral question.
Documentation-	To qualify a patient as LEVEL 4 or to qualify the patient as a "YES" to HALLUCINATIONS, the following conditions must be met: o Active treatment plan for the behavioral problem must be in current use. o Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. The problem addressed by this assessment must still be exhibited by the patient.
Definitions-	The terms used on the PRI should be interpreted only as they are defined below: o PATIENT'S BEHAVIOR: Measure it as displayed with the behavior modification and treatment plan in effect during the past four weeks. o DISRUPTION: Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur. o NONDISRUPTION: Verbal outbursts and/or physical actions by the patient

	may be irritating, but do not create a need for immediate action by the staff. o UNPREDICTABLE BEHAVIOR: The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern. o PREDICTABLE BEHAVIOR: Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and can plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS

23. VERBAL DISRUPTION: Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.

24. PHYSICAL AGGRESSION: Note that the definition states "with intent for injury."

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: Note that the definition states this behavior is physical and creates disruption.
EXCLUDE the following behaviors:

o Verbal outbursts
o Social withdrawal
o Hoarding
o Paranoia

26. HALLUCINATIONS: For a "YES" response, the hallucinations must occur at least once per week during the past four weeks, in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment.

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

o For each therapy these three types of information will be entered on the PRI; "Level", "Days" and "Time" (hour and minutes).

o For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as #1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will be 0 (zero).

o Use the chart on the following page to understand the qualifiers for each of the three types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART THAT FOLLOWS FOR THE SPECIFIC QUALIFIERS.

27. *LEVEL QUESTION:	**QUALIFIERS (see level 4 below)	
QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY = LEVEL 2	RESTORATIVE THERAPY = LEVEL 3
DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL / ADL ABILITY	None. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement.	There is positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.
PHYSICIAN ORDER, NURSE PRACTITIONER ORDER (IN CONFORMANCE WITH A WRITTEN PRACTICE AGREEMENT WITH A PHYSICIAN), OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER	Yes	Yes, monthly
PROGRAM DESIGN AND EVALUATION QUALIFIER	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.

TIME PERIOD QUALIFIER	Treatments have been provided during the past four weeks.	Treatments have been provided during the past four weeks.
NEW ADMISSION QUALIFIER	Not Applicable	New admissions of less than four weeks can be marked for restorative therapy if: o There is a physician order, nurse practitioner order (in conformance with a written agreement with a physician), or appropriately cosigned physician assistant order for therapy and patient is receiving it. o The licensed therapist has documented in the care/plan that therapy is needed for at least 4 weeks. o A new admission includes readmission to a residential health care facility.
* After completion of the ALevel@ question, proceed to the separate ADays@ and ATime@ qualifiers on the next page. ** QUALIFIERS NOT MET = LEVEL 4 ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS FOR LEVELS 2 OR 3 IS NOT MET.		
27. DAYS AND TIME PER WEEK QUESTION: QUALIFIERS*		
QUALIFIERS FOR DAYS AND TIME*	MAINTENANCE THERAPY (i.e.,level 2 or 4 under ALevel@ question)	RESTORATIVE THERAPY (i.e., If level 3 or 4 under ALevel@ question)
TYPE OF THERAPY SESSION	Count only one-to-one care. Exclude group sessions (*e.g.*,	Count only one-to-one care. Exclude group sessions

	PT exercise session, OT cooking session).	(*e.g.*, PT exercise session, OT cooking session).
SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY)	A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.	A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides).
* QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THE QUALIFIERS UNDER EACH LEVEL OF THERAPY.		

28. NUMBER OF PHYSICIAN VISITS: Enter A0" (zero) unless the patient need qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits that meet the physician, nurse practitioner, or physician assistant visit qualifiers

o PATIENT TYPE/NEED QUALIFIERS: The patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).

o PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT VISIT QUALIFIER: If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits during the past four weeks that meet the following qualifications:

o A visit qualifies only if there is physician, nurse practitioner, or physician assistant documentation that she/he has personally examined the patient to address the pertinent medical problem. The physician, nurse practitioner, or physician assistant must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (*e.g.*, change medications, renew treatment orders, nursing orders, order lab tests).

o Do not include phone calls as a visit nor visits which could have been accomplished over the phone.

o A visit qualifies whether it is on-site or off-site, as long as the patient is not an inpatient in a hospital/other facility.

29. MEDICATIONS

A. Monthly average number of all medications ordered: Enter the monthly average number of different medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months determine the monthly average number of medications ordered based on the number of months since admission. The average should include the total number of ordered medications whether or not they were administered: (PRN medications; injectables, ointments, creams, ophthalmics, short-term antibiotic regimens and over-the-counter medications, etc.)

B. Monthly average number of psychoactive medications ordered: Enter the monthly average number of psychoactive medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months, determine the monthly average of psychoactive medications ordered based on the number of months since admission. The average should include all ordered psychoactive medications whether or not they were actually administered.

A Apsychoactive@ mediation is defined as a medication that is intended to affect mental and/or physical processes, namely to sedate, stimulate, or otherwise change mood, thinking or behavior.

The following are classes of psychoactive medications with several examples listed in each:

o	Antidepressants-	Amitriptyline (Elavil); Imipramine (Tofranil); Doxepin (Sinequan); Tranylcpromine (Parnate); Phenelzine (Nardil)
o	Anticholinergics-	Benztropine (Cogentin); Trihexyphenidyl (Artane)
o	Antihistamines-	Diphenhydramine (Benadryl); Hydroxyzine (Atarax)
o	Anxiolytics-	Chlordiazepoxide (Librium); Diazepam (Valium)
o	Cerebral Stimulants-	Methylphenidate (Ritalin); Amphetamines (Benzedrine)
o	Neuroleptics-	Phenothiazines; Thiothixene (Navane); Haloperidol (Haldol); Chlorpromezine (Thorazine); Thioridazine (Mellaril)
o	Somnifacients-	Barbituates (Nembutal); Temazepam (Restoril); Glutethimide (Doriden); Flurazepam (Dalmane)

VI. DIAGNOSIS

30. PRIMARY MEDICAL PROBLEM: Follow the guideline stated below when answering this question.

o NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks. A review of the medical record for nursing and physician, nurse practitioner, or physician assistant notes during the past four weeks may be necessary.

o JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.

o ICD-9 Refer to the ICD-9 Codes for Common Diagnoses attached at the end of these instructions for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.

o NO ICD-9 NUMBER: Enter A0" (zero) in the far right box if no ICD-9 number can be found for the patient=s primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

o NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV infection.

31: QUALIFIED ASSESSOR NUMBER: The qualified assessor who is attesting to the accuracy of the assessment must sign the completed form and enter the assessor Identification Number which was assigned at an approved N.Y.S. Department of Health Training Program.

Since the PRI is completed and submitted for the purposes of a reimbursement assessment cycle, the certified assessor must have actually completed the patient assessment, utilizing medical records and/or observations or interviews of the patient. This should be indicated by checking the YES box.

38. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups:

1. WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

2. WHITE/HISPANIC: A person who meets the definition of both White and Hispanic

(See Hispanic Below)

3. BLACK: A person having origins in any of the Black racial groups of Africa.

4. BLACK/HISPANIC: A person who meets the definition of both Black and Hispanic (see below).

5. ASIAN OR PACIFIC ISLANDER: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

6. ASIAN or PACIFIC ISLAND/HISPANIC: A person who meets the definition of both Asian or
Pacific Islander and Hispanic (see below).

7. AMERICAN INDIAN or ALASKAN NATIVE: A person having origins in any of the original peoples of North American and who maintains tribal affiliation or community recognition.

8. AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. OTHER: Other groups not included in previous categories.

HISPANIC: A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

CLARIFICATION SHEET: PATIENT REVIEW INSTRUMENT

THIS SHEET ADDRESSES COMMON QUESTIONS ON THE PRI INSTRUCTIONS. IT SHOULD BE USED TO CLARIFY CERTAIN PRI QUESTIONS IN CONJUNCTION WITH THE INSTRUCTIONS, AND DOES NOT CONTAIN CHANGES TO THE INSTRUCTIONS. THE ANSWERS PROVIDED ARE FOR **NURSING HOMES** COMPLETING THE PRI FOR REIMBURSEMENT PURPOSES AND MAY NOT APPLY TO HOSPITALS AND HOME HEALTH AGENCIES.

PLEASE NOTE THAT ALL REFERENCES IN THIS CLARIFICATION SHEET TO THE APPLICABILITY OF PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERVICES FOR PRI PURPOSES (E.G.: COUNTING OF MEDICAL VISITS FOR UNSTABLE CONDITIONS AND ORDERING TREATMENTS) ARE EFFECTIVE SOLELY FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON AND AFTER JULY 1, 1999.

IN ADDITION, DUE TO AN AMENDMENT TO ARTICLE 37 OF THE PUBLIC HEALTH LAW, REFERENCES IN THE PRI CLARIFICATION SHEET REGARDING APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDERS HAVE BEEN AMENDED. EFFECTIVE WITH PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON OR AFTER NOVEMBER 23, 2005, PHYSICAN ASSISTANTS MAY WRITE INPATIENT MEDICAL ORDERS WITHOUT A SUPERVISING PHYSICIAN'S COUNTERSIGNATURE, IF PERMITTED BY THE PHYSICIAN AND THE FACILITY'S BY-LAWS, RULES, AND REGULATIONS.

FURTHER, FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON OR AFTER NOVEMBER 23, 2005, PHYSICIAN ASSISTANT'S INPATIENT MEDICAL ORDERS THAT ARE NOT COSIGNED BY A SUPERVISING PHYSICIAN ARE DEEMED TO MEET THE REQUIREMENTS IN THE PRI INSTRUCTIONS FOR "APPROPRIATELY COSIGNED" IF THE LACK OF SUCH A COSIGNATURE IS PERMITTED BY THE SUPERVISING PHYSICIAN AND THE FACILITY'S BYLAWS, RULES, AND REGULATIONS.

PLEASE NOTE THAT ALL REFERENCES IN THIS CLARIFICATION SHEET TO THE ALLOWABILITY OF NEW ADMISSION QUALIFIERS FOR MEDICAL TREATMENTS, INCLUDING OXYGEN THERAPY, ARE EFFECTIVE SOLELY FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON AND AFTER JULY 1, 1999.

SECTION I. ADMINISTRATIVE DATA

2. SOCIAL SECURITY NUMBER:

Q) *What can be entered for the social security number?*

A) Use only the number that has been specifically designated for the resident and not the spouse of the resident. Use only the number that has been assigned by the federal Social Security Administration. If there is no such number for a resident, a system has been developed to enable ALL FACILITIES in the state to assign a unique ID number to those residents without a social security number. To assign a resident ID number in lieu of a social security number, use the first three (3) letters of the resident's last name and the six number date of birth. Example: Mary Jones was born January 25, 1901. Her number would be JON012501.

Q) *If no social security number exists, can the railroad retirement number be used instead?*

A) NO. Enter the first three (3) letters of the last name and the six number date of birth. See example above.

Q) *If a social security number becomes available later, can it be used?*

A) Yes. Use the correct number when it becomes available. Be aware, however, that the social security number on a discharge must match that used on the full house PRI.

3. RESIDENT IS LOCATED:

Q) Does this question have to be answered?

A) YES. Former stand-alone Health Related Facilities (HRFs) must enter a '1' for all residents. All other facilities may use a '2'.

4. PATIENT NAME:

Q) *How should the resident name be entered?*

A) Begin entering the resident name on the left. Unused boxes should be on the right.

6. MEDICAL RECORD NUMBER:
AND
7. ROOM NUMBER:

Q) *Do these responses need to be accurate?*

A) Yes. Be accurate with these numbers and check whether they are updated. For example: if a resident has been re-admitted from the hospital (after loss of bed hold) there could be a new medical record number.

Q) *How is Traumatic Brain Injury - Extended Care entered under room number? What are the qualifiers?*

A) To record this type of resident, enter 'TBI99' in the five spaces of room number, question 7. A qualifying resident is one who is at least three months post-injury, and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage or anoxia. In addition, this person must have participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home, and have been assessed by a neurologist or physiatrist who determined that the person would no longer benefit from an intensive rehabilitation program. There must also be a classification system for measuring the physical, affective, behavioral, and cognitive level of functioning, as well as an active treatment plan.

8. UNIT NUMBER:

Q) Where is this number found and why can't the facility enter its actual unit number/name on the PRI?

A) Since the facilities use names, numbers, letters or any combination of these to label their units, it would be difficult to accommodate these differences for the PRI answer key. The Unit Identification Form serves to standardize the format of answers entered in this question. A copy of the Unit Identification Form should be returned with all PRI certification submissions. Use the unit number your facility has assigned to each unit on the Unit Identification Form of the RUG-II Project.

Q) *Do the unit numbers need to be assigned in a specific way?*

A) The assignment can be made in any way convenient to the facility. The Unit Identification Form serves to tie the assigned number to the facility name for the unit.

9. DATE OF BIRTH:

Q) *If the entire date of birth is unknown, that is, the date and/or month, can only the year be entered on the PRI?*

A) No. Enter at a minimum the correct birth year of the resident and estimate the month and day.

Q) *Several residents' birth dates have been discovered to be erroneous since our last submission. If the correct date is entered on the next PRI will the computer pick it up as an error?*

A) NO. An error will not occur if the date is changed during a full house submission. DO NOT change this type of information on quarterly admit and discharge submissions.

12. MEDICAID NUMBER:

Q) *Is the recipient or facility number used?*

A) Use the recipient number which is used for the purpose of billing the Medicaid Management Information System (MMIS). Check with your business office, if necessary, to determine which is the recipient's number.

13. MEDICARE NUMBER:

Q) *How are Medicare numbers entered?*

A) Enter the first ten (10) digits/letters of the Medicare number on the PRI and drop any additional digits/letters. The last box is for the Medicare suffix (letter). Not all Medicare numbers include this suffix.

14. PRIMARY PAYOR:

Q) *What should be entered if the resident is Medicaid pending?*

A) Enter the PRI response "Medicaid" if the resident is using no other primary source of coverage for the nursing home stay. Do NOT enter "Medicaid" for the resident who is using another source of coverage which is coming to an end, such as Medicare, private or self pay and are Medicaid pending.

SECTION II. MEDICAL EVENTS

16. DECUBITUS LEVEL:

Q) *If the decubitus level has changed during the past four weeks, is the present or previous level entered on the PRI?*

A) Enter the most severe level the resident has had anytime during the past four weeks.

Q) *Can the cause for a decubitus be other than a pressure point, such as a skin tear or other skin disorders?*

A) NO. Only an ulcer which has formed at a pressure point.

Q) *How detailed of an explanation in the medical record is needed to substantiate the level of decubitus, particularly level 4? Is diagnosis or hospitalization sufficient?*

A) Only level 4 has documentation qualifiers specific to the PRI as stated in the PRI Instructions. It must be evident from the medical record why the resident is at level 4; one of the useful pieces of information could be the diagnosis, but diagnosis in itself is not specific enough. For residents in a nursing home who developed the decubitus while in the hospital, hospitalization is an acceptable rationale for cause.

Q) *Who may document as the "Licensed Clinician" for level 4?*

A) The licensed clinician may be a physician, physician assistant, nurse practitioner, registered nurse, or a licensed practical nurse whose note is co-signed by a RN. The reason the LPN's note must be co-signed is because the documentation of a level 4 decubitus is in the nature of a clinical assessment rather than a description of care provided.

Q) *Must a Stage IV decubitus be necrotic?*

A) YES. According to the PRI definitions, a stage IV decubitus is a "necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia, and bone". Documentation must be present to substantiate the level and probable cause of the decubitus. It is not necessary, however, that necrotic tissue be present during the time frame of the PRI submission. Even if a level 4 decubitus is debrided, it remains a level
4 until it takes on the clinical profile of a level 3. Documentation must be present to substantiate that the necrosis did exist, and that the decubitus did have the clinical profile of a level 4 at some time during the 28-day period. Enter the most severe level the resident has had during the past four weeks.

17. MEDICAL CONDITIONS:

A. COMATOSE

Q) *What if the coma does not exist during the entire four-week period?*

A) The coma has to be present for any four (4) or more days during the time period. The four (4) days do not have to be consecutive.

B. DEHYDRATION

Q) *Can the dehydration occur in the hospital?*

A) The dehydration must occur in the nursing home. However, the care for the dehydration may be in the hospital. The resident must be back from the hospital during the PRI data collection period in the facility to substantiate the dehydration.

C. INTERNAL BLEEDING

Q) *Does monitoring a resident for possible drug side effects qualify here?*

A) No. There must be evidence of an active bleed. Monitoring for drug side effects does not meet this qualifier.

E. TERMINALLY ILL

Q) *Is a terminal diagnosis sufficient in and of itself to capture a resident as terminally ill*

for PRI purposes?

A) No. There must also be evidence of a rapid decline in condition to capture the resident as terminally ill under the PRI. The medical record should provide evidence of the rapid deterioration.

F. CONTRACTURES

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore. please automatically enter a '2' for a negative response.

G. DIABETES MELLITUS

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore please automatically enter a '2' for a negative response.

H. URINARY TRACT INFECTION

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

Q) *If there is a 'YES' response to question 17H, UTI, will that put a resident in the clinically complex hierarchy?*

A) NO. The UTI ICD-9 code 599.0 must be entered in response to Question 30. In order to claim UTI for question 30, the condition must have existed during the past 28 days and must be the medical condition requiring the largest amount of nursing time.

J. ACCIDENT

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

K. VENTILATOR DEPENDENT

Q) *What is the time frame for this question?*

A) Answer 'YES' on the PRI for all the following: a resident who was admitted to the facility during the 28 day relevant period and was on a ventilator upon admission or was ventilator dependent within five days prior to admission; a resident who has

been extubated for no more than one month at the close of the 28 day relevant period **if** he/she is receiving active respiratory rehabilitation services during the period; and a resident who decompensates and requires intubation.

18. MEDICAL TREATMENTS:

Q) *Can these treatments be claimed for a new admission?*

A) Effective for PRI submissions attributable to assessment periods on and after July 1,1999, a new admission qualifier will be instituted for medical treatments. For PRI submissions prior to July 1, 1999, there is no new admission qualifier for medical treatments.

Q) *The PRI instructions, which are in regulation, make a requirement for a physician order for medical treatments. Does the order of a physician assistant or nurse practitioner satisfy the requirement for a physician order?*

A) The Department is implementing a policy whereby nurse practitioners' and physician assistants' orders for medical treatments do count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on and after July 1, 1999. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of the SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

A. TRACHEOSTOMY CARE

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

C. OXYGEN (DAILY)

Q) *What does daily mean?*

A) Daily means seven days per week; it does not have to be given during the entire twenty-four hours of each day.

Q) *Does the resident need to be in the facility for the full 28 days to be captured as having received oxygen therapy?*

A) Effective for PRI submissions attributable to assessment periods on and after July 1, 1999, a new admission qualifier will be instituted for oxygen therapy. A resident will not need to have been in the facility for the full 28 days to be captured as having received oxygen therapy. For PRI submissions attributable to assessment periods prior to July 1, 1999, there is no new admission qualifier for oxygen therapy so residents must have been in the facility the full 28 days to be captured as having received oxygen therapy.

Q) *Are oxygen enrichers acceptable means of providing oxygen daily?*

A) YES.

D. RESPIRATORY CARE (DAILY)

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

Q) *Is suctioning included with "respiratory care"?*

A) NO. Suctioning is a separate treatment. Both "suctioning" and "respiratory care" can be checked on the PRI if the other respiratory treatments are being provided in addition to suctioning. If daily oxygen is being provided as well as daily respiratory care, check both on the PRI.

E. NASAL GASTRIC FEEDING

Q) *Is gastrostomy tube feeding captured here?*

A) No. Do not include gastrostomy feeding; this is captured under level 5 of the Eating question.

G. WOUND CARE

Q) *Must the wound care have already been provided for three weeks at the time of PRI completion for it to be entered? Does the "still required" qualifier apply to wound care?*

A) If the wound care has been provided for three consecutive weeks during the 28 day period, it does not have to be 'still required' at the close of the 28 day period. If the wound care has not been provided for three consecutive weeks by the close of the 28-day assessment period, it does need to be in progress at the close of the period and the condition of the wound (e.g., circumference, depth) must necessitate at least three consecutive weeks of care. For example, if at the close of the period wound care has been in progress for two consecutive weeks and is anticipated to be needed for one more week, this would meet the qualifier.

Q) *Is there a specified frequency for wound care?*

A) Although there is no specified frequency for the provision of wound care, there must have been some wound care provided during each of three consecutive weeks during the 28 day period or, in the alternative, it must be evident that wound care which has commenced to be given by the end of the period will be needed for three consecutive weeks.

Q) *Are specific treatments required to capture wound care? Does it matter where the* treatments *are given?*

A) The qualifiers for wound care relate to the nature of the wound (subcutaneous lesion resulting from surgery, trauma, or open cancerous ulcers) and to the duration of treatment (at least three weeks). Any treatment is allowable if it is ordered by a physician, nurse practitioner or physician assistant (with physician cosign) and provided by appropriate clinical personnel. For example, whirlpool treatments given for wound care in the therapy department, by a therapist, would be allowable. It should be noted, however, that several types of lesions (e.g. decubiti), which may be treated with a whirlpool, are specifically excluded from wound care by the PRI instructions. In reference to physician assistant orders with physician cosign, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

H. CHEMOTHERAPY

Q) *Are radiation or cobalt treatments considered chemotherapy?*

A) NO.

Q) *What chemical agents are countable under the PRI system as Chemotherapy? How may these medications be administered?*

A) Any oral or intravenously administered chemical agent that a physician, nurse practitioner or physician assistant (with physician cosign) documents as being ordered to treat a carcinoma is acceptable for PRI purposes as chemotherapy. Medications administered intramuscularly cannot be counted as chemotherapy. In reference to physician assistant orders with physician cosign, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

I. TRANSFUSION

Q) *According to the PRI definition, how many transfusions have to be given during the past four weeks and does the "still required" qualifier apply to transfusions?*

A) One or more transfusions must have been given during the 28 day relevant period and there must be a likelihood that additional periodic transfusions will be required, based on the resident's condition. A resident who received a transfusion for a one-time acute medical episode would not meet the 'still required' qualifier because additional transfusions would not likely be needed.

K. BOWEL AND BLADDER REHABILITATION

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

L. CATHETER

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

M. PHYSICAL RESTRAINTS (DAYTIME ONLY)

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

SECTION III. ACTIVITIES OF DAILY LIVING

19. EATING:

Q) *What level should be entered for a resident on "Do Not Feed" orders?*

A) Enter a level 1, because no staff involvement is required.

20. MOBILITY:

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '1' for the lowest level.

21. TRANSFER:

Q) *Should transfers to bath or toilet be included?*

A) No. Exclude transfers to bath or toilet.

Q) *Assistance of one person is required but the resident does not participate in the transfer. Is this resident still a level 3?*

A) YES. The key issue is how many people assist in the transfer. The resident who is at level 3 may or may not participate in the transfer.

Q) *Since the resident is small and lightweight, the assistance of only one person is needed with the lifting equipment. However, in most cases, the assistance of two people would be required with this equipment. Which transfer level is correct?*

A) Level 3, “requires one person...” is the correct PRI level. The key issue is the amount of assistance the resident actually receives.

Q) *Should a resident who needs the assistance of two people to transfer rather than one person have documented why this additional staff assistance is needed?*

A) YES. If a 2 person transfer is required, there must be a logical reason why the resident needs the help of 2 people to transfer. Documentation must support this need.

22. TOILETING:

Q) What is meant by the 60 percent rule?

A) There are actually two 60 percent rules that apply to toileting. As with other ADL questions, assess how the resident completed the task 60 percent of the time. Additionally, the **incontinent** resident is defined as one who loses control of his/her bladder or bowel functions (with or without equipment) 60 percent or more of the time. Equally, the **continent** resident is one who has control of his/her bladder **and** bowel functions 60 percent or more of the time. This continence may be achieved through the use of equipment, such as a catheter. Keep in mind that for levels 1 and 2, this second 60 percent rule is irrelevant because it is immaterial for PRI classification purposes whether the resident is continent or incontinent. For level 3 the resident must be continent by the 60 percent rule, while for levels 4 and 5 the resident must be incontinent by the 60 percent rule.

Q) *What kinds of residents are included at level 3?*

A) Level 3 includes residents who are continent of both bowel and bladder function 60 percent of the time and require constant supervision and/or constant physical assistance with major/all parts of the task. This 'continence' may be due to the use of toileting appliances: e.g. colostomy, ileostomy and/or urinary catheter devices. If a resident is continent of both functions but does not require constant help, then this resident is a level 1 or 2. Residents who are continent 60 percent of the time and are scheduled to be toileted just after meals are appropriately categorized as level 3, not level 5. Level 5 residents require a more individualized plan, as described in later questions.

Q) *What kinds of residents are included at level 5 and what are the associated care planning requirements?*

A) Level 5 requires that the resident is incontinent presently and is on a scheduled toileting program. If the resident *appears* continent *only* because he/she is on this formal toileting schedule, then this is applicable for level 5. The resident's care plan must establish a toileting assistance program that is based on an assessment of resident needs. The assessment should establish the needs of the resident which led to the development of the program. The program documented in the care plan must constitute more than taking the resident to the bathroom after meals. The goal of this program may be for restoration or maintenance; refer to the PRI Instructions for examples. The plan must establish either specific times or time intervals for toileting assistance to be provided. In no instance can the plan establish a toileting assistance schedule with any less frequency than every 2-4 hours during the day. The toileting intervals may vary during the day; for example, the resident may be toileted at two-hour intervals during the morning and at four-hour intervals during the afternoon and evening. The plan may provide for use of a bed pan at night as needed. The care plan document is separate and apart from the document used to record when toileting occurs and who provides toileting assistance.

Q) *A resident has a diagnosis of CVA with a left hemiplegia. Although he is able to take himself to the bathroom and to complete his own toileting, he does require staff help to pull up his pants when he is finished voiding. What level is appropriate for PRI categorization of this resident?*

A) This resident would be considered a level 2, as he requires only **minor** physical assistance.

Q) *Which level is the resident who needs 'constant assistance' with elimination devices/equipment (e.g. catheter)?*

A) Level 3. This level includes the continent resident who needs constant assistance with appliances such as a catheter or ileostomy.

