

PASRR

Preadmission Screening and Resident Review

Regulatory Services and PASRR:

PASRR for Providers

August 2017



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Introduction to PASRR

Let's start with the basics about PASRR.

1. PASRR stands for **P**re-**A**dmission **S**creening and **R**esident **R**eview.
2. PASRR addresses treatment and placement of individuals with mental illness (MI), intellectual disabilities (ID), or developmental disabilities (DD).
3. PASRR applies to all Medicaid-certified Nursing Facilities (NFs).



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The Goal

PASRR requires all applicants to and residents of a Medicaid-certified nursing facility:

1. be evaluated for MI, ID, or DD;
2. be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
3. receive the services they need in those settings.



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Source: [medicaid.gov](https://www.medicaid.gov)

Objectives

In this presentation, we will:

1. review the basic PASRR process;
2. identify the responsibilities of local authorities regarding residents with MI, ID, or DD;
3. distinguish specialized services from regular NF services; and
4. review the NF responsibilities to ensure PASRR compliance.



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PASRR Screening

Coordination is key!

Let's look at what PASRR requires of NFs, local IDD authorities (LIDDAs), and local mental health authorities (LMHAs).

Neal will be our guide.



PASRR Screening

NFs must ensure all residents receive a PASRR Level 1 (PL1) screening. The three central elements to the PL1 are below.



Neal may be either a new admission or current resident at the NF.

The referring entity (RE) states Neal may have MI, ID, or DD.

The PL1 screening is the first simple assessment of Neal.

PASRR Screening

An RE usually provides the PL1 to the NF. If the RE is a family member, legally authorized representative, or emergency referral, the NF may help the RE.



Neal may be either a new admission or current resident at the NF.

The referring entity (RE) states Neal may have MI, ID, or DD.

The PL1 screening is the first simple assessment of Neal.

40 TAC §19.2704 (a)-

(b)

40 TAC §19.2704(a)-(b)

(a) If an individual seeks admission to a nursing facility, the nursing facility:

(1) must coordinate with the referring entity to ensure the referring entity conducts a PL1; and

(2) may provide assistance in completing the PL1, if the referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source and requests assistance in completing the PL1.

(b) A nursing facility must not admit an individual who has not had a PL1 conducted before the individual is admitted to the facility.



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PASRR Screening

The PL1 screening determines if there is a possibility Neal or any individual may have MI, ID, or DD.



Neal may be either a new admission or current resident at the NF.

The referring entity (RE) states Neal may have MI, ID or DD.

The PL1 screening is the first simple assessment of Neal.

40 TAC

§19.2703(31)

40 TAC

§19.2703(31)

(31) PL1—PASRR Level I screening. The process of screening an individual to identify whether the individual is suspected of having MI, ID, or DD.



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PASRR Screening

The RE does not have to be a medical professional. The RE can be a hospital discharge nurse or a family member. The PL1 is a statement the person, Neal in this case, *may have* MI, ID, or DD.



Referring Entity
(RE)

40 TAC §19.2703(33)



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40 TAC

§19.2703(33)

(33) Referring entity—The entity that refers an individual to a nursing facility, such as a hospital, attending physician, LAR or other personal representative selected by the individual, a family member of the individual, or a representative from an emergency placement source, such as law enforcement.



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PASRR Screening

If the screening shows negative for possible MI, ID, or DD, the NF may admit the individual and must enter the PL1 into the LTC Online Portal.



40 TAC §19.2704(c)



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40 TAC §19.2704(c)

(c) If an individual's PL1 indicates the individual is not suspected of having MI, ID, or DD, a nursing facility must enter the PL1 from the referring entity into the long-term care (LTC) Online Portal. The nursing facility may admit the individual into the facility through the routine admission process.



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PASRR Screening

Medicaid funds will not be released to the NF unless a PL1 is entered into the LTC Portal.



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LTC Portal

LTC Online Portal

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records.

DLN Individual

PASRR Evaluation

Section A

Submitter Information

A0100. Name <input type="text"/>		
A0200A. Street Address <input type="text"/>		
A0200B. City <input type="text"/>		
A0200C. State <input type="text"/>	A0200D. ZIP Code <input type="text"/>	A0300. NPI/API <input type="text"/>
A0400. Contract No. <input type="text"/>	A0500. Vendor No. <input type="text"/>	

Evaluation Information

A0600. Type of Evaluation(s) <input type="text"/>
1. IDD only 2. MI only 3. IDD and MI

IDD Information

A0700. LA - IDD Contract No. <input type="text"/>	A0800. IDD Vendor No. <input type="text"/>
A0900. LA - IDD NPI/API <input type="text"/>	A1000. Date of IDD Assessment <input type="text"/>
A1100A. First Name <input type="text"/>	A1100B. Middle Initial <input type="text"/>
A1100C. Last Name <input type="text"/>	A1100D. Suffix <input type="text"/>

NFs and the LIDDA/ LMHA communicate through the LTC Online Portal. NFs must use the portal to:

- check daily for PASRR communications;
- obtain a PASRR Evaluation (PE);
- certify that a resident's needs can be met; and
- schedule an Interdisciplinary Team (IDT) meeting.

