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Preadmission Screening & Resident Review (PASRR)

Webinar for Providers – A Regulatory Perspective

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Objectives

1. By the end of this overview, you will be able to:
2. Identify nursing facility (NF) responsibilities for residents who are PASRR eligible as determined by a PASRR Evaluation (PE).
3. Sequence the responsibilities of all parties involved in the PASRR process.
4. Reference the relevant Texas Administrative Code (TAC), Title 40, Part 1, Chapter 19, Subchapter BB section to identify state PASRR requirements.
5. Reference the relevant Code of Federal Regulations (CFR) section and State Operations Manual (SOM Appendix PP tags (F-tags) to identify federal PASRR requirements.
6. Identify CMS Form 20090 Preadmission Screening and Resident Review Critical Element Pathway
7. Describe PASRR specialized services and the benefits of these services.

[Required] Throughout this webinar note the blue clipboard icon. Items marked with this icon are the required NF responsibilities related to PASRR and also listed on the Surveyor Notes Worksheet.

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PASRR Basics

1. Let's review some basic facts about PASRR:
2. PASRR stands for Preadmission Screening and Resident Review.
3. Medicaid-certified nursing facilities are required to comply with PASRR. PASRR is a federally mandated review process, requiring all people seeking Medicaid-certified nursing facilities admissions are screened for mental illness (MI), intellectual disability (ID), developmental disability (DD) individuals who have a mental illness (MI), an intellectual disability (ID) or a developmental disability (DD) (also known as related conditions) regardless of funding source or age.
4. Many people with MI, ID or DD can safely live in a community setting while receiving the support services they need. PASRR is a process that helps ensure people who need these supports are only placed in a nursing facility when appropriate.
5. PASRR helps to ensure individuals receive the specialized services they require for their MI, ID or DD to be properly supported in a NF.
6. Note: A list of approved related conditions (developmental disabilities) can be found here:
7. Approved Diagnostic Codes for Persons with Related Conditions List

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What is a Referring Entity?

1. A referring entity (RE) is an entity that refers a person to a Medicaid-certified NF such as:
2. Hospitals
3. Family Members/Legally Authorized Representatives (LAR)
4. Nursing Facilities
5. Hospice
6. Physicians
7. Assisted Living Communities
8. Group Homes
9. Adult Protective Services
10. Law Enforcement

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RE Responsibility in the PASRR Process

1. The RE is responsible for completing the PASRR Level 1 Screening (PL1) form for any person seeking admission to a Medicaid-certified Nursing Facility.

2. Per state rules, the PL1 form must not only be completed prior to admission, but NFs cannot admit a person without receiving a completed PL1.

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What is the PL1?

- The PASRR process requires an initial screening (PL1) for persons seeking admission to a NF.
- The PL1 is completed by the RE to identify whether a person is suspected of having MI, ID or DD/RC.
- If the PL1 identifies a person suspected of having MI, ID, or DD/RC, then a PASRR evaluation (PE) is completed to confirm or deny this suspicion.

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What is the PL1 (Cont.)

- [Required] If the admission type is Preadmission, the NF may provide assistance in completing the PL1, if the RE is a family member, other personal representative selected by the individual (or a representative from an emergency placement source).

If an individual goes to an acute care hospital for less than 30 days and is readmitted to the same NF, then a new PL1 is not required.

40 TAC §19.2704(a) 40 TAC §19.2704(b)

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Admission Processes

There are 4 types of admission processes:

1. Negative
2. Exempted
3. Expedited
4. Preadmission

Note: The type of admission process used by the RE depends on where the person is residing at the time of the referral

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Negative Admission

All REs may use the negative admission process, if applicable:

- Negative PASRR Eligibility – if the PL1 screening is negative (all fields in Section C are all "No" as there is no suspicion of MI, ID or DD/RC), then the RE sends the PL1 to the admitting NF with the person.

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Exempted Hospital Discharge

Acute Care Hospitals only:

- This type of admission occurs when a physician has certified that a person, who is being discharged from an acute care hospital, is likely to require less than 30 days of NF services.
- The physician's certification is not on the PL1 but recorded in the medical records that accompany the person to the NF.