Q) *If a resident needs constant assistance with his/her catheter (level 3) and is on a formal bowel program (level 5) which level is entered on the PRI.?*

A) Level 5. A person can not be both level 3 and level 5 since level 3 requires 60 percent **continence of *both* bowel and bladder function** while level 5 pertains to a resident **incontinent of *at least one*** of these functions

Q) *If the resident cannot transfer onto a toilet, is this assistance considered level 2 'minor physical assistance' or level 3 'major physical assistance'?*

A) Level 3, major physical assistance

Q) *What documentation is needed at level 5 to adequately demonstrate that the resident has been toileted in conformance with the care plan?*

A) The facility MUST have a mechanism in place to substantiate that the resident is taken to the bathroom in conformance with the schedule established in the care plan. This mechanism for documentation could be in the form of a checklist or flowsheet. The name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance is provided. In instances where use of a bedpan is documented on the toileting record, this must be distinguished from taking the resident to the toilet. The document used to record when toileting occurs and who provides toileting assistance is separate and apart from the care plan.

Q) *Can the resident at level 5 routinely be taken to a toilet during the day but use a bedpan at night?*

A) YES. The PRI states 'as needed at night'.

Q) *If a resident is on a toileting schedule but a commode is used, does this person qualify for a level 5?*

A) YES because level 5 refers to being taken to a bathroom, whether within or outside the resident's room.

Q) *Which level applies to the resident only on a bedpan schedule (during the day and night)?*

A) Level 4. Level 5 refers to being taken to a bathroom, whether within or outside of the resident's room.

Q) *If a resident is taken to the bathroom about twice per day on an 'as needed' basis and during the rest of the toileting time the resident is* ***changed*** *in bed, is this a level 4 or 5?*

A) Level 4. The 60 percent rule must be used in this case; further, level 5 refers to a formal schedule, not an ad hoc 'as needed' basis.

SECTION IV. BEHAVIORS

Q) *Can the psychiatric assessment be a general one?*

A) In order to qualify for level 4 for questions 23, 24, 25 or a 'YES' for question 26, the psychiatric assessment MUST address the specific problem behavior and the behavior must still be exhibited by the resident. The assessment must specifically address the behaviors exhibited to be considered clinically valid and countable.

Q) *Who may do the psychiatric assessment?*

A) This qualifier refers to a professional who has a formal academic degree or specialization in the psychiatric field and works as a psychiatric specialist. Other than a psychiatrist or psychologist, this may be a psychiatric social worker or a registered nurse who has an advanced degree in psychiatric nursing. Psychiatric experience, without formal training, does not fulfill this educational requirement. 'Mental health workshops' or psychiatric seminars do not constitute formal education. If the psychiatric assessment is done by anyone other than a psychologist or psychiatrist, evidence of this person's psychiatric formal training must be produced upon request of the PRI reviewer.

Q) *What are the qualifications of the psychiatric registered nurse or social worker?*

A) This professional must be recognized by others as being a **specialist** in the psychiatric field. This specialty and recognition has been acquired though these methods: psychiatric education, psychiatric training and psychiatric experience. There is not a specific PRI qualifier for the amount of psychiatric training and experience to acquire this specialty. However, to be recognized and practice as a psychiatric professional does denote considerable years of training, education and experience. Experience working with psychiatric patients is not sufficient in itself.

Q) *For what time period is a psychiatric evaluation valid in terms of this PRI qualifier?*

A) The PRI does not provide a specific frequency for psychiatric evaluations. However, the evaluation must be clinically valid, meaning the assessment must be specific in terms of addressing the resident's behaviors and type of mental disability.

Q) *What type of documentation is required for a level 4 (questions 23, 24, 25) or a 'YES' for question 26?*

A) There must be appropriate notes on the chart describing **each occurrence** of the behavior, the date and time, the intervention and the results of the intervention. Behavior must occur at least once per week and be **unpredictable**. The psychiatric assessment must address the specific problem behavior and the behavior must still be exhibited by the resident. There must be an active treatment plan currently in use.

Q) *Can 'flow sheets' and/or monthly summaries be the sole documentation for Behavioral problems?*

A) Monthly summaries require supportive documentation specifically recording incidents of the behavior, the intervention required and the results of the intervention. "Flow sheets" are acceptable **as long as** all the required information and endorsements are present.

Q) *Does a dementia diagnosis on question 30 automatically qualify a resident for the behavioral hierarchy?*

A) No, The resident must meet the behavioral qualifiers to be included in the behavioral hierarchy.

Q) *What does weekly mean? Is this a calendar week?*

A) Weekly means once in each of the four seven-day cycles which commence on the first day of the 28 day relevant period. For example, for a PRI completed on a Wednesday, there must have been a behavioral incident within each of the Thursday through Wednesday periods in the preceding 28 days. Weekly does NOT mean merely four episodes at any time within the 28 days; two episodes in one week would not offset a week with no episodes.

23. VERBAL DISRUPTION:

Q) *Are verbal suicidal tendencies measured by this question?*

A) NO.

24. PHYSICAL AGGRESSION:

Q) *What does 'intent for injury' mean in the PRI definition of aggression?*

A) 'Intent for injury' means the resident was aggressive on purpose (may be due to the resident's physical or mental disfunction) and this behavior **could or did** hurt the resident or others. Behavior such as throwing a pillow on the floor would hurt neither the resident nor others and would not be considered aggressive behavior. The staff would not have to intervene immediately.

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:

Q) *Do behaviors need to be disruptive to be captured here?*

A) Yes. Include only physical actions which need **immediate** attention by the staff. The examples provided on the PRI are good illustrations of the intensity of the behaviors included under this question. Do not include physical actions by the resident which are unusual or anti-social but do not cause the staff to stop what they are doing at the very moment they observe the resident's behavior. For example, messy clothes, clothing thrown on the floor or unusual eating habits may be irritating or cause reaction by the staff some time in the future, but are not immediately disruptive.

Q) *Are 'sloppy' eating habits considered socially inappropriate behavior? For example, the resident smears food on the tray or mixes food together.*

A) The key is whether this socially inappropriate behavior is **disruptive**. Whether 'sloppy' eating is socially inappropriate and disruptive to staff depends on the severity of this behavior. If the resident smears food and makes a slight mess, but it does not require immediate staff intervention, then this is NOT a behavioral problem.

Q) *The resident displays a number of **different** infantile behaviors. Does the assessor separately measure each of these infantile behaviors?*

A) Measure together all the **infantile** behaviors which are **disruptive** to determine how often per week these behaviors occur.

<u>SECTION V. SPECIALIZED SERVICES</u>

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

(Q) *What is the General Approach to answering these questions?*

A) The information required is filled out in a two step process. ***Step one*** requires a determination as to ***therapy level*** for physical therapy (PT) and occupation therapy (OT). Level of therapy is a function of various qualifiers: whether therapy was provided, what was the duration of therapy, whether the therapy was restorative or maintenance, whether there was a physician, nurse practitioner or appropriately cosigned physician assistant order for therapy, and whether there was an evaluation and treatment plan. Once the level of therapy is delineated, ***step two*** involves identifying the number of ***days*** and amount of ***time*** the specific type of therapy (e.g. restorative physical therapy) was delivered. To count a day of therapy or amount of time of therapy, there are certain rules related to what type of

professional performed the therapy and under what conditions. The combination of all these answers determines whether a resident is categorized in the rehabilitation hierarchy. **Please read all the Qs and As associated with Question 27 to gain a full picture of the correct application of qualifiers.** In reference to appropriately cosigned physician assistant order for therapy, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

LEVEL

Q) What are the qualifiers for entering level 3 restorative therapy for PT and/or OT and what are the associated day and time qualifiers?

A) To determine the therapy to be level three restorative, the following qualifiers must all be met.

1) A physician, nurse practitioner or cosigned physician assistant order must be present which refers the resident for a therapy evaluation and treatment plan. This order does not have to specify whether the referral is for maintenance or restorative therapy, but should specify the reason for the referral. The physician, nurse practitioner or physician assistant must also sign the therapy plan of care to further support that the resident needs therapy. The physician, nurse practitioner or cosigned physician assistant order must be updated **monthly**. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

2) An Initial Evaluation and Treatment Plan by a licensed therapist must exist as a follow up to the physician's, cosigned physician assistant's or nurse practitioner's order. The evaluation must confirm whether the therapy is required and specify whether it is maintenance or restorative. The immediate and ultimate rehabilitation goals must be written and in accordance with the physician's, physician assistant's or nurse practitioner's diagnosis. The Treatment Plan should specify the type and number of treatments needed by the resident. It should include the intensity of the treatment; duration of the program, number of days per week, and length of treatment sessions. In reference to cosigned physician assistant order, effective for PRI

submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

3) There must be a positive potential for significant improvement in a resident's functional status within a short and predictable period of time. Consequently, the therapy plan of care should support that the resident has this potential and is improving.

4) The therapist, in accordance with professional practices, should assess the resident's progress and responses to treatments, and at least every 30 days, review the resident's progress with the physician, physician assistant or nurse practitioner and revise the treatment plan as necessary. The therapist must be a licensed professional person with a four year, specialized therapy degree.

5) The therapy must be provided for the four consecutive weeks covered by the PRI, unless the resident is a new admission or readmission. If the resident is a new admission or re-admission, the following are the duration related qualifiers:

   -- There must have been at least one treatment, in addition to the evaluation. An evaluation is not to be counted as treatment.

   -- A licensed therapist must have documented in the care plan that the therapy is restorative in nature and needed for 4 consecutive weeks.

If all the above qualifiers are met, the resident is appropriately marked level three restorative. The next step is to mark separately the number of days and amount of time spent providing the restorative PT and/or restorative OT. For a resident to be included in the rehabilitation hierarchy, the restorative therapy must be provided fives times each week for at least 2.5 hours in total. The following are qualifiers associated with marking a day or time as having been spent on restorative therapy.

1) Care must be provided **one to one** rather than on a group basis. Enter only the total days and time **per week** (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the **constant assistance** of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which

are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) Care must have been given by either a certified therapist (a person with a two year specialized therapy degree who has been certified by the NYS Education Department) or a licensed therapist (a person with at least a four year specialized therapy degree licensed by the NYS Education Department). A therapy aide may not provide restorative therapy. If a certified therapist provides the care, then a licensed therapist must be in the facility (but not necessarily in the treatment room) at the time the therapy is provided. For occupational therapy, a certified therapist is a certified occupational therapy assistant (COTA) and for physical therapy, a certified therapist is a physical therapy assistant (PTA).

Q) What are the qualifiers for entering level 2 maintenance therapy for PT and/or OT and what are the associated day and time qualifiers?

A) To determine the therapy to be level two maintenance, the following qualifiers must all be met.

1) A physician, nurse practitioner or cosigned physician assistant order must be present which refers the resident for a therapy evaluation and treatment plan. This order does not have to specify whether the referral is for maintenance or restorative therapy, but should specify the reason for the referral. The physician, physician assistant or nurse practitioner must also sign the therapy plan of care to further support that the resident needs therapy. Unlike the qualifier for restorative therapy, such orders are not required to be updated monthly. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

2) An Initial Evaluation and Treatment Plan by a licensed therapist must exist as a follow up to the physician's, nurse practitioner's or cosigned physician assistant's order. The evaluation must confirm whether the therapy is required and specify whether it is maintenance or restorative. The immediate and ultimate rehabilitation goals must be written and in accordance with the physician's, physician assistant's or nurse practitioner's diagnosis. The Treatment Plan should specify the type and number of treatments needed by the resident. It should include the intensity of the treatment; duration of the program, number of days per week, and length of treatment sessions. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23,

2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

3) Therapy must be provided to maintain and/or retard deterioration of current functional/ADL status.

4) The therapist, in accordance with professional practices, should assess the resident's progress and responses to treatments, and at least every 30 days, review the resident's progress with the physician, physician assistant or nurse practitioner, and revise the treatment plan as necessary. The evaluator must be a licensed professional person with a four year, specialized therapy degree.

5) The therapy must be provided for four consecutive weeks (at least once per-week). There is no new admission qualifier.

If all the above qualifiers are met, the resident is appropriately marked level two maintenance therapy. The next step is to mark the number of days and amount of time spent providing only the maintenance therapy. The following are qualifiers associated with marking a day or time as having been spent on maintenance therapy. Effective March 1, 2006, the Department will no longer use this information for level two maintenance therapy. Therefore, please automatically enter "0" for days and "0000" for time.

1) Care must be provided **one to one** rather than a group basis. Enter only the total days and time **per week** (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the **constant assistance** of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) Care may be given by a therapy aide, certified therapist (a person with a two year specialized therapy degree who has been certified by the NYS Education Department) or a licensed therapist (a person with at least a four year specialized therapy degree licensed by the NYS Education Department). If a therapy aide provides the care, then a certified therapist or licensed therapist must be in the facility (but not necessarily in the treatment room) at the time the therapy is provided. Unlike the qualifier

related to restorative therapy days and time, if a certified therapist provides the therapy, there is no requirement that a licensed therapist be in the facility. For occupational therapy, a certified therapist is a certified occupational therapy assistant (COTA) and for physical therapy, a certified therapist is a Physical Therapy Assistant (PTA).

ADDITIONAL QUESTIONS SPECIFIC TO LEVEL DETERMINATION

Q) When is it appropriate to enter level 1 for PT and/or OT?

A) Level one applies when no therapy has been provided.

Q) When is it appropriate to enter level 4 for PT and/or OT?

A) Level 4 applies when maintenance or restorative therapy has been provided but one or more of the other level qualifiers has not been met. There may not have been a physician, appropriately cosigned physician assistant or nurse practitioner order for the therapy, an appropriate evaluation and treatment plan may not have been performed, or the therapy may not have been provided at least once per-week for four consecutive weeks. Therapy provided for less than four consecutive weeks is permissible only if the resident meets the new admission or re-admission qualifiers for restorative therapy. It is not appropriate to enter level 4 based on the number of days per week and/or amount of time therapy was provided since these are not qualifiers for level of therapy. In addition, effective March 1, 2006, the Department will no longer require facilities to provide days and time when a resident is appropriately marked level "4". In reference to appropriately cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

Q) *Can a re-admission to the facility qualify for level 3?*

A) If a resident is discharged to the hospital, returns to the facility and meets the new admit qualifiers for rehab therapy, they may be assessed at this level. Changes in resident condition between the full house and the quarterly assessment periods are not included under the new admit qualifiers.

Q) *Is the definition of restorative and maintenance therapy as explained in the PRI instructions a qualifier?*

A) YES. If the resident meets the PRI definition of restorative therapy (as defined under the 'potential for Increased Functional/ADL Ability' qualifier), then this resident cannot be entered on the PRI as a maintenance therapy resident and vice versa.

Q) *If the resident is receiving both maintenance and restorative therapy, what is entered as the Level on the PRI?*

A) Enter that the resident is receiving restorative therapy, but when computing days and time the assessor must only enter those days and time restorative therapy has been provided.

Q) *The PRI instructions, which are in regulation, make a requirement for a physician order for therapy. Does the order of a physician assistant or nurse practitioner satisfy the requirement for a physician order?*

A) The Department is implementing a policy whereby nurse practitioners' and physician assistants' orders for therapy do count for PRI submissions attributable to assessment periods on or after July 1, 1999. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *Does a routine standing order for a therapy evaluation on admission meet the requirement for a physician, physician assistant or nurse practitioner order?*

A) No. The order must state the reason for the referral and the specific condition to be addressed by the therapist.

Q) *How is the qualifier for an on-site specialized professional to supervise/provide care accounted for under 'Level'?*

A) It is not accounted for under 'Level'. (Level qualifiers address the program evaluation and design, not the professional providing therapy). The type and frequency of the on-site specialized professional is only a qualifier for 'Days' and 'Time'.

Q) *If a resident experiences a new physical occurrence which necessitates specialized therapy, but the therapy has NOT been provided yet for four consecutive weeks, what is entered on the PRI?*

A) Level 4, unless the resident is a new admission or a re-admission and meets the new admission/re-admission qualifier stated in the instructions.

Q) *If the resident has been receiving therapy, but due to physical complications the resident's therapy has been on hold during the past two weeks, what is entered on the PRI?*

A) Level 4. The resident does not meet the PRI 'Level' qualifier of receiving therapy for at least 'four consecutive weeks'.

Q *If the resident starts receiving a course of therapy, but has only received two weeks so far, what level is entered on the PRI?*

A) Level 4, unless the resident is a new admission or a re-admission receiving restorative therapy and meets all the new admission qualifiers stated in the instructions.

Q) *To meet the new admit qualifiers for level 3, how soon after admission does an evaluation need to be performed and when must therapy begin?*

A) The therapy evaluation must be done within one week of the day on which the physician, physician assistant or nurse practitioner orders an evaluation for therapy. Treatment must begin within 48 hours subsequent to the physician, physician assistant or nurse practitioner order for treatment and be provided daily thereafter. Keep in mind that at least one treatment must have been given to claim a level 3 under the new admit qualifiers.

Q) *Is a hospital admission necessary to claim restorative therapy?*

A) No, but a medical event precipitating a hospital admission can often result in a clinical profile predictive of the likelihood for a resident to improve significantly within a short and predictable time, as is required for restorative therapy classification.

Q) *Do certain diagnoses, such as dementia, preclude a classification as restorative?*

A) No, each case must be judged individually. Certain diagnoses do call into question the appropriateness of restorative classification. If a resident with Parkinson's

Disease falls and has a fracture, therapy may restore the resident to pre-fall capabilities. Because the disease is degenerative, however, restoration without such an event is improbable.

Q *A resident has been in the facility for four years. She was able to transfer with an assist of one, but was unable to ambulate. The resident has become generally weaker in ADLs during the last ten days but there was no identifiable precipitating event for this deterioration. She is alert and oriented. The physician, physician assistant or nurse practitioner has ordered physical therapy evaluation and treatment as appropriate. Is the therapy provided maintenance or restorative?*

A) The therapy is **maintenance**--to maintain and/or retard deterioration of current functional/ADL status. The lack of a precipitating event for this resident's deterioration makes restorative classification inappropriate because it is likely the deterioration was avoidable. Further, since the resident has been non-ambulatory for four years, she cannot realistically be expected to have improved functional status in a short and predictable period of time. The goal is to maintain her current status

Q) *A resident has been hospitalized recently for three days. Upon return to the facility, an occupational therapy evaluation is ordered. The evaluation notes decline in ADL status from prior to hospitalization but no change in mental status. Resident has no carry-over ability; alert and oriented to the person only, he is able to follow most simple one-step commands with numerous repetitions. Is the therapy provided maintenance or restorative?*

A) The therapy is **maintenance**--to maintain and/or retard deterioration of current functional/ADL status. Due to the mental status, the resident does not have a positive potential for improved functional status within a short and predictable period of time.

Q) *A resident sustained a fractured left leg after an incident at the facility, was admitted to the hospital, and now has been readmitted to the nursing facility. There is a physician, physician assistant or nurse practitioner order for a physical therapy evaluation and treatment on the day of readmission. The evaluation is completed the following day, with a short term goal of ambulating with a walker independently and a long term goal of returning to independent ambulation. Resident is alert, but still not weight bearing on the left leg. Resident is able to keep leg elevated and take steps with assist of walker and therapist. Range of motion and gait training tolerated well. Potential expected to be good. Is the therapy provided maintenance or restorative?*

A) The therapy is **restorative**--there is a positive potential for improved functional status within a short and predictable time.

Q) Is a resident on traumatic brain injured extended care status automatically precluded from restorative therapy categorization because one of the qualifiers for such status is that the resident has been assessed as being inappropriate for an intensive rehabilitation program?

A) No. It must be determined whether the qualifiers for restorative therapy have been met without regard to the resident's TBI status.

QUESTIONS SPECIFIC TO DAY AND TIME DETERMINATIONS

Q) What qualifiers should be considered before entering the days and time for therapies?

A) There are two general qualifiers.

1) Care Must Be One to One Care: For both a maintenance program and restorative therapy, enter only the total days and time per week (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the constant assistance of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) There Must Be A Specialized Licensed Professional On-site While Care Is Being Provided. Please note that Certified Occupational Therapy Assistants (COTAs), Physical Therapy Assistant (PTAs) and aides are not specialized licensed professionals.

Q *What factors should be considered in determining days and time for maintenance as opposed to restorative therapy?*

A) There are only two differences between maintenance and restorative therapy when entering the 'Days and Time' per week?:

1) **Restorative** Therapy requires a **licensed** therapist to be within that facility at the **time the therapy is being provided to the resident.** This does not mean the licensed therapist has to be in the treatment room with the certified professional. A **maintenance** program requires a **certified**, NOT licensed, therapist to be within the facility at the time of the therapy.

2) A therapy aide CANNOT provide **restorative** therapy and have it be included in the treatment time for the resident on the PRI. A therapy aide CAN provide **maintenance** therapy and this time can be included on the PRI provided either a 4 year therapist or 2 year certified therapy assistant is in house at the time. A certified therapy assistant can provide maintenance therapy without the supervision of a 4 year therapist, but restorative therapy REQUIRES a 4 year therapist in house. NOTE: Effective March 1, 2006, the Department will no longer require facilities to provide days and time when a

resident is appropriately marked level “2” for maintenance therapy or level “4” received therapy, but does not fulfill the qualifier’s stated in the instructions.

Q) *Is there a distinction between physical and occupational therapy staff?*

A) Licensed professionals cannot supervise the certified professionals from a different therapy discipline. For example, a licensed registered Physical Therapist CANNOT supervise the Certified Occupational Therapy Assistant, NOR can licensed practical nurses be substituted as Physical Therapy or Occupational Therapy Assistants. Moreover, a licensed physical therapist cannot provide therapy that has been ordered by a physician, physician assistant or nurse practitioner as occupational therapy and a licensed occupational therapist cannot provide therapy that has been ordered by a physician, physician assistant or nurse practitioner as physical therapy.

Q) *If a resident is receiving physical therapy and occupational therapy, can the days and time be combined in order to qualify for restorative therapy?*

A) NO. Each specialized service must be considered independently.

Q) *Is a **licensed physical therapist** able to supervise the **certified occupational assistant**? In other words, can a licensed therapist supervise personnel who are in a **different** therapy field/discipline?*

A) NO. The personnel providing therapy must be supervised by a professional of the same discipline.

Q) *For restorative therapy - New Admission or Re-admission to the facility that meets all other qualifiers. What days and time should be entered if the resident has just started the program?*

A) If all qualifiers are met - enter level 3 for Restorative Therapy. Enter the assumed days and time as stated in the therapist plan of care for the resident. The licensed therapist MUST document in the care plan that therapy is needed for **four (4) consecutive weeks.**

Q) *Can whirlpool treatments or Hubbard tank treatments be captured under P.T.?*

A) Not for restorative therapy or maintenance therapy. The days and time would be entered as zero because **supervision** of a resident in a whirlpool or Hubbard Tank does NOT constitute hands on care.

Q) *Can treatments provided in the therapy department for decubitus care be captured under P.T.?*

A) No.

Q) *For restorative therapy, is the treatment time provided by therapy aides included?*

A) NO. For restorative therapy, aide time is NOT considered. However, for a maintenance program, therapy aide time can be counted.

Q) *Do the 'minutes' under the 'Times Per Week' question **have** to be entered only by the quarter hour?*

A) NO. But minutes can be rounded off to 15, 30 or 45. If there are no minutes of therapy, the time would be entered as four zeros (0000).

Q) *Can a resident be receiving maintenance or restorative therapy under the 'Level' question and be a zero for the 'Days and Time' question?*

A) YES. If the 'Days and Time' qualifiers are not met.

Q) *How exact does the documentation have to be for 'Days and Time' of therapy?*

A) 'Days' have to be EXACT; there needs to be a schedule and therapy notes stating the resident received therapy for each day. 'Time' needs documentation which should minimally verify the time blocks the resident receives therapy. For instance, a time block may be 9-10 on the given days of scheduled therapy. **However, the assessor will need to discuss with the therapists how much treatment time was actually provided during this time block.**

17) *If the days and time are more than five days/2.5 hours per week, what should be entered on the PRI?*

A) Enter the actual days and time. Five days/2.5 hours per week of restorative therapy is the minimum for being in the rehabilitation hierarchy, and higher amounts will also qualify.

Q) *If the resident's therapy schedule has changed within the past four weeks, what is entered on the PRI?*

A) An **average** is computed for the past four weeks, regardless of whether the schedule, in terms of days and time, has decreased or increased. To compute an average, divide the total days and the hours during the past four weeks by four.

Q) *Can restorative therapy (level 3) be provided by a certified (2 year degree) therapy professional?*

A) YES. If there is a licensed (4 year) therapy professional supervising on-site.

Q) *What is the rule for allowable absences?*

A) A resident may miss unlimited sessions for legal holidays and religions observance. Legal holidays for a RHCF are defined as those holidays written in the facility's personnel policy manual as paid time off for all employees. Further, for absences related to religious observance, there must be documentation that the resident

actually observed these holidays. Missed sessions are also allowable for illnesses, refusals or social engagements **only TO THE EXTENT THAT absences of this type do not cause the resident to have more than two absences in aggregate for all reasons**. For example, if a resident had 2 or more absences due to legal holidays and/or religious observance, no additional absences would be allowed for illness, refusal or social engagements. If a resident had 1 absence due to legal holidays and/or religious observance, one additional absence would be allowed for illness, refusal or social engagements. If a resident had no absences due to legal holidays and/or religious observance, two absences would be allowed for illness, refusal or social engagements.

Q) *If due to a holiday/religious observance therapy is not given, do the days and times have to be averaged?*

A) NO. If therapy is not provided due to a legal holiday or religious observance the plan of care may be assumed. The legal holidays for a RHCF are defined as those holidays written in the facility's personnel policy manual as paid time off for the employee. However, if the resident misses two days of therapy due to legal holidays and/or religious observances, no ADDITIONAL days may be missed for any other reason. EXAMPLE: A resident misses 3 days of therapy for legal holidays and missed 2 additional days for a social engagement, the days and time must be averaged for the 28 day period.

Q) *If there are 4 (or more) religious holidays during the 28 day PRI period, could the restorative resident still fall in the heavy rehab category?*

A) YES. The documentation MUST substantiate that the RESIDENT observed these holidays and that he/she missed NO other sessions. The resident must also meet the level qualifiers for restorative therapy. All other qualifiers must be met as well.

Q) *If the physical or occupational therapist was on vacation/leave during a portion of the four week period, how are 'Days and Time' counted for the residents?*

A) Compute an average of the therapy actually provided during the past four weeks. For example, if the therapist did not provide therapy for one week, the assessor should total the days and time of therapy provided during three of the four weeks and divide by four.

Q) *If more than two therapy sessions are missed, can they be made up?*

A) Sessions missed in a week may be made up on days during that week when therapy is not normally provided. The intent of the system is that therapy be given five days in each of the four weeks of the assessment period; not, for example, six days in one week then four days in another week. If therapy sessions missed in one week are made-up in a different week, there would need to be a justifiable reason and the Department should be notified of these circumstances and consulted as to their appropriateness.