40 TAC

§§19.2704(d)&(h)

40 TAC

§§19.2704(d)&(h)

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

(1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

(A) expedited admission; or

(B) exempted hospital discharge; and

(2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

(1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.



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LTC Portal

LTC Online Portal

The screenshot shows a web browser window displaying the LTC Online Portal. The browser's address bar shows the URL http://www.tmhp.com/Provider_Forr. The page title is "PASRR Evaluation". The form is titled "PASRR Evaluation" and is divided into several sections:

- Section A: Submitter Information**
 - A0100. Name
 - A0200A. Street Address
 - A0200B. City
 - A0200C. State
 - A0200D. ZIP Code
 - A0300. NPI/API
 - A0400. Contract No.
 - A0500. Vendor No.
- Evaluation Information**
 - A0600. Type of Evaluation(s)
 - 1. IDD only
 - 2. MI only
 - 3. IDD and MI
- IDD Information**
 - A0700. LA - IDD Contract No.
 - A0800. IDD Vendor No.
 - A0900. LA - IDD NPI/API
 - A1000. Date of IDD Assessment
 - A1100A. First Name
 - A1100B. Middle Initial
 - A1100C. Last Name
 - A1100D. Suffix

To be clear, making reports in the LTC Online Portal and checking the portal *daily* for notifications is mandatory for NFs.

40 TAC

§19.2704(g)

40 TAC §19.2704(g)

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.



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PASRR Evaluation

If the PL1 is positive, the NF must obtain a PASRR Level II Evaluation (PE) from the LIDDA or LMHA.

NF



Neal

LIDDA, LMHA

PASSR Level 2
Evaluation
(PE)

40 TAC §19.2704(d)



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40 TAC §19.2704(d)

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

(1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

- (A) expedited admission; or
- (B) exempted hospital discharge; and

(2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.



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PASSR Evaluation

In Neal's case, the RE suspects ID. The NF reports the PL1 on the LTC Portal. The LIDDA completes Neal's PE.



Neal

LIDDA, LMHA

PASSR Level 2
Evaluation
(PE)



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PASSR Level 2 Evaluation

If the LIDDA PE confirms a diagnosis of ID, the LIDDA recommends the specialized services Neal requires. The LIDDA lists these specialized services in the PE.



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Neal

LIDDA, LMHA

PASSR Level 2
Evaluation
(PE)

40 TAC §19.2703(30)

40 TAC

§19.2703(30)

(30) PE--PASRR Level II evaluation. A face-to-face evaluation of an individual suspected of having MI, ID, or DD performed by a LIDDA or an LMHA to determine if the individual has MI, ID, or DD, and if so to:

- (A) assess the individual's need for care in a nursing facility;
- (B) assess the individual's need for nursing facility specialized services, LIDDA specialized services and LMHA specialized services; and
- (C) identify alternate placement options.



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LTC Portal

The LIDDA posts the final PE in the LTC Portal.

The NF acquires Neal's PE from the LTC portal.

The NF *must* check the portal daily.

LTC Online Portal

The screenshot shows a web browser window displaying the LTC Online Portal. The browser address bar shows the URL: http://www.tmhp.com/Provider_Ferr.... The page title is "PASRR Evaluation". The form contains the following sections:

- Section A**
- Submitter Information**
- Evaluation Information**
- IDD Information**

Submitter Information		
A0100. Name		
A0200A. Street Address		
A0200B. City		
A0200C. State	A0200D. ZIP Code	A0300. NPI/API
A0400. Contract No.	A0500. Vendor No.	

Evaluation Information	
A0600. Type of Evaluation(s)	
1. IDD only	
2. MI only	
3. IDD and MI	

IDD Information	
A0700. LA - IDD Contract No.	A0800. IDD Vendor No.
A0900. LA - IDD NPI/API	A1000. Date of IDD Assessment
A1100A. First Name	A1100B. Middle Initial
A1100C. Last Name	A1100D. Suffix

40 TAC §19.2704

(9)

40 TAC §19.2704(g)

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.