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Expedited Admission

Acute Care Hospitals and Nursing Facilities only:

This type of admission occurs when a person meets the criteria for one of the following categories:

- Convalescent Care
- Terminally Ill
- Severe Physical Illness
- Delirium
- Emergency Protective Services
- Respite
- Coma

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Preadmission (1 of 3)

- Any admission from the community that is not expedited or exempted (i.e.: coming from a psychiatric hospital, home, hospice, group home, assisted living, jail, etc.)

- Not for persons coming from Acute Care Hospitals or Nursing Facilities

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Preadmission (2 of 3)

If the PL1 screening is positive:

- The RE faxes PL1 to local authority (LA). This starts the 72-hour timer for the LA to meet face to face with the individual.
- The local authority (LA) submits the PL1 into the Long-Term Care (LTC) Online Portal.

Note: LA includes the local intellectual and developmental disability authority (LIDDA), local mental health authority (LMHA) and local behavioral health authority (LBHA).

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Preadmission (3 of 3)

- The LA completes and submits the PE into the LTC portal within 7 days.

- The NF reviews PE and certifies on the PL1 if they are “Able” or “Unable” to serve individual and Medical Necessity must be met before the individual is admitted.

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Long Term Care Online Portal (LTCOP)

NFs and the LA communicate through the LTCOP.

The PL1 must be entered into the LTCOP as follows:

- Negative PL1 – the NF enters the PL1 into the LTCOP and the PASRR process ends.
- Positive PL1 – the NF or LA (in the case of a preadmission) enters the PL1 into the LTCOP and the LA will receive an alert to complete a PASRR Evaluation (PE)

40 TAC §19.2704(c),(g),(h),(i)

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LTCOP (cont.)

NFs must use the portal to:

- check daily for PASRR communications;
- download a copy of the PE and review all the recommended specialized services;
- certify that a resident's needs can be met in their facility;
- document the interdisciplinary team (IDT) meeting;
- request NF specialized services and durable medical equipment; and
- annually document all specialized services being provided to the resident.

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PASRR Evaluation (1 of 2)

When the NF enters the positive PL1 into the LTCOP, it generates an alert to either the LIDDA or the LMHA/LBHA to conduct a PE. The LIDDA and LMHA/LBHA have 72 hours from the time they receive the alert to conduct a face-to-face interview with the individual, and 7 calendar days from the alert to enter the completed PE into the LTCOP.

A PE is a face-to-face evaluation of an individual suspected of having MI, ID, or DD performed by a LIDDA or an LMHA/LBHA to determine if the individual has ID, DD, MI or ID/DD and MI if the person is suspected of having a dual diagnosis and if so:

- assess the individual's need for care in a nursing facility;
- assess the individual's need for nursing facility specialized services, LIDDA specialized services and LMHA/LBHA specialized services; and
- identify alternate placement options.

The NF is required to provide staff from the LIDDA or LMHA/LBHA access to the individual suspected of having ID, DD, or MI, and to the individual’s facility records upon request.

40 TAC §19.2704(i)

PASRR Evaluation (2 of 2)

The LIDDA or LMHA/LBHA PE evaluator ensures the PE identifies which specialized services to recommend for the purpose of improving or maintaining the person's level of functioning. These are services not normally provided by NFs and are reimbursed separately from the Medicaid daily rate for the individual's case.

We will discuss specialized services in greater detail in a moment.

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Resident Review

A Resident Review is a face-to-face evaluation of a resident performed by a LIDDA or LMHA/LBHA:

1. for a resident with MI, ID, DD who experienced a significant change in status, to:
   a) assess the resident's need for continued care in a nursing facility;
   b) assess the resident's need for nursing facility specialized services, LIDDA specialized services and LMHA/LBHA specialized services; and
   c) identify alternate placement options; and
2. for a resident suspected of having MI, ID, or DD, to determine whether the resident has MI, ID, or DD and, if so:
   a) assess the resident's need for continued care in a nursing facility;
   b) assess the resident's need for nursing facility specialized services, LIDDA specialized services, and LMHA/LBHA specialized services; and
   c) identify alternate placement options.

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NF Actions After the PE (1 of 2)

[Required] Within seven calendar days after the LIDDA or LMHA/LBHA has entered a positive PE into the LTCOP, an NF must:

a) review the recommended list of NF, LIDDA, and LMHA/LBHA specialized services; and

b) certify in the LTC portal whether the individual's needs can be met in the NF.

