

PASRR 101 for South Dakota PASRR Providers

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Objectives



UNDERSTAND THE CONCEPT
AND REGULATIONS
SURROUNDING PASRR



DISCUSS THE STRUCTURE AND
PURPOSE OF PASRR



DEVELOP AN UNDERSTANDING
OF THE IMPORTANCE OF PASRR
AND YOUR ROLE



maximus

Webinar Acronyms

What do we mean when we say:

PASRR

Pre-Admission Screening and Resident Review

SMI

Serious Mental Illness

ID

Intellectual Disability

What do we mean when we say:

RC

Related Condition

NF

Nursing Facility

LOC

Level of Care

Level II

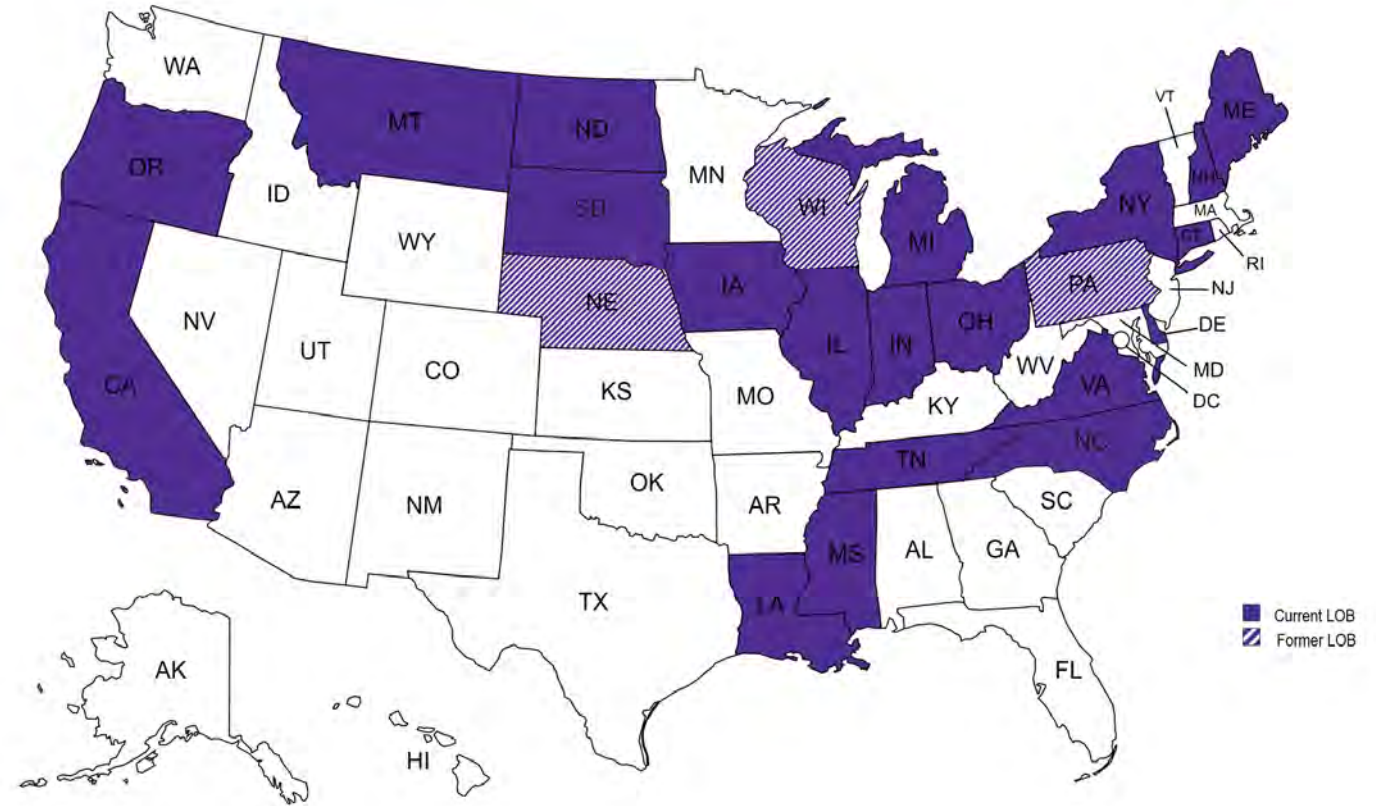
Level II PASRR evaluation

Who We Are



Who We Are

- + Global company in 10 different countries
- + Headquartered in Northern Virginia;
 - Based in Franklin, Tennessee
 - 300 Employees across the country
 - Network of 800+ independent contractor clinicians and physicians
- + Services Provided
 - Conflict-free clinical assessment services
 - Customized data systems and clinical algorithms
 - Intense focus on clinical quality
 - produce highly defensible outcomes