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NF Responsibilities

The process for arriving at a specialized care plan for Neal involves extensive collaboration. The NF along with the LIDDA and/or LMHA play key roles in the process.



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Neal

NF Responsibilities

The NF must:

1. convene an interdisciplinary team (IDT) meeting;
2. record the specialized services to be provided in the LTC Online Portal;
3. initiate NF specialized services within 30 days;
4. work with the LIDDA service coordinator to convene a meeting of the service planning team (SPT);
5. contribute to the development of Neal's individual service plan (ISP);
6. help coordinate and monitor Neal's specialized services care; and
7. regularly monitor and report via the LTC Online Portal.



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NF Responsibilities

All of the NF responsibilities will be discussed later during this course.

First, let's take a look at what is meant by specialized services.



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Specialized Services

PASRR resident support

Upon receiving a PE, an NF must:

1. determine if it will admit the individual;
and
2. certify on the LTC portal it can provide or support the services recommended in the PE if it does admit the individual.



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40 TAC §19.2704(h)

40 TAC §19.2704(h)

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

(1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.



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Specialized Services

Specialized services are any services recommended by the PE for a specific resident which are not traditionally provided in NFs.

For Neal, this could mean more intensive therapy than offered by the NF.

For individuals with MI, mental health services can be provided.



Specialized Services

There are three types of specialized services based upon who administers the service:

1. NF specialized services;
2. LIDDA specialized services; and
3. LMHA specialized services.



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NF Specialized Services

NF specialized services include:

- physical therapy (PT);
- occupational therapy (OT);
- speech therapy (ST);
- customized manual wheelchair; and
- durable or adaptive medical equipment.

What makes them specialized services in terms of PASRR?



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NF Specialized Services

For PASRR, NFs provide specialized services, including PT, OT, and ST. NF specialized services, often referred to as *habilitative services*, differ from rehabilitative services.

Rehabilitative services help the resident regain and maintain a skill lost due to illness, injury, or disabling condition. Rehabilitative therapy is restorative and usually has an end point.

Habilitative specialized services help a resident maintain a skill, learn a new skill, or improve a skill. PASRR specialized services are typically provided on an ongoing basis.



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40 TAC §19.2703(27)

40 TAC

§19.2703(27)

(27) Nursing facility specialized services--Support services, other than nursing facility services, that are identified through the PE and may be provided to a resident who has ID or DD. Nursing facility specialized services are:

(A) physical therapy, occupational therapy, and speech therapy;

(B) customized manual wheelchair; and

(C) durable medical equipment, which consists of:

(i) a gait trainer;

(ii) a standing board;

(iii) a special needs car seat or travel restraint;

(iv) a specialized or treated pressure-reducing support surface mattress;

(v) a positioning wedge;

(vi) a prosthetic device; and

(vii) an orthotic device.



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LIDDA Specialized Services

LIDDA specialized services include:

1. service coordination, which includes alternate placement assistance;
2. employment assistance;
3. supported employment;
4. day habilitation;
5. independent living skills training; and
6. behavioral support.



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40 TAC §19.2703(19)

40 TAC

§19.2703(27)

(19) LIDDA specialized services--Support services, other than nursing facility services, that are identified through the PE or resident review and may be provided to a resident who has ID or DD. LIDDA specialized services are:

- (A) service coordination, which includes alternate placement assistance;
- (B) employment assistance;
- (C) supported employment;
- (D) day habilitation;
- (E) independent living skills training; and
- (F) behavioral support.



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LMHA Specialized Services

LMHA specialized services include:

1. skills training;
2. medication training;
3. psychosocial rehabilitation;
4. case management; and
5. psychiatric diagnostic examination.



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40 TAC §19.2703(21)

40 TAC

§19.2703(21)

(21) LMHA specialized services--Support services, other than nursing facility services, that are identified through the PE or resident review and may be provided to a resident who has MI. LMHA specialized services are defined in 25 TAC Chapter 412, Subchapter I (relating to MH Case Management), including alternate placement, and 25 TAC Chapter 416, Subchapter A (relating to Mental Health Rehabilitative Services).



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Specialized Services

NFs must coordinate and assist in provision of LIDDA and LMHA specialized services.