40 TAC §19.2704(h)

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NF Actions After the PE (2 of 2)

Some NFs may not be able to provide or support the recommended specialized services for a particular individual. If a NF cannot provide or support the recommended specialized services, the NF cannot admit the individual (Preadmission) or will need to assist in finding alternate placement if the individual is admitted and already in the facility through the exempted hospital discharge or expeditated admission types.

If the NF decides that it can provide and support the recommended specialized services, there are additional steps to take. Let's review the next steps for the NF.

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IDT Meeting: NF Schedules

[Required] Parameters for scheduling the IDT meeting are as follows:

a) the NF must contact the LA to schedule an IDT meeting within two calendar days after admission or for a resident review, two calendar days after the LTCOP sent an alert to the LA to complete a PE

b) the NF must convene the IDT meeting within 14 calendar days after admission or, for a resident review, 14 calendar days after the LTCOP sent an alert to the LA to complete a PE.

40 TAC §19.2704(i)

IDT Meeting: NF Facilitates (1 of 2)

The NF must facilitate the IDT meeting. The IDT meeting is distinct from other NF care planning meetings and must include specific participants.

The IDT meeting must include:

a. the PASRR resident;
b. resident representative or legally authorized representative (if any);
c. a registered nurse from the NF with responsibility for the resident;
d. a representative of a LIDDA or LMHA/LBHA; and
e. other persons as needed.

Note: A resident has the right to refuse attending the IDT meeting, or (if due to illness) it may not be appropriate for the resident to attend. When there is a concern about a LIDDA/LMHA/LBHA not attending an IDT meeting, after reviewing documented invitation attempts, the surveyor can send this information to the Contract Accountability and Oversight (CAO) Unit at Complaints@hhsc.state.tx.us.

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IDT Meeting: NF Facilitates (2 of 2)

Participants in the IDT meeting:

1. review the specialized service recommendations of the PE;
2. identify the specialized services the individual wants to receive;
3. determine whether the resident is best served in the NF or a community setting.

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After the IDT Meeting: NF Responsibilities (1 of 2)

- [Required] Once the IDT identifies the specialized services the individual wants to receive, the NF must document the IDT meeting and all identified specialized services in the LTCOP within three business days after the IDT meeting (and annually thereafter).

The IDT meeting and outcomes, including agreed upon specialized services, are documented in the LTCOP on the PASRR Comprehensive Service Plan (PCSP). An example PCSP can be found here.

Surveyors will ask providers to show them that they have met this requirement by having the facility show the LTCOP screens or print outs from the LTCOP with the appropriate dates.

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After the IDT Meeting: NF Responsibilities (2 of 2)

[Required] IDT documentation must include:

- the date of the IDT meeting;
- the names of the participants in the meeting;
- the NF, LMHA/LBHA, or LIDDA specialized services agreed to in the meeting; and
- the determination of whether the resident is best served in a facility or a community setting;

Although the IDT meeting is distinct from other care planning meetings, its decisions are also **recorded in the resident's comprehensive care plan**. The identified specialized services and the NF's responsibilities related to the provision of each specialized service are also documented in the comprehensive care plan.

40 TAC §19.2704(i)

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Specialized Services

Centers for Medicare & Medicaid Services (CMS) defines "specialized services" as those services the state is required to provide, or arrange, that raise the intensity of services to the level needed by the resident.

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

a. NF specialized services are for individuals with ID, DD.
b. LIDDA specialized services are for individuals with ID, DD.
c. LMHA specialized services are for individuals with MI.

Note: If a resident refuses specialized services, the refusal is documented in the LTCOP on the PASRR Comprehensive Service Plan form.

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NF Specialized Services

NF specialized services are:

1. habilitative physical therapy (PT);
2. habilitative occupational therapy (OT);
3. habilitative speech therapy (ST);
4. customized manual wheelchair; and
5. durable or adaptive medical equipment:
    a. gait trainer;
    b. standing board;
    c. special needs car seat or travel restraint;
    d. specialized or treated pressure reducing support mattress;
    e. prosthetic device;
    f. orthotic device; or
    g. positioning wedge.

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Habilitative Therapy & Rehab: What's the Difference?

Specialized services are "add-ons" to the traditional NF rehab services. For individuals with ID, DD this means habilitative therapies, rather than rehabilitative therapies

Habilitative therapies (OT, PT and ST specialized services under PASRR) help a person keep, learn or improve function and skills for daily living. Habilitative therapies are typically provided over a longer period of time compared to rehabilitation therapy. They are provided to help the person attain functional skills never learned as well as to maintain or prevent deterioration of existing skills.

