

Pre-Admission Screening and Resident Review (PASRR) Frequently Asked Questions Updated as of December 30, 2009

This PASRR FAQ document was built from questions gathered via the October/November 2009 webinars and questions received via e-mail and phone following the 12/1/09 effective date. The questions and answers are organized by topic area and reflect the policy guidance of the interagency team (the Departments of Job and Family Services (ODJFS), Mental Health (ODMH), Aging (ODA), and Developmental Disabilities (ODODD)).

Rules and forms are located at: <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/pre-admission-screening-and-resident-review/webinar-materials.shtml>. Any further questions and/or comments can be sent to BHCS@jfs.ohio.gov.

Pre-Admission Screening Identification (PAS-ID) Questions

1. Where do I send the JFS Form #03622?

Answer: For a pre-admission screen (PAS), send the form, along with supporting documentation to the PASSPORT Administrative Agency (PAA). You must receive a PAS determination approving the admission from the PAA, or if required, from ODMH or ODODD prior to admitting the individual. See OAC rule 5101:3-3-15.1(B).

2. Is there a new cover sheet for PASRR (pre-admission screening resident review) or LOC (level of care) when sending to the PAA?

Answer: Currently, there are varying cover sheets developed by the PAAs to provide submitters with an easier way to document needed information that is not found on the forms required for a PASRR or LOC request or on the forms generally used by submitters. Our intention is to develop a single cover sheet to be used by all PAAs. For now, continue to use the cover sheets as recommended by the PAAs.

3. Do we complete a PAS regardless of condition or payment source?

Answer: Yes. Every individual, regardless of condition or payment source, may only be admitted to a nursing facility (NF) after the PAS review has been completed, or the criteria for a Hospital Exemption have been met. See OAC rule 5101:3-3-15.1(B).

4. If the person has a mini mental status exam (MMSE) and the person scores as “impaired cognitively”, does this support dementia and can the MMSE be submitted as documentation?

Answer: No. Only a diagnosis of dementia confirmed by a physician is sufficient. Only check the box on the JFS Form #03622 if there is a diagnosis confirmed by a physician. Validation of a diagnosis of dementia occurs later in the pre-admission screening process. You can still submit the MMSE as part of supporting documentation to the request for pre-admission screening. See OAC rule 5101:3-3-14(B)(5) and (B)(6).

5. Please summarize the situations when a PAS versus RR is needed, who completes the forms, and who receives the submission.

Answer: The process is dependent on whether a PAS or RR is sought.

PAS: A PAS is needed prior to any new admission to the NF. Anyone can complete the PAS screen (JFS Form #03622) and submit it to the PAA for review/determination, but it is ultimately the responsibility of the NF to ensure that the determination approving the NF admission has been rendered before admitting the individual.

RR: An RR (Resident Review) is needed for current NF residents whenever the person is admitted under a time-limited approval (e.g., 30-day hospital exemption, 14-day respite, 7-day emergency) that is going to expire and the person needs to stay longer, or when there is a significant change of condition as defined in OAC rule 5101:3-3-14(B)(33). The NF is to complete the form (JFS Form #03622) for any RR and submit to ODODD and/or DDM Ascend (for ODMH) when there are indications of serious mental illness (SMI) and/or developmental disabilities (DD). When there are no indications, the NF shall place the form in the resident’s file. At no time, should an RR request be sent to the PAA.

See OAC rules 5101:3-3-15.1(B) and 5101:3-3-15.2(C).

6. How do we request a LOC now that the PASRR form (JFS #03622) is modified?

Answer: There is no change to the current LOC process.

7. If the AAA receives an incomplete PAS on a Saturday and then requests supporting documentation on Monday, the PAA cannot make the PAS effective until all documentation is received on Monday, correct? How does this affect NF payment?

How will the NF know that the PAS is “backdated” to the date a complete record was received? Will the determination specify the new date?