Maximus and South Dakota PASRR

The **South Dakota Department of Social Services, Medical Services Division** has contracted with Maximus to:

- Review all positive Level I Screens suggesting potential MI/ID/RC
- Determine if there is a confirmed or suspected PASRR condition, and, if so, which is needed:
 - Categorical (or abbreviated evaluation), **or**
 - Full Level II evaluation

If Maximus determines the person needs a full SMI Level II evaluation, Maximus will complete the Level II evaluation

Program Overview



Structure & Purpose of PASRR



Preadmission Screening & Resident Review



Administered by CMS

Created in 1987



Anyone in Medicaid-certified NF
screened for:

SMI, ID, DD/RC



Known or suspected condition =
evaluation

To ensure NF is most appropriate placement
To ensure receipt of needed services

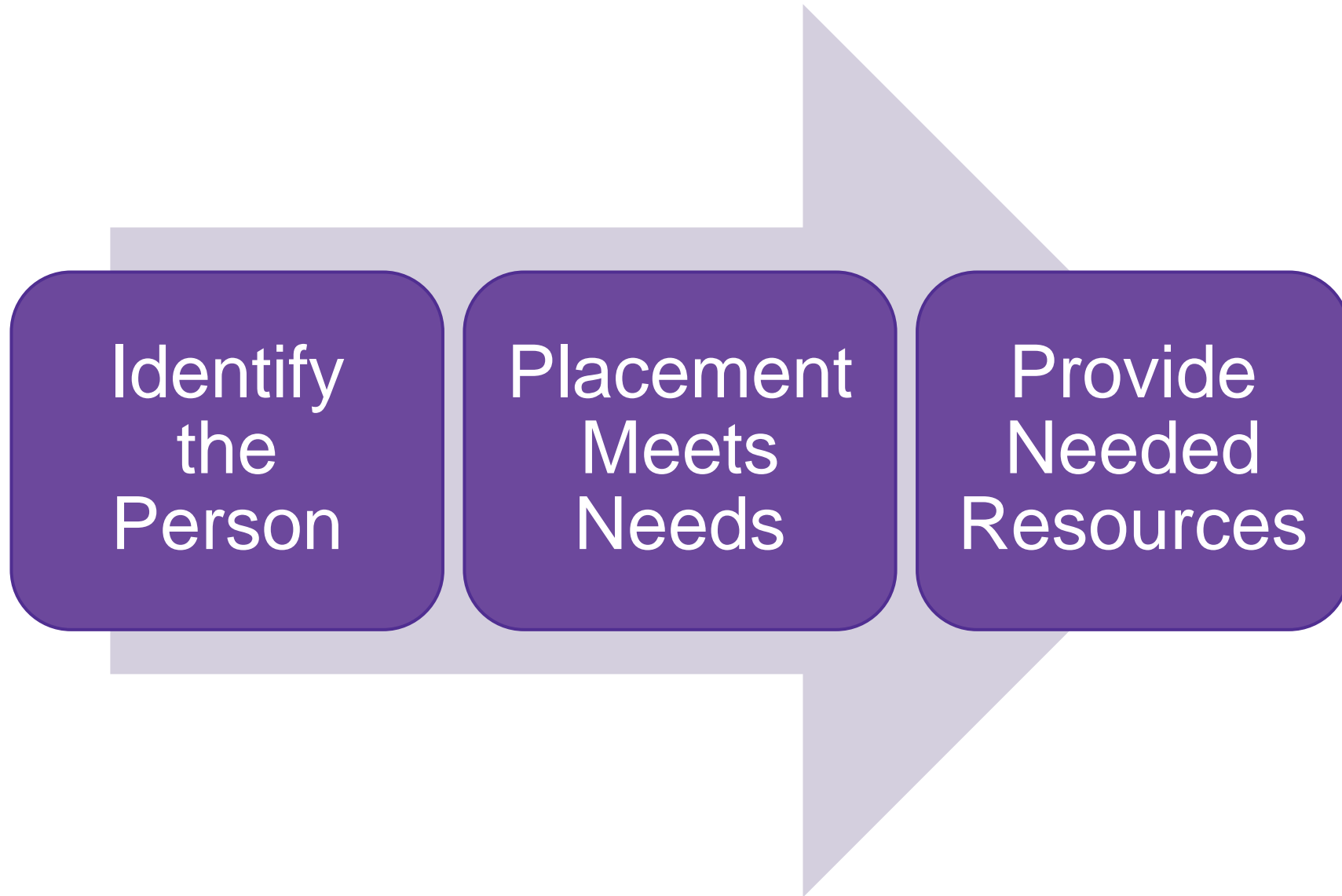
**Optimize an individual's
placement success, treatment
success, and
QUALITY OF LIFE**