Habilitative PT, OT, and ST must be provided by professionals licensed by the state of Texas. A speech language pathologist must provide ST, a physical therapist or physical therapist assistant must provide PT, and an occupational therapist or occupational therapy assistant must provide OT.

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Habilitative Therapy & Rehab: General Definitions

Habilitation	Rehabilitation
Health care services that help a person keep, learn or improve function and skills for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitation services are typically long-term. Habilitation services are health care services that help an individual: • Acquire skills; • Keep skills; • Learn new skills; • Improve current skills; and • Utilize skills and functioning for communication and daily living.	Therapy that is provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition. Rehabilitation is geared toward helping a person keep, reacquire or improve skills and functioning for daily living and must be provided with the expectation that the resident's functioning will improve measurably in 30 days. Rehabilitation is typically short-term.

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How Regulatory Checks NF is Providing Specialized Habilitative Therapies vs. Regular Therapies

A surveyor will have to look at the current PCSP in the LTC online portal, or have the facility print out that document, and at the comprehensive service plan. An example PCSP can be found Here.

The PCSP documents the outcomes of the IDT and the service planning team (SPT) (a LIDDA lead meeting). The specialized services are listed in this document.

NF specialized services, such a habilitative OT, PT, or ST or durable medical equipment, must be initiated by completing the Nursing Facility Specialized Services (NFSS) form in the LTCOP. Examples of the NFSS form can be found Here.

Before providing a PASRR nursing facility specialized service, a nursing facility must request and receive authorization from HHSC through the LTCOP to deliver the service.

In summary, if a surveyor sees NF specialized services listed in the PCSP, then there must be accompanying completed NFSS forms entered within 20 business days of the IDT or SPT into the LTCOP. A NF must start providing a specialized habilitative therapy (OT, PT, or ST) service within three business days after receiving approval from HHSC in the LTCOP. NFs must order a DME item or CMWC within five business days after receiving notification of the approval through the LTCOP in accordance with §19.2754(e)

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LIDDA Specialized Services

LIDDA specialized services include:

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

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LMHA/LBHA Specialized Services

LMHA/LBHA specialized services for individuals with MI include but not limited to:

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

See PCSP Form for a detailed list.

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Dual Eligibility: Residents with ID or DD and MI

Some residents have dual eligibility because they have ID, DD or RC and MI. These residents may receive all three types of specialized services. NFs are responsible for coordinating with the LIDDA or LMHA/LBHA to facilitate the successful provision of LIDDA specialized services or LMHA/LBHA specialized services.

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MI Diagnosis

Which MI diagnoses make a resident eligible to receive PASRR specialized services? Is there a list of the MI diagnoses?

The Code of Federal Regulation (CFR) defines MI in accordance to 42 CFR 483.102(b).

A mental illness is defined as the following: a schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental illness that may lead to a chronic disability (Depression, unless listed as major depression, is not defined as a mental illness).

Please note that an individual can have a MI diagnosis and not be PASRR eligible. The PE ultimately determines if an individual is PASRR eligible. The specific kinds of MI and levels of impairment needed are reviewed in the next slides.

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Examples of MI

Examples of MI diagnoses are:

- Schizophrenia
- Mood Disorder (Bipolar Disorder, Major Depressive Disorder or other mood disorder)
- Paranoid Disorder
- Severe Anxiety Disorder
- Schizoaffective Disorder
- Post Traumatic Stress Syndrome

Please note that an individual can have a MI diagnosis and not be PASRR positive for MI.

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What is Not an MI

What is not considered an MI:

- Neurocognitive Disorders, such as Alzheimer's disease, other types of dementia, Parkinson's disease, and Huntington's, are not indicative of a mental illness. (DSM-5)
- Depression, unless diagnosed as Major Depression, is not defined as an MI.
- Anxiety, unless diagnosed as severe anxiety disorder, is not defined as an MI.

Note: DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

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Dementia and PASRR

Dementia - Dementia including Alzheimer's disease or a related disorder, is a neurologically driven disease that through evaluation is not indicative of a mental illness. It is a medical condition. Psychosis related to dementia is also not considered a mental illness.