Q) *If residents are sent outside of the facility for therapy, can this therapy be counted on the PRI?*

A) NO. Unless the facility is a hospital-based nursing home and the therapy is provided in the hospital's department, rather than physically in the nursing home.

Q) *If a resident receives restorative P.T. 3 days a week and each session is one hour, does this resident fall into the heavy rehab category?*

A) NO. A resident who meets the level qualifiers must be receiving therapy 5 days a week and at least 2 1/2/hours per week.

28. NUMBER OF PHYSICIAN VISITS

Q) *Do all the physician, physician assistant or nurse practitioner visits need to be for the same unstable condition?*

A) No. The cause of the unstable condition may change over the four week period. The diagnoses and symptoms of the unstable condition(s) may change over the four week period.

Q) *Do visits of physician assistants or nurse practitioners satisfy the requirement for a physician visit?*

A) The Department is implementing a policy whereby visits by nurse practitioners and physician assistants do count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on or after July 1, 1999. This does not in any way change the patient type/need qualifiers. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners

and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *Does the resident have to be medically unstable during the **entire** past four weeks?*

A) NO. The resident qualifies if he/she has been medically unstable for any period of time during the past four weeks. However, only the physician, nurse practitioner or physician assistant visits to care for the unstable condition during this time period are to be entered on the PRI.

Q *Do the physician, nurse practitioner or physician assistant visits have to occur once in every week of the 28 day period?*

A) No, the four visits may occur at any time during the four weeks, corresponding to the instability of the resident. Count only those visits during which the physician, nurse practitioner or physician assistant personally examines the resident to address an unstable condition.

Q) *Can the visits of all the different physicians, nurse practitioners and physician assistants caring for the resident be counted (e.g. specialist, primary physician, ophthalmologist)?*

A) ONLY **physicians, physicians assistants and nurse practitioners caring for the resident's medically unstable condition(s)** can be considered in counting the number of visits.

Q) *Is a podiatrist or dentist considered a physician?*

A) NO.

Q) *Can visits by psychiatrists be included?*

A) No. PRI regulations specifically prohibit the counting of psychiatrist visits.

Q) *Is a fracture considered medical instability?*

A) In most resident cases a fracture would cause medical instability. However, a fracture, such as a fractured finger, may not cause medical instability.

Q) *Are the regulatory visits (e.g. 30, 60, 90 days) by physicians counted?*

A) ONLY if the resident is medically unstable at the time of the regulatory visit and during this visit the physician cares for the medically unstable condition as documented.

29. MEDICATIONS

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '00' for both 29A and 29B.

VI. DIAGNOSIS

30. PRIMARY PROBLEM

Q) *Can only the attachment in the PRI instructions titled "ICD-9 Codes for Common Diagnoses" be used to answer this questions?*

A) NO. The ICD-9 Code books in your nursing office and/or medical records office will offer a more complete listing of ICD-9 Codes. If your facility has a medical records office, their personnel can help in locating the ICD-9 codes for the diagnoses listed by the assessors.

Q) *Some residents may have a primary problem that is NOT listed in the ICD-9 books. Generally this is because the primary problem for the residents in terms of nursing time is not a medical diagnosis. What is entered on the PRI?*

A) Enter a zero in the far right hand box for any Primary Problems not readily available in the ICD-9 books.

Q) *Most of the ICD-9 categories/classifications, such as organic brain syndrome, are also broken down further into more specific ICD-9 codes describing origin, severity, etc. How specific does an assessor have to be in diagnosing and choosing these specific ICD-9 codes?*

A) The **general** ICD-9 diagnosis code is acceptable to enter on the PRI. **Specific** variations of this diagnosis can be entered on the PRI but considerable time should not be spent deciding between two different variations of the diagnosis. For example, the specific variation of the diagnosis, organic brain syndrome, should not be a major concern for an assessor. However, be specific with quadriplegia and UTI ICD-9 codes; INCLUDE DIGITS AFTER THE DECIMAL IF DIGITS EXIST. (e.g. 599.0)

Q) *Does the primary problem have to be diagnosed by a physician?*

A) NO. The primary problem is a reflection of nursing time and this should be exemplified in the nursing notes. Please note, however, that all the diagnoses which assign a resident to a RUG category are among those that must be made by a physician, nurse practitioner or physician assistant. The Department is implementing a policy whereby such diagnoses made by nurse practitioners and physician assistants will also count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on or after July 1, 1999. The

following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *How much time should be spent looking for an ICD-9 code*?

A) Most diagnoses not listed in the PRI instructions can be easily located by using the index in the ICD-9 code books. However, some "primary problems" for the resident may not be listed in the ICD-9 code books since the problem is not actually a diagnosis. For instance, if the resident's main problem in terms of nursing time is the need for psychological support or supervision, then an ICD-9 code will not be available for this problem. Enter a zero (0) on the PRI if no diagnosis if found.

Q) *A resident with a diagnosis of hemiplegia experiences a UTI during the 28 day PRI period. What is the primary diagnosis?*

A) Whatever created the most need for nursing care during the 28 day period. For example, if the resident was unstable because the UTI was severe then the diagnosis would be UTI. This should be documented in the medical record.

Q) *Does a missing limb on the affected side of the body preclude a diagnosis of hemiplegia?*

A) No, as long as the remaining limb is affected by the hemiplegia.

Q) *How does a resident qualify for dementia reimbursement through the ICD-9 code answer to question 30?*

A) A resident MUST fall into one of the following RUG-II groups: Clinical A, Behavioral A, Physical A or Physical B and have the specific ICD-9 code listed in the regulations reported under question 30 in order to qualify for additional reimbursement. There are 30 specific ICD-9 codes that will qualify a resident for dementia reimbursement. These codes must appear EXACTLY AS SHOWN in Part 86-2.10(o) in question 30 on the PRI.

Q) *Does the computer read those diagnoses written without an ICD-9 code?*

A) NO. If there is no diagnosis, enter a zero (0) on the PRI.

Q) *If no ICD-9 code is entered but rather the diagnosis is written, will the computer pick this up as an error?*

A) YES. A zero must be entered in the far right hand box if no ICD-9 code is entered.

Q) *Is hemiparesis included in the RUG-II system besides hemiplegia?*

A) YES. Either diagnosis qualifies a resident for the clinically complex hierarchy.

Q) I*s quadriparesis included in the RUG-II system besides quadriplegia?*

A) NO. Only quadriplegia qualifies a resident for the special care hierarchy.

Q) *The physician, physician assistant or nurse practitioner wrote a diagnosis of quadriparesis. Does this resident fall into the special care category?*

A) NO. Quadriplegia, not quadriparesis, places a resident in the special care category. DO NOT use the ICD-9 code for quadriplegia (344.0) if the resident has quadriparesis. Further, the ICD-9 for quadriplegia should not be used in instances where a resident has not incurred a spinal cord injury or spinal cord disease. The medical record must indicate the etiology of the quadriplegia to be spinal cord injury or spinal cord disease for quadriplegia to be cited. Factors other than spinal cord injury or spinal cord disease often result in the symptoms of quadriplegia or 'functional quadriplegia' but these are not appropriate for quadriplegia classification on the PRI.

Q) *If a resident has the capacity for voluntary movement, is he/she precluded from being classified quadriplegic?*

A) NO. The ICD-9 code for quadriplegia is correct if the appropriate spinal cord injury or spinal cord disease has occurred and the resident meets all the other quadriplegia criteria under the ICD-9 classification system.

Q) *Does a specific ICD-9 code need to be entered to capture a resident as qualifying for Traumatic Brain Injury - Extended Care?*

A) No. Traumatic Brain Injury - Extended Care status is reported by entering "TBI99" for question 7, room number.

Q) *What are the specific ICD-9 codes which qualify a resident for a hierarchy? Do they have to be entered in a special way?*

A) There are only five ICD-9 codes which assign a resident to a hierarchy group, as shown in the following table. All must be entered as indicated to qualify a resident for the hierarchy.

Hierarchy	Diagnosis	Code	Comment
Special Care	Quadriplegia	344.0	Enter exactly. Any last digit may be used.
	Multiple Sclerosis	340.	Any last two digits may be used
Clinically Complex	Cerebral Palsy	343.	Any last two digits may be used
	Urinary Tract Infection	599.0	Enter exactly. Leave last data field blank
	Hemiplegia / Hemiparesis	342.	Any last two digits may be used

GENERAL DATA COLLECTION PROCEDURES

Q) *What should be done in case of an error detected in completing the PRI?*

A) All PRI submissions should be checked for accuracy. Once the data have been submitted electronically and accepted, the facility is given an additional seven days to make corrections. Enter the correct data, re-run the edit checks, re-encrypt, and resubmit the ENTIRE file. This must be done by the update date provided in the acceptance message. **NO CORRECTIONS WILL BE ALLOWED AFTER THE UPDATE DATE.**

Q) *Does the facility get a copy of the responses entered on all the PRIs?*

A) NO. As the facility keys the data, it is the responsibility of the facility to ensure that the data have been entered correctly on the file. Because changes are not permitted after the update date, checking the data is an important step.

Q) *For the twenty eight day review period, which day is considered the 28th day?*

A) The 28th day is the day the PRI is completed. Be sure to complete the whole PRI on the same day, so all questions will have the same 28 day period.

Q) *What happens if a resident is on bed hold or enters the hospital during the data collection period?*

A) Effective January 1, 1999, a PRI should be submitted for **all** residents on the nursing facility's census at 4:00 PM on the last day of the collection period. The only residents excluded would be those out of the facility on bed hold or therapeutic leave. This means that if a patient is on bed hold a PRI is NOT submitted. If a PRI is completed on a resident who then enters the hospital/leaves the facility before 4:00 PM on the last day of the collection period, then the PRI for this resident is NOT to be used.

Q) *How is the date completed data field (Question 5) used during the on-site review?*

A) The completion date is used to determine the specific 28-day period for each resident. It is, therefore, **very important** that this date be accurate. It should be within the data collection period provided by the Department. **DO NOT** use the date the PRI is keyed, or the date the file is created.

Q) *For residents to be classified under Special Care of the RUG-II system, must an ADL sum of 5 of more be applicable? Is this new to the system?*

A) YES. An ADL sum of 5 or more and the specific special care problem MUST be present to be classified as Special Care. NO. This is not new to the system.

Q) *Do only Medicaid residents have a PRI completed?*

A) No. A PRI is to be completed on ALL residents in a facility.

Q) *Who is the on-site reviewer and what will she/he be doing in the facility?*

A) The on-site reviewer is a registered nurse who has experience in long term care and with assessment measures. This reviewer is NOT a Department of Health employee; rather has been hired through a contractor and trained independently by the Department of Health for this data collection.

Q) *What is the purpose of the Stage I on-site review?*

A) The purpose of this visit is to review the selected residents, in particular, to focus on certain PRI indicators. This is a reliability measure to insure accurate data. The reviewer will read medical records, interview facility personnel, (e.g. unit nurses) and observe residents to complete the resident reviews. This on-site reviewer will NOT be judging quality of care. The reviewer will not be comparing her/his PRI review of residents with the facility's PRI review. A major function is to pinpoint systematic errors that would trigger a more intense audit.

Q) *At the end of the on-site reviewer's visit (Stage I review), will she/he discuss her/his results, such as the facility error rate?*

A) NO. The on-site reviewer is not comparing her/his data with the facility's PRI data. The Stage I review is a "blind" review and the reviewer is not aware of the facility's responses on the PRI. Any questions on the audit process should be directed to the Department of Health.

Q) *Will the on-site reviewer need the assistance of facility staff?*

A) Yes. Each facility's documentation is different, so the reviewer will need assistance in finding and interpreting facility medical records. If the reviewer cannot find the documentation to support a hierarchy reported by the facility, she/he will ask the facility staff for assistance in finding the record. If no documentation can be found for a resident, ADL responses will be reduced to the lowest level and other questions will be denied.

Q) *Will the on-site reviewer help a facility with their error report?*

A) NO. The error report should be reviewed by facility staff. All errors must be corrected before the data will be accepted electronically. Note, however, that either a keying or coding error will affect the audit outcome. The facility should make every effort to ensure that the PRI is correctly keyed.

Q *When can medical record charts be thinned?*

A) This is a decision that each facility must make independently. Please keep in mind that an auditor may still need to see these records. Facilities are encouraged to keep thinned records accessible and in order until processing of PRIs for the relevant time frame has been completed.

Q) *If a facility needs more PRIs, what should they do?*

A) Now that the data are collected electronically, the PRI used for reimbursement (DOH-3) is no longer printed and supplied to facilities. Each facility must arrange for printing or copying to ensure an adequate supply.

Q) *Are PRI admits and discharges always the same as the facility admits and discharges?*

A) No. The RUG-II system uses a snapshot of who is in the facility, rather than tracking all residents. PRI admits and discharges are an adjustment to the previous full house. Submit an admit PRI for those residents **currently** in the facility but who were **not** included in the full house. Submit a discharge for those residents who **were** in the previous full house but are **no longer** in the facility.

Q) *If a resident goes to the hospital, loses bed hold, and is then readmitted to the facility between the full house and admit and discharge dates, should an admit be submitted?*

A) No. No forms should be submitted for this resident. The loss of bed hold is irrelevant. The resident was in the facility on both collection dates, so only the full house PRI is submitted.

Q) *Is there a quick way to check that the correct number of admits and discharges are being submitted?*

A) Start with the number of records submitted for the previous full house, add the number of admit PRIs, then subtract the number of discharges. This should yield the number of residents in the facility on the last day of the assessment period (the census date). This test will not catch all errors, but will help to detect simple ones.

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: HOSPITAL AND COMMUNITY PATIENT REVIEW INSTRUMENT (H/C-PRI)

GENERAL CONCEPTS

1. PURPOSE: Preadmission review to a Residential Health Care Facility (RHCF) from the hospital and community based residences and facilities, such as personal dwelling, domicillary care facility/adult home and congregate housing.

2. ASSESSORS: As qualified through the N.Y.S. Department of Health PRI Training Program - hospital discharge planners, certified home health care agency registered nurses, RHCF registered nurses, county public health nurses and other utilization review personnel as designated.

3. USING THESE INSTRUCTIONS: These instructions should be read before completing the H/C-PRI and should be kept with the H/C-PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE H/C-PRI ACCURATELY.

4. ANSWER ALL QUESTIONS Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number: /__/_9/_6/_2/_1/_0/. If there are unused boxes, they should be on the left side of the number as shown in the example.

5. QUALIFIERS: Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered "yes". These qualifiers take the following forms:

   - TIME PERIOD - The time period for the questions is the past week. For the patients who have been in the hospital less than one week use the time from admission to H/C-PRI completion as the time frame. If the community assessor (e.g., certified home health care agency, RHCF assessor) does not have any history on the patient, then the day of the H/C-PRI assessment is the timeframe. See "Sources of Information" below.

   - FREQUENCY - The frequency specifies how often something needs to occur to meet the qualifier. For example, suctioning needs to occur daily for at least one week or the PRI cannot be checked for this patient as receiving this care.

   - DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered "yes" for the patient.

- o EXCLUSIONS - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from oxygen therapy.

6. SOURCES OF INFORMATION: For community based referred patients, the sources of information may not be as accessible as in the hospital. Discussion with the patient's family members, other caregivers and personal physician(s) will help provide more accurate information. The patient may be receiving community services or may have in the past.

7. ACTIVITIES OF DAILY LIVING (ADLs): The approach to measuring ADLs is slightly different from other PRI questions. Measure how **capable** the patient is in completing each ADL 60% or more of the time it needs to be performed. CAPABILITY - Reviewing the patient's physical and mental status, measure the **present** capability of the patient to perform each ADL. This is in contrast to how the patient may be actually performing the ADLs in the hospital/facility or in the community. **Read the specific instructions on ADLs to understand the CHANGED CONDITION RULE, the specific ADL definitions and the measurement of capability.**

8. CORRECTIONS: Cross out any responses which you wish to change and reenter clearly to the right of the original response. Example: /3/ 4

INSTRUCTIONS: H/C-PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the seven or eight character identifier stated on the facility's/agency's operating certificate. For a hospital there will always be seven (7) numbers followed by an "H" in the eighth box. For a certified home health agency and a county Department of Health, there will only be seven (7) numbers with no letters. This means the first answer box to the left will remain blank. For a residential health care facility, there will be seven (7) numbers followed by a "P" for a health related facility (HRF) or an "N" for a skilled nursing facility (SNF).

2. SOCIAL SECURITY NUMBER: Do not leave blank; enter zero in far right hand box if patient does not have a number.

3. OFFICIAL FACILITY NAME: Print the formal name of the hospital/community agency, etc.

4. PATIENT NAME: When completing the H/C-PRI do not use nicknames. Print last name first (e.g., Brant, Diana C).

6. MEDICAL RECORD NUMBER/CASE NUMBER: Enter the unique number assigned by the hospital/agency to identify each patient. It is not the Medicaid, Medicare or Social Security number, unless that is the number used to identify patients. If there is no assigned case number for the community based patient, leave this question blank.

7. **HOSPITAL ROOM NUMBER:** Enter the numbers and/or letters which identify the patient's room in the hospital or other applicable community facility. If the patient is residing in the community when the H/C-PRI review is completed, then print the address in Question 4., "Patient Name." (Community is defined as a personal dwelling, Adult Home, congregate housing, or other domicillary type facilities/dwellings.)

8. **NAME OF HOSPITAL UNIT/BUILDING/DIVISION:** Print the name of the hospital unit, such as "med-surgery", where the patient was reviewed. Include any other unique hospital location identifiers, such as specific building names where the unit is located. However, if the patient has changed units or buildings or will be moving, then print instead where the patient can be located in the future (if known). If the patient is reviewed in the community, then this question is not applicable and can be left blank.

11A. **DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT:** Enter in numerical format the month, day and year the patient was admitted to this hospital for the purposes of this review. (Use most recent hospitalization date for multiple hospitalizations.) Do not include the date of Alternate Level of Care status, rather enter this date, if applicable, in Question 11B.

If the patient is being reviewed in the community, enter the date of the initial patient visit by the certified home health care agency, nursing home or any other qualified agency/organization. This visit may be a followup to a referral made by the patient, the patient's family, the patient's physician, etc.

11B. **DATE OF ALTERNATE LEVEL OF CARE STATUS:** Enter in numerical format the day, month and year the patient went onto Alternate Level of Care status (ALC) in the hospital. If the patient has entered ALC status more than once during this hospital stay, enter the most recent ALC admission date. (That is, this patient was on ALC status, but was discharged because of an acute episode and then went back to ALC status.) If the patient is not on ALC status or is in the community during this review, enter a zero (0) in far right hand box.

12. **MEDICAID NUMBER:**
13. **MEDICARE NUMBER:** Enter these numbers if patient has such coverage available, whether or not the coverage is being used. If not, enter only one zero in the far right hand box.

14. **PRIMARY PAYOR:** Enter the one source of coverage which pays for most of the patient's current hospitalized stay; for patients in the community enter what is covering the patient's community health care needs. Code "other" only if the primary payor is not Medicaid or Medicare. "Other" includes self-pay and private insurance.

15. **REASON FOR PRI COMPLETION:** Select the one reason why the PRI is being completed. This is for preadmission review purposes.

#1 RHCF Application from Hospital means the patient resides in the hospital at the time of this H/C-PRI review and is applying for admission into a residential health care facility (RHCF, HRF or SNF). This H/C-PRI is being completed by a qualified hospital assessor or another qualified assessor (i.e., RHCF assessor, certified home health care agency assessor) who enters the hospital to review the patient.

#2 RHCF Application for Community means the patient resides in the community during this H/C-PRI review. Include Adult Homes and other domicillary care facilities.

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

Documentation - For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components:

- o A description of the patient's decubitus.
- o Circumstances or medical condition which lead to the decubitus.
- o An active treatment plan.

Definition

LEVELS:

#0 No reddened skin or breakdown.
#1 Reddened skin, potential breakdown.
#2 Blushed skin, dusty colored, superficial layer of broken or blistered skin.
#3 Subcutaneous skin is broken down.
#4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.
#5 Patient is at level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a YES to be answered for any of these conditions, all of the following qualifiers must be met:

Time Period - Condition must have existed during the past week.

Documentation - Written support exists that the patient has the condition.

Definitions - See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17A. COMATOSE: Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days.	Brain insult Hepatic encephalopathy Cardiovascular accident	Total ADL Intake & output Parenteral feeding
17B. DEHYDRATION: Excessive loss of body fluids requiring immediate medical treatment and ADL care.	Fever Acute urinary tract infections Pneumonia Vomiting Unstable diabetes	Intake & output Electrolyte lab tests Parenteral hydration Nasal feedings
17C. INTERNAL BLEEDING: Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention.	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood every 60 days likely to be needed
17D. STASIS ULCER: Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.	Severe edema Diabetes PVD	Sterile dressing Compresses Whirlpool Leg elevation
17E. TERMINALLY ILL: Professional prognosis (judgment) is that patient is rapidly deteriorating and will likely die within three months.	End stages of: Carcinoma, Renal disease, Cardiac diseases	ADL Care Social/emotional support
17F. CONTRACTURES: A shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to contractures and not only due to spasticity paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.		

DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
To qualify as "YES" on the H/C PRI the following qualifiers must be met: 1. The contracture must be documented by a physician, physicial therapist or occupational therapist. 2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis. There does not need to be an active treatment plan to enter "YES" to contractures.		
17G. DIABETES MELLITUS: A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.	Destruction/ malfunction of the pancreas Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus.	Special diet Oral agents Insulin Exercise
17H. URINARY TRACT INFECTION: During the past week, signs and symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts, cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q. 29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (e.g., mentally confused or incontinent patients).	Exclude if symptoms are present, but the lab values are negative.	Antibiotics Fluids

DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17I. HIV INFECTION SYMPTOMATIC: HIV (Human Immunodeficiency Virus) Infection, Symptomatic includes: Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection and a positive finding is documented AND the patient has had symptoms, documented by a physician as related to the HIV infection. Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become syptomatic, and patients who have not received the results of the HIV test.		
17J. ACCIDENT: An event resulting in serious bodily harm, such as, a fracture, a laceration which requires closure, a second or third degree burn or any injury requiring admission to a hospital. To qualify as "YES" on the H/C PRI the following qualifier must be met: 1. During the past six months serious bodily harm occurred as the result of one or more accidents.		
17K. VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.		

DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS

All services shall be provided in accordance with Part 416.13, Part 711.5 and Part 713.21 of Chapter V of Title 10 of the Official Compilation of Codes Rules and Regulations of the State of New York.

18. MEDICAL TREATMENTS: For a "YES" to be answered for any of these, the following qualifiers must be met:

Time Period	-	Treatment must have been given during the past week and is still required.
Frequency	-	As specified in the chart below.
Documentation	-	Physician order specifies that treatment should be given and includes frequency as cited below, where appropriate.
Exclusions	-	See Chart on the next page.

DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18A. TRACHEOSTOMY CARE: Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.	Daily for the past week (7 days) or will continue to be required for 7 days.	Self-care patients
18B. SUCTIONING: Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.	Daily for the past week (7 days) or will continue to be required for 7 days.	Any tracheostomy Suctioning
18C. OXYGEN THERAPY: Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (e.g., cardiopulmonary condition).	Daily for the past week (7 days) or will continue to be required for 7 days.	Inhalators Oxygen in room, but not in use
18D. RESPIRATORY CARE: Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.	Daily for the past week (7 days) or will continue to be required for 7 days.	Suctioning
18E. NASAL GASTRIC FEEDING: Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.	None	None Gastrostomy not applicable
18F. PARENTERAL FEEDING: Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (e.g., comatose, damaged stomach).	None	None Gastrostomy not applicable
18G. WOUND CARE: Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers.	Care has been provided or is professionally judged to be needed for at least 3 consecutive weeks	Decubiti Stasis ulcers Skin tears Feeding tubes

DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18H. **CHEMOTHERAPY:** Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician. (Community based patient may have to go to a hospital for treatment.)	None	None
18I. **TRANSFUSIONS:** Introduction of whole blood or blood components directly into the blood stream. (Community based patients may have to go to a hospital for treatment.)	None	None
18J **DIALYSIS:** The process of separating components, as in kidney dialysis (e.g., renal failures, leukemia, blood dyscrasia. Community based patients may have to go to a hospital for treatment.)	None	None
18K. **BOWEL AND/OR BLADDER REHABILITATION:** The goal of this treatment to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (i.e., usually not longer than six weeks). NOT all patients at level 5 under Toileting Q. 22 may be a "YES" with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:	Very specific and unique for each patient	Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions.
Bladder rehabilitation: Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1)mental and physical assessment of the patient to determine training capacity; (2) a 24		

DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.		
Bowel rehabilitation: A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (e.g., bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.		Exclude a bowel maintenance program which controls bowel incontinence by development of a routine bowel schedule
18L. CATHETER: During the past week an indwelling or external catheter has been needed. The indwelling catheter has been used for any duration during the past week; a physician order is present. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past week; a physician order is not required.		Exclude catheters used to empty the bladder once, secure a specimen or instill medication
18M. PHYSICAL RESTRAINTS: A physical device used to restrict patient movement. Physical restraints include belts, vests,cuffs, mitts, jackets harnesses and geriatric chairs.	At least two continuous daytime hours anytime during the past week (7 days)	Exclude all of the following: Medication used for the sole purpose of modifying patient behavior Application only at night

DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
To Qualify as "YES" on the H/C PRI the following qualifiers must be met: 1. The restraint must have been applied for at least two continuous daytime hours anytime during the past week (7 days). Daytime includes the time from when the patient gets up in the morning to when the patient goes to bed at night. 2. An assessment of need for the physical restraint must be written by an M.D. or R.N. 3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint.		Application for less than two continuous daytime hours Devices which the patient can release/remove such as velcro seatbelts on wheelchairs Patients who are bed bound Siderails, locked doors/gates, domes

III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING

Use the following qualifiers in answering each ADL question:

Time Period - Past week (7 days).

Frequency - Assess the capability level of the patient to perform each ADL 60% or more of the time performed since the ADL status may fluctuate during a 24 hour period).

CHANGED CONDITION RULE: When a patient's ADL has improved or deteriorated during the past week (7 days) and this course is unlikely to change, measure the ADL according to its present status.

MEASUREMENT APPROACH: Measure the present capability of the patient to complete each ADL. This may be in contrast to what the patient may actually be doing. The reason why you are assessing capacity, rather than actual performance, is so that only patient characteristics are taken into account when measuring ADLs. Omit nonpatient considerations when assessing ADLs. For example, physical barriers, such as stairs or no ramps, may prevent the patient from performing ADLs at the level s/he is actually capable. Or a facility safety policy or clinical order, such as bedrest, may prevent the patient from performing ADLs. Or informal supports in the community or hospital staff may be providing more assistance with ADLs (e.g., toileting) than the patient actually needs.