Answer: The supporting documentation is required to be submitted along with the JFS Form #03622. If not, then the PAA does not have the information required to make a determination, and the request is not considered complete. The submitter should always provide both the JFS Form #03622 and supporting documentation together in the same submission.

The LOC effective date cannot precede the point in time when the PASRR requirements are met. The PAA has no authority to “backdate” a PAS unless there are NO indications of SMI and/or DD. If there are no indications, the PAA may “backdate” the PAS to the date a complete and accurate record was received. See OAC rule 5101:3-3-15.1(B)(4)(a).

8. Are VA (Veteran’s Administration) NF’s subject to PAS?

Answer: The PASRR requirements only apply to Medicaid-certified nursing facilities. If you are uncertain about the status of your facility, you may research whether or not you have a Medicaid provider agreement with ODJFS, or contact the Ohio Department of Health who performs Medicaid certification for nursing facilities.

9. How does Hospice affect a PAS-ID?

Answer: Any individual seeking admission to a Medicaid-certified nursing facility, regardless of payment source, must meet the PASRR requirement prior to admission. This includes those being admitted with the intent to receive Hospice services.

10. How is “physical limiting factor” in LOC world affected by the new PASRR changes?

Answer: No impact. There have been no changes to the current LOC rules or process.

11. If a person runs out of bed-hold days, does the person need a new PAS or a new LOC?

Answer: Depends on whether the individual is using bed-hold days in the hospital or in a community setting. If in a hospital, no PAS is needed because it is a readmission to the same NF. If community; a new PAS is needed to admit to the NF. A new LOC is needed whenever bed-hold days are exhausted. Per OAC rule 5101:3-3-16.4, in the situation where a person exhausts their bed-hold days while out of the facility it is considered a “NF discharge” for purposes of Medicaid payment.

Hospital Exemption Questions

1. Can a Nurse or other Hospital staff help with the completion of the JFS Form #07000?

Answer: Yes. The physician must sign the JFS Form #07000 certifying that the person meets ALL three criteria of the hospital exemption. A nurse or other hospital staff can complete the remainder of the form for the physician.

2. When do I submit the JFS Form #07000?

Answer: It is best to submit the JFS Form #07000 when you know which nursing facility the person will be admitted to. It is ok to get the physician signature earlier, but the form should be submitted only after you know where the person is going. It is critical that ODMH and/or ODODD have the nursing facility contact information for follow-up purposes. Keep in mind that the PAA is not approving the JFS Form #07000 so there is no need to submit too early. The PAAs are collecting the forms and checking for completeness. The approval for the hospital exemption occurs when the physician certifies that hospital exemption criteria are met.

3. Are hospital exemptions only for Medicaid?

Answer: No. The PAS process, in its entirety, applies to all people seeking admission to a Medicaid certified NF regardless of payer source. *See OAC rules 5101:3-3-15.1(A) and 5101:3-3-14(B)(17).*

4. If a person is admitted to the NF from the hospital, has indications of SMI, but is private pay/Medicare, do I complete the hospital exemption form or can the person be admitted to the NF until a determination is made?

Answer: If a person is requesting admission to a Medicaid certified NF, all PAS requirements shall be met. So, PRIOR TO ADMISSION, either the hospital exemption (through completion of the JFS Form #07000) must be submitted if the three criteria outlined in 5101:3-3-14(B)(9) are met or the regular PAS (through completion of the JFS Form #03622) must be submitted. Again, the PAS requirements apply regardless of payer source. *See OAC rule 5101:3-3-15.1(B) and (G) for more information.*

5. Does the exemption apply to long term residents?

Answer: A long term resident is not considered a new admission. The exemption applies to all persons who are seeking a new admission to a NF for a stay of up to 30 days to complete treatment for the condition for which the individual was being treated in the hospital. *See OAC rule 5101:3-3-14(B)(14).*

6. If I submit the hospital exemption, when is it correct to submit the JFS Form #03622?

Answer: A hospital may submit either the JFS Form #07000 OR JFS Form #03622 (do not submit both at the same time), however the JFS Form #07000 shall only be submitted if the physician is able to certify that the individual requires treatment for up to 30 days for the condition for which the individual was being treated in the hospital. The JFS Form #03622 is only needed once it is known that the individual may require more than 30 days following admission to the NF. The NF is then required to submit the JFS Form #03622 to request a resident review. See OAC rule 5101:3-3-15.1(B) and (G).