Psychological changes which can co-occur with dementia and may be confused with mental illness:

- Personality Changes
- Depression
- Anxiety
- Inappropriate Behavior
- Paranoia
- Agitation
- Hallucinations

Note: Unless an individual has a MI before a diagnosis of Dementia, these changes are caused by their Dementia

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MI, Dementia, and Form 1012 (1 of 2)

The guidance in Title 42 Code of Federal Regulations (CFR) §483.20(e) Coordination (Federal tag F644) indicates that any resident with newly evident or possible serious mental disorder, ID or a related condition must be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for review.

Form 1012 – Mental Illness/Dementia Resident Review is used to determine if a resident with a current negative PL1 needs further evaluation for MI.

Form 1012 is used to determine whether the individual has a primary dementia diagnosis or if the individual has a (MI) diagnosis

This form also serves as the NFs documentation for the individual's medical record as to why further evaluation was or was not completed.

Completion of Form 1012 may be part of an overall screening program upon discovery of newly evident issues that require a determination by the facility of whether to make such a referral (entering a new PL1 in the LTCOP).

The form may also be used as part of a plan of correction.

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MI, Dementia, and Form 1012 (2 of 2)

Form 1012 is not used when:

- A person has a positive PL1 and a negative PE;
- A person has a positive PE for MI but now has a primary diagnosis of dementia; or
- A person with a negative PL1 but is suspected of having an ID/DD/RC.

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Service Planning Team (1 of 3)

For ongoing review of specialized services, the LIDDA appoints a habilitation coordinator to monitor the resident's care and to facilitate service planning team (SPT) meetings. The SPT activities described in the next few pages are specifically for residents with ID, DD or RC. These planning activities are in addition to the service planning activities a NF provides for all residents.

*Per rule, the IDT differs from the SPT in that the IDT's focus is to discuss and agree to services, including specialized services, the PASRR individual needs and to discuss where the individual can best receive the services they need.

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Service Planning Team (2 of 3)

For a resident with ID or DD the assigned LIDDA habilitation coordinator convenes and facilitates a SPT meeting 90 days after the IDT to develop a habilitation service plan (HSP) for the resident.

The SPT members are:

1. the designated resident;
2. the designated resident's LAR, if any;
3. the service coordinator;
4. nursing facility staff familiar with the designated resident's needs;
5. persons providing nursing facility specialized services and LIDDA specialized services for the designated resident;
6. a representative from a community provider, if one has been selected; and
7. a representative from the LMHA/LBHA, if the designated resident has MI.
8. Other participants on the SPT may include:
9. a concerned person whose inclusion is requested by the designated resident or the LAR; and
10. at the discretion of the LIDDA, a person who is directly involved in the delivery of services to people with ID or DD.

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Service Planning Team (3 of 3)

Following the initial SPT meeting, the SPT meets:

1. on a quarterly basis;
2. if requested by the resident or resident representative (if applicable); and
3. when there is a change in resident's service needs.

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The NF and the SPT (1 of 2)

[Required] The NF must designate staff or necessary contractors, or both, to be members of the SPT for a designated resident.

Staff and providers/contractors of NF specialized services who are members of the SPT must:

1. attend and participate in the resident's SPT meetings;
2. contribute to the development of the resident's ISP, including identifying NF PASRR support activities (covered in next slide) to facilitate the successful provision of LIDDA specialized services (and facilitate the successful provision of LMHA/LBHA specialized services if the resident has MI in addition to ID, DD or RC); and
3. assist the SPT in its responsibilities and required activities.

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NF PASRR Support Activities

[Required] NF PASRR support activities include but not limited to:

- arranging transportation for a designated resident to participate in a LIDDA specialized service or a LMHA specialized service outside the nursing facility;
- sending a resident to a scheduled LIDDA specialized service or a LMHA specialized service with food and medications required by the resident; and
- including in the comprehensive care plan an agreement to avoid, when possible, scheduling nursing facility services at times that conflict with LIDDA specialized services or LMHA specialized services.

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The NF and the SPT (2 of 2)

[Required] A NF must ensure its staff and contractors who are members of a designated resident's SPT assist the SPT by:

1. monitoring all NF, LIDDA, and LMHA specialized services to ensure the resident’s needs are being met;
2. making timely referrals, service changes, and amendments to the ISP as needed;
3. coordinating NF specialized services, NF support activities, and LIDDA/LIDDA/LBHA specialized services with the comprehensive care plan (NF scheduling should not conflict with the scheduled specialized services) and the ISP;
4. developing a transition plan (for a resident who has expressed interest in community living); and
5. reviewing and discussing the information included in the ISP (and transition plan) with key nursing staff who work with the resident.