Definitions - SUPERVISION means verbal encouragement and observation, not physical hands-on care.

ASSISTANCE means physical hands-on care.

INTERMITTENT means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.

CONSTANT means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

CLARIFICATION OF ADL RESPONSES

19. EATING:

#3 "Requires continual help..." means that the patient requires a staff person's continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

#5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.

20. MOBILITY:

#3 "Walks with constant supervision and/or assistance..." may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be logical medical reasons why the patient needs the help of two people to transfer. This reason should be documented in the medical record.

#5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 "Continent... Requires no or intermittent supervision" and #2 "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 "Continent... Requires constant supervision/total assistance..." refers to a patient who may not be able to balance him/herself and transfer, has contractures, has a fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bedbound or is mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, this should be documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel incontinence.

Example 2:

The patient requires intermittent supervision for bowel function (level 2), and is taken to the toilet every two hours to a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

IV. BEHAVIORS - VERBAL DISRUPTION, PHYSICAL AGGRESSION, DISRUPTIVE, INFANTILE/SOCIALLY INAPPROPRIATE BEHAVIOR, AND HALLUCINATIONS

The following qualifiers must be met:

Time Period - Past week (7 days).

Frequency - As stated in the responses to each behavioral question.

Documentation - To qualify a patient as LEVEL 4 or to qualify the patient as a "YES" to HALLUCINATIONS, the following conditions must be met:

- o Active treatment plan for the behavioral problem must be in current use.
- o Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. This assessment must still be exhibited by the patient.

Definitions - The terms used on the PRI should be interpreted only as they are defined below:

- o PATIENT'S BEHAVIOR: Measure it as displayed with the behavior modification and treatment plan in effect during the past week.

- o DISRUPTION: Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.

- o NONDISRUPTION: Verbal outbursts and/or physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.

- o UNPREDICTABLE BEHAVIOR: The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern.

- o PREDICTABLE BEHAVIOR: Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS

23. VERBAL DISRUPTION: Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.

24. PHYSICAL AGGRESSION: Note that the definition states "with intent for injury."

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: Note that the definition states this behavior is physical and creates disruption. EXCLUDE the following behaviors:

- Verbal outbursts
- Social withdrawal
- Hoarding
- Paranoia

26. HALLUCINATIONS: For a "YES" response, the hallucinations must occur at least once during the past week (7 days) (in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment).

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

- For each therapy these three types of information will be entered on the PRI; "Level", "Days" and "Time" (hours and minutes).

- For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as #1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will be 0 (zero).

- Use the chart on the following page to understand the qualifiers for each of the three tyes of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART ON NEXT PAGE FOR THE SPECIFIC QUALIFIERS.

27. LEVEL QUESTION: QUALIFIERS

QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY = LEVEL 2	RESTORATIVE THERAPY = LEVEL 3	QUALIFIERS NOT MET = LEVEL 4
DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL/ ADL ABILITY	No potential for increased functional ADL ability. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement.	There IS positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.	ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS
PHYSICIAN ORDER QUALIFIER	Yes	Yes, monthly	LEVELS 2 OR 3 IS NOT MET
PROGRAM DESIGN AND EVALUATION QUALIFIER	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	
TIME PERIOD QUALIFIER	Treatments have been provided during the past week.	Treatments have been provided during the past week.	
NEW ADMISSION QUALIFIER	Not Applicable	New admissions of less than one week can be marked for restorative therapy if: o There is a physician order for therapy and patient is receiving it. o A new admission includes re-admissions to a residential health care facility.	

27. DAYS AND TIME PER WEEK QUESTION: QUALIFIERS

QUALIFIERS FOR DAYS AND TIME*	MAINTENANCE THERAPY (i.e.,level 2 or 4 under "Level" question)	RESTORATIVE THERAPY (i.e., If level 3 or 4 under "Level" question)
		o The licensed therapist has documented in the care/plan that therapy is needed for at least one week.
TYPE OF THERAPY SESSION	Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).	Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).
SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY)	A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.	A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides.)

*QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THESE QUALIFIERS UNDER EACH TYPE OF THERAPY.

28. NUMBER OF PHYSICIAN VISITS: Enter "0" (zero) unless the patient need qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits that meet the physician visit qualifiers.

- o Do not answer this question for hospitalized patients, unless on Alternate Level of Care status. Enter "0" (zero).
- o PATIENT TYPE/NEED QUALIFIERS: The patient has a medical condition that is (1) is unstable and changing or (2) is stable, but there is high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).

- PHYSICIAN VISIT QUALIFIER: If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits during the past week that meets the following qualifications:

  - A visit qualifies only if there is physician documentation that s/he has personally examined the patient to address the pertinent medical problem. The physician must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (e.g., change medications, renew treatment orders, nursing orders, order lab tests).

  - Do not include phone calls as a visit nor visits which could be accomplished over the phone.

  - For community based patient, the physician visit may occur in the patient's own home, physician's office, outpatient clinic or hospital.

DIAGNOSIS

29. PRIMARY MEDICAL PROBLEM: Follow the guidelines stated below when answering this question.

- NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past week (7 days). A review of the medical record for nursing and physician notes during the past week may be necessary. For community based patients review what is requiring the most care time from informal supports and health care professionals if any.

- JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.

- ICD-9: Refer to the ICD-9 codes for common diagnoses (attached at the end of these instructions) for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.

- o NO ICD-9 NUMBER: Enter "0" (zero) in the far right box if no ICD-9 number can be found for the patient's primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042-044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV Infection.

34. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups:

1. WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

2. WHITE/HISPANIC: a person who meets the definition of both White and Hispanic (See Hispanic below).

3. BLACK: A person having origins in any of the Black racial groups of Africa.

4. BLACK/HISPANIC: A person who meets the definition of both Black and Hispanic (see below).

5. ASIAN or PACIFIC ISLANDER: a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

6. ASIAN or PACIFIC ISLAND/HISPANIC: A person who meets the definition of both Asian or Pacific Islander and Hispanic (see below).

7. AMERICAN INDIAN OR ALASKAN NATIVE: A person having origins in any of the original peoples of North America and who maintains tribal affiliation or community recognition.

8. AMERICAN INDIAN OR ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. OTHER: Other groups not included in previous categories.

HISPANIC: a person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.

35. **QUALIFIED ASSESSOR:** The individual who has completed and/or reviewed the PRI. To be complete, each assessment must be signed by the qualified nurse assessor.

Attachment 4

Screen Instructions

SCREEN

Instruction Manual

The Long Term Care Patient Screening Instrument: to be used with Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI)

NEW YORK STATE DEPARTMENT OF
SOCIAL SERVICES
Division of Administration
Office of Human Resources Development

NEW YORK STATE DEPARTMENT
OF HEALTH
Office of Health Systems Management
Bureau of Long Term Care Services

TABLE OF CONTENTS

page

The SCREEN Instrument....3
Instructions for Completing the SCREEN....7
General Instruction....7
Pediatric Instruction....11
Instructions in Detail....12
Identification....12
Direct Referral Factor for RHCF....13
Direct Referral Factors for Home Assessment....14
Home and Caregiving Arrangements....20
Referral Decision....31
Dementia Qualifier....32
Level I Review for Possible Mental Illness....34
Level I Review for Possible Mental Retardation/Developmental Disability (MR/DD)....36
Categorical Determination....43
Danger to Self or Others....47
Level II Referrals....49
Level II Determinations....51
Patient/.Resident/Person Disposition....52
Patient/Resident/Person or Representative Acknowledgement....53
Qualified Screener....55
Update....56
Appendices....57
Appendix A: PASARR Program....58

The Screen Instrument

The SCREEN currently serves two purposes. The first function of the SCREEN is to determine the person's potential to be cared for in a non-RHCF setting. This function is also carried out by qualified screeners in hospitals, Certified Home Health Care Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and other community-based agencies prior to referral of a person to an RHCF, and also by RHCFs upon discharge of the resident to another NYS RHCF or into the community.

The second purpose is to assess persons for potential mental illness (MI) and/or mental retardation or developmental disabilities (MR/DD). Persons with indicators of possible MI and/or MR/DD must be referred, unless certain exclusions are met, to the Office of Mental Health (OMH) or a designated assessor and/or the appropriate Office of Mental Retardation and Developmental Disabilities (OMR/DD) Developmental Disabilities Service Office (DDSO) for determinations as to whether the person requires specialized services for MI or MR/DD. This function of the SCREEN is carried out by qualified screeners in hospitals, CHHAs, LTHHCPs and other community-based agencies prior to referring a person to an RHCF.

In order to complete the SCREEN, the screener must review a completed Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI).

There are three (3) components to the SCREEN. The components that must be completed depend on the function being carried out by the SCREEN.

The first component is the identification information found under IDENTIFICATION, (items 1-6). These items must be completed every time the SCREEN is completed.

The second component of the SCREEN (items 7-21) is used to determine the person's potential for placement in a community setting. This component is completed prior to admission to an RHCF and for RHCF discharge to the community or to another NYS RHCF for placement.

The section labeled DIRECT REFERRAL FACTOR FOR RHCF begins the information needed for screening of potential placement in the community. This section asks whether the person has an available home in the community, whether appropriate community-based living space can be arranged, or whether the person is eligible for an Adult Care Facility (ACF). Those persons who do not have a home and for whom one cannot be arranged, and who are not eligible for an ACF are referred directly to a RHCF.

The section labeled DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT consists of five (5) indicators of the person's potential for home placement, called direct referral factors. Experts in the field of long terms care recommend that the presence of any one (1) of these characteristics be an indicator that community-based placement should be further explored. This section addresses the person's attitude toward placement, the person's pay source, the presence of informal supports, the person's level of dependency in Activities of Daily Living (ADLs), and the person's previous functioning status.

Referral Guidelines were developed by long term care professionals, and specify a response by the screener based on the information documented. These referral guidelines reflect an expert opinion that if the person has a community dwelling or one can be arranged <u>and</u> a positive response for any one (1) of the five (5) direct referral factors, his or her potential for community-based care should be further evaluated.

HOME AND CAREGIVING ARRANGEMENTS is completed for those persons who have a community-based dwelling and do <u>not</u> have a positive response to <u>any</u> of the five (5) direct referral factors for home assessment. These persons do not have nay obvious characteristics indicating that either an RHCF placement or community-based care should be further evaluated.

In general, the column of questions on the left (13, 16, and 19) addresses the person's resources. In these questions, the screener documents the current situation of the person. In each question, if unmet need is not documented, the screener simply proceeds vertically downward to the next question. In other words, if unmet need is not documented, that item need not be considered further.

If unmet need is documented in <u>any</u> of questions 13, 16, or 19, the screener proceeds horizontally to the right. In the questions in the center column (14 and 17), the screener documents service intervention by asking – "Can this unmet need be met in the community?" If community-based intervention will address the unmet need, then the screener documents this and follows the arrows back to the left-hand column to consider the next need area.

If it is documented that community-based intervention will not address unmet need in questions 14 and 17, or if undue risk is documented in question 19, the screener proceeds horizontally to the right. The screener documents the principal reason that those areas of unmet need cannot be met in the community.

Completion of the section labeled HOME AND CAREGIVING ARRANGMENTS is simple. The screener documents the answer to each question and follows the arrows. According to experts in long term care, these questions must be considered when selecting the setting for long term care for those persons who do not have obvious potential for community based care. Use of this format is important because it is computer compatible and collects this information in a systematic way. In addition, this format helps to isolate each problem and consider community-based alternatives, in the complex decision-making process,

The final REFERRAL DECISION (item 21) is based on the information in items 7-20 and Referral Guidelines. The Referral Guidelines and REFERRAL DECISION reflect expert opinion that reasons documented in items 15, 18, and 20, indicate that the person's unmet needs cannot be met in the community and are indicators of the need for RHCF placement. If none of these are entered, then the person does not have indicators of the need for RHCF placement, and the person's potential for home placement should be explored further. Screeners direct persons to home assessment, or assessment for ACF, RHCF placement for restorative services, RHCF placement for other services, investigation of both community-based and RHCF care, or RHCF care even though indicators of community-based care exist.

The third component of the form (items 22-35) documents pre-admission and annual assessments of prospective or current residents for possible MI or MR/DD (LEVEL I review) and refers some cases to OMH and/or OMR/DD or their designees for further review (LEVEL II assessment/specialized services determination) when appropriate.

This component is required to be completed prior to admission to an RHCF (PAS) and for annual resident reviews (ARR) of residents in RHCFs. Although RHCFs will not generally be responsible for the completion of this component prior to admission, the RHCF may not admit a resident if the SCREEN has not been properly completed by the hospital, CHHA, LTHHCP or community-based screener. The RHCF will be required to maintain a completed copy of the "prior to" admission screens (PAS) on file as well as annual resident reviews.

This component of the form consists of seven sections as follows:

- DEMENTIA QUALIFIER
- LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS
- LEVEL II REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY
- CATEGORICAL DETERMINATIONS
- DANGER TO SELF OR OTHER QUALIFIERS
- LEVEL II REFERRALS
- LEVEL II DETERMINATIONS

The DEMENTIA QUALIFIER asks whether the person has a primary diagnosis of dementia. If this is the case, the person is considered appropriate for consideration of RHCF care unless the person also has a diagnosis of MR/DD. The rest of this component is bypassed and the screener would proceed directly to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

The section labeled LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS consists of one (1) question, which is based on federal regulations. This question is used to determine whether the person has an indicator of MI. Similarly, the section labeled, LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/ DEVELOPMENTAL DISABILITY asks four (4) questions which are used to determine whether the person has indicators of MR/DD. If these two (2) sections indicate no possible MI and/or MR/DD, the rest of this component is bypassed. The screener would proceed directly to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

Even if the person has indicators of possible MI and/or MR/DD, the LEVEL II assessments may not be required if certain categorical determinations exist. The existence of these (convalescent care, seriously ill, terminally ill, or very brief and finite stay or provisional emergency admission) is documented in the section labeled, categorical determinations. If a categorical determination exists, a determination whether the person is a danger to self or others must be made and documented in the section labeled DANGER TO SELF OR OTHERS QUALIFIERS. If the person has a categorical determination and is deemed to be a danger to self or others, the remainder of this component of the SCREEN is bypassed. The screener would proceed directly to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

The section labeled LEVEL II REFERRALS documents for those persons with indicators of possible MI, and/or MR/DD, and whom did not meet any of the categorical determination guidelines, the appropriate LEVEL II referral decision(s). If the person has an indicator of a possible MI, a LEVEL II referral will be made to the OMH designated assessor. If the person has indicators of possible MR/DD, a LEVEL II referral will be made to the appropriate OMR/DD Developmental Disabilities Service Office (DDSO).

Once the need for a LEVEL II referral is established, (item 34), the rest of the SCREEN is not completed until such time as a response from OMH and/or OMR/DD is received indicating whether the person requires specialized services for MI or MR/DD. The screener will be responsible for making the LEVEL II referral to the appropriate agency or agencies including all required documentation. The LEVEL II referral process is discussed in the detailed instructions that follow.

Once the LEVEL II determinations are made by OMH and/or OMR/DD and transmitted back to the RHCF, hospital, CHHA, LTHHCP, or other community-based agency, the screener will document the determination in the section labeled LEVEL II DETERMINATIONS (item 35). If the determination is that the person requires specialized services for MI or MR/DD, the rest of the SCREEN form is completed and the person may be placed or discharged to the appropriate care setting. If it is determined that the person is appropriate for consideration of or continued RHCF care, the screener would then complete the PATIENT/PERSON/RESIDENT DISPOSITION question (item 36).

INSTRUCTIONS FOR COMPLETING THE SCREEN

GENERAL INSTRUCTIONS

The step-by-step instructions that follow explain in detail how the SCREEN instrument should be filled out. If the instructions are followed, completing the form should be a fast, simple process.

The SCREEN instrument uses a decision tree model to format the questions. In a decision tree model, each branching junction represents a decision point and each branch represents a decision option or outcome.

A decision tree can provide a structure for analyzing a problem, which makes data analysis easier and clearer. It can help insure that no important pieces of information are overlooked in documenting the decisions. In effect, it provides a useful checklist of needed information and also an orderly and clear-cut documentation of the rationale for the decision, and the person's destination.

Many of the questions are arranged in such a way that either a YES or NO answer is the only possible outcome. Whether the screener answers YES or NO determines which question is answered next. Thus the questions must be answered in the appropriate sequence.

The sequence can be visualized in Figures 1 and 2.

SOURCES OF DATA

Use as many sources of data as are relevant and available. Examples include:

HOSPITAL/RHCF

- patient
- informal supports – family, friends
- professional staff
  - nursing
  - social work
  - medical
  - OT, PT
- auxiliary staff
  - aides
- patient record

COMMUNITY

- patient
- informal supports – family, friends, neighbors
- professional staff
  - nursing
  - social work
  - medical
  - OT, PT, speech
  - aides
- formal service agencies
- records

FIGURE 1

Sequence for completing SCREEN when determining RHCF eligibility

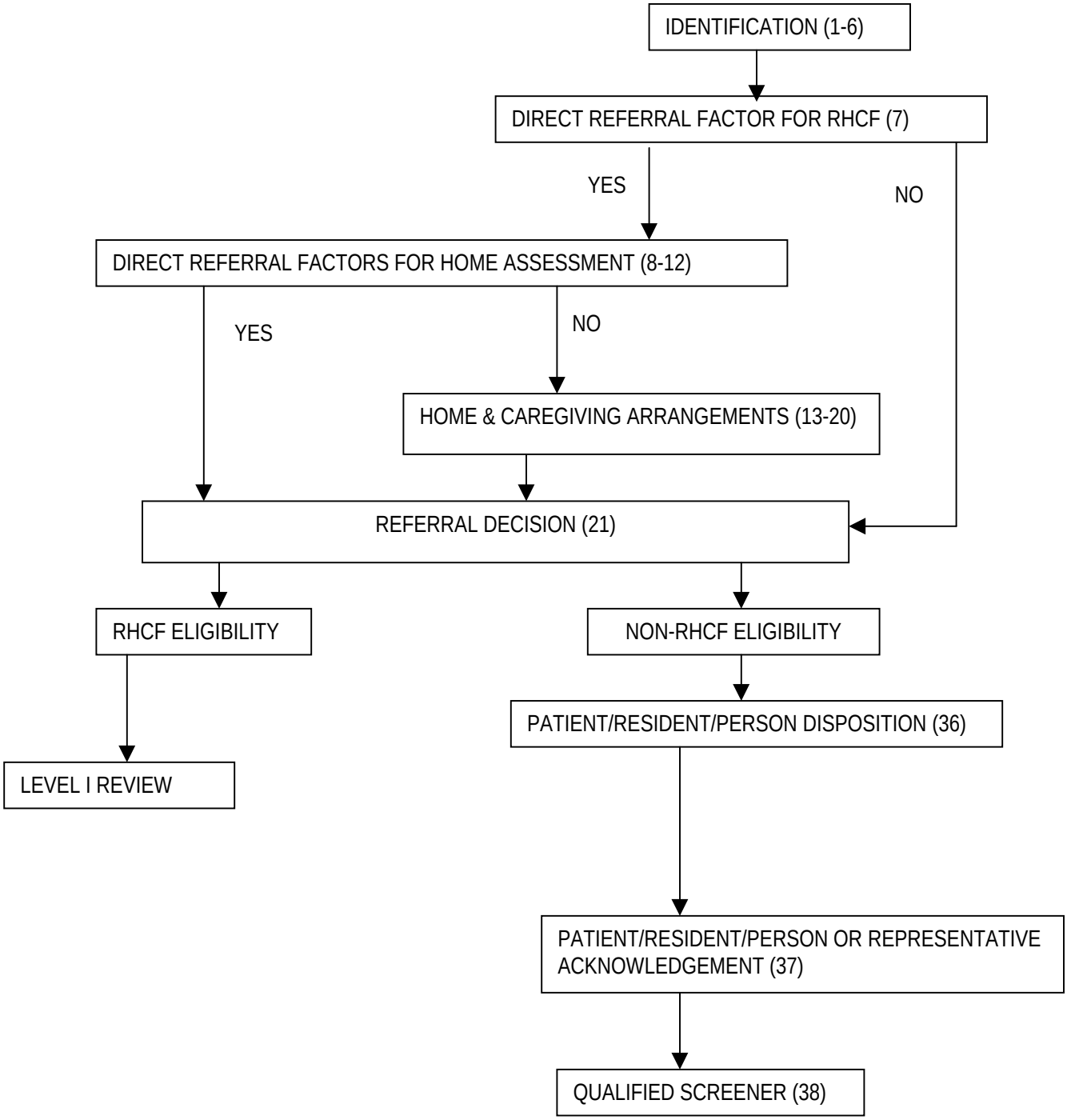
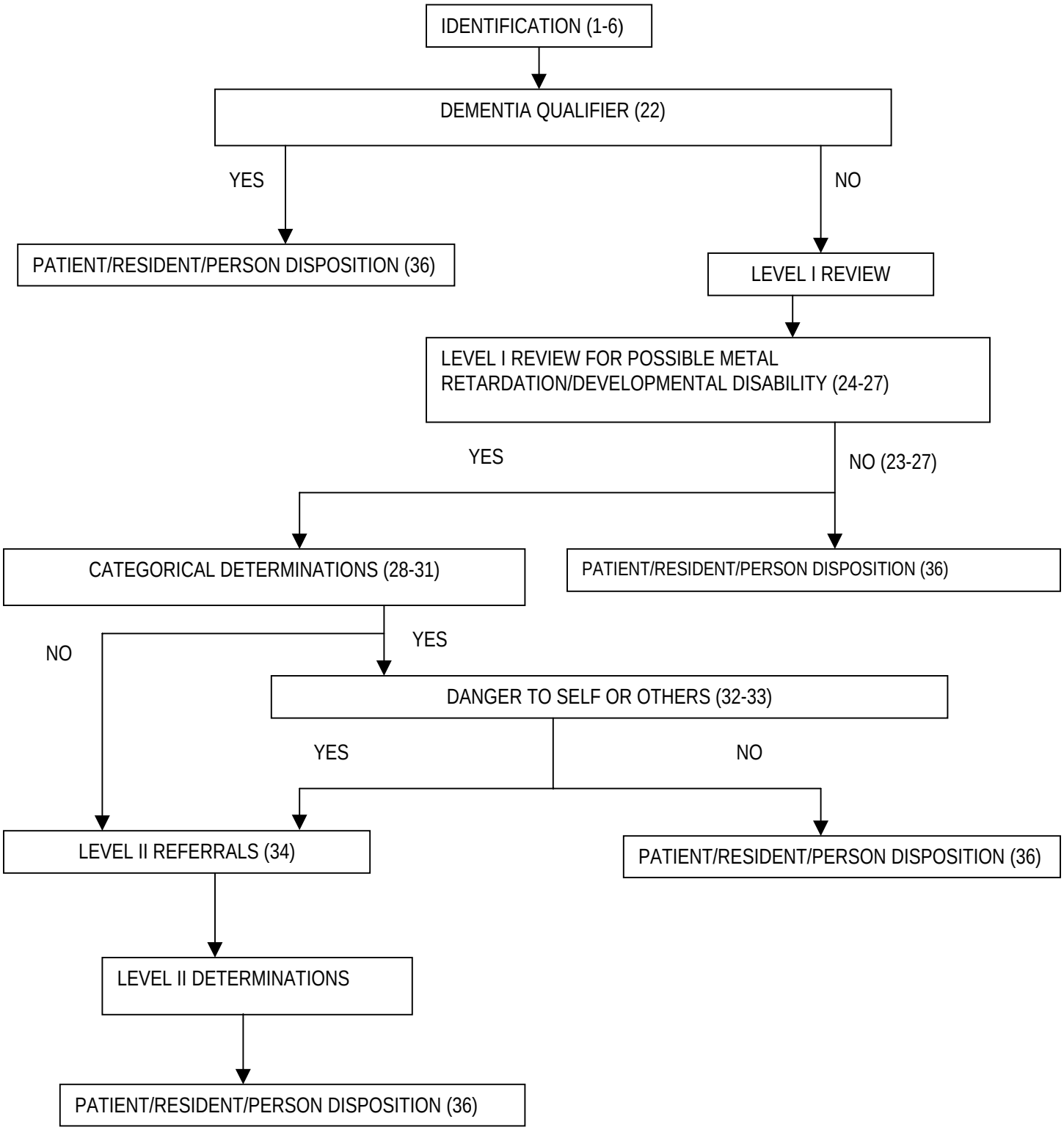


FIGURE 2

Sequence for completing SCREEN when MI and MR/DD LEVEL I Review is required.



The "Instructions in Detail" section that follows, provides important information for filling out the SCREEN on an item by item basis. Filling out items 1-6 is straightforward and uncomplicated. Instructions for items 7-37, which are the heart of the instrument, may appear more complicated at first glance. These are the sections of the instrument in which YES or NO answers are required. For each question, additional information or common examples are provided which serve to aid the screener in understanding whether the criteria of that indicator are met. The criteria are organized where appropriate in YES and NO columns underneath the question to which they refer. The criteria under the YES column are conditions for a YES answer, and those under the NO column are conditions for a NO answer. Please pay particular attention to the ANDs and ORs between these criteria. When an AND appears, more than one (1) condition is necessary to mark that answer. For example, in order to mark YES to item 9 "Patient is aware of the cost of necessary community services and desires to use private resources (e.g. insurance, income, savings) to purchase care at home or in an Adult Care Facility," the patient must have private financial resources to pay for community living expenses and services and agree to use these financial resources for care at home or in an Adult Care Facility.

Some questions require special direction, definition or exceptions in addition to the conditions specified in the YES / NO columns. These special directions are contained in "NOTES" directly below the relevant question.

Item 36 provides for a simple documentation of the work that has been done in the preceding sections.

In summary, it is important to complete the form in the appropriate sequence, to use the information contained in the YES / NO columns and the NOTES, and to document decisions as you proceed.

This is a legal document and therefore it is subject to strict confidentiality.

Black ink is required to enter your answers. If an incorrect entry is made, simply cross off the wrong answer and enter the correct one. Do not use whiteout.

PEDIATRIC RESIDENT COMPLETION PROCEDURES FOR THE SCREEN INCLUDING PASRR

UNDER THE AGE OF 18:

- Complete questions 1-6 and 22-35 ONLY. You are not required to do questions 7-21 and 36-37

- Question 28, CONVALESCENT CARE is amended to 365 days.

