PASRR FAQs for Nursing Facilities

Nursing facility staff and other interested professionals

What is the purpose of PASRR?

The preadmission screening and resident review is a federally mandated mental health and intellectual/developmental disability screening for all individuals admitting to a nursing facility that accepts Medicaid payment. The goal of PASRR is to prevent the 'warehousing' of individuals with serious mental illness and/or intellectual/developmental disabilities in nursing facilities. If it is determined that an individual with a serious mental illness and/or intellectual/developmental disability requires nursing facility placement, the individual should be evaluated to determine if they would benefit from any specialized services or specialized rehabilitative services during their stay.

How long does a Level I (87) review take?

Once the Level I (87) and complete supporting documentation is submitted and received by BLTC, the Abbreviated Level II (90) is typically completed within a few hours or by end of business. Exceptions to this time frame occur when an individual requires a full Level II (88 or 89), if the Level I and supporting documentation is received after 3:30pm Monday through Friday. PASRR reviews are not completed after normal business hours, on weekends or state holidays. PASRRs are processed in the order they are received, urgent or ASAP requests are not accepted. Please plan accordingly.

When should a Significant Change Level I (87) be submitted?

A significant change is considered as any of the following:

- any medication changes from those listed on the Level I to a different drug class, such as antidepressants to an anxiolytic
- a dosage increase of double or more of medication(s) listed on previous Level I
- a decline in condition (such as the onset or progression of dementia) that indicates specialized services are no longer beneficial for the individual
- an improvement in condition that indicates the individual may benefit from specialized services
- a new mental health or developmental/intellectual disability diagnosis

Which PASRR forms need to be submitted in a Long Term Case File to DXC?

Each submission requires the Level I (87) form. If the individual screens positive for potential mental illness or intellectual or developmental disability then the Level I should be accompanied with, at least, the Abbreviated Level II (90). If the Abbreviated Level II (90) indicates further evaluation is needed, aka a Face to Face Evaluation, then the Level I (87), Abbreviated Level II (90) and the Level II (88/89)

need to be submitted. Further information can be found on DXC's User Guide, Trading Partner Account: Long Term Care User Guide for State of Idaho MMIS.

The PASRR should have been sent for review but wasn't and the individual has already been admitted. What should I do?

Don't panic. Send the original Level I and an updated Level I, if the original was not correct, to the regional BLTC fax number. Medicaid reimbursement will be effective no earlier than the date the Abbreviated Level II (90) and, if needed, a Level II (88/89) are completed and returned to the nursing facility.

All individuals admitting to a nursing facility that receives Medicaid dollars has the right to have an accurate PASRR to determine if they would benefit from specialized or specialized rehabilitative services during their nursing facility stay.

What is a temporary Leave of Absence (LOA)?

Nursing facilities can utilize a Leave of Absence (LOA) for individuals enrolled in Idaho Medicaid that are temporarily out of the facility for **3 days or less** due to a home visit or hospital stay. The nursing facility indicates LOA days on the UB1400 form. See the Provider Handbook or UB1400 for further information.

An individual is returning after temporary Leave of Absence (LOA). Do they need a new Level I (87)?

If a nursing facility exercises the LOA option for an individual, a PASRR does not need to be completed.

An individual is readmitting to our facility. Do they need a new Level I (87)?

Not necessarily. If the previous Level I (87) is still accurate, with **no changes** to medications or diagnoses, then the previous Level I (87) can be submitted for review. Evaluators will compare the information in the H&P, admission/discharge orders to validate current medications and diagnoses. If the previous Level I (87) is **no longer accurate**, then a new Level I (87) must be completed.

If the Level I (87) is updated with significant changes, it will reduce the PASRR review time from evaluators and quicken readmission to the nursing facility.

A new resident has a Level II with recommendations. What do I do?

A Level II (88/89) contains the result of a face to face evaluation that was completed with the individual, usually while in the hospital but may occur in the individuals home. A Level II can have the any of three (3) determinations; individual would benefit from specialized services with

recommendations, individual would benefit from specialized rehabilitation services, individual would not benefit from specialized services.

It is the nursing facilities responsibility to present the Level II recommendations to the individual. The individual has the right to either accept all, part or none of the recommendations. If the individual accepts all or part of the recommendations, the recommendations should be added to the care plan and nursing facility staff can facilitate arranging the services. If the individual declines all or part of the recommendations, it should be clearly documented. The nursing facility must send the care plan and/or documentation of declined recommendations **within two (2) weeks of admission** to the regional BLTC office by fax.

Is the nursing facility responsible for payment of Specialized Services or Specialized Rehabilitation Services?

Specialized Services are outside the typical scope of cares and services provided in a nursing facility and the nursing facility is not responsible for payment of these services. The nursing facility is responsible for arranging services and transportation to the service provider if needed. The Specialized Services should be paid for by the individuals health insurer. All individuals with Specialized Services enrolled in Medicaid during their nursing facility stay can access these services. Medicaid service providers should bill Medicaid as they would for any other Medicaid participant.

Specialized Rehabilitation Services are within the scope of cares and services provided in a nursing facility. The nursing facility is responsible for furnishing these services and are not reimbursed at a higher rate for these services.

A nursing facility should not admit an individual when the recommended Specialized Services or Specialized Rehabilitation Services cannot be provided due to lack of service providers in the area or rehabilitation services not offered at the nursing facility.