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Authorization for NF Specialized Services

[Required] Once the designated resident's IDT or SPT agrees to services, a NF is responsible for requesting authorization from HHSC to provide the NF specialized services. The NF utilizes the LTCOP to request and receive authorization from HHSC.

The NF must submit a complete and accurate request for NF specialized services in the LTCOP within 20 business days after the date of the IDT meeting. The NF must start providing any identified therapy service within three business days after receiving approval from HHSC. NFs must order a DME item or CMWC within five business days after receiving notification of the approval through the LTCOP in accordance with § 19.2754(e)

Note: Surveyors can request a NF to provide the PASRR Transaction Identifier (PTID) notes to verify if a NF has submitted a request to HHSC for specialized services on the NFSS request forms.

40 TAC §19.2704(i)

Providing Habilatative Therapy

[Required] Before providing a therapy service (OT, PT or ST), the NF must ensure:

a. the therapy service was required by the designated resident's comprehensive care plan;

b. the designated resident had a diagnosis relevant to the need for the therapy service;

c. the therapy service was ordered by the designated resident's attending physician; and

d. a qualified therapy provider completed an assessment within 30 days before the NF requested an authorization to provide the therapy service.

[Required] An occupational therapist or physical therapist may assess a designated resident at any time to evaluate the needs of the designated resident for a therapy service, but HHSC does not pay for an assessment of a designated resident conducted within 180 days after the previous assessment of the designated resident.

[Required] The NF must submit a complete and accurate claim for a therapy service within 12 months after the last day of an authorization from HHSC to provide the therapy service.

40 TAC §19.2751(a)
40 TAC §19.2753(d),(e)

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Requesting Authorization for DME (1 of 2)

[Required] When requesting authorization to provide durable medical equipment (DME), the NF must ensure a PT or OT licensed in Texas assessed the resident for DME or a customized manual wheelchair (CMWC), and that the assessment was completed within 30 days before the requested authorization.

The assessment must include:

1. a diagnosis of the designated resident relevant to the need for DME or a CMWC;
2. the specific DME or CMWC, including any adaptations recommended for the designated resident; and
3. a description of how the DME or CMWC meets the specific needs of the designated resident.

40 TAC §19.2754(a),(c)

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Requesting Authorization for DME (2 of 2)

- [Required] The request to provide DME or a CMWC must include:
  a. the assessment of the designated resident;
  b. a statement signed by the designated resident's attending physician that the DME or CMWC was medically necessary; and
  c. detailed specifications of the DME or CMWC from a DME supplier.

- [Required] The NF must order the DME or CMWC from a DME supplier within five business days after receiving notification of the approval through the LTCOP.

40 TAC §19.2754(b),(e)

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Payment Claims (1 of 2)

- [Required] Before the NF can submit a claim for payment for DME or a CMWC, the OT or PT must verify that the DME or CMWC meets the original specifications and the needs of the resident; and the NF must document this verification in the LTC Portal.

- [Required] An occupational therapist or physical therapist may assess a designated resident at any time to evaluate the needs of the designated resident for DME or a CMWC, but HHSC does not pay for an assessment of a designated resident conducted within 180 days after the previous assessment of the designated resident.

40 TAC §19.2755(b),(d)

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Payment Claims (2 of 2)

[Required] The NF must submit a complete and accurate claim for DME or a CMWC within 12 months after the day the DME or CMWC was purchased.

Note: The NF should fully explore and use other sources of payment for DME or a CMWC before requesting payment from HHSC. If the NF did not obtain authorization or did not submit necessary documentation before purchasing DME or a CMWC, the NF should not charge a designated resident or the resident's family for DME or a CMWC.

40 TAC §19.2755(a),(c)

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DME and CMWC: Personal Property

- [Required] The NF must identify the DME or CMWC as the personal property of the designated resident and ensure that only the designated resident uses the equipment.
- [Required] Upon discharge from the NF, the NF must ensure that the resident retains the DME or CMWC. If the resident (or a representative of the designated resident's estate) donates or sells the DME or a CMWC to the NF, **determine whether the NF documented the donation or sale** (the transaction must be documented in accordance with 40 TAC §19.416 relating to personal property).
- [Required] The NF must maintain and repair all medically necessary DME or a CMWC, beginning six months after delivery to the resident.
- [Required] Determine whether the NF submitted a request to replace a CMWC within 5 years of the current CMWC purchase that included an order from the resident's physician and an assessment by a PT or OT with documentation explaining why the current CMWC no longer meets the designated resident's needs.