7. Can a person enter the NF from an emergency room or observation bed?

Answer: Yes, but only through the regular PAS process (via submission of the JFS Form #03622), not through a hospital exemption. The individual must be an inpatient to utilize the hospital exemption. See OAC rule 5101:3-3-14(B)(9).

8. When does the 30 day clock begin – on the date of admission or the date the form was faxed?

Answer: The clock begins on the date of admission. See OAC rule 5101:3-3-15.1(G)(7).

9. Do I have to wait for the PAA to approve the hospital exemption before the NF can accept the admission? Will the PAA use the JFS Form #07000 when determining LOC for the hospital exemption period?

Answer: No, the PAA does not approve hospital exemptions. The NF may admit the individual if all three requirements of the hospital exemption are met. The hospital exemption is an exemption from the PAS process, not from LOC. The PAA will NOT use the JFS Form #07000 to determine LOC.

10. Does the person qualify for a hospital exemption if they are discharged from a hospital based swing bed unit (using SNF benefits)?

Answer: No, hospital exemptions are only applicable to acute inpatient care. See OAC rule 5101:3-3-14(B)(9).

11. What is an adverse PAS? If there is an adverse PAS in the last 60 days, will ODMH and/or ODODD answer our call given HIPAA? Will ODMH and/or ODODD be available on weekends to receive the calls?

Answer: An adverse PAS is a PAS with a “No-NF” determination. See Rule 5101:3-3-14 (B)(2). ODMH and ODODD will answer questions regarding adverse determinations. Both systems are available Monday through Friday.

12. Do I still need the transfer sheet for a hospital exemption now that the JFS Form #07000 exists?

Answer: No. You don’t need a transfer sheet when you do a JFS Form #07000, but you can use the transfer form as supporting documentation for the JFS Form #03622.

13. Can an out of state person enter the NF through the hospital exemption?

Answer: Only from an Ohio hospital. If from an out-of-state hospital, the individual may not use the hospital exemption.

RR-ID Questions

1. If an individual is admitted under the hospital exemption and following admission requires more than 30 days, when should I file the RR? Is the RR filed in the medical record or sent to the PAA?

Answer: For a person with indications of SMI and/or MR/DD, the PAA is not involved in the RR process.

For an individual with indications of SMI, the RR should be submitted as soon as the NF determines the individual will need to stay longer than the 30 days. This RR should be submitted to DDM Ascend. Often, when there are indications of SMI, ODMH will contact the NF administration on day 15 to inquire whether the individual has been discharged. If not, ODMH will inquire whether the individual will be discharged on or before day 30. If no, ODMH will initiate a Level II evaluation and issue a determination.

For a person with indications of DD, the RR should be submitted around the 25th day of the hospital exemption stay to the ODODD.

For a person without indications, the RR is placed in the person’s medical record.

See OAC rule 5101:3-3-15.1(G), 5123:2-14-01(J), 5122-21-03(H).

2. When is it appropriate to seek a resident review for a specified period of time? Are these sent to the PAA for approval? If I seek an unspecified period of time, can ODMH and/or ODODD approve a specified instead?

Answer: It is appropriate to see a resident review for a specified period of time any time an individual will not need the level of services provided by a NF indefinitely. The NF is advised to seek approval for a specified period if an individual needs additional rehabilitative services that would extend beyond the 30th day following admission for a hospital exemption or the individual requires additional time to pursue a safe and orderly discharge.