- Should you require:
  - a Level II Review for Mental Illness, contact IPRO
  - a Level II for MR contact the local Developmental Disability Services Office (DDSO), (See Appendix D).

FOR RESIDENTS 18 YEARS OF AGE OR OLDER, OR FOR EMANCIAPTED MINORS, FOLLOW THE RULES FOR THE ADULT POPULATION.

HOSPITALS DISCHARGING TO PEDIATRIC FACILITIES:

IF THE PATIENT IS UNDER 18 YEARS OF AGE, DO ONLY QUESTIONS 1-6, 22-35 AND 38.

INSTRUCTIONS IN DETAIL

IDENTIFICATION

1. FACILITY OPERATING CERTIFICATE NUMBER
   - Seven numbers followed by a letter (H or N)
     - H = hospital
     - N = Nursing Facility
   - CHHA certificates consist of seven numbers with no letter. Use the last seven boxes. Leave the first box on the left blank.

2. PATIENT/RESIDENT/PERSON SOCIAL SECURITY NUMBER
   - Use boxes to print numbers, one (1) per box.
   - If there is no number or it is not known, print "0" in the far right box only.

3. NAME OF PERSON(S) COMPLETING SCREEN
   - Print or type
   - First name first, then last name

4. PATIENT/RESIDENT/PERSON NAME
   - Print or type
   - First name first, then last name

5. DATE OF HC-PRI OR PRI COMPLETION
   - Enter the date of the H/C PRI or PRI to complete the SCREEN

6. a. DATE OF SCREEN INITIATION
   - Enter the date that the SCREEN was begun

6. b. DATE OF SCREEN COMPLETION
   - Enter the date that the SCREEN was completed i.e., item 38 completed

DIRECT REFERRAL FACTOR FOR RHCF

7. Person has a home in the community (owns or rents a home, lives in an ACF or with family or friends) and that place is still available OR appropriate community based living space can be arranged OR the person is eligible for an Adult Care Facility.

If NO, explain:

NOTE: This question Addresses Physical Living Space Only!

NOTE: GUIDELINES FOR ADULT CARE FACILITIES

The characteristics of Adult Care Facility residents vary among facilities. As a guideline, a person can be cared for in an Adult Care Facility if
:

- all PRI or H/C PRI ADL responses = 1 or 2 (see PRI part III, Items 19-22) and
- the person can vacate the building independently in the event of an emergency.

YES

a) The person owns or rents a home

OR

he/she lives with family or friends

OR

he/she lives in an Adult Care Facility

AND

that place is still available for the person to live.

OR

b) The person is eligible for an Adult Care Facility.

NO

a) All potential alternatives for community based living space have been investigated and none can be arranged.

REFERRAL GUIDELINES: If item 7 is marked NO, explain above and refer to RHCF. Proceed to REFERRAL DECISION (item 21). If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT (item 8).

DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT

NOTE:
- Check YES if both parts of a question (8, 9, 10, 12) are answered YES.
- Check NO if one (1) part of the question is NO – OR- if the answer cannot be determined.

8. Person understands information given and strongly opposes placement/continued stay in a residential health care facility.

YES

a) The person has a realistic understanding of self-abilities and disabilities

AND

he/she is strongly motivated to return to or remain at home

AND

he/she understands and accepts any risk associated with home placement.

NO

a) The person considers nursing home placement/continued stay to be a favorable alternative

AND

he/she has considered entering/remaining in a nursing home.

OR

b) The person opposes entering/remaining in a nursing home but is unrealistic about ability to return to/remain at home.

OR

c) The person does not understand risk associated with home placement.

OR

d) The person is non-responsive (i.e., heavily medicated, or comatose).

9. Person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, saving) to purchase care at home or in an Adult Care Facility.

NOTE:	Explore all private resources such as insurance coverage, savings, income or financial aid provided by spouse, relative or friend. Medicare and Medicaid resources should not be included as private financial resources.

YES	NO
a) The person has private financial resources to pay for community living expenses and services	a) Private financial resources are obviously not sufficient to purchase the amount of care needed and to cover living expenses.
AND	OR
he/she agrees to use these financial resources for care at home or in an Adult Care Facility.	b) The person refuses to use private resources for home care.

10. Person has a good informal support system – willing and capable (physically and mentally) of caring for most of the specific needs of the person.

NOTE:	An informal support is any person who provides any service to the person on a voluntary (not paid) basis. Include service providers which charge no fee or a nominal fee (i.e., friendly visiting) as informal supports.

YES

a) The person has someone to provide service on a voluntary (not paid) basis

AND

informal supports have a realistic understanding of his/her needs

AND

informal supports are willing and physically and mentally capable of caring for most of those needs or will be capable with instruction

AND

the person wants to receive care from informal supports.

NO

a) Informal supports have limitations which render them incapable of caring for most of the person's needs such as:
   - mental illness
   - physical illness
   - full time employment
   - significant distance
   - care of young children
   - care of other disabled persons.

OR

b) Informal supports are not willing to meet most of the specific needs of the person.

OR

c) The person does not want to receive care from informal supports.

11. All ADL responses = 1 or 2 (see PRI PART III, 19-22).

NOTE:	Refer to the H/C PRI or the PRI, PART III, ACTIVITIES OF DAILY LIVING, questions 19-22.

YES	NO
a) All responses are either 1 or 2. Include Eating, Mobility, and Toileting.	a) Any of ADL responses are a 3, 4, or 5.

12. Person was independent in ADL prior to most recent acute episode and shows good rate of return of physical and mental functioning.

NOTE:	This decision should be based on information from the person, medical records and informal supports. "Independent" means being able to perform ADL and IADL without supervision or physical assistance. IADL means instrumental activities of daily living (e.g. shopping, laundry, housekeeping.)

YES	NO
a) The person performed ADL and IADL independently prior to his/her most recent acute episode (or most recent acute exacerbation of chronic illness)	a) The person needed supervision or assistance with ADL or IADL prior to the most recent acute episode (or most recent exacerbation of chronic illness).
AND	OR
his/her good rate of return is exhibited by increasing strength and ability to bear weight and to perform active range of motion.	b) The person is recovering functioning at a substantially lesser rate than expected.
OR	
if the person has mental impairment, a good rate of return is exhibited by increasing orientation and ability to perform daily tasks.	

REFERRAL GUIDELINES:

1. If any direct referral factor (8-12) is marked YES, refer to HOME ASSESSMENT OR ASSESSMENT FOR ADULT CARE FACILITY.

NOTE: Home Assessment Guidelines

What is a home assessment?

A review of a person's environment, informal supports, economic status and physical and mental needs, as they relate to the possibility of care being provided to them in the community.

It does not require that an actual visit be made to the person's home.

Who can do a home assessment?

Only individuals from authorized agencies, which include:

1. all certified home health care agencies including VNA and Public Health
2. the Lombardi Long Term Home Health Care Program
3. CASA's

What information should the written report contain?

1. There is no required form, only what a particular agency chooses to use.
2. Name and phone number of agency, date of assessment.
3. Name and case number of resident/patient/person.
4. Determination:
   a) if the individual can be cared for at home, include a recommended plan of care.
   b) if individual cannot be cared for at home, include reasons.

While there is no mandatory time frames for completion of the home assessment, the screen process cannot continue until the results of the home assessment are obtained.

Results:

1. Once the home assessment is returned to the screener, the form is attached to the screen
2. If the home assessment indicates that care cannot be given in the community, the screener continues with the Home and Caregiving Arrangements section on the screen.

If the home assessment indicates that care can be given in the community, the screener goes directly to referral decision (item 21) and enters a "3" in the box, signs the form and enters his/her certification number.

2. If all direct referral factors (8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS.

HOME AND CAREGIVING ARRANGEMENTS

- These questions should be answered according to the information that is available at the time you are completing this form, unless otherwise indicated.

- Check YES or NO boxes to document each response. For questions on the far right, enter the number of the answer that best applies.

13. a. Estimate the total number of hours per day that informal supports are willing and able to provide supervision or assistance to the person.

> NOTE: Do not consider the times of day, only the number of hours.
>
> An informal support is:
>
> - any person who provides any service to the person on a voluntary (not paid) basis.
> - service providers which charge no fee or a nominal fee (e.g. friendly visiting).
> - people providing simple services (telephone checking) or complex services (trained administration of medication or treatments)

1. Consider all informal support persons who could provide help and total the hours per day that these people are willing and able to provide supervision or assistance. Include sleeping time if informal support persons are willing and able to attend to the person's needs during these hours.

OR

Average the hours of informal support time per day. If persons cannot be present daily or if hours per day vary, total the number of hours per week for all informal supports and divide by seven to arrive at the average daily hours.

2. In the blank, enter the hours per day that informal supports are available.

b. Estimate the total number of hours per day that the person can be alone.

> NOTE: Do not consider the times of day, only the number of hours.
>
> Do not consider any assistance by informal or formal supports for the purpose of the estimate.

1. Consider:
   - Person's ability to perform unscheduled activities (such as toileting or use of toileting equipment (PRI PART II, 22).
   - All tasks that the person can perform without supervision or assistance (PRI PART III, 19-22)

- The amount of time the person is not engaged in physical activity.

- The person's orientation. Can the patient perform daily tasks? Is there a history of unpredictable behavior?

2. Average the hours per day. If the person is independent in activities or not physically active less than daily or if hours per day vary, total the number of hours per week that the person can be alone and divide by seven for the average daily hours.

3. In the blank, enter the hours per day.

c. Add a and b (a + b = c)

1. Add 13a (total number of hours per day of informal support) to 13b (total number of hours per day that the person can be alone.)
2. In the blank, enter the hours per day.

d. Is the number of hours in line c, twelve (12) or more?

YES	NO
a) The sum of 13a and 13b (as recorded in 13c) is twelve (12) or more.	a) The sum of 13a and 13b is less than twelve (12).

NOTE: Answer only if response to 13d is NO.

14. Within six months can the number of hours per day that the person is attended by self or informal supports be increased to twelve (12) or more?

YES	NO
a) According to your estimate, the number of hours that the person can be alone (as recorded in 13b) or attended by informal supports (as recorded in 13a) can be increased to twelve (12) or more within six (6) months.	a) The number of hours the person can be alone or attended by informal supports is not expected to increase to twelve (12) hours or more within six months.

NOTE: Increase in the number of hours that the person can be alone or attended by informal supports may occur because of:

- increased assistance from family members and non-kin already providing care;

OR

- assistance from family members or non-kin that have not previously provided assistance;

OR

- use of informal services providers such as Home Delivered Meals or transportation at either no charge or a nominal fee;

OR

- rehabilitation of the person.

NOTE:	Answer only if the answer to 14 is NO. Enter the primary reason that the person cannot be attended by self or informal supports for twelve (12) hours or more per day.

15. If NO, enter principal reason (1, 2 or 3):

1. Person understands options and has decided to enter or remain in a nursing home.

2. Person has no informal supports

3. Informal supports are unable or unwilling to provide additional assistance or person does not want care from informal supports.

GO TO 16

1. Person understands options and has decided to enter or remain in a nursing home.

YES	NO
a) The person states that RHCF placement is the best option and will not reverse this decision when community alternatives have been explained.	a) The person will accept increased home care as an alternative to RHCF placement. OR b) The person is temporarily upset and influenced by informal supports' suggestion of nursing home placement.

2. Person has no informal supports.
   a) No one can provide any service to the person on a voluntary basis.

3. Informal supports are unable or unwilling to provide additional assistance or person does not want care from informal supports.
   a) There are people who provide assistance on a voluntary basis, but they will be limited in the amount of assistance they can provide because of:
      - full-time employment;
      - physical/mental incapacity
      - caring for young children or another disabled person;
      - distance from person and travel is unrealistic.

OR

   b) Informal supports are unwilling to provide additional assistance.

OR

   c) The person does not want care from informal supports.
      - informal supports are available, but person has stated that he/she does not want additional care from informal supports.

16. Is there a need for restorative services which is documented by a physician or rehabilitation specialist?

NOTE: "Restorative Services"

- are provided to persons expected to improve or regain functioning.
- are not maintenance or preventative services.
- require a licensed, professional therapist for supervision or performance.
- include physical, mental or sensory restoration.

"Rehabilitation Specialist" is a licensed professional with specialized rehabilitative training (psychiatrist, physical therapist, occupational therapist, speech pathologist).

YES	NO
a) A rehabilitation specialist or physician has evaluated the person	a) The person has not been evaluated for restorative potential.
AND	OR
the rehabilitation specialist or physician has documented that he/she needs restorative services in order to regain functioning.	b) The person has been evaluated and the rehabilitation specialist or physician has not documented need for restorative services.
	OR
	c) The person has been evaluated and the rehabilitative specialist or physician has documented need for services to maintain present level of functioning or to prevent deterioration.

NOTE:	Answer 17 only if answer to 16 is YES.

17. Can person receive restorative services at home, at adult day care or as an outpatient?

YES	NO
a) Adequate restorative services are available in the person's community. AND he/she can access these services AND he/she can afford the services or they are covered by his/her insurance.	a) All available community based restorative services have been investigated AND the person cannot receive restorative services at home, at adult day care or as an outpatient.

NOTE:	Answer 18 only if answer to 17 is NO. Enter the primary reason that restorative services cannot be received at home.

18. If NO, enter principal reason (1,2, or 3).

    1. Restorative services are not available in person's community.

    2. Restorative services are too costly or not covered.

    3. Person cannot access restorative services.

    1. Restorative services are not available in person's community.

NOTE:	Enter this response only after investigating all sources of restorative services in the community. "Community" means the person's home or outpatient setting.

- Restorative services are needed at a frequency not available in person's community.

OR

- Intensity of services needed exceeds that which is available in the person's community. "Intensity" means the number of times per day services are need, duration of visits, types of service and special equipment requirements.

    2. Restorative services are too costly or not covered.

NOTE:	Investigate person's insurance coverage. Compare the cost of community based restorative services with the cost of nursing home placement.

- Services are not covered by person's insurance.

OR

- Services would be less costly if person entered or remained in a nursing home to receive them.

3. Person cannot access restorative services. (Access does not mean availability of services.)

NOTE:	Investigate availability and cost of transportation. Investigate person's medical tolerance.

- Transportation cannot be arranged for outpatient visits.

OR

- Cost of transportation is prohibitive.

OR

- Transportation cannot be tolerated by the person for medical purposes.

19. Can the person be placed in the community without causing undue risk to self or others? (Only consider reasons listed in item 20)

YES

a) the person has no identifiable risks: this is determined by knowing the patient's physical and mental functioning and using professional judgement after interacting with patient, family and caregivers.

OR

b) the person is determined to BE at risk, but the risk does not fit SCREEN definitions: this is determined by looking at the risks as defined in your SCREEN INSTRUCTION MANUAL

OR

c) the person IS at risk according to SCREEN, BUT the risk is TEMPORARY: temporary means the risk will not exist after 6 months. Use professional judgement for this question after talking to physicians, therapists, and caregivers.

OR

d) the person IS at risk according to SCREEN, BUT the risk would not be substantially reduced if placed in an RHCF setting.

NO

a) the risk you have identified FITS into 1 of the 4 reasons as defined in the INSTRUCTION MANUAL

AND

b) the risk will still exist after 6 months; therapeutic intervention or rehabilitation are not likely to correct the problem, use professional judgement after talking to therapists, physicians, caregivers

AND

c) the risk WOULD BE substantially reduced if the patient were placed in an RHCF setting.

NOTES:	Answer only if the answer to 19 is NO. Enter the principle reason that undue risk exists if the person is placed in the community.

20. If question 19 is NO, enter principal reason (1, 2, 3 or 4):

    1. Person has history of unpredictable behaviors and may injure self or others. This condition is not temporary.

    2. Comatose or all ADL responses = 4 or 5 (PRI PART III, 19-22).

    3. Requires constant monitoring due to health threatening medical conditions.

    4. Skilled services are need as least one (1) time per day and cannot be delegated to nonprofessionals or informal supports.

        1. Person has history of unpredictable behaviors and may injure self or others. This condition is not temporary.

        <u>YES</u>

        a) The person exhibits frequent violent or unsafe behaviors toward self or others

        OR

        he/she exhibits regressive or passive behavior to the point of failing to care for self or receive care

        AND

        he/she requires constant supervision or his/her behavior will result in injury to self or others. .

        <u>NO</u>

        a) The patient is somewhat forgetful.

        OR

        b) The condition is expected to improve within six months due to rehabilitation or therapeutic intervention.

        2. Comatose or all ADL responses = 4 or 5 (PRI PART III, 19-22).

        <u>YES</u>

        a) Person is comatose as documented on the PRI (PART II A.)

        OR

        b) All ADL responses equal 4 or 5 on the PRI (PART III, 19-22)

        <u>NO</u>

        a) There is no undue risk due to these conditions because person is constantly attended by informal supports.

        OR

        b) Person is expected to improve or be rehabilitated within six months.

3. Requires constant monitoring due to health threatening medical problems.

YES	NO
a) The person's life will be threatened or health will decline significantly if person is not in close proximity to constant monitoring.	a) There is no undue risk to the person if not constantly monitored. OR b) The person is expected to improve or be rehabilitated within six months.

4. Skilled services are need at least one (1) time per day and cannot be delegated to nonprofessionals or informal supports.

NOTE:	Skilled Services do not include rehabilitation services.

YES	NO
a) Skilled services, such as nursing treatments, respiratory therapy, and others (see PRI PART II 18, A-J) are absolutely necessary at least one (1) time per day. AND these services must be performed by a licensed professional AND these services cannot be learned by informal supports or nonprofessional/paraprofessional personnel AND the need for these services is not temporary but continuous; that is, within six (6) months, the condition is not likely to improve to the point that these services will not be necessary on a daily basis.	a) The person does not need skilled services at least one (1) time per day. OR b) Informal supports could be trained to perform the services. OR c) The person's condition is expected to improve to the point that skilled services will not be needed every day within the next six (6)months.

REFERRAL DECISION

21. Enter principal reason (1, 2, 3, 4, or 5):

1. RHCF: Item 7 is marked NO OR an entry appears in item 15 or 20 OR a home assessment was done by an authorized home care agency and it was determined that the person cannot be cared for in the community. This home assessment represents the person's current status.

2. RHCF for Restorative Services: There is an entry in item 18.

3. Home Assessment or Assessment for Adult Care Facility: One (1) or more of items 8-12 are marked YES or no entries appear in items 15, 18 or 20.

4. Community based and RHCF care are both being investigated.

5. Referral Decision indicates Home Assessment or Assessment for Adult Care Facility but RHCF care is recommended.

If response 4 or 5 is chosen explain:

4. Community based and RHCF care are both being investigated: this item identifies persons for whom dual planning is necessary because the most appropriate setting for care cannot be determined at the time the SCREEN is completed. Briefly explain the circumstances in the space provided.

5. Referral Decision indicates Home Assessment or Assessment for Adult Care Facility but RHCF care is recommended: this item identifies persons who have indicators of potential to be cared for in the community, but in the best judgement of the screener, the community based placement is unsafe. Briefly explain the circumstances in the space provided.

GUIDELINES:

- If principal reasons 1, 2 or 5 have been chosen, proceed to item 22.

- If the results of principal reasons 3 or 4 indicate community placement, proceed to Patient/Resident/Person Disposition (item 36). If the results indicate RHCF placement, proceed to Dementia Qualifier (item 22).

DEMENTIA QUALIFIER

22. Does the person have a documented diagnosis of dementia (including Alzheimer's Disease) without a diagnosis or MR/DD?

NOTE: A diagnosis of Dementia, including Alzheimer's disease or a related disorder, can generally be confirmed through the following diagnostic studies:

EXAMPLES:
1. a comprehensive history including a drug/medication review
2. a complete physical exam including evaluation of motor cranial nerves and abnormal reflexes
3. computed tomography (CT scan) of the brain or magnetic resonance imaging (MRI) eg. results indicating brain atrophy.

The diagnostics above are only EXAMPLES of the evaluative methods that can be used to diagnose Dementia or Alzheimer's.

Diagnostic testing terminates as soon as the result of the test conducted lead to a determination on Dementia or Alzheimer's. The SCRENNER does not need to see the actual diagnostic results as long as they can be verified by the physician.

YES

a) The person has a diagnosis of dementia, Alzheimer's or other related disorder that is documented or verified

AND

this diagnosis is based on documented or verified diagnostic results.

NO

a) The person does not have a diagnosis of dementia, Alzheimer's or other related disorders.

OR

b) The person has a diagnosis of dementia, Alzheimer's or related disorders that is documented or verified

AND

this diagnosis is not based on documented or verified diagnostic results.

OR

c) The person has a diagnosis of dementia, Alzheimer's or related disorders documented or verified

AND

a documented or verified diagnosis of MR/DD as defined in question 24.

GUIDELINE: If item 22 is marked YES, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36). If it is marked NO, proceed to LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (item 23).

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS

NOTE:	Proceed to Level I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY AFTER ANSWERING THIS QUESTION (item 24).

23. Does the person have a serious mental illness?

YES

An individual is considered to have a serious mental illness (MI) if the individual meets all of the following requirements on diagnosis, level of impairment and duration of illness:

(i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987.
The mental disorder is:
   A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but
   B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder

AND

(ii) Level of Impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one (1) of the following characteristics on a continuing or intermittent basis:
   A) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;
   B) Concentration, persistence and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured

NO

The person does not meet all criteria listed in the YES column:

- Diagnosis
- Level of impairment
- Recent treatment

activities occurring in school or home settings, manifest difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

C) Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

AND

(iii) Recent treatment. The treatment history indicates that the individual has experienced at least one (1) of the following:

A) Psychiatric Treatment more intensive than outpatient care more than once in the past two (2) years (e.g., partial hospitalization, or inpatient hospitalization); OR

B) Within the last two (2) years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer items 24-27 in order; as soon as an item is marked YES, proceed to CATEGORICAL DETERMINATIONS (items 28-31).

24. Does the person have a current diagnosis of mental retardation or a developmental disability (cerebral palsy, autism or epilepsy)

AND

did the mental retardation or developmental disability manifest itself prior to age twenty-two (22)

AND

results in substantial functional limitations in three (3)or more areas of major life activity.

NOTE:

- ACTIVE DIAGNOSIS MEANS A DOCUMENTED DIAGNOSIS made by either a physician or licensed psychologist.

  This question refers ONLY to the following diagnoses:

  - Retardation
    - Mild Mental Retardation (317.0)
    - Moderate Mental Retardation (318.0)
    - Severe Mental Retardation (318.1)
    - Profound Mental Retardation (318.2)
    - Unspecified Mental Retardation (319.0)

  - Epilepsy
    - General Nonconvulsive Epilepsy (345.0)
    - Generalized Convulsive Epilepsy (345.1)
    - Petit Mal Status (345.2)
    - Grand Mal Status (345.3)
    - Partial Epilepsy, With Impairment of Consciousness (345.4)
    - Partial Epilepsy, Without Mention of Impairment or Consciousness (345.6)
    - Infantile Spasms (345.6)
    - Epilepsia Partialis Continua (345.7)
    - Other Forms of Epilepsy (345.8)
    - Epilepsy, Unspecified (345.9)

  - Pervasive Developmental Disorder
    - Autistic Disorder
    - Not Otherwise Specified (299.80)

- Cerebral Palsy
  - Diplegic (343.0)
  - Hemiplegic (343.1)
  - Quadriplegic (343.2)
  - Monoplegic (343.3)
  - Infantile Hemiplegia (343.4)
  - Other Specified Infantile Cerebral Palsy (343.8)
  - Infantile Cerebral Palsy, Unspecified (343.9)
  - Symptomatic Torsion Dystonia (333.7)

The screener may rely on documentation of the above evidence in existing records or may rely on his/her observations or conversations. If the screener relies on observation or interviews for determining onset of the problem and degree of substantial functional limitations, he/she must document affirmative responses to each item.

DEFINTIONS

"Mental Retardation" means subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

"Developmental disability" means a disability of a person which:

(a) (1) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment or autism;

(2) is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such person; or services similar to those required for such person; or

(3) is attributable to dyslexia resulting from a disability described in subparagraph (1) or of this paragraph;

(b) originates before such person attains age twenty-two (22);

(c) has continued or can be expected to continue indefinitely; and

(d) constitutes a substantial handicap to such person's ability to function normally in society.

YES	NO
a) The person has a diagnosis of mental retardation or a developmental disability as defined above and documented in the medical record.	a) The person does not have a diagnosis of mental retardation or a developmental disability as defined above and documented in the medical record.
AND	OR

b) It is manifested before the person reaches age twenty-two (22).

AND

c) It is likely to continue indefinitely.

AND

d) It results in substantial functional limitations in three (3) or more of the areas of major life activity:

Major life activities include:

- self care
- understanding and use of language
- learning
- mobility
- self direction
- capacity for independent living

b) Person does not meet criteria listed in b, c and d under the YES column.

25. Was this person referred by an agency that serves person with MR/DD or has this person ever been deemed eligible AND received MR/DD services current or past?

NOTES:	If there is a question regarding a particular agency, contact the appropriate OMR/DD DDSO. Refer to the list of DDSOs in Attachment D. Many such agencies serve persons other than a population with mental retardation. There must be some verification that the services provided by an agency were provided because the person had mental retardation or a developmental disability, as opposed to other mental or physical disorders. Verification may be documented in the medical records or may be made by contacting the appropriate agency. The screener should document verbal evidence.

YES

a) The person is currently receiving services from an agency that serves persons with MR/DD

OR

the person was receiving services from an agency that serves person with MR/DD prior to hospitalization

OR

the person was referred to the hospital, CHHA, etc. by an agency that serves persons with MR/DD

OR

the person was deemed eligible for that agency's services because of MR/DD.

NO

a) The person is currently receiving services from an agency that serves persons with MR/DD

OR

the person was receiving services from an agency that serves persons with MR/DD prior to hospitalization

OR

the person was referred to the hospital, CHHA, etc., by an agency that serves persons with MR/DD

AND

the person was receiving services for reasons other than MR or DD diagnosis.

OR

b) The person is not currently receiving services from an agency that serves person with MR/DD

AND

the person was not receiving services from an agency that serves persons with MR/DD prior to hospitalization

AND

the person was not referred to the hospital, CHHA, etc., by an agency that serves persons with MR/DD.

26. Is there a documented history of mental retardation or developmental disability in the person's past?

NOTE:

- There should be clear factual evidence documented in available records for any indicator. This history of disability must clearly indicate that it was manifested before the person reached age twenty-two (22). Such evidence could include that the person missed or experienced significant delay in achieving a developmental milestone. Such evidence could also include a prior history of services rendered by an agency or educational institution that serves persons with mental retardation. However, such evidence should indicate that the services provided were for mental retardation or developmental disability.