40 TAC §19.2756(a),(b),(d),(e),(f)

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PASRR Regulations

NFs that are state licensed and Medicaid-certified must comply with both state and federal PASRR requirements.

The key PASRR requirements from the federal government and Texas Health and Human Services Commission (HHSC) are found in the following rules and regulations:

1. Code of Federal Regulations (CFR), Title 42, Part 483,and Subpart C;
2. State Operations Manual, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities*

Nursing Facility Responsibilities Related to PASRR: TAC, Title 40, Part 1, Chapter 19, Subchapter BB. Note: There are 83 state PASRR related tags. Each state rule section is considered a tag.

Local Intellectual Developmental Disability Authority (LIDDA) and Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) Responsibilities Related to PASRR: TAC, Title 26, Part 1, Chapter 303. Note: Surveyors do not enforce these rules.

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Federal PASRR Tags

NFs that are state licensed and Medicaid-certified must comply with both state and federal PASRR requirements.

The table below lists the old and new F-tag numbers and the relevant CFR reference. Note: The Critical Elements Decisions in CMS Form 20090 *PASRR Critical Element Pathway* will guide surveyors through the key federal tags in a YES or NO decision making process.

Old Ftag#	New Ftag#	Code of Federal Regulation (CFR)	Name of Tag
------	F655	483.21(a)(1)-(3)	Baseline Care Plan
F279	F656	483.21(b)(1)	Develop/Implement Comprehensive Care Plan
F285	F644	483.20(e)(1)(2)	Coordination of PASAEE and Assessments
F285	F645	483.20(k)(1)-(3)	PASARR Screening for MD & ID
F285	F646	483.20(k)(4)	MD/ID Significant change notification
F406	F825	483.65(a)(1)-(2)	Provide/Obtain Specialized Rehab Services
F407	F826	483.65(b)	Rehab Services-Physician Order/Qualified Person
F514	F842	483.70(i)	Medical Records

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Surveyor Responsibilities

1. Surveyors check compliance with state and federal requirements during the standard survey process, PASRR focused survey and during any PASRR complaint investigation. State requirements are found 40 TAC Chapter 19 Subchapter BB

2. In addition, surveyors review the Critical Elements Decisions in CMS Form 20090 PASRR Critical Element Pathway to guide them through the key federal tags in a YES or NO (met or not met) checklist.

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PASRR and Survey

1. During an entrance conference, the team coordinator asks if all residents have had a PL1 prior to admission and requests a list of residents who receive specialized services or are PASRR eligible. If a NF has any PASRR residents [as determined by the PASRR Evaluation (PE)], at least one of those residents will be included in the standard survey sample. Surveyors compete the a PASRR Focused Review as part of a standard survey or complaint investigation.

2. A PASRR eligible resident is a resident identified through a PE or resident review as having ID, DD or MI. The PASRR resident may also be included for other issues being examined by the surveyor or survey team.

3. PASRR rules and regulations will also be investigated if a complaint or incident is reported involving a PASRR resident.

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Survey Samples

1. Surveyor Sample Selection Guidelines
2. For facilities with five or fewer PASRR residents (a resident with ID, DD, or MI), include all of them.
3. For facilities with 20 or fewer PASRR residents, include a minimum of five PASRR residents.
4. For facilities with 20-40 PASRR residents, include at least 25% of the PASRR residents.
5. For facilities with 40 or more PASRR residents, include at least 10 PASRR residents.
6. When a NF has residents from both PASRR populations (those with ID, DD or RC and those with MI) the sample, regardless of size, must include a representative number of residents from both PASRR populations.

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Resources

1. PASRR - Regulatory Policy and Rule Questions
2. Phone: 512-438-3161
3. Email: policyrulestraining@hhsc.state.tx.us

4. PASRR Unit
5. Phone: 855-435-7180
6. Email: PASRR.support@hhsc.state.tx.us

7. PASRR Forms and Instructions:
8. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/preadmission-screening-resident-review-pasrr/pasrr-forms-instructions

9. PASRR web-based training:
10. https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/long-term-care-provider-web-based-training

11. Training updates and archives :
12. https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-training

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Thank you