The most appropriate services

In the most appropriate place

At the most appropriate time

Reaching that Goal



Four Questions of PASRR

1

Does the individual have a PASRR condition?

2

What is the most appropriate placement for this individual? (acute enough/too acute)

3

Might this individual be a candidate for transition to the community? What supports or services would be necessary to return to his/her community?

4

What unique disability supports and services does this individual need while a resident of a NF to ensure safety, health, and well-being?

1. Does the individual have a PASRR condition?

THE FOUR Ds OF PASRR: SMI



Diagnosis
(or suspicion of)



Dementia:
If present, is
it primary?



Duration



Disability

1. Does the individual have a PASRR condition?

THE THREE Ds OF PASRR: IDD



Diagnosis
(or suspicion of)



Duration



Disability

Possible PASRR Related Conditions

Anoxia at birth	Arthrogryposis	Autism	Congenital Blindness	Cerebral Palsy	Congenital Deafness	Down Syndrome
Encephalitis	Fetal Alcohol Syndrome	Fredreich's Ataxia	Hemiparesis	Hemiplegia	Hydrocephaly	Klippel-Feil Syndrome
Meningitis	Multiple Sclerosis	Muscular Dystrophy	Paraparesis	Paraplegia	Polio	PDD
Prader-Willi syndrome	Quadraplegia	Seizure Disorder	Spina Bifida	Spinal Cord Injury	Traumatic Brain Injury	XXY Syndrome

2. What is the most appropriate placement for this person?

Least restrictive level of care

- Too acute/not acute enough

NF (meets LOC and this NF can meet needs)

- NF MUST incorporate ALL PASRR-identified services into the care plan

Specialized Services

- Disability-specific services to the person to meet required needs

Alternative Placement or Community Placement Services

3. Might this person be a candidate for transition to the community? What supports or services would be necessary for them to return to the community?

Community Placement

- Independent Living
- Group Home
- Assisted Living

Community Supports

- Person-directed care
- Consumer Directed Attendance Care
- Assertive Community Treatment (ACT)
- Guardian/Conservator

4. What unique disability supports and services are needed while a resident of the NF to ensure safety, health, and well-being?