- Documented evidence may include, but is not limited to, a notation in the medical record by the physician, evidence provided by a service agency or school records.

- Head trauma victims can be included in this item provided they meet the following criteria:
  1. It is manifested before the person reaches age twenty-two (22).
  2. It is likely to continue indefinitely.
  3. It results in substantial functional limitations in three (3) or more of the following areas of major life activity:
     a) Self-care;
     b) Understanding and use of language;
     c) Learning;
     d) Mobility;
     e) Self-direction; and
     f) Capacity for independent living.

- The screen may rely on documentation of items 1-3 above in the existing records or may rely on his/her observations or conversations. If the screener relies on observations or conversations, he/she must be able to document affirmative responses to 1-3.

- For any individual who has sustained a head trauma injury and is to be discharged to a long-term inpatient rehabilitation program for head-injured patients as defined in NYCRR 416.11.
  - Make a notation in item 34 that the MR/DD Level II assessment is waived due to placement in a long-term inpatient rehabilitation program for head-injured patients
  - Screener then proceeds to item 36
    - Please note that if a Level II review is required for mental illness you CANNOT waive the MI level II review process.

The MR/DD LEVEL II assessment cannot be waived if there are no other MR/DD triggers not associated with the head injury or if the individual is to be placed in a regular RHCF unit; i.e., other than a long term inpatient rehabilitation program for head-injured patients.

YES	NO
a) There is clear functional evidence as described above in the available records that the person has a history of MR/DD.	a) There is no clear factual evidence as described above in the available records that the person ahs a history of MR/DD.
OR	OR
b) Meets the head trauma criteria as described in the note box.	b) Does not meet head trauma criteria as described in note box.

27. Does the person present documented evidence (cognitive or behavior functions) that may indicate the presence of mental retardation or developmental disability?

NOTE: Presenting evidence may include any of the following:

- Conversation related evidence regarding intellectual skill limitations (e.g., problems in thinking or use of language)

- Observations in behavior in day-to--day activities, involving demonstrated deficits in adaptive skills, (e.g., ADLs)

- Data found in records.

Any presenting evidence <u>must</u> also meet <u>all</u> of the following conditions:

1. It is attributable to:
   a) Cerebral palsy or epilepsy; or
   b) Any other condition (including autism), other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment of service similar to those required for these persons.

"Any other condition" refers to ANY condition that meets conditions 2-4 in the note box. For example, if an individual does not have a diagnosis of Cerebral Palsy, Epilepsy or Autism, but criteria 2-4 are met, the definition of "any other condition" would be met.

2. It is manifested before the person reaches twenty-two (22).

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three (3) or more of the following areas of major life activity:
   - Self care;
   - Understanding and use of language;
   - Learning;
   - Mobility;
   - Self direction; and
   - Capacity for independent living.

The screener may rely on documentation of the above evidence in the existing records or may rely on his/her observations or conversations. If the screener relies on observations or conversations, he/she must be able to document affirmative responses to items 1-4.

- For any individual who has sustained a head trauma injury and is to be discharged to a long-term inpatient rehabilitation program for head-injured patients as defined in NYCRR 416.11,
  - Make a notation in item 34 that the MR/DD Level II assessment is waived due to placement for head-injured patients.
  - Screener then proceeds to item 36.

The MR/DD LEVEL II assessment cannot be waived if there are other MR/DD triggers not associated with the head injury or if the individual is to be placed in a regular RHCF unit; i.e., other than a long-term inpatient rehabilitation program for head-injured patients.

YES

a) The person presents documented evidence, as described above, which may indicate the presence of mental retardation or developmental disability.

OR

b) Verbal evidence, as described above and which has been documented by the screener, exits which may indicate the presence of mental retardation or developmental disability.

OR

c) Meets the head trauma criteria as described in the note box.

NO

a) The person does not present documented evidence, as described above, which may indicate the presence of mental retardation or developmental disability.

AND

b) Verbal evidence, as described above has not been documented by the screener

OR

c) Does not meet head trauma criteria as described in the note box.

GUIDELINE: If items 23-27 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).

If any of items 23-27 are marked YES, proceed to Categorical Determinations (items 28-31).

CATEGORICAL DETERMINATION

28. Does the person qualify for convalescent care?

NOTE:	Convalescent care is defined as a medically prescribed period of post acute hospital care recovery in a RHCF not to exceed one-hundred twenty (120) days as documented by physician in the medical record, e.g. discharge plan.

YES	NO
a) The person qualifies for convalescent care as defined above.	a) The person does not qualify for convalescent care as defined above.

29. Is the person seriously ill?

NOTE:	Examples of a seriously ill person can include a person who is comatose, ventilator dependent, or has a diagnosis of one (1) of the following chronic debilitating conditions at a severe level: Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis or Congestive Heart Failure as documented in the medical record and whose PRI or HC/PRI responses are 3, 4, or 5 (see PRI or HC/PRI Part III, items 19-22).

YES	NO
a) The person meets the above definition of seriously ill.	a) The person does not meet the above definition of seriously ill.
AND	OR
b) All PRI or H/C PRI responses are 3, 4, or 5.	b) All PRI or HC/PRI responses are NOT 3, 4, or 5.

30. Is the person terminally ill?

NOTE:	A terminally ill person is a person for whom there is documentation in the medical record by a physician that his/her life expectancy is six (6) months or less.

YES	NO
a) The person meets the above definition of terminally ill.	a) The person does not meet the above definition of terminally ill.

31. Is the person admitted for a very brief and finite stay or a provisional emergency admission?

NOTE:

- A very brief and finite stay is defined as a stay whose duration is expected to be 28 days or less (e.g., scheduled short term care stay (respite)).
- A provisional emergency admission is defined as a stay whose duration is not to exceed 7 days and whose purpose is to provide protective services.
- Documentation describing either of the above "stays' is required.

YES	NO
a) The person meets the criteria stated in the note box.	a) The person does NOT meet the criteria state in the note box

GUIDELINE: If any of the items 28-31 is marked YES, proceed to DANGER TO SELF OR OTHERS QUALIFIERS (item 32). If all are marked NO, proceed to LEVEL II REFERRALS (item 34).

DANGER TO SELF OR OTHERS

32. Based on your interview of the person and/or available informants, and/or a review of the person's medical record, is there any evidence to suggests that the person has or may have had homicidal or suicidal thinking or behavior during the past two (2) years?

NOTE:	If your interview of the person and/or knowledgeable informants, and/or review of the person' s medical records raises <u>any</u> questions about whether the person is a danger to self or others, answer this question YES and seek a psychiatric evaluation.

YES	NO
a) Based upon consideration of the above factors, the person may be homicidal or suicidal in thinking or behavior.	a) Based upon consideration of the above factors, you do not consider the person to be homicidal or suicidal in thinking or behavior.

GUIDELINE: If item is marked YES, proceed to item 33. If NO, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

33. Based on a current mental health consultation, has the person been deemed homicidal or suicidal by a qualified mental health specialist?

NOTE:

- A current consultation is one, which has been completed within three (3) months prior to the date of this SCREEN completion.
- An existing psychiatric evaluation must address the issue of homicide or suicide for the evaluation to be valid.
- If there is no existing psychiatric evaluation one must be completed. It does not need to be a full psychiatric evaluation but must address the issue of homicide or suicide.
- There is no mandatory form required for purposes of completing the psychiatric evaluation.
- All psychiatric evaluations for this item must be completed by one of the following:
  - board certified/eligible psychiatrist
  - Ph.D. psychologist
  - psychiatric nurse
  - MSW social worker

THE SCREEN PROCESS CANNOT CONTINUE UNTIL THE RESULTS OF THE PSYCHIATRIC EVALUATION HAVE BEEN DETERMINED.

YES	NO
a) A current consultation as defined above has been done which indicates that the person is homicidal or suicidal.	a) A current consultation as defined above has been done which indicates that the person is not homicidal or suicidal.

GUIDELINES: If item 33 is marked YES, proceed to LEVEL II REFERRALS (item 34). If NO, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

LEVEL II REFERRALS

34. Enter the Level II Referral decision (1, 2, or 3)
    1. Level II mental illness assessment.
    2. Level II assessment and determination by the Office of Mental Retardation and Developmental Disabilities.
    3. Both 1 and 2.

1. Level II mental illness assessment
   Enter a {1} if:
   - there is a YES response in item 23, and there is a NO response in all of items 24-27.

2. Level II assessment and determination by the Office of Mental Retardation and Developmental Disabilities.
   Enter a {2} if:
   - there is a NO response in item 23 and there is a YES response in any of items 24-27.

3. Both 1 and 2.
   Enter a {3} if:
   - there is a YES response in item 23, and there is a YES response in any of items 24-27.

(1) GUIDELINES FOR A LEVEL II REVIEW FOR MENTAL ILLNESS

NOTE: If a {1} has been entered in item 34, the Screener must do the following:

- The Screener is required to complete all necessary intake information as specified by the designated state contractor.
- Upon completion of the full psychiatric review, if the contractor determines that specialized services are not required he/she documents the decision and notifies the appropriate individuals.
- Upon completion of the full psychiatric review, if the contractor determines that specialized serves are required he/she forwards all applicable information to the local OMH Clinical Director for a specialized services determination.
- Complete item 35 only after obtaining the Level II determination from the OMH office or designated contractor.

(2) GUIDELINES FOR A LEVEL II REVIEW FOR MENTAL RETARDATION/DEVELOPMENTAL DISABILITY

NOTE: If a {2} has been entered in item 34, the screener must do the following:

a) Compile a packet of material required for the completion of the OMR/DD Level II assessment which shall include the following:

- a copy of the SCREEN completed to this point;
- a copy of the most current H/C PRI;
- a copy of the primary care physician's comprehensive history and physical examination which must include:
  1) complete medical history;
  2) review of all body systems
  3) evaluation of the neurological system;
  4) medical diagnosis; and
  5) drug history

b) Deliver the completed packet to the appropriate OMR/DD DDSO Assessment Coordinator (Attachment D)

c) Maintain contact with the appropriate OMR/DD DDSO Assessment Coordinator to ensure the completion of the specialized services determination.

d) Receive the Level II determination from the OMR/DD DDSO Assessment Coordinator.

e) Continue with the SCREEN completion of LEVEL II DETERMINATIONS (item 35) only after obtaining the Level II determination from OMR/DD.

(3) GUIDELINES FOR A DUAL LEVEL II REVIEW FOR BOTH MI AND MR/DD

NOTE: If a {3} has been entered in item 34, the screener must do the following:

If the individual's IQ level is known or is available in the medical record, the referral should be made based on IQ level. If the IQ level is greater than 70, the referral should be made first to OMH. If the IQ level is less than 50, the referral should be made first to OMR/DD. If the IQ level is unknown or is between 50 and 70 inclusive, the screener is to use his/her judgement to determine the individual's overriding needs and make the referral accordingly.

If a dual referral is required (MI and MR/DD) upon the determination of the first referral, the screener must then initiate referral to the other state agency.

Complete item 35 only after obtaining the LEVEL II determination(s) from the appropriate Office of Mental Health (OMH) and/or Office of Mental Retardation and Developmental Disabilities (OMR/DD) designee.

LEVEL II DETERMINATIONS

35. Based upon the Level II determination(s), specialized services are required.

YES	NO
It has been determined that the person requires specialized services	It has been determined that the person does not require specialized services.

REFERRAL GUIDELINE: If item 35 is marked YES, complete item 38. If item 35 is marked NO, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).

PATIENT/RESIDENT/PERSON DISPOSITION

36. Enter one (1) response (1, 2, 3, 4, 5, 6, 7, or 8)

1. Home
2. Home with home care services
3. Adult Care Facility
4. Adult Care Facility with home care services
5. RHCF for restorative services
6. RHCF for other services
7. Person died
8. Other (specify) _____

Mark the destination of the person when he/she is discharged from the hospital.

If a community based RHCF screener is completing this item, mark the setting in which the person will receive long-term care, at the time the setting is determined.

This item is not routinely required to complete in the RHCF setting.

PATIENT/RESIDENT/PERSON OR REPRESENTATIVE ACKNOWELDGEMENT

GUIDELINE: Check the appropriate box(es).

37.

☐ a. I have had the opportunity to participate in decisions regarding arrangements for my continuing care and I have received verbal and written information regarding the range of services in my community.

☐ b. I have been informed in writing that the Office of Mental Health and/or Office of Mental Retardation and Developmental Disabilities (please circle the appropriate office(s)) will now be involved in determining my appropriate service/placement.

NOTE:
37a.

- Signing DOES NOT MEAN that the person agrees with anything.
- Signing DOES mean the person has been given verbal and written information about services in the community and they have participated in decision – RE: RHCF Arrangements
- The patient representative NEED NOT BE a LEGAL representative.

The acknowledgement may be LEFT BLANK IF:

a) The patient or representative is unwilling to acknowledge participation.

b) The patient is unable to sign AND:

1. it is documented that a representative cannot be located

OR

2. patient has no representative

OR

3. patient is in process of conservatorship

OR

4. patient notifies hospital or agency that she/he objects to the participation of the representative

SCREENER MUST enter the reason for leaving Question 37 blank in the space where the signature is required.

NOTE:
37b.

- Signing DOES NOT MEAN that the person agrees with anything.

- The patient representative NEED NOT BE a LEGAL representative.

The acknowledgement may be LEFT BLANK IF:

a) The patient is unwilling to sign
b) The patient is unable to sign AND

1. it is documented that a representative cannot be located

OR

2. patient has no representative

OR

3. patient is in process of conservatorship

OR

4. patient notifies hospital or agency that she/he objects to the participation of the representative

Screener MUST enter the reason for leaving Question 37 blank in the space where the signature is required.

QUALIFED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN:

I certify that I am a trained and qualified screener and the information contained herein is a true abstract of the person's condition and circumstances.

YES	NO
a) The qualified screener has personally completed this form.	a) The qualified screener has not personally completed the SCREEN form but is attesting to its accuracy.

NOTE:	The qualified Screener must sign here and enter his or her screener identification number.

UPDATE

39. The information contained herein has not changed and is a true abstract of the person's condition and circumstances.

Residential health care facility residents and applicants in hospitals and in the community must be reassessed, and new documents completed at scheduled intervals. If a SCREEN has been completed, and at the time of the scheduled review no changes in the person's condition or circumstances have taken place, (as documented on the SCREEN) then the trained and qualified screener may update the SCREEN.

By signing an update in item 39 of the SCREEN, the screener attests that the information is a true abstract of the person's condition and circumstances.

The screener enters the date of completion of the PRI or H/C PRI upon which the SCREEN information is based. The screener also enters the date that the current SCREEN was reviewed.

When all UPDATE sections are used, a new form must be utilized.

APPENDICES

APPENDIX A

PASARR PROGRAM

1. History of PASARR

With the passage of the Omnibus Budget Reconciliation Act of 1987, which included the nursing home reform law, Congress mandated requirements to improve nursing home patient care to be carried out by the Medicare and Medicaid programs. One of the areas addressed in the nursing home reform legislation was the obligation that patients seeking admission to certified Medicaid nursing facilities (NF's) be screened and to screen current NF residents for mental illness and/or mental retardation (MI/MR).

The legislative intent was to assure that mentally retarded and mentally ill patients are appropriately placed in facilities equipped and staffed to provide for the treatment needs of MI/MR patients. Congress was concerned that in some states patients requiring specialized services were being warehoused in NF's and that these facilities lacked the capability or resources to provide the needed treatment services.

On November 30, 1992, HCFA published its final rule for state requirements for the Pre Admission Screening and Annual Resident Review (PASRR) program in the Federal Register. The rule requires that the Medicaid agency have the final responsibility for assuring that the PASARR requirements are met, including arrangements for recording, reporting and exchanging medical and social information about patients who are subject to the program and ensuring that timely screening is performed.

The final HCFA rule requires that patients with a MI diagnosis have an assessment based upon a physical and mental evaluation, which is conducted by an independent person or entity. The independent assessment is required to include a face-to-face evaluation of the patient and a review of medical documentation. Evaluators experienced in determining the patient's psychological needs are required to conduct the assessment.

The New York State Department of Social Services (SDSS) has contracted with the Island Peer Review Organization (IPRO), to conduct these assessments. IPRO's contract with the New York State Department of Social Services (SDSS) is for the evaluation of MI only, all future references will be regarding the MI process.

The state mental health authority maintains the responsibility for determining whether mentally ill nursing facility applicants need the level of services a NF provides and, if so, whether they need specialized services for their mental illness. The state mental health authority is also responsible for determining whether mentally ill nursing facility residents need the level of services a NF provides and, regardless of the residents' need for NF services, whether the residents need specialized services for their mental illness.

2. Overview of PASARR Review Process

The requirements, as detailed in the Federal Register, include a Level I review, which in New York is completed as part of the Department of Health's SCREEN process. The Level I review is an initial screening of NF applicants/residents to determine if the patient has a known or suspected mental illness (MI).

Patients who meet the Level I criteria (i.e., when question 23 on the SCREEN is answered yes) are required to have a comprehensive Level II assessment to document the presence of a serious mental illness which may require specialized services. When performed for nursing facility applicants, the process is called Pre-Admission Screening (PAS). When performed for residents of NF's, the process is called Annual Resident Review (ARR). This Level II assessment should correspond to the patient's current functional level.

The Level II assessment includes a comprehensive history and psychiatric evaluation of the patient including:

- A complete psychiatric history;
- An evaluation of intellectual functioning, memory functioning and orientation;
- A description of current attitudes and overt behaviors;
- A description of affect, suicidal or homicidal ideation;
- A description of paranoia; and
- A description of the degree of reality testing (presence and content of delusions) and hallucinations

The Level II evaluation is used to determine if the patient requires Specialized Services. Specialized Services, as described in the final rule means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that:

(i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and, as appropriate, other professionals.
(ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
(iii) Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of the mental health services to below the level of specialized services at the earliest possible time.

3. IPRO's Responsibility

IPRO is responsible for performing the Level II comprehensive psychiatric evaluations of mentally ill nursing facility (NF) applicants or residents, regardless of the source of payment for the NF services.

The Level II evaluation shall be performed by:

- A psychiatrist who is board-certified or board-eligible;
- A social worker who has a master's degree in social work and experience in performing comprehensive psychiatric evaluations;
- A registered nurse who has experience in performing comprehensive psychiatric evaluations; or
- A psychologist who has experience in performing comprehensive psychiatric evaluations.

The evaluation may use relevant date, and historical information that will assist in making a valid and accurate determination of the patient's current functional status. Therefore, the evaluation will be explicit and capable of identifying psychiatric diagnoses that require specialized services. The evaluation is also required to be capable and/or adaptable to the patient's cultural background, language, ethnic origin, and means of communication used by the person being evaluated. The completed evaluation report includes:

- A summary of the medical and social history of the evaluated individual, including his or her positive traits or weaknesses; and

- Any specific mental health services required to meet the evaluated individual's needs, if the evaluator recommend specialized services;

- Any specific mental health services which are of a lesser intensity than specialized services and are required to meet the evaluated individual's needs, if the evaluator does not recommend specialized services;

- The name and professional title of the person who performed the comprehensive psychiatric evaluation and the date on which each portion of the evaluation was administered.

The person who completes the comprehensive psychiatric evaluation must also complete an Office of Mental Health Psychiatric Evaluation checklist and Summary form for each mentally ill nursing facility applicant or resident who is evaluated. The evaluator must provide a summary on this form of his or her findings in each of these clinical areas. The evaluator must also identify those psychiatric diagnoses that, pursuant to federal requirements, require Specialized Services and recommend whether the person evaluated requires Specialized Services for mental illness.

As in the Level I review, which utilizes the New York State Department of Health SCREEN to determine whether the patient has a possible mental illness, the Level II evaluation may be terminated if it is determined that the individual does not have a mental illness or has a diagnosis of dementia, including Alzheimer's Disease, or a related disorder, and does not have a diagnosis of a mental illness or a related condition.

At a minimum PASARR evaluations will be performed for any one (1) of the following categories of NF applicants or residents:

- Schizophrenia
- Paranoia
- Major Affective Disorders
- Schizo Affective Disorders
- Atypical psychosis

As part of the PASARR evaluation, IPRO shall request that the following documents be provided from the entity referring the Level I review:

1) The Level I Screen;

2) The Hospital and Community Patient Review Instrument (H/C PRI) or Patient Review Instrument (PRI);

3) The Comprehensive history and physical examination of the evaluated person, as completed by his or her primary care physician. The comprehensive history and physical examination shall include a copy of the following items:

   (i) Complete medical history;

(ii) Review of all body systems;

(iii) Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes;

(iv) In case of abnormal findings that are the basis for a nursing facility placement, additional evaluations conducted by appropriate specialists;

(v) Medical diagnosis; and

(vi) A comprehensive drug history.

When the IPRO evaluator recommends that the patient requires specialized services, IPRO shall provide the Office of Mental Health Clinical Director, for the catchment area where the applicant resides or is receiving care, the documents listed above as well as the evaluation report, checklist and summary recommendation. Please be aware that the Clinical Director shall be responsible for making the final determination whether the mentally ill nursing facility applicant or resident requires Specialized Services. This determination will be made by the Clinical Director within two (2) working days of receipt from IPRO of the evaluator documentation, provided necessary clarifications are provided on a timely basis.

When the Clinical Director has completed his or her review of the evaluation and documentation, he or she will notify IPRO of the specialized services determination. In turn, IPRO will notify the entity that performed the Level I Screen and the evaluated individual, or his or her legal representative, of the specialized services determination. IPRO will also provide a copy of the written evaluation report and the psychiatric evaluation checklist and summary form to the evaluated individual, or his or her legal representative *, and explain the report's findings to the individual or the representative. In those instances where IPRO does not recommend specialized services, IPRO will notify the entity that performed the Level I Screen and the evaluated individual, or his or her legal representative, of the evaluator's recommendation. IPRO will also provide the evaluated individual, or his or her legal representative, with a copy of the written evaluation report and the psychiatric evaluation checklist and summary form and explain the report's findings to the individual or the representative.

As part of the notification process, the parties will be informed of the opportunity for a conference with an OMH Clinical Director and/or for a fair hearing for any person adversely affected by the PASARR determination. When such a fair hearing is requested, in accordance with DSS regulations 18 NYCRR Part 358, IPRO will provide the documentary evidence in its files, including the comprehensive psychiatric evaluation written report, checklist, and summary form and participate in the fair hearing process.

*The person could be nursing facility applicant's or resident's guardian, committee, conservator, family member, or any other person that the nursing facility applicant or resident has indicated may act on his or her behalf.

4. Process Description

a) The Referral Entity

The PASARR evaluation process, see flow chart on page A-7, is initiated by a referral entity. The referral entity's State Certified Screener(s) will have completed the Level I assessment, which identifies patients with known or suspected mental illness (MI). The referral entity's Screener(s) will have been trained in accordance with the DSS and DOH SCREEN Instruction Manual for Long Term Care patients. The SCREEN is utilized in conjunction with the

Patient Review Instrument (H/C PRI) or the MDS + (if the H/C PRI or PRI is discontinued), to determine a patient's medical condition and need for NF service.

As detailed on the SCREEN, when a patient does not meet the Dementia Qualified, Item 22 on the SCREEN, and Item 23 is answered in the affirmative, the Level I Screener must refer the case to IPRO for a Level II assessment.

b) Intake Process

The Referral Entity contacts IPRO at 516-326-2110 or 1-800-633-9441, and provides basic demographic data to IPRO's PASARR coordinator(s). This information can also be faxed to 516-326-6179. This intake information assists IPRO in scheduling the Level II assessment, notifying the entity and individual of the assessment determinations, assuring that appropriate information is available to conduct the evaluation, and forwarding appropriate documents to an OMH Clinical Director, if necessary.

Information regarding the patient includes:

- Patient name
- Address of facility
- Contact person or responsible party for patient
- Date of birth
- Pay Source
- Medicaid number
- Social Security number
- Phone number
- Placement date (or anticipated date)
- Language spoken
- RUGS Score

Information regarding the referral entity that is requested includes:

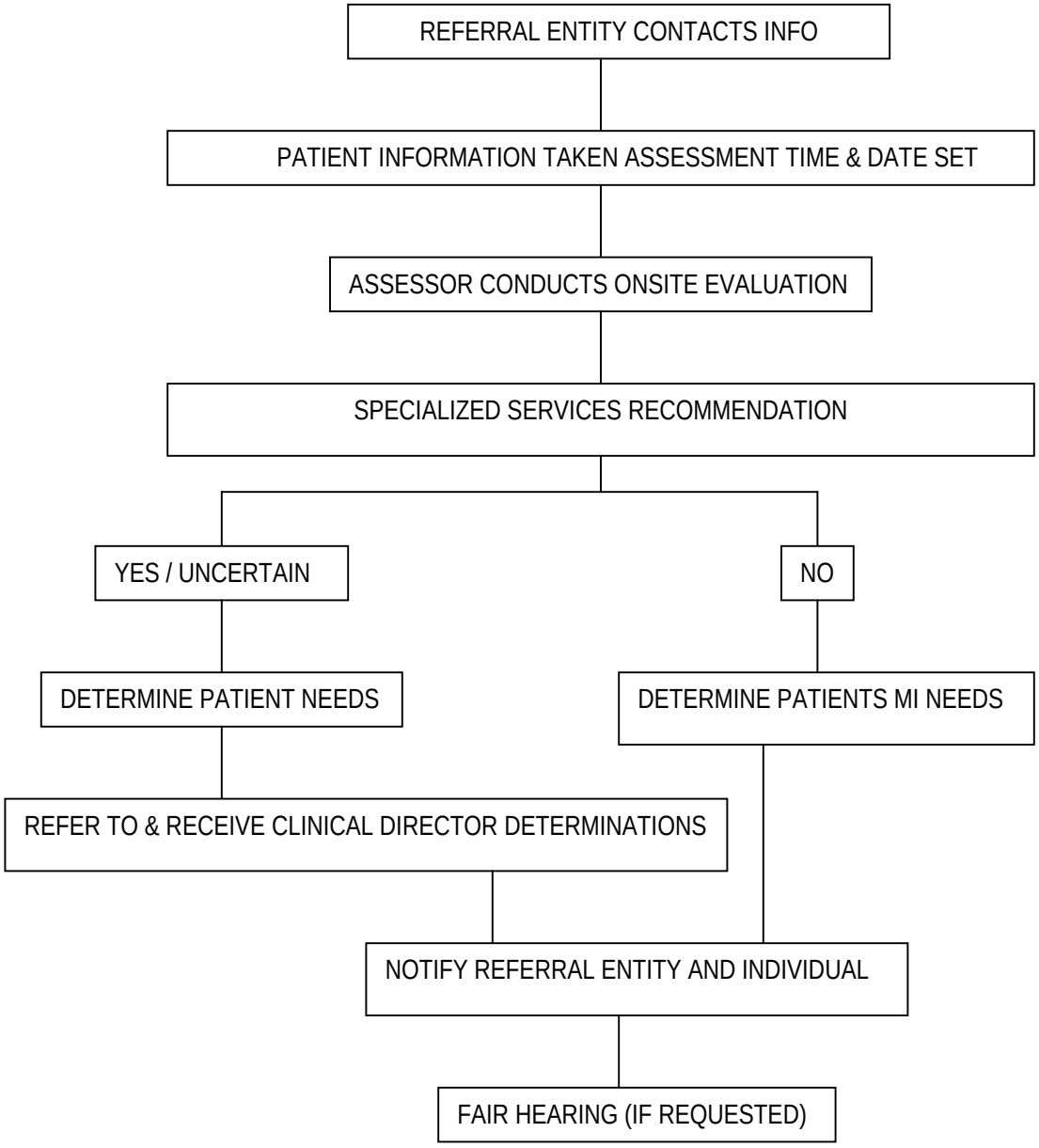
- Caller name
- Address
- Contact person
- Department/Organization
- Phone number
- Medical record or case number

In addition, IPRO requires that the following relevant evaluation date be available to conduct the assessment of the individual:

1. *Complete Medical history including last 2 years of impatient history and treatment and current drug history.
2. *H/C PRI
3. * SCREEN
4. *Physician Request for Services (written order or documentation for continued NF placement)
5. Specific evaluation of the patient's neurological system in areas of motor functioning.
6. Sensory functioning, gait, deep tendon reflexes, cranial nerves and deep abnormal reflexes.
7. Psychosocial evaluation including current living arrangements, medical and support systems.
8. Psychiatric evaluation including psychiatric history, evaluation or intellectual function, memory function and orientation. If the patient has had a psychiatric hospitalization within the past two (2) years a discharge summary should be available.