An approval for a specified period is a part of the resident review process, therefore at no time should a request for resident review be sent to the PAA. All resident reviews are sent directly to the ODODD and/or DDM Ascend (for ODMH).

The ODODD and ODMH retain the right to approve a specified period, even when the NF applies for an unspecified approval.

See OAC rule 5101:3-3-15.2(D)(3).

3. When do I seek an extension to a resident review approved for a specified period of time?

Answer: The NF is required to submit a request for extension to an approved specified period, no later than 30-days prior to the expiration of the approved specified period. Please note that documentation is required to support the request for an extension. *See OAC rule 5101:3-3-15.2(D)(3)(d).*

4. What is a significant change in condition? What if there is no improvement or decline?

Answer: A significant change in condition may be defined as an improvement in the resident's medical condition or behavior. A decline in the resident's medical condition or behavior is also considered a significant change in condition. Admission to a psychiatric unit is also viewed as a significant change in condition. If there is no improvement or decline, then there is no significant change in condition. *See OAC rule 5101:3-3-14(B)(33).*

5. If a person has an approved respite stay, can the individual use the respite stay as often as s/he likes any time during the 60 day approval?

Answer: An approval for respite stay is a presumptive determination that the individual requires the level of services provided in a NF, and does not require specialized services. Should the individual require multiple admissions for respite, then an approval is required for each admission. It is possible to request more than one respite stay at a time when submitting the original request. Specific dates must be identified and those dates are considered individual in the determination made by ODODD and/or ODMH. See OAC rules 5101:3-3-14(B)(3), 5123:2-14-01(F), and 5122-21-03(F)(2)(b).

6. Are previous RR's going to be grandfathered in or do we need to resubmit RR's on all residents beginning 12/1/09?

Answer: Anyone in need of a resident review will initiate a resident review in accordance with the revised rules effective 12/1/09. There is no need to resubmit resident reviews already approved under previous 12/1/09 rules.

7. What happens if a person enters a psychiatric hospital from the NF? Is a new JFS Form #03622 needed?

Answer: When a NF resident is admitted to a psychiatric unit, this is a significant change in the individual's condition (See OAC rule 5101:3-3-14(B)(33)), which warrants a new JFS Form #03622 if the individual wishes to return to the NF. The exceptions to this are:

- Should the resident be under a hospital exemption during admission to the psychiatric unit, then the resident may return to the NF within the 30-days allotted by the exemption. See OAC rule 5101:3-3-15.1(G)(7).
- Should the resident be classified the status of a long-term resident, requiring specialized services, then the resident may return to the NF upon discharge from the psychiatric unit. See OAC rule 5101:3-3-14(B)(14) and 5122-21-03(F)(4).

MH and/or DD Level II process questions

1. What documents should I submit for a PASRR (e.g. MDS, H&P)?

Answer: The NF is advised to submit any documentation that will validate an individual's condition, as indicated on the JFS form #03622. This could include the most recent MDS, H&P, physician's orders, functional assessments, therapy evaluations and progress notes, discharge potential, list of medications and any other documentation necessary to support the request for nursing facility services. See OAC rules 5123:2-14-01(E) and 5122-21-03(C).

2. Please explain specialized services for SMI. If an individual leaves the NF to receive the specialized services, can the person return to the NF? If so, who completes the RR?

Answer: Specialized Services for SMI are those services which are provided in a psychiatric unit licensed or operated by ODMH. When a resident leaves a NF to receive specialized services for SMI, this is considered a significant change. Therefore, it is the responsibility of the NF to initiate the resident review. If the resident is discharged from the psychiatric unit prior to the ODMH (known as Level II) evaluation, the resident may return to the NF to await the assessment and determination. Please note that in the case of a long-term resident, ODMH will initiate the subsequent resident review following specialized services for SMI. See OAC rule 5101:3-3-14(B)(34) and 5122-21-03(F)(3).