Rehabilitative Services

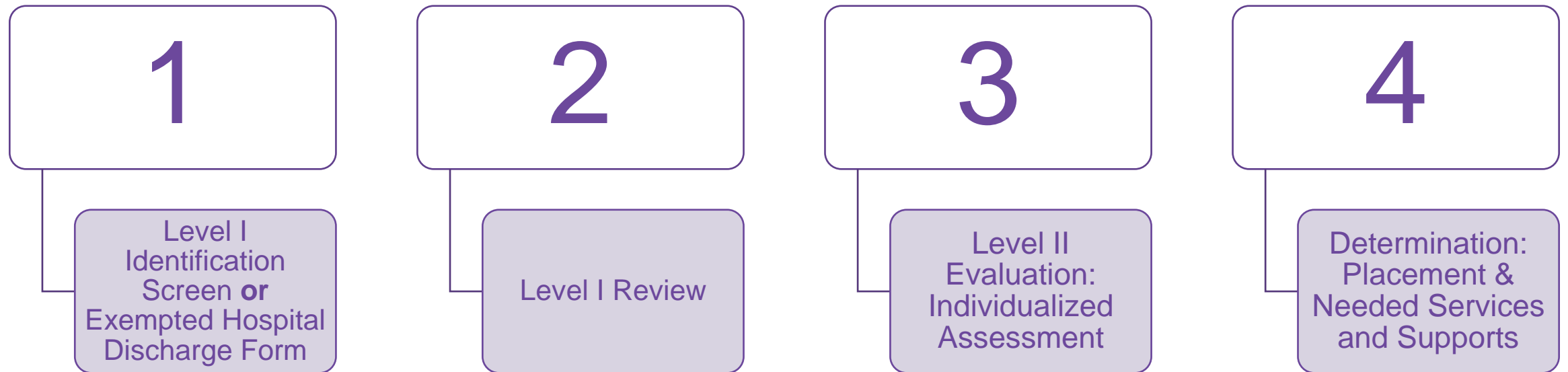
Specialized Services

Highest practicable physical, mental, and psychosocial well-being

- Any needed service/support

Not limited to facility's existing resources

PASRR Process Overview



Level I



Level I Importance



Identification screen

Known or suspected diagnoses
MI, ID, RC
Substance use
Dementia
Symptoms
Medications



First step in process



Accuracy ensures better transition

South Dakota PASRR Program
PRE-SCREENING FORM

Type of Facility (select one): Nursing Facility Swing Bed
Type of Screen (select one): Pre-Admission Resident Review

APPLICANT DEMOGRAPHICS			
LAST NAME	FIRST NAME	MI	DATE OF BIRTH
SOCIAL SECURITY NUMBER	MEDICAID NUMBER (IF APPLICABLE)	PRIMARY LANGUAGE	
CURRENT LOCATION OF APPLICANT			
FACILITY NAME	CITY	STATE	
PRIMARY CONTACT REGARDING PASRR	CONTACT EMAIL	CONTACT PHONE	FAX
SECONDARY CONTACT REGARDING PASRR	SECONDARY CONTACT EMAIL	SECONDARY CONTACT PHONE	
ADMITTING FACILITY			
FACILITY NAME	FACILITY CONTACT REGARDING PASRR		
CITY	STATE	ZIP CODE	PHONE NUMBER
DIAGNOSES			
PRIMARY ADMITTING DIAGNOSIS			
SECONDARY DIAGNOSES			
SCREENING QUESTIONS			
	YES	NO	Unknown
1. Does the individual have a condition of, or is there any presenting evidence* that may indicate the individual may have an intellectual or developmental disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the individual being referred by an agency that provides support for individuals with intellectual or developmental disabilities and has the individual been determined to be eligible for that agency's services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does this individual have a condition of, or is there any presenting evidence* that may indicate the individual may have mental illness? Indicate a "YES" response if the individual has any type of physician documented dementia diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Prior to this nursing facility admission request, did this individual receive any Medicaid funded, State paid, or privately paid in-home services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*See PASRR Manual Exhibit A for presenting evidence definition.

If any of the answers for questions 1 through 3 (as listed in the table above) are "YES", or "Unknown" email Maximus at PASRR@state.sd.us with supporting documentation. If all the answers are "NO", the individual may be placed without further evaluation and this form is saved in the individual's file.

- This individual does not need to be referred for further evaluation.
 This individual was referred to Maximus on _____ (date) and _____ (time)

Signature of Designated Facility Representative

Date Signed

Who receives a
Level I?



Regardless of payer source

EVERYONE
entering/residing in a
Medicaid-certified NF
or Swing Bed



Regardless of diagnoses



Regardless of current location

When Do Providers Submit a Level I?

Before NF admission

- Pre-Admission

Expiration of a time-limited stay

- Resident Review
- Submit **at least 7** days before end date

Significant change in status

- Resident Review
- Submit **at least 14** days following the status change event

X Status Change

- Section 1919(e)(7)(B)(iii) of the Social Security Act, indicates that Resident Reviews are required for NF residents experiencing a ‘significant change in condition.’
- A ‘significant change’ is a major decline or improvement in a resident’s status that:
 - Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions;
 - Impacts more than one area of the resident’s health status; **and**
 - Requires interdisciplinary review and/or revision of the care plan

X Status Changes Where the Individual WAS Previously Identified to Have a PASRR Condition

- A resident who:
 - Demonstrates increased behavioral, psychiatric, or mood-related symptoms
 - Has behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment
 - Experiences an improved medical condition-such that the resident's plan of care or placement recommendations may require modification
 - Has a significant physical change but with mental health, behavioral symptoms or cognitive abilities, that may influence adjustment to an altered pattern of daily living
 - Indicates a preference to leave the facility
 - Has a PASRR condition that treatment is or will be significantly different than described in the resident's most recent Level II evaluation and determination