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40 TAC

§19.2706(c)(3)

40 TAC

§19.2706(c)(3)

(3) [The NF must] assist the SPT by:

- (A) monitoring all nursing facility specialized services, LIDDA specialized services and LMHA specialized services, if applicable, provided to the resident to ensure the resident's needs are being met;
- (B) making timely referrals, service changes, and amendments to the ISP as needed;
- (C) ensuring that the resident's ISP, including nursing facility specialized services, nursing facility PASRR support activities, and LIDDA specialized services, is coordinated with the nursing facility's comprehensive care plan;
- (D) developing a transition plan for a resident who has expressed interest in community living and, if no transition plan is recommended due to identified barriers, participating to identify the action the SPT will take to address concerns and remove the barriers; and
- (E) reviewing and discussing the information included in the ISP and transition plan with key nursing facility staff who work with the resident.



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Let's Review



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Interdisciplinary Team Meeting

Face-to-face coordination

After admitting Neal and filing a report in the LTC Portal, the NF must use the LTC Portal to arrange for an IDT meeting.

The IDT meeting is distinct from other NF care planning meetings and must meet specific requirements.



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40 TAC §19.2704(i)(1)-(2)

40 TAC

§19.2704(i)(1)-(2)

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(1) contact the LIDDA or LMHA within two calendar days after the individual's admission or, for a resident, within two calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA, to schedule an IDT meeting to discuss nursing facility specialized services, LIDDA specialized services, and LMHA specialized services;

(2) convene the IDT meeting within 14 calendar days after admission or, for a resident review, within 14 calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA;



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Interdisciplinary Team Meeting

The IDT meeting must include:

- the resident with MI, ID, or DD;
- the resident's legally authorized representative (LAR), if any;
- a registered nurse from the NF with responsibility for the resident;
- a representative of the LIDDA or LMHA; and
- other persons as needed.

Neal



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40 TAC §19.2703(27)

40 TAC

§19.2703(14)

(14) IDT--Interdisciplinary team. A team consisting of:

(A) a resident with MI, ID, or DD;

(B) the resident's LAR, if any;

(C) a registered nurse from the nursing facility with responsibility for the resident;

(D) a representative of a LIDDA or LMHA, or if the resident has MI and DD or MI and ID, a representative of the LIDDA and LMHA; and

(E) other persons, as follows:

(i) a concerned person whose inclusion is requested by the resident or LAR;

(ii) a person specified by the resident or LAR, nursing facility, or LIDDA or LMHA, as applicable, who is professionally qualified or certified or licensed with special training and experience in the diagnosis, management, needs and treatment of people with MI, ID, or DD; and

(iii) a representative of the appropriate school district if the resident is school age and inclusion of the district representative is requested by the resident or LAR.



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Interdisciplinary Team Meeting

Participants in the IDT meeting:

1. review the specialized services recommendations of the PE; and
2. identify the most appropriate entity to provide those specialized services—the NF, LIDDA, or LMHA.



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40 TAC §19.2704 (i)(3)

40 TAC

§19.2704(i)(3)

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(3) participate in the IDT meeting to:

(A) identify which of the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive; and

(B) determine whether the resident is best served in a facility or community setting.



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Post-IDT Meeting Responsibilities

Within three business days of the IDT meeting, the NF must enter the following into the LTC Portal:

1. The date of the IDT meeting
2. The names of the persons who participated in the IDT meeting
3. The nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting
4. The determination of whether the resident is best served in a facility or community setting



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40 TAC §19.2704 (i)(5)

40 TAC

§19.2704(i)(5)

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(5) enter into the LTC Online Portal within 3 business days after the IDT meeting for a resident:

(A) the date of the IDT meeting;

(B) the name of the persons who participated in the IDT meeting;

(C) the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting; and

(D) the determination of whether the resident is best served in a facility or community setting.



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Post-IDT Meeting Responsibilities

Once the IDT makes its determinations about specialized care, the NF must:

1. include all specialized services and support activities in the resident's comprehensive care plan;
2. provide NF specialized services within 30 days of IDT meeting; and
3. annually document all specialized services in the LTC Online Portal.



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40 TAC §§19.2704 (i)(6),(7)&(8)

40 TAC

§§19.2704(i)(6),(7)&(8)

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(6) include in the comprehensive care plan:

(A) the nursing facility specialized services agreed to by the resident or LAR; and

(B) the nursing facility PASRR support activities;

(7) if Medicaid or other funding is available:

(A) initiate nursing facility specialized services within 30 days after the date that the services are agreed to in the IDT meeting; and

(B) provide nursing facility specialized services agreed to in the IDT meeting to the resident; and

(8) for a resident who is a Medicaid recipient, annually document in the LTC Online Portal all nursing facility specialized services, LIDDA specialized services, and LMHA specialized services currently being provided to a resident.