3. If a resident is moving from one NF to another and PASRR records cannot be located, can the receiving NF call the ODMH and/or ODODD to obtain the records? Can the receiving NF still accept the transfer even though the PAS determination due to no records is still under review?

Answer: In the case of a resident being transferred between Medicaid-certified NFs, either of the NFs may contact the ODODD and/or ODMH as applicable to verify the existence of a PASRR approval. If there is a PASRR approval on record, ODODD and/or ODMH may provide a copy. However, if there is no record or there is an adverse determination on file, then the receiving NF may not accept the transfer until PASRR requirements are met. See OAC rule 5101:3-3-15.1(B)(7) and 5101:3-3-15.2(B)(2), (C)(1)(b), (C)(5), and (C)(7)(c).

4. What happens if a person is dual MH/DD and only one agency "rules the person out" for further review? Is a "rule out" indefinite?

Answer: The ODODD and ODMH collaborate on cases in which there are dual diagnoses of SMI and DD. As such, either state agency may issue a "rule-out". However, the other state agency would still need to review and issue a determination even though one agency may "rule-out for further review". A "rule-out" is not indefinite. See OAC rule 5101:3-3-14(B)(31).

5. What is considered an emergency PAS? Does an emergency room or adult protective service referral count as an emergency?

Answer: An emergency PAS means that the individual is being admitted pending further assessment for a period not to exceed 7 days *when the placement is necessary to avoid serious risk to the individual of immediate harm or death.*

Each request for an emergency PAS is reviewed individually per the definition outlined in OAC rule. See OAC rule 5101:3-3-14(B)(7).

6. How do we determine if a person has received SSI or SSDI due to mental impairment in the last two years?

Answer: The only authority that can definitively confirm SSI or SSDI due to mental impairment is the Social Security Administration.

7. Where do I find the list of DD diagnoses?

Answer: Reference OAC rule 5123:2-14-01 (C) (8). A list of diagnoses does not adequately determine whether or not a person has a developmental disability. Additional criteria have to be met as written in rule.

8. Do specialized services for DD include attendance at a DD rehab or work center?

Answer: It may if it is determined necessary by the individual, their team and is written into their Individual Service Plan.

9. Please explain dementia and persons with DD.

Answer: A person with DD who has dementia and is seeking NF placement should go through the regular PAS process for evaluation and a determination.

10. If a person has a primary diagnosis of dementia and an MR diagnosis, is the information forwarded to the local county board or to ODODD?

Answer: It is processed as a regular PAS and therefore forwarded to the local county board. See OAC rule 5123:2-14-01(D).

JFS Form #03622 and #07000 Questions

1. What is the effective date of the forms?

Answer: The effective date of the forms is 12/1/09, however we are allowing a "grace period" of 60 days. The 60 days is a grace period to allow time for training and technical assistance. Please submit feedback on the forms to BHCS@jfs.ohio.gov by January 31, 2010. We plan to revise the forms based on feedback received and will alert you when the forms are reloaded to JFS forms central at <http://www.odjfs.state.oh.us/forms/inter.asp>.

2. How do we fill out section B of the JFS #03622 form? When do I check 1 and 2 versus the RR codes 3 through 7?

Answer: **If you are seeking a pre-admission screen**, you check either 1 or 2 depending on whether the pre-admission screen request is a request from an Ohio resident or an out of state resident.

If you are seeking a resident review, you check codes 3 through 7 depending on whether you are seeking a resident review because the hospital exemption (code 3) is about to expire, the emergency admission (code 4) is about to expire, the respite admission (code 5) is about to expire, the person is transferring and has no PASRR records on file (code 6) or there is a significant change in condition warranting a resident review (code 7).