**Note: This is not an exhaustive list*

Status Changes Where the Individual WAS NOT Previously Identified to Have a PASRR Condition

A resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of mental illness

A resident whose intellectual disability or related condition was not previously identified and evaluated through PASRR

A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay

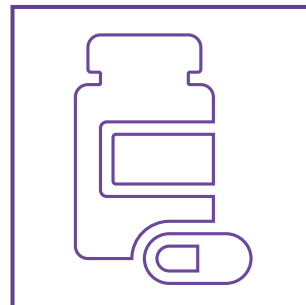
***Note: This is not an exhaustive list**

Admissions and Readmissions



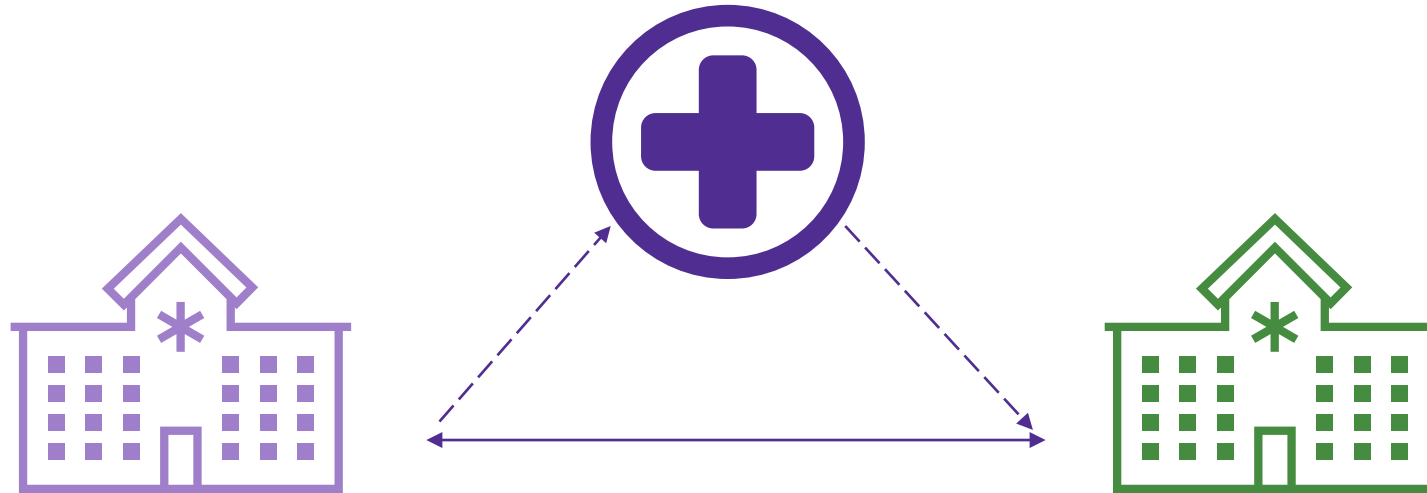
New Admission: Individual admitted to any NF for the first time or does not qualify as a readmission

Readmissions: Individual was readmitted to a facility from a hospital to which he or she was transferred for the purpose of receiving care



Psychiatric admissions are distinct during the Readmission process. Frequently, these mean a status change has occurred

Interfacility Transfers



A new PASRR is not required if the individual is transferring NF to NF as long as a status change event has not occurred

Required Documentation

Pre-Admission Screening	Resident Review
Level I Screening Form	Copy of original Level I Screen and new screen
Demographic Face Sheet	Demographic Face Sheet
History and Physical or physician note within the past 30 days	History and Physical or physician note within the past 30 days
Current medication list	Current medication list
*Orders required for certain categorical decisions	Copy of order for new diagnosis, medication, or other reason you may be requesting a Status Change

Intent of Categorical Options

- Certain categories, like conditions, severity of illness, or need for certain services that can indicate, by nature of being in that category, that the person typically needs NF care OR typically does not need specialized services

Remember: These are not designed to be a shortcut around a Level II assessment

BASIC REQUIREMENTS FOR APPLICATION OF CATEGORICAL DETERMINATIONS

- Must have a known/suspected PASRR condition
- Must be psychiatrically stable and NOT a danger to self or others
- Each outcome has specific criteria

Level I Categoricals

1. Terminal Illness Categorical

- A terminal illness diagnosis with 6 months or less prognosis documented by a physician
- Requires physician note documenting end-of-life stage

2. Serious Illness Categorical

- Severe physical illness which has resulted in a coma or ventilator dependence (ex: functioning at a brain stem level, or a diagnosis such as end-stage COPD, Parkinson's disease, Huntington's, amyotrophic lateral sclerosis (ALS), which results in a level of impairment so severe that a person cannot be expected to benefit from active treatment)
- Requires documentation of severe physical illness that is valid and reliable (History and Physical, physician progress note)
- Question to consider: Does it look like the individual cannot benefit from services?