Copies of the four (4) asterisk (*) items are to be available at the time of the assessment; if the patient is in the community the referral entity may provide the information at the individual's residence in a sealed envelope. Items five (5) through eight (8) should be provided at the time of the evaluation, if available.

PASARR PROGRAM FLOW



c) Scheduling and Conducting the Assessment

Based upon the information provided, an IPRO PASARR Coordinator will coordinate with the Evaluator, the referral entity and/or the individual to be assessed, the date and time of the evaluation.

IPRO's Evaluator, upon arrival at the facility or the residence will introduce himself/herself to the contact person and the individual being assessed. The Evaluator describes the process to be followed and responds to any questions raised. The evaluator receives the information that has been previously requested and which will be verified for accuracy and currency during the evaluation.

When conducting the assessment, if the IPRO PASARR Evaluator determines that the individual being evaluated does not have MI or has a primary diagnosis of dementia, including Alzheimer's Disease or a related disorder based on the appropriated workup, the evaluation will be terminated, and the appropriate portions of the IPRO PASARR Evaluation Worksheet completed.

The Evaluator can make the following recommendations regarding the individual:

- Nursing facility services not needed;
- Needs specialized services;
- Needs nursing services – specialized services not needed;
- Needs specailized services – advanced years, chooses NF;
- Convalescent care;
- Terminal illness;
- Severity of physical illness;
- Dementia Qualifier;
- Needs nursing services – specialized services not needed, but requires mental health services of a lesser intensity;
- Other.

If the PASARR Evaluator believes that the data provided is not accurate or does not reflect the individual's current functional MI or medical needs i.e., patient may have dementia or Alzheimer's Disease, the Evaluator may recommend a thorough mental status examination which focuses on cognitive functioning and which is performed in the context of a complete neuropsychiatric examination.

d) Specialized Services and Recommendation

If the evaluator's recommendation was other than specialized services, the entity referring the individual, and the evaluate individual or his/her legal representative will be notified, in writing, of the determination; the rights of the individual to appeal the determination; and, the recommendations for MI services of a lesser intensity, if any, that the individual may need. The notice will also provide for the opportunity to discuss the review determination with IPRO.

If the evaluator recommends specialized services or the potential need for specialized services, all individual information including the clinical data provided and IPRO's psychiatric evaluation and worksheet will be forwarded to the OMH Clinical Director for a determination.

e) OMH Clinical Director Determination

IPRO will provide the appropriate OMH Clinical Director with copies, either by fax or overnight mail, of the IPRO Evaluation Worksheet, H/C/ PRI or PRI, SCREEN, individual's medical history, the physician's request for services, the OMH Level Psychiatric Evaluation Checklist and Summary, as well as the recommendation for specialized services or potential specialized services.

As stated earlier, the OMH Clinical Director has the authority for making determinations regarding the patient's need for specialized services. The PASARR Evaluators and IPRO facilitate in the process by assuring appropriate referrals are made as well as collecting the necessary data.

The OMH Clinical Director shall determine whether the patient requires specialized services based upon the documentation provided and/or discussion with IPRO. This may occur when the information provided needs to be clarified and/or additional information needs to be solicited in order to make a determination by the Clinical Director.

The Clinical Director then makes his/her determination which is provided to IPRO, who notifies the referral entity and individual of the determination.

f) Notification of the Referral Entity and Individual of Clinical Director's Determination

Upon notification of the Clinical Director's determination, IPRO will provide a written notice to the referral notice to the referral entity and the individual or his/her legal representative detailing the individual's specialized services or MI services at a lesser intensity, if appropriate; the rights of the individual to request a conference with an OMH Clinical Director and/or request an appeal of the determination by Fair Hearing. In addition, the notice will include the name and telephone number for the individual and/or the legal representative to contact should they require clarification of an explanation regarding the IPRO PASARR evaluation process, the review determination, or how to appeal the determination.

g) OMH Clinical Director Review and/or Fair Hearing

Upon request by the individual or his/her legal representative, IPRO will coordinate a meeting either by teleconference or at an OMH facility, with the OMH Clinical Director when a determination for specialized services in made. This meeting will provide the individual with the relevant information that led to the action taken by IPRO or the Clinical Director. It will discuss the data utilized by the Clinical Director in making a determination for specialized services as well as for providing clarification regarding the options available for specialized services as well as for providing clarification regarding the options available for the provision of specialized services or other MI services the individual may require.

Should the individual and/or his legal representative, after meeting with IPRO or the Clinical Director, still believe that they have been adversely affected by the PASARR evaluation process they will be afforded the opportunity to request a Fair Hearing from the New York State Department of Health. The DOH shall be responsible for conducting the Fair Hearing. IPRO will provide DOH with documents and records in its files regarding the case being reviewed.

Attachment 5

Text of PRI Audit Areas

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
ADL VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 9

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-4).

	FIELD # (23-24)	AUDIT LEVEL (25)
EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE).		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. FEEDS SELF WITHOUT SUPERVISION OR PHYSICAL ASSISTANCE. MAY USE ADAPTIVE EQUIPMENT. OR REQUIRES INTERMITTENT SUPERVISION (THAT IS, VERBAL ENCOURAGEMENT/GUIDANCE) AND/OR MINIMAL PHYSICAL ASSISTANCE WITH MINOR PARTS OF EATING, SUCH AS CUTTING FOOD, BUTTERING BREAD OR OPENING MILK CARTON.	50	_____
2= CONTINUAL SUPERVISION/ASSISTANCE. REQUIRES CONTINUAL HELP (ENCOURAGEMENT/TEACHING/PHYSICAL ASSISTANCE) WITH EATING OR MEAL WILL NOT BE COMPLETED.		
3= TOTAL FEEDING BY HAND. TOTALLY FED BY HAND; PATIENT DOES NOT MANUALLY PARTICIPATE.		
4= TUBE OR PARENTERAL FEEDING. TUBE OR PARENTERAL FEEDING FOR PRIMARY INTAKE OF FOOD. (NOT JUST FOR SUPPLEMENTAL NOURISHMENTS).		

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
ADL VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 9

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-3).

	FIELD # (23-24)	AUDIT LEVEL (25)
TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING. (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. REQUIRES NO SUPERVISION OR PHYSICAL ASSISTANCE TO COMPLETE NECESSARY TRANSFERS. MAY USE EQUIPMENT, SUCH AS RAILINGS, TRAPEZE. OR REQUIRES INTERMITTENT SUPERVISION (THAT IS, VERBAL CUEING/GUIDANCE) AND/OR PHYSICAL ASSISTANCE FOR DIFFICULT MANEUVERS ONLY.	51	_____

2= CONSTANT SUPERVISION/ASSISTANCE BY ONE PERSON. REQUIRES ONE PERSON TO PROVIDE CONSTANT GUIDANCE, STEADINESS AND/OR PHYSICAL ASSISTANCE OR TASK WILL NOT BE COMPLETED. PATIENT MAY PARTICIPATE IN TRANSFER.

3= CONSTANT SUPERVISION/ASSISTANCE BY TWO PEOPLE OR BEDFAST. REQUIRES TWO PEOPLE TO PROVIDE CONSTANT SUPERVISION AND/OR PHYSICALLY LIFT OR TASK WILL NOT BE COMPLETED. MAY NEED LIFTING EQUIPMENT. OR CANNOT AND IS NOT GOTTEN OUT OF BED.

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
ADL VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 9

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-3).

	FIELD # (23-24)	AUDIT LEVEL (25)
TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. REQUIRES NO SUPERVISION OR PHYSICAL ASSISTANCE. MAY REQUIRE SPECIAL EQUIPMENT, SUCH AS A RAISED TOILET OR GRAB BARS. OR REQUIRES INTERMITTENT SUPERVISION FOR SAFETY OR ENCOURAGEMENT; OR MINOR PHYSICAL ASSISTANCE (FOR EXAMPLE, ADJUSTING CLOTHES OR WASHING HANDS).	52	_____
2= CONSTANT SUPERVISION/ASSISTANCE (CONTINENT WITH OR WITHOUT EQUIPMENT) OR INCONTINENT - NOT TOILETED. CONTINENT OF BOWEL, AND BLADDER, REQUIRES CONSTANT SUPERVISION AND/OR PHYSICAL ASSISTANCE WITH MAJOR OR ALL PARTS OF THE TASK OR TASK WILL NOT BE COMPLETED, INCLUDING APPLIANCES (I.E. COLOSTOMY, ILEOSTOMY, URINARY CATHETER). OR IS INCONTINENT OF BOWEL AND/OR BLADDER AND IS NOT TAKEN TO A BATHROOM.		
3= INCONTINENT - TOILETED. INCONTINENT OF BOWEL AND/OR BLADDER AND IS TAKEN TO A BATHROOM EVERY 2-4 HOURS DURING THE DAY AND AS NEEDED AT NIGHT.		

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____
CHECKLIST (18) 1
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - COMATOSE		
A. PATIENT UNCONSCIOUS, CANNOT BE AROUSED, AND CAN AT MOST RESPOND ONLY TO POWERFUL STIMULI	50	_____
B. AT A MINIMUM, PATIENT WAS COMATOSE FOR AT LEAST FOUR DAYS DURING THE PAST 4 WEEKS.	51	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND AN ACTIVE TREATMENT PLAN EXISTS	52	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - QUADRIPLEGIA		
A. ALL FOUR LIMBS OF PATIENT ARE PARALYZED AND DIAGNOSIS IS QUADRIPLEGIA.	54	_____
B. AMONG ALL THE MEDICAL PROBLEMS, QUADRIPLEGIA CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	55	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - MULTIPLE SCLEROSIS		
A. DEMYELINATION IN THE PATIENT'S CENTRAL NERVOUS SYSTEM; SYMPTOMS INCLUDE WEAKNESS, UNCOORDINATION, PARESTHESIAS, SPEECH DISTURBANCES, AND VISUAL COMPLAINTS. DIAGNOSIS IS MULTIPLE SCLEROSIS	58	_____
B. AMONG ALL THE MEDICAL PROBLEMS, MULTIPLE SCLEROSIS CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	59	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DECUBITUS LEVEL - STAGE 4		
A. PATIENT HAS NECROTIC BREAKDOWN OF SKIN AND SUBCUTANEOUS TISSUE AT A PRESSURE POINT, WHICH MAY INVOLVE MUSCLE, FASCIA, AND BONE	61	_____
B. DOCUMENTATION BY A LICENSED CLINICIAN EXISTS WHICH DESCRIBES DECUBITUS AT STAGE 4 LEVEL, GIVES CIRCUMSTANCES OR MEDICAL CONDITION WHICH LED TO THIS DECUBITUS, AND PROVIDES ACTIVE TREATMENT PLAN .	62	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - NASAL GASTRIC FEEDING		
A. PATIENT'S PRIMARY FOOD INTAKE IS BY A TUBE INSERTED THROUGH A NOSTRIL AND INTO THE STOMACH; RESORTED TO WHEN IT IS THE ONLY ROUTE TO THE STOMACH (GASTROSTOMY NOT APPLICABLE)	63	_____
B. TREATMENT WAS GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY)	64	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - NASAL GASTRIC FEEDING		
A. PATIENT'S PRIMARY FOOD INTAKE IS BY A TUBE INSERTED THROUGH A NOSTRIL AND INTO THE STOMACH; RESORTED TO WHEN IT IS THE ONLY ROUTE TO THE STOMACH (GASTROSTOMY NOT APPLICABLE)	63	_____
B. TREATMENT WAS GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY)	64	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE).	66	_____
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY).	67	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	68	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE).	66	_____
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY).	67	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	68	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE).	66	_____
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY).	67	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	68	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE.	70	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	_____
D. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	72	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 1
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

JULY 1, 1999 - NOVEMBER 22, 2005

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	70	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	_____
D. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY DESIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	72	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	70	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	_____
D. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	72	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
SPECIALIZED SERVICES - PHYSICAL THERAPY		
A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE	53	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	55	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	56	_____
H. THERE IS A PHYSICIAN ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY.	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 2
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
SPECIALIZED SERVICES - PHYSICAL THERAPY		
A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE	53	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL)	55	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL)	56	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 2
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
SPECIALIZED SERVICES - PHYSICAL THERAPY		
A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE	53	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL)	55	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL)	56	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 2
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME		
OR		
FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME		
OR		
FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - CEREBRAL PALSY		
A. PATIENT HAS PERSISTANT QUALITATIVE MOTOR DISORDER DUE TO DAMAGE TO THE BRAIN. DIAGNOSED AS CEREBRAL PALSY.	51	_____
B. AMONG ALL THE MEDICAL PROBLEMS, CEREBRAL PALSY CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	52	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - HEMIPLEGIA		
A. ONE SIDE OF PATIENT'S BODY PARALYZED AND THE DIAGNOSIS IS HEMIPLEGIA.	55	_____
B. AMONG ALL THE MEDICAL PROBLEMS, HEMIPLEGIA CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	56	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - URINARY TRACT INFECTION		
A. PATIENT'S URINARY TRACT INFECTED AND DIAGNOSIS IS URINARY TRACT INFECTION.	59	_____
B. AMONG ALL THE MEDICAL PROBLEMS, URINARY TRACT INFECTION IS THE MAJOR PROBLEM OF THE PATIENT. IT CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	60	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - DEHYDRATION		
A. PATIENT HAS EXCESSIVE LOSS OF BODY FLUIDS REQUIRING IMMEDIATE MEDICAL TREATMENT AND ADL CARE	62	_____
B. PATIENT DEHYDRATED AT SOME TIME DURING THE PAST 4 WEEKS.	63	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND ACTIVE TREATMENT PLAN EXISTS.	64	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - INTERNAL BLEEDING		
A. PATIENT HAS BLOOD LOSS STEMMING FROM A SUBACUTE OR CHRONIC CONDITION (E.G. GASTROINTESTINAL, RESPIRATORY OR GENITOURINARY CONDITIONS) WHICH MAY RESULT IN LOW BLOOD PRESSURE AND HEMOGLOBIN, PALLOR, DIZZINESS, FATIGUE, OR RAPID RESPIRATION. THIS EXCLUDES EXTERNAL HEMORRHOIDS OR OTHER MINOR BLOOD LOSS WHICH IS NOT DANGEROUS AND REQUIRES ONLY MINOR INTERVENTION	65	_____
B. PATIENT BLEEDING INTERNALLY AT SOME TIME DURING THE PAST 4 WEEKS	66	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND AN ACTIVE TREATMENT PLAN EXISTS	67	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - STASIS ULCER		
A. PATIENT HAS OPEN LESION, USUALLY IN LOWER EXTREMITIES, CAUSED BY DECREASED BLOOD FLOW FROM CHRONIC VENOUS INSUFFICIENCY	68	_____
B. PATIENT HAS HAD STASIS ULCER(S) AT SOME TIME DURING PAST 4 WEEKS	69	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND ACTIVE TREATMENT PLAN EXISTS.	70	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - TERMINAL ILLNESS		
A. PATIENT'S CONDITION IS RAPIDLY DETERIORATING DURING THE LAST FOUR WEEKS AND PATIENT WILL LIKELY DIE WITHIN 3 MONTHS ACCORDING TO PROFESSIONAL PROGNOSIS (JUDGMENT)	71	_____
B. THERE IS DOCUMENTATION OF CONDITION WHICH WOULD LEAD YOU TO JUDGE THAT A TERMINAL ILLNESS EXISTS. . .	73	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 3
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	75	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	_____
D. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	77	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABLITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	75	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	_____
D. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY.	77	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABLITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	75	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	_____
D. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY.	77	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	80	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	80	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 3
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 9 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	80	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - CHEMOTHERAPY		
A. PATIENT'S CARCINOMA TREATED THROUGH IV AND/OR ORAL CHEMOTHERAPEUTIC AGENTS. (MAY HAVE TO GO TO A HOSPITAL FOR TREATMENT).	81	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	83	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - CHEMOTHERAPY		
A. PATIENT'S CARCINOMA TREATED THROUGH IV AND/OR ORAL CHEMOTHERAPEUTIC AGENTS. (MAY HAVE TO GO TO A HOSPITAL FOR TREATMENT).	81	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	83	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - CHEMOTHERAPY		
A. PATIENT'S CARCINOMA TREATED THROUGH IV AND/OR ORAL CHEMOTHERAPEUTIC AGENTS. (MAY HAVE TO GO TO A HOSPITAL FOR TREATMENT).	81	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	83	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	86	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	86	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	86	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - DIALYSIS		
A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	88	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	89	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - DIALYSIS		
A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	88	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	89	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - DIALYSIS		
A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	88	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	89	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

OP. CERT. # (1-8) _____
PATIENT ID (9-17) _____
CHECKLIST (18) 3
REVIEWER ID (19-22) _____
*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
NUMBER OF PHYSICIAN VISITS		
A. PATIENT HAS MEDICAL CONDITION THAT IS: -- UNSTABLE AND CHANGING OR -- STABLE, BUT WITH HIGH RISK OF INSTABILITY. IF NOT MONITORED AND TREATED CLOSELY BY MEDICAL STAFF, AN ACUTE EPISODE OR SEVERE DETERIORATION CAN RESULT	90	_____
B. PHYSICIAN (NOT A PSYCHIATRIST, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER) HAS PERSONALLY EXAMINED PATIENT TO ADDRESS PERTINENT MEDICAL PROBLEMS ON EACH OCCASION	91	_____
C. PHYSICIAN'S DOCUMENTATION EXISTS SUPPORTING PATIENT'S ACTUAL OR POTENTIAL UNSTABLE CONDITION (E.G. TERMINAL ILLNESS, ACUTE EPISODE, RECENT HOSPITALIZATION, POST SURGERY) AND THE RESULTS OF PHYSICIAN'S EXAMINATION ARE DOCUMENTED (E.G., CHANGE IN MEDICATION ORDER, RENEWAL OF TREATMENT ORDERS, NURSING ORDERS, ORDER LAB TESTS)	92	_____
D. THERE HAVE BEEN AT LEAST FOUR VISITS IN THE PAST 4 WEEKS EXCLUSIVE OF PHONE CALLS OR VISITS WHICH COULD BE ACCOMPLISHED OVER THE PHONE. PHYSICIAN MAY VISIT PATIENT OR PATIENT MAY VISIT PHYSICIAN AS LONG AS THE PATIENT IS NOT AN INPATIENT IN A HOSPITAL / OTHER FACILITY.	93	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
NUMBER OF PHYSICIAN VISITS		
A. PATIENT HAS MEDICAL CONDITION THAT IS: -- UNSTABLE AND CHANGING OR -- STABLE, BUT WITH HIGH RISK OF INSTABILITY. IF NOT MONITORED AND TREATED CLOSELY BY MEDICAL STAFF, AN ACUTE EPISODE OR SEVERE DETERIORATION CAN RESULT	90	_____
B. PHYSICIAN (NOT A PSYCHIATRIST), NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT HAS PERSONALLY EXAMINED PATIENT TO ADDRESS PERTINENT MEDICAL PROBLEMS ON EACH OCCASION	91	_____
C. PHYSICIAN'S, NURSE PRACTITIONER'S, OR PHYSICIAN ASSISTANT'S DOCUMENTATION EXISTS SUPPORTING PATIENT'S ACTUAL OR POTENTIAL UNSTABLE CONDITION (E.G. TERMINAL ILLNESS, ACUTE EPISODE, RECENT HOSPITALIZATION, POST SURGERY) AND THE RESULTS OF THAT EXAMINATION ARE DOCUMENTED (E.G. CHANGE IN MEDICATION ORDER, RENEWAL OF TREATMENT ORDERS, NURSING ORDERS, ORDER LAB TESTS).	92	_____
D. THERE HAVE BEEN AT LEAST FOUR VISITS IN THE PAST 4 WEEKS EXCLUSIVE OF PHONE CALLS OR VISITS WHICH COULD BE ACCOMPLISHED OVER THE PHONE. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT MAY VISIT PATIENT OR PATIENT MAY VISIT PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT AS LONG AS THE PATIENT IS NOT AN INPATIENT IN A HOSPITAL / OTHER FACILITY	93	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
VERBAL DISRUPTION		
A. PATIENT EXHIBITS UNPREDICTABLE, RECURRING VERBAL DISRUPTION BY YELLING, BAITING, THREATENING, ETC., FOR NO FORETOLD REASON. THIS EXCLUDES VERBAL OUTBURSTS/EXPRESSIONS/UTTERANCES WHICH DO NOT CREATE DISRUPTION	50	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	51	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	52	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	53	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PHYSICAL AGGRESSION		
A. PATIENT EXHIBITS UNPREDICTABLE, RECURRING ASSAULTIVE OR COMBATIVE BEHAVIOR TO SELF OR OTHERS WITH INTENT FOR INJURY FOR NO APPARENT OR FORETOLD REASON (THAT IS, NOT JUST DURING SPECIFIC CARE ROUTINES OR AS A REACTION TO NORMAL STIMULI). (E.G. HITS SELF, THROWS OBJECTS, PUNCHES, MANEUVERS DANGEROUSLY WITH WHEELCHAIR)	54	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	55	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	56	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR		
A. PATIENT EXHIBITS CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES DISRUPTION WITH OTHERS (E.G. CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING SELF TO OTHERS). THIS EXCLUDES VERBAL OUTBURSTS, SOCIAL WITHDRAWAL, HOARDING, PARANOIA.	58	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	59	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	60	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	61	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
HALLUCINATIONS		
A. PATIENT EXPERIENCES VISUAL, AUDITORY, OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY	62	_____
B. A HALLUCINATORY EPISODE OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS.	63	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT THE PATIENT HAS A SEVERE BEHAVIORAL PROBLEM	64	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
TBI VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 7

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
TBI - EXTENDED CARE		
A. RESIDENT HAS BEEN DIAGNOSED AS HAVING A COGNITIVE AND/OR PHYSICAL CONDITION THAT HAS RESULTED FROM TRAUMATICALLY ACQUIRED, NON-DEGENERATIVE, STRUCTURAL BRAIN DAMAGE, OR ANOXIA	50	_____
B. DOCUMENTATION THAT RESIDENT HAS PARTICIPATED IN A SPECIALIZED INTENSIVE REHABILITATION PROGRAM FOR PERSONS WITH TBI, (NF, HOSP. REHAB. CTR.), EXISTS	51	_____
C. DOCUMENTATION THAT RESIDENT HAS BEEN ASSESSED BY A NEUROLOGIST OR A PHYSIATRIST WHO DETERMINED THAT THE INDIVIDUAL WILL NO LONGER BENEFIT FROM AN INTENSIVE REHABILITATION PROGRAM	52	_____
D. A CLASSIFICATION SYSTEM FOR MEASURING PHYSICAL, AFFECTIVE, BEHAVIORAL AND COGNITIVE LEVEL OF FUNCTIONING EXISTS	53	_____
E. DOCUMENTATION THAT AN ACTIVE TREATMENT PLAN EXISTS	54	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
DEMENTIA VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 7

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - DEMENTIA		
A. PATIENT HAS A DIAGNOSIS OF DEMENTIA.	55	_____
B. AMONG ALL THE MEDICAL PROBLEMS, DEMENTIA IS THE MAJOR PROBLEM OF THE PATIENT. IT CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION	56	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Sample

Attachment 6

New York State Department of Health
Bid Form

NEW YORK STATE
DEPARTMENT OF HEALTH

BID FORM

PROCUREMENT TITLE: _____FAU #_____

Bidder Name:
Bidder Address:

Bidder Fed ID No:

A. _____bids a total price of $_____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller ("restricted period") to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document.* DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):

   No Yes

   If yes, please answer the next questions:

   1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):

   No Yes

   1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

   No Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity:_____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

_____
_____
_____
_____
_____

(Add additional pages as necessary)

1d. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No Yes

1e. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

_____
_____
_____
_____
_____

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

D. Offerer/Bidder agrees to provide the following documentation either *with their submitted bid/proposal or upon award* as indicated below:

With Bid	Upon Award	
☐	☐	1. A completed N.Y.S Taxation and Finance Contractor Certification Form ST-220.
☐	☐	2. A completed N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to $100,000)

☐ ☐ 3. A completed State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

---

_____ _____

(Officer Signature) (Date)

_____ _____

(Officer Title) (Telephone)

_____

(e-mail Address)

NEW YORK STATE
DEPARTMENT OF HEALTH

NO-BID FORM

PROCUREMENT TITLE: _____FAU #_____

Bidders choosing not to bid are requested to complete the portion of the form below:

☐ We do not provide the requested services. Please remove our firm from your mailing list

☐ We are unable to bid at this time because:

_____

_____

_____

_____

☐ Please retain our firm on your mailing list.