Codes 3, 4, 5 and 7 have sub-codes. The new OAC rules allow for resident reviews to be “time-limited” if more time is needed for rehabilitation and/or discharge planning. So, the use of codes 3, 4, 5 and 7 require a check beside the sub-codes a, b, or c. Sub-code “a” should be checked if the person is seeking a resident review for an unspecified period of time. Sub-code “b” should be checked if the person is seeking a resident review for a certain period of time (e.g. for another 90 days for rehabilitation purposes). If sub-code “b” is checked, section G must also be completed. Sub-code “c” is checked when a person already received a “time-limited” resident review approval and needs more time. This is called an extension of the resident review. If sub-code “c” is checked, section G is also completed.

3. When do we complete Section F of the JFS Form #03622? What if there is a significant change but the person does not have indications, do we still fill out section F and file or send to the PAA?

Answer: The purpose of section F is to gather information on the barriers to community placement AND assist with linkage to services and supports to help with potential discharge. The section should be answered for all applicants and residents regardless of payer source.

4. Do I insert the managed care plan regardless of payer or only Medicaid managed care plans on JFS Form #03622 Section A?

Answer: Please insert the Medicaid managed care plan in Section A. The information is used to link/coordinate with Medicaid managed care plans.

5. Can a nurse sign the JFS Form #07000 for the physician via telephone order?

Answer: No. 42. U.S.C 1396(r) indicates that the “physician has certified, before admission to the facility, the individual is likely to require less than 30 days of nursing facility services”.

6. Do I need to complete Section H if there are no indications of SMI or DD?

Answer: Section H #1 and #3 should be completed for all persons regardless of indications of SMI and/or DD. We will modify the form following receipt of all feedback (see question 1 under “JFS Form #03622 and #07000 questions”) to add further clarity regarding when Section H should be completed.

7. When do I complete section G of the JFS Form #03622?

Answer: You complete section G if you are seeking a resident review for a specified period of time. For example, if a person needs only a little more time to meet rehabilitation goals or a person needs a little more time to locate housing or establish community supports upon discharge, it is appropriate to complete section G. If there is no need for a resident review for a specified period of time, then skip section G. We will modify the form following receipt of all feedback (see question 1 under “JFS Form #03622 and #07000 questions”) to add further clarity regarding this section.

8. In section C of JFS Form #03622, what is meant by “Diagnosis at admission” versus “Resident review diagnosis”? Do I only list those diagnoses related to MH and DD and only those that changed or all?

Answer: The bottom portion of Section C is only applicable to resident reviews. The section is asking whether the diagnosis at the time of the resident review *is different* than the diagnosis at the time of admission. If different, specify *all* diagnoses that are different when compared to the diagnoses at admission to the NF. For example, an individual is admitted to a NF with a diagnosis of dementia. The NF requests a resident review due to change in condition with a new diagnosis of depression. Because dementia is no longer listed as a diagnosis, the submitter would check “yes” that the diagnosis changed and then write “dementia” in the open spot. The submitter will need to review the records to locate the original diagnosis leading to NF admission.

9. How do I request a categorical PAS? What box do I complete on the JFS Form #03622?

Answer: The submitter should check 1 as the PAA will indicate on their documentation that this is a categorical request. A categorical request is an “expedited” PAS. See OAC rule 5101:3-3-14(B)(3).

10. What is meant by “service and support alternatives” in section F of the JFS Form #03622?

Answer: The form is asking whether alternatives to nursing facility placement were shared with the individual (e.g. home health, home and community based waiver services, other non-Medicaid supports).

11. How should hospitals answer the question regarding “living arrangement at the time of request for PASRR” in Section A of the JFS Form #03622?

Answer: We will clarify this section of the form when we make amendments in early 2010 (see question 1 under “JFS Form #03622 and #07000 questions”). The current JFS Form #03622 specifies living arrangement “at the time of request for PASRR” so please respond to the living arrangement at the time of the request even if the living arrangement is the psychiatric hospital.