Level I Categoricals

3. 75 years or Older Categorical

- The person is 75 or older as determined from their demographic face sheet provided with the Level I screen

4. Convalescent Categorical (Less than 100 Days)

- The physician has identified the need for NF or Swing Bed stay following hospitalization which will be less than 100 days for an acute medical or functional need that is expected to resolve in 100 days or less
- Requires supporting documentation signed by the medical provider (physician's note, H&P, or attestation) before admission to the facility which allows us to determine that the individual is likely to require less than 100 days of NF care

Level I Categoricals

5. Respite Categorical (30 Days)

- Physician order for a respite stay of 30 days or less
- Requires physician order. Can be in a medical progress note

Exempted Hospital Discharge

- Is discharging to a nursing facility or swing bed from a hospital after receiving acute inpatient hospital care
- Requires nursing facility services for the condition for which he/she received care in the hospital
- As the physician, they certify no later than the date of discharge, that the individual requires less than 30 days of nursing facility or swing bed services
- Exempted Hospital Discharge form is required

Reminder: A new Level I Screen must be completed as soon as the NF realizes the individual needs to stay longer than the original 30 days and forwarded to Maximus as quickly as possible.

If the screen is positive, a Level II evaluation must be conducted within 40 calendar days of the date of admission.

**PRE-ADMISSION HOSPITAL EXEMPTION
TO THE NURSING FACILITY or SWING BED**

1. Send this notification to the nursing facility and Maximus (pasrr@state.sd.us) **PRIOR** to discharge from the hospital.
2. This form must be completed fully (Sections A-D) for the nursing facility to accept payment for services.
3. Incomplete forms will be returned.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT			
Last Name	First Name	MI	
Living arrangement prior to the hospital admission:			
<input type="checkbox"/> group home	<input type="checkbox"/> psychiatric hospital	<input type="checkbox"/> own home/apt - alone	
<input type="checkbox"/> own home/apt - with friend or relative	<input type="checkbox"/> homeless	<input type="checkbox"/> prison	
<input type="checkbox"/> nursing facility	<input type="checkbox"/> other (please specify) _____		
Street Address	City	State	Zip
SD Country of Residence	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	
Social Security #	Medicaid Recipient <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> pending		
Hospital Name	Hospital Phone #		
Hospital Contact	Discharge from Psychiatric Unit to NF? <input type="checkbox"/> yes <input type="checkbox"/> no		
SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS or INTELLECTUAL and DEVELOPMENTAL DISABILITIES			
1) If applicable, date of most recent Level II PASRR determination* _____ (mm/dd/yyyy) <input type="checkbox"/> not applicable			
* The date of the most recent Level II PASRR is only applicable for persons with diagnoses of serious mental illness or intellectual and developmental disabilities as indicated in this section. Contact Maximus if unable to verify.			
2) Does the individual have a diagnosis of any of the mental illness as defined in the DSM-IV most recent version? <input type="checkbox"/> yes <input type="checkbox"/> no If yes please list below.			
<input type="checkbox"/> schizophrenia	<input type="checkbox"/> personality disorder		
<input type="checkbox"/> mood disorder	<input type="checkbox"/> other psychotic disorder		
<input type="checkbox"/> delusional (paranoid) disorder	<input type="checkbox"/> another mental disorder other than ID		
<input type="checkbox"/> panic or other severe anxiety disorder	If so, describe _____		
<input type="checkbox"/> somatoform disorder			
3) Does the individual have a diagnosis of intellectual or developmental disability (ID/DD) (mild, moderate, severe or profound) as described in the ARSD? 67:54:04:05. <input type="checkbox"/> yes <input type="checkbox"/> no			
4) Does the individual have a severe, chronic disability that is attributable to a condition other than intellectual disability (ID), but is closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID and requires treatment or services similar to those required for persons with ID? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please specify: _____			

SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION	
As the individual's physician, I certify that the individual: *Is discharging to a nursing facility or swing bed directly from a hospital after receiving acute inpatient hospital care; and *Requires nursing facility services for the condition for which he/she received care in the hospital; and *As the physician, I certify, no later than the date of discharge, that the individual requires less than 30 days of nursing facility or swing bed services.	
Physician's Printed Name	
Physician's Signature	Date (mm/dd/yyyy)
<i>Please note:</i> The individual cannot be admitted to the nursing facility through the hospital exemption if all three criteria are not met. If the individual does not meet the three criteria for exemption, the individual may still seek nursing facility admission through a pre-admission screen via completion of the "PASRR Screening Form" and referral to Maximus, if applicable.	
SECTION D: IDENTIFYING INFORMATION FOR THE NURSING FACILITY TO WHICH AN INDIVIDUAL WILL BE ADMITTED	
Facility Name	Facility Contact
Street Address	City
	State
	Zip
Date of Expected Admission (mm/dd/yyyy)	Phone #
	Fax #
Printed Name of Hospital Staff completing this form	Time emailed to Maximus
Signature of Hospital staff completing this form	Date (mm/dd/yyyy) emailed to Maximus

THIS NOTIFICATION FORM MUST BE KEPT IN THE NURSING FACILITY RESIDENT'S ACTIVE FILE. BY ACCEPTING ADMISSION, THE NURSING FACILITY CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF SOUTH DAKOTA'S PASRR PROGRAM ARE MET. THE NURSING FACILITY ACCEPTS THE ADMISSION ONLY AFTER RECEIPT AND REVIEW OF THIS NOTIFICATION FORM FOR 100% ACCURACY AND COMPLETION. THE NURSING FACILITY ACCEPTS RESPONSIBILITY FOR REQUESTING A RESIDENT REVIEW (IF REQUIRED) FROM MAXIMUS PRIOR TO THE 30th DAY FOLLOWING ADMISSION FROM THE HOSPITAL.

Frequently Asked Question: *When should I send my Level I screen?*

For Pre-Admission Screenings:

We encourage providers to send Maximus their positive Level I screens and required documentation as soon as it is indicated that the individual needs a nursing facility. An expected turnaround time for a Level II is 5 days, which begins at the time of receipt of all required documentation

It is important to think of the current psychiatric stability of your PASRR individual or their status in the next few days. PASRR looks at the current psychiatric stability of the individual at the time of the Level II assessment and whether the nursing facility can truly meet their needs

For Resident Reviews:

Positive Level I Screens should be sent to Maximus prior to a time-limited approval period ending or no later than **14 days** after a status change event has occurred

Send the positive Level I Screen and required documentation as soon as the status change is discovered to ensure timely completion

Level II Assessments



Importance of the Level II

In-depth assessment

Meet the person for
bio/psycho/social
interview

Tells who the person is

- Likes/dislikes
- History
- Needs
- Diagnoses

Review medical
records

Interview support/care
providers

State and Federally
required

After the Assessment



The Level II Summary Report has critical information NF providers need to determine if they can provide the needed services to the person

New PASRR Resource Page

- Be sure to save the Maximus Provider Resource website to your bookmarks!
- Access tools, videos, user guides, forms, and resources for your role in the PASRR process 24/7.

https://maximusclinicalservices.com/svcs/south_dakota

Contact Information

For information about Medicaid or policy related questions, contact:

Emily Johnson
South Dakota Program Manager

Email: Emily.Johnson@state.sd.us
email preferred

Phone: 605.773.8434

For information on PASRR, Level I referral submissions, or inquiries regarding a specific case, contact:

Maximus – South Dakota PASRR Help Desk

Email: SDPASRR@maximus.com

Phone: 833.957.2777

Fax: 877.431.9568

The Maximus – South Dakota Help Desk is available 8 am – 5 pm CT, Monday – Friday

Submit your Level I Referrals, supporting documentation, and Exempted Hospital Discharge forms directly to one centralized State email inbox:

Email: PASRR@state.sd.us

Do you have any suggestions or ideas on how we can improve your learning experience?

Complete our brief survey to share your feedback:

Enter this survey link into your browser

OR

Using your phone, scan the QR code

<https://maximus.surveymonkey.com/r/SDPASRR>



A large, stylized 'X' logo composed of four triangular segments meeting at the center. The segments are colored in a dark purple and white checkerboard pattern. The word 'maximus' is written in white lowercase letters on the left purple segment.

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