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Service Planning Team

Cooperate and Coordinate



LIDDAs/LMHAs should actively coordinate specialized services, but NFs must also cooperate and coordinate with service providers and the LIDDA or LMHA to ensure resident needs are being met.

40 TAC §19.2703(c)(3)

40 TAC

§19.2706(c)(3)

(c) A nursing facility must ensure its staff and contractors who are members of a designated resident's SPT:

(3) assist the SPT by:

(A) monitoring all nursing facility specialized services, LIDDA specialized services and LMHA specialized services, if applicable, provided to the resident to ensure the resident's needs are being met;

(B) making timely referrals, service changes, and amendments to the ISP as needed;

(C) ensuring that the resident's ISP, including nursing facility specialized services, nursing facility PASRR support activities, and LIDDA specialized services, is coordinated with the nursing facility's comprehensive care plan;

(D) developing a transition plan for a resident who has expressed interest in community living and, if no transition plan is recommended due to identified barriers, participating to identify the action the SPT will take to address concerns and remove the barriers; and

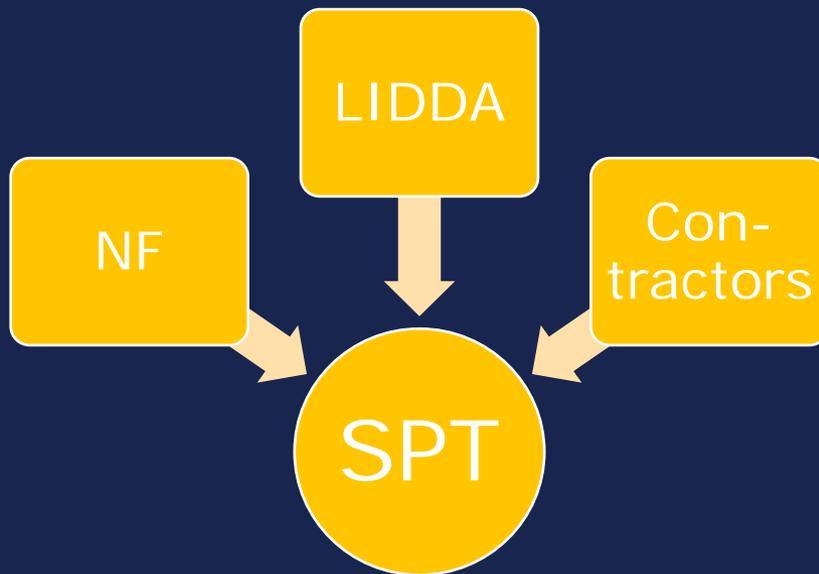
(E) reviewing and discussing the information included in the ISP and transition plan with key nursing facility staff who work with the resident.



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Service Planning Team

For ongoing review of specialized services, the LIDDA appoints a **service coordinator** to monitor Neal's care and to call meetings of the **Service Planning Team (SPT)**.



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The NF and the SPT

An NF must:

- designate staff and necessary contractors to be members of the SPT for a designated resident;
- contribute to the development of an individual service plan (ISP) by assisting the SPT; and
- participate in ongoing SPT meetings.



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The NF and the SPT

To assist the SPT, the NF must:

1. monitor all specialized services;
2. make referrals and changes to the ISP as needed;
3. coordinate specialized services with the comprehensive care plan; and
4. develop a transition plan for a resident who has expressed interest in community living.



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40 TAC §19.2703(c)(3)

40 TAC

§19.2706(c)(3)

(c) A nursing facility must ensure its staff and contractors who are members of a designated resident's SPT:

(3) assist the SPT by:

(A) monitoring all nursing facility specialized services, LIDDA specialized services and LMHA specialized services, if applicable, provided to the resident to ensure the resident's needs are being met;

(B) making timely referrals, service changes, and amendments to the ISP as needed;

(C) ensuring that the resident's ISP, including nursing facility specialized services, nursing facility PASRR support activities, and LIDDA specialized services, is coordinated with the nursing facility's comprehensive care plan;

(D) developing a transition plan for a resident who has expressed interest in community living and, if no transition plan is recommended due to identified barriers, participating to identify the action the SPT will take to address concerns and remove the barriers; and

(E) reviewing and discussing the information included in the ISP and transition plan with key nursing facility staff who work with the resident.



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When PASRR Works

With proper screening, evaluation and care planning, Neal can benefit from specialized services and perhaps move from the NF to another setting, if he so desires.



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If You Have Further Questions

To get answers for your questions about this training or other issues specific to the nursing facility regulations governing PASRR, please contact:

DADS Regulatory Services
Policy, Rules, and Curriculum Section
512-438-3161



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Thank you