_____
(Firm Name)

_____ _____
(Officer Signature) (Date)

_____ _____
(Officer Title) (Telephone)

_____
(e-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

Attachment 7

New York State Office of the State Comptroller Vendor Responsibility Questionnaire

New York State

OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS

Vendor Responsibility Questionnaire

A contracting agency is required to conduct a review of a prospective contractor to provide reasonable assurances that the vendor is responsible. This questionnaire is designed to provide information to assist a contracting agency in assessing a vendor's responsibility prior to entering into a contract with the vendor. Vendor responsibility is determined by a review of each bidder or proposer's authorization to do business in New York, business integrity, financial and organizational capacity, and performance history.

Prospective contractors must answer every question contained in this questionnaire. Each "Yes" response requires additional information. The vendor must attach a written response that adequately details each affirmative response. The completed questionnaire and attached responses will become part of the procurement record.

It is imperative that the person completing the vendor responsibility questionnaire be knowledgeable about the proposing contractor's business and operations as the questionnaire information must be attested to by an owner or officer of the vendor. **Please read the certification requirement at the end of this questionnaire.**

STATE OF NEW YORK

OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS

VENDOR RESPONSIBILITY QUESTIONNAIRE

FEIN #

1. VENDOR IS: ☐ PRIME CONTRACTOR ☐ SUB-CONTRACTOR		
2. VENDOR'S LEGAL BUSINESS NAME	**3. IDENTIFICATION NUMBERS** a) FEIN # b) DUNS #	
4. D/B/A – Doing Business As (if applicable) **& COUNTY FILED:**	**5. WEBSITE ADDRESS** (if applicable)	
6. ADDRESS OF PRIMARY PLACE OF BUSINESS/EXECUTIVE OFFICE	**7. TELEPHONE NUMBER**	**8. FAX NUMBER**
9. ADDRESS OF PRIMARY PLACE OF BUSINESS/EXECUTIVE OFFICE *IN NEW YORK STATE*, if different from above	**10. TELEPHONE NUMBER**	**11. FAX NUMBER**
12. PRIMARY PLACE OF BUSINESS IN NEW YORK STATE IS: ☐ Owned ☐ Rented If rented, please provide landlord's name, address, and telephone number below:	**13. AUTHORIZED CONTACT FOR THIS QUESTIONNAIRE** Name Title Telephone Number Fax Number e-mail	

14. VENDOR'S BUSINESS ENTITY IS (please check appropriate box and provide additional information):

a) ☐ Business Corporation	Date of Incorporation	State of Incorporation*
b) ☐ Sole Proprietor	Date Established	
c) ☐ General Partnership	Date Established	
d) ☐ Not-for-Profit Corporation	Date of Incorporation	State of Incorporation* Charities Registration Number
e) ☐ Limited Liability Company (LLC)	Date Established	
f) ☐ Limited Liability Partnership	Date Established	
g) ☐ Other – Specify:	Date Established	Jurisdiction Filed (if applicable)

* If not incorporated in New York State, please provide a copy of authorization to do business in New York.

15. PRIMARY BUSINESS ACTIVITY - (Please identify the primary business categories, products or services provided by your business)

16. NAME OF WORKERS' COMPENSATION INSURANCE CARRIER:

17. LIST ALL OF THE VENDOR'S PRINCIPAL OWNERS AND THE THREE OFFICERS WHO DIRECT THE DAILY OPERATIONS OF THE VENDOR (Attach additional pages if necessary):

a) NAME (print)	TITLE	b) NAME (print)	TITLE
c) NAME (print)	TITLE	d) NAME (print)	TITLE

FEIN #

A DETAILED EXPLANATION IS REQUIRED FOR EACH QUESTION ANSWERED WITH A "YES," AND MUST BE PROVIDED AS AN ATTACHMENT TO THE COMPLETED QUESTIONNAIRE. YOU MUST PROVIDE ADEQUATE DETAILS OR DOCUMENTS TO AID THE CONTRACTING AGENCY IN MAKING A DETERMINATION OF VENDOR RESPONSIBILITY. PLEASE NUMBER EACH RESPONSE TO MATCH THE QUESTION NUMBER.

18. Is the vendor certified in New York State as a (check please): ☐ Yes ☐ No

☐ Minority Business Enterprise (MBE)
☐ Women's Business Enterprise (WBE)
☐ Disadvantaged Business Enterprise (DBE)?

Please provide a copy of any of the above certifications that apply.

19. Does the vendor use, or has it used in the past ten (10) years, any other Business Name, FEIN, or D/B/A other than those listed in items 2-4 above? ☐ Yes ☐ No

List all other business name(s), Federal Employer Identification Number(s) or any D/B/A names and the dates that these names or numbers were/are in use. Explain the relationship to the vendor.

20. Are there any individuals now serving in a managerial or consulting capacity to the vendor, including principal owners and officers, who now serve or in the past three (3) years have served as:

a) An elected or appointed public official or officer? ☐ Yes ☐ No

List each individual's name, business title, the name of the organization and position elected or appointed to, and dates of service.

b) A full or part-time employee in a New York State agency or as a consultant, in their individual capacity, to any New York State agency? ☐ Yes ☐ No

List each individual's name, business title or consulting capacity and the New York State agency name, and employment position with applicable service dates.

c) If yes to item #20b, did this individual perform services related to the solicitation, negotiation, operation and/or administration of public contracts for the contracting agency? ☐ Yes ☐ No

List each individual's name, business title or consulting capacity and the New York State agency name, and consulting/advisory position with applicable service dates. List each contract name and assigned NYS number.

d) An officer of any political party organization in New York State, whether paid or unpaid? ☐ Yes ☐ No

List each individual's name, business title or consulting capacity and the official political party position held with applicable service dates.

FEIN #

21. Within the past five (5) years, has the vendor, any individuals serving in managerial or consulting capacity, principal owners, officers, major stockholder(s) (10% or more of the voting shares for publicly traded companies, 25% or more of the shares for all other companies), affiliate[1] or any person involved in the bidding or contracting process: **a)** 1. been suspended, debarred or terminated by a local, state or federal authority in connection with a contract or contracting process; 2. been disqualified for cause as a bidder on any permit, license, concession franchise or lease; 3. entered into an agreement to a voluntary exclusion from bidding/contracting; 4. had a bid rejected on a New York State contract for failure to comply with the MacBride Fair Employment Principles; 5. had a low bid rejected on a local, state or federal contract for failure to meet statutory affirmative action or M/WBE requirements on a previously held contract; 6. had status as a Women's Business Enterprise, Minority Business Enterprise or Disadvantaged Business Enterprise denied, de-certified, revoked or forfeited; 7. been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any local, state or federal government contract; 8. been denied an award of a local, state or federal government contract, had a contract suspended or had a contract terminated for non-responsibility; or 9. had a local, state or federal government contract suspended or terminated for cause prior to the completion of the term of the contract?	☐ Yes	☐ No
b) been indicted, convicted, received a judgment against them or a grant of immunity for any business-related conduct constituting a crime under local, state or federal law including but not limited to, fraud, extortion, bribery, racketeering, price-fixing, bid collusion or any crime related to truthfulness and/or business conduct?	☐ Yes	☐ No
c) been issued a citation, notice, violation order, or are pending an administrative hearing or proceeding or determination for violations of: 1. federal, state or local health laws, rules or regulations, including but not limited to Occupational Safety & Health Administration (OSHA) or New York State labor law; 2. state or federal environmental laws; 3. unemployment insurance or workers' compensation coverage or claim requirements; 4. Employee Retirement Income Security Act (ERISA); 5. federal, state or local human rights laws; 6. civil rights laws; 7. federal or state security laws;	☐ Yes	☐ No

FEIN #

	8. federal Immigration and Naturalization Services (INS) and Alienage laws; 9. state or federal anti-trust laws; or 10. charity or consumer laws? ***For any of the above, detail the situation(s), the date(s), the name(s), title(s), address(es) of any individuals involved and, if applicable, any contracting agency, specific details related to the situation(s) and any corrective action(s) taken by the vendor.***		
22.	In the past three (3) years, has the vendor or its affiliates[1] had any claims, judgments, injunctions, liens, fines or penalties secured by any governmental agency? ***Indicate if this is applicable to the submitting vendor or affiliate. State whether the situation(s) was a claim, judgment, injunction, lien or other with an explanation. Provide the name(s) and address(es) of the agency, the amount of the original obligation and outstanding balance. If any of these items are open, unsatisfied, indicate the status of each item as "open" or "unsatisfied."***	☐ Yes	☐ No
23.	Has the vendor (for profit and not-for profit corporations) or its affiliates[1], in the past three (3) years, had any governmental audits that revealed material weaknesses in its system of internal controls, compliance with contractual agreements and/or laws and regulations or any material disallowances? ***Indicate if this is applicable to the submitting vendor or affiliate. Detail the type of material weakness found or the situation(s) that gave rise to the disallowance, any corrective action taken by the vendor and the name of the auditing agency.***	☐ Yes	☐ No
24.	Is the vendor exempt from income taxes under the Internal Revenue Code? ***Indicate the reason for the exemption and provide a copy of any supporting information.***	☐ Yes	☐ No
25.	During the past three (3) years, has the vendor failed to:		
	a) file returns or pay any applicable federal, state or city taxes? ***Identify the taxing jurisdiction, type of tax, liability year(s), and tax liability amount the vendor failed to file/pay and the current status of the liability.***	☐ Yes	☐ No
	b) file returns or pay New York State unemployment insurance? ***Indicate the years the vendor failed to file/pay the insurance and the current status of the liability.***	☐ Yes	☐ No
26.	Have any bankruptcy proceedings been initiated by or against the vendor or its affiliates[1] within the past seven (7) years (whether or not closed) or is any bankruptcy proceeding pending by or against the vendor or its affiliates regardless of the date of filing? ***Indicate if this is applicable to the submitting vendor or affiliate. If it is an affiliate, include the affiliate's name and FEIN. Provide the court name, address and docket number. Indicate if the proceedings have been initiated, remain pending or have been closed. If closed, provide the date closed.***	☐ Yes	☐ No

FEIN #

27.	Is the vendor currently insolvent, or does vendor currently have reason to believe that an involuntary bankruptcy proceeding may be brought against it? ***Provide financial information to support the vendor's current position, for example, Current Ratio, Debt Ratio, Age of Accounts Payable, Cash Flow and any documents that will provide the agency with an understanding of the vendor's situation.***	☐ Yes	☐ No
28.	Has the vendor been a contractor or subcontractor on any contract with any New York State agency in the past five (5) years? ***List the agency name, address, and contract effective dates. Also provide state contract identification number, if known.***	☐ Yes	☐ No
29.	In the past five (5) years, has the vendor or any affiliates[1]: **a)** defaulted or been terminated on, or had its surety called upon to complete, any contract (public or private) awarded; **b)** received an overall unsatisfactory performance assessment from any government agency on any contract; or **c)** had any liens or claims over $25,000 filed against the firm which remain undischarged or were unsatisfied for more than 90 days ? ***Indicate if this is applicable to the submitting vendor or affiliate. Detail the situation(s) that gave rise to the negative action, any corrective action taken by the vendor and the name of the contracting agency.***	☐ Yes	☐ No

[1] "Affiliate" meaning: (a) any entity in which the vendor owns more than 50% of the voting stock; (b) any individual, entity or group of principal owners or officers who own more than 50% of the voting stock of the vendor; or (c) any entity whose voting stock is more than 50% owned by the same individual, entity or group described in clause (b). In addition, if a vendor owns less than 50% of the voting stock of another entity, but directs or has the right to direct such entity's daily operations, that entity will be an "affiliate" for purposes of this questionnaire.

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
VENDOR RESPONSIBILITY QUESTIONNAIRE

FEIN #

State of:)
) ss:
County of:)

CERTIFICATION:

The undersigned: recognizes that this questionnaire is submitted for the express purpose of assisting the State of New York or its agencies or political subdivisions in making a determination regarding an award of contract or approval of a subcontract; acknowledges that the State or its agencies and political subdivisions may in its discretion, by means which it may choose, verify the truth and accuracy of all statements made herein; acknowledges that intentional submission of false or misleading information may constitute a felony under Penal Law Section 210.40 or a misdemeanor under Penal Law Section 210.35 or Section 210.45, and may also be punishable by a fine and/or imprisonment of up to five years under 18 USC Section 1001 and may result in contract termination; and states that the information submitted in this questionnaire and any attached pages is true, accurate and complete.

The undersigned certifies that he/she:

- has not altered the content of the questions in the questionnaire in any manner;
- has read and understands all of the items contained in the questionnaire and any pages attached by the submitting vendor;
- has supplied full and complete responses to each item therein to the best of his/her knowledge, information and belief;
- is knowledgeable about the submitting vendor's business and operations;
- understands that New York State will rely on the information supplied in this questionnaire when entering into a contract with the vendor; and
- is under duty to notify the procuring State Agency of any material changes to the vendor's responses herein prior to the State Comptroller's approval of the contract.

Name of Business

Address

City, State, Zip

Signature of Owner/Officer_____

Printed Name of Signatory

Title

Sworn to before me this _____ day of _____, 20____;

_____
Notary Public

_____
Print Name

_____
Signature

_____
Date

Attachment 8

New York State Taxation and Finance
Contractor Certification Form
ST-220

New York State Department of Taxation and Finance

Contractor Certification

(Pursuant to Section 5-a of the Tax Law)

ST-220
(1/05)

For more information, see Publication 222, *Question and Answers Concerning Section 5-a.*

Contractor name				*For office use only* *Contract number*
Contractor's principal place of business	City	State	ZIP code	
Mailing address *(if different than above)*				*Estimated contract value*
Contractor's federal employer Identification number (EIN)	Contractor's sales tax ID number *(if different from contractor's EIN)*			$
Contractor's telephone number ( )	Contracting state agency			

I, _____ *(name)*, hereby affirm, under penalty of perjury, that I am _____ *(title)*

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and that:

Part I. Contract services that are not services for purposes of Tax Law section 5-a

(Mark an **X** *in the box if this statement is applicable. If you mark this box, you do not have to complete Parts II - V.)*

☐ The requirements of Tax Law section 5-a do not apply because the subject matter of the contract concerns the performance of services which are not *services* within the meaning of Tax Law section 5-a.

(If you did not mark the box next to the statement in Part I, mark an **X** *next to the applicable statement in Parts II through V.)*

Part II. Contractor registration status

☐ The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made, and is registered for New York State and local sales and compensating use tax purposes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law.

☐ As of the date of this certification, the contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

Part III. Affiliate registration status

☐ As of the date of this certification, the contractor does not have any affiliates.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made, and each affiliate exceeding the $300,000 sales threshold during such periods is registered for New York State and local sales and compensating use tax purposes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed on Schedule A of this certification the name, address, and identification number of each affiliate exceeding the $300,000 sales threshold during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates and, as of the date of this certification, each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

Part IV. Subcontractor registration status

☐ As of the date of this certification, the contractor does not have any subcontractors.

☐ The contractor has one or more subcontractors, and each subcontractor has informed the contractor of whether or not, as of the date of this certification, it has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made. Each subcontractor informing the contractor that it has made sales in excess of the $300,000 threshold during such periods has further informed the contractor that it is registered for New York State and local sales and compensating use tax purposes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed on Schedule A of this certification the name, address and identification number of each subcontractor exceeding the $300,000 sales threshold during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

☐ The contractor has one or more subcontractors, and each subcontractor has informed the contractor that, as of the date of this certification, it has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

Part V. Subcontractor affiliate registration status

☐ The contractor has one or more subcontractors, and each subcontractor has informed the contractor that, as of the date of this certification, it does not have any affiliates.

☐ The contractor has one or more subcontractors, and each subcontractor has informed the contractor of whether or not, as of the date of this certification, it has any affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made. Each subcontractor informing the contractor that it has one or more affiliates having made sales in excess of the $300,000 threshold during such periods has further informed the contractor that each such affiliate is registered for New York State and local sales and compensating use tax purposes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed on Schedule A of this certification the name, address and identification number of each affiliate exceeding the $300,000 sales threshold during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

☐ The contractor has one or more subcontractors, and each subcontractor has informed the contractor that, as of the date of this certification, it has no affiliate having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made.

Sworn to this ____ day of _____, 20 _____

_____ _____

(signature) *(title)*

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the day ___ of _____ in the year 20__, before me personally appeared _____,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
_he resides at _____,
Town of _____,
County of _____,
State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____
of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is the _____
of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of, _____ LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No.

Schedule A — List of affiliates, subcontractors, and affiliates of subcontractors

A Relationship to Contractor	B Name	C Address	D ID Number	E Sales Tax ID Number	F Proof of Registration

Column A – Enter ***C*** if the contractor; do not complete columns C, D, and E. Enter ***A*** if an affiliate of the contractor; ***S*** if a subcontractor; or ***SA*** if an affiliate of a subcontractor, and complete columns B through F.

Column B – Name - If person is a corporation or limited liability company, enter the exact legal name as registered with the NY Department of State. If person is a partnership or sole proprietor, enter the name of the partnership and each partner's given name, or the given name(s) of the owner(s), as applicable. If person has a different DBA (doing business as) name, enter that name as well.

Column C – Address - Enter the street address of person's principal place of business. Do not enter a PO box.

Column D – ID number - Enter the federal identification number assigned to the person or person's business, as applicable.

Column E – Sales tax ID number - Enter only if different from federal ID number in column D.

Column F – Enter ***CA*** if a paper copy of the certificate of authority is attached; or ***RC*** if person is registered with DTF and has confirmed this status with DTF.

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Instructions

General information

On August 20, 2004, New York State enacted section 5-a of the Tax Law requiring persons awarded contracts valued at more than $15,000 with state agencies, public authorities or public benefit corporations to certify that they, their affiliates, their subcontractors, and the affiliates of their subcontractors have a valid certificate of authority to collect New York State and local sales and compensating use taxes. A contractor, affiliate, subcontractor or affiliate of a subcontractor must be certified as having a valid certificate of authority if such person makes, or has made, aggregate sales delivered within New York State of more than $300,000 during the four quarterly periods ending on the last day of February, May, August, and November which immediately precede the quarterly period in which this certification is made. A contractor must use Form ST-220, *Contractor Certification*, to make this certification before the contract may be approved by the Office of the State Comptroller (OSC), or other contract approver if OSC is not required to approve the contract.

This statute applies to contracts resulting from solicitations to purchase issued by governmental entities on or after January 1, 2005. In the case of contracts resulting from issuance of an invitation for bid (IFB) or a request for proposal (RFP), the statute would apply if the IFB or RFP was first issued on or after January 1, 2005. The statute would not apply if the bid document was first issued before January 1, 2005, even if the bid document was amended, or the resulting contract was awarded, approved, amended, or extended after January 1, 2005.

The statute does not apply to purchases from preferred sources. For additional information, please see Publication 222, *Questions and Answers Concerning Tax Law Section 5-a.*

Definition of terms associated with section 5-a

The following is a partial list. Please see Publication 222 for additional information.

A *contractor* is defined as a person awarded a contract by a covered agency.

The term *person* is defined as any entity in business for either profit or not-for-profit purposes and can refer to an individual, partnership, limited liability company, society, association, joint stock company, or corporation.

A *covered agency* is defined as New York State or any department, board, bureau, commission, division, office, council or agency of New York State; public authorities and public benefit corporations. The State Legislature, the judiciary, Department of Law, Office of State Comptroller, State Education Department, State University of New York and the senior colleges of City University of New York are included in this definition.

An *affiliate* is an entity which, through stock ownership or any other affiliation, directly, indirectly or constructively, controls another entity, is controlled by another entity, or is, along with another entity, under the control of a common parent company.

A *subcontractor* is an entity specifically engaged by a contractor or another subcontractor to provide commodities or perform services necessary to allow a contractor to fulfill a particular contract with a covered agency.

Commodities means, other than with respect to contracts for State printing, material goods, supplies, products, construction items or other standard articles of commerce other than technology which are the subject of any purchase or other exchange.

Tangible personal property means physical personal property, of any nature, that has a material existence and is perceptible to the human senses. Tangible personal property includes, without limitation: (1) raw materials, such as wood, metal, rubber and minerals; (2) manufactured items, such as gasoline, oil, diesel motor fuel and kero-jet fuel, chemicals, jewelry, furniture, machinery and equipment, parts, tools, supplies, computers, clothing, motor vehicles, boats, yachts, appliances, lighting fixtures, building materials; (3) pre-written off-the-shelf software; (4) artistic items such as sketches, paintings, photographs, moving picture films and recordings; (5) animals, trees, shrubs, plants and seeds; (6) bottled water, soda and beer; (7) candy and confections; (8) cigarettes and tobacco products; (9) cosmetics and toiletries; (10) coins and other numismatic items, when purchased for purposes other than for use as a medium of exchange; (11) postage stamps, when purchased for purposes other than mailing; and (12) precious metals in the form of bullion, ingots, wafers and other forms.

Completing Form ST-220

Identification information

Contractor name: Enter the exact legal name of the person or entity who is contracting to provide commodities or services to a covered agency of New York State. This is the name registered with the New York Department of State.

Contractor's principal place of business: Enter a street address, not a PO box number.

Mailing address: Enter the address where contractor receives mail, if different than the principal place of business.

Contracting state agency: Enter the state agency awarding the contract to the contractor.

Certification statement: If the contractor is a corporation, the statement must be completed by the president, vice president, treasurer, assistant treasurer, chief accounting officer, or other officer authorized by the corporation. If the contractor is a partnership, the statement must be completed by a partner or person authorized by the partnership. If the contractor is a limited liability company, the statement must be completed by a member of the LLC and be authorized by the LLC.

Part I – Contract services not pursuant to Tax Law section 5-a

If the services to be performed under the contract are not services within the meaning of Tax Law section 5-a, mark an ***X***. You do not have to complete Parts II through V. You must sign and have the certification acknowledged.

For procurement law purposes, *services* means, other than with respect to contracts for State printing, the performance of a task or tasks and may include a material good or a quantity of material goods, and which is the subject of any purchase or other exchange. For procurement law purposes, technology is a service. The term *services* for procurement law purposes does not apply to contracts for architectural, engineering or surveying services, or to contracts with not-for-profit organizations approved in accordance with Article eleven-B of the State Finance Law.

The term *taxable services* for New York State and local sales and compensating use tax law purposes includes, but is not limited to: 1) providing information by printed, mimeographed or multigraphed matter or by duplicating written or printed manner in any other

manner; 2) processing, assembling, fabricating, printing or imprinting tangible personal property furnished by a customer who did not purchase the tangible personal property for resale; 3) installing, maintaining, servicing, or repairing tangible personal property that is not held for sale by the purchaser of the service in the regular course of business (for example, servicing automobiles, installing appliances, and repairing radio and television sets); 4) storing tangible personal property that is not being held for sale; 5) renting safe deposit boxes, vaults, and similar storage facilities; 6) maintaining, servicing, or repairing real property both inside and outside buildings (for example, cleaning, painting, gardening, snow plowing, trash removal, and general repairs); 7) providing parking, garaging, or storing services for motor vehicles; 8) interior decorating and designing; 9) protective or detective services; and 10) entertainment or information services provided by means of telephony or telegraphy.

Parts II through V

If the contract is covered under Tax Law section 5-a, you must mark an ***X*** in one box in each of these parts. You must also sign and have the certification acknowledged, and complete Schedule A.

Schedule A

Column A – Relationship to the contractor

The contractor should enter a ***C***. It is not necessary for the contractor to complete columns C through E since this information has been provided on page 1.

If the person listed in column B is an affiliate of the contractor, enter an ***A***; if a subcontractor, enter an ***S***; if an affiliate of a subcontractor, enter ***SA***.

Column B – Name

Enter the exact legal name as registered with the New York Department of State of each corporation or limited liability company. If the person is a partnership or sole proprietor, enter each partner's or the owner's given name. If the person uses a different name or DBA (doing business as), enter that name as well.

Column C – Address

Enter the street address of the person's principal place of business. Do not enter a PO box.

Column D – ID number

If the person listed in column B is an individual, enter the social security number of that person. Otherwise enter the employer identification number (EIN) assigned to the person.

Column E – Sales tax ID number

Enter the sales tax identification number, if different from the federal identification.

Column F – Proof of registration

Enter ***CA*** and attach a copy of the certificate of authority for the person.

If the certificate of authority is not readily available and if the person is registered with the Department of Taxation and Finance and has confirmed this status with the DTF, enter ***RC***.

Return a signed and acknowledged original Form ST-220, and a copy, with the contract to the procuring state agency.

Attachment 9

State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

State Consultant Services

FORM A

OSC Use Only
Reporting Code:
Category Code:
Date Contract Approved:

Contractor's Planned Employment
From Contract Start Date through End of Contract Term

New York State Department of Health — Agency Code 12000
Contractor Name: — Contract Number:

Contract Start Date: / / — Contract End Date: / /

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	$ 0.00
Grand Total:	0	0	$ 0.00

Name of person who prepared this report:

Title: — Phone #:

Preparer's signature:
Date Prepared: / /

Page of
(use additional pages if necessary)

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. the designated payment office (DPO) outlined in the consulting contract.

2. NYS Office of the State Comptroller
   Bureau of Contracts
   110 State Street, 11th Floor
   Albany, NY 12236
   Attn: Consultant Reporting
   or via fax to –
   (518) 474-8030 or (518) 473-8808

3. NYS Department of Civil Service
   Alfred E. Smith Office Building
   Albany, NY 12239
   Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

Attachment 10

State Consultant Services Form B, Contractor’s Annual Employment Report

State Consultant Services

FORM B

OSC Use Only
Reporting Code:
Category Code:

Contractor's Annual Employment Report
Report Period: April 1, ____ to March 31, ____

New York State Department of Health
Agency Code 12000
Contract Number:
Contract Start Date: / /
Contract End Date: / /
Contractor Name:
Contractor Address:

Description of Services Being Provided:

Scope of Contract (Chose one that best fits):

Analysis	Evaluation	Research
Training	Data Processing	Computer Programming
Other IT Consulting	Engineering	Architect Services
Surveying	Environmental Services	Health Services
Mental Health Services	Accounting	Auditing
Paralegal	Legal	Other Consulting

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	$ 0.00
Grand Total:	0	0	$ 0.00

Name of person who prepared this report:
Title:
Phone #:

Preparer's signature:
Date Prepared: / /

Page of
(use additional pages if necessary)

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. the designated payment office (DPO) outlined in the consulting contract.

2. NYS Office of the State Comptroller
   Bureau of Contracts
   110 State Street, 11th Floor
   Albany, NY 12236
   Attn: Consultant Reporting
   or via fax to –
   (518) 474-8030 or (518) 473-8808

3. NYS Department of Civil Service
   Alfred E. Smith Office Building
   Albany, NY 12239
   Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at ~~online.onetcenter.org~~ to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.