



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nursing Home & PASRR Training



Presented by:

Gainwell Technologies

Alliant Health Solutions

Georgia Collaborative ASO

**For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information
-> Provider Notices – "Presentation – Nursing Home & PASRR Training – June 2022"**



Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.



Introductions

- Gainwell Technologies
 - Kendall Telfair, Provider Relations Field Services Representative
- Georgia Department of Community Health
 - Wylean Thomas, MFP Program Manager
- Alliant Health Solutions
 - Leigh Hamilton, RN, PAUM Manager
- Georgia Collaborative ASO
 - Ashley Tricquet, LPC, Clinical Director
 - Melissa Travers, LPC, PASRR Supervisor

Objectives for Training

- Claims Information
- Timely Filing
- QMB Medicaid Recipients
- Common Edits and Audits
- DMA 520/Administrative Review
- Understand PASRR Regulations
- Identify PASRR Responsibilities
- Describe the PASRR Process & Requirements
- PASRR Reviews & Determinations

Claims Information

Rates

- Rates are updated quarterly. Nursing Facilities will receive written notification of all rate changes.
- Claims are mass adjusted by Gainwell Technologies quarterly.

Claims Information/Timely Filing

- If a member has a type of Medicaid in GAMMIS (SSI, QMB, SLMB, S99, etc), during the time in which a member is in a NH facility, the provider is supposed to bill and receive those denials; which will lock in their rendering service/span dates and prevent claims from denying timely.
- Once Long-Term Care eligibility is established, the claims will process in the cycle as the system is designed to do. Providers are not supposed to wait for DFCS to change the category of service in order to bill when the member has a class of Medicaid in the system, as stated in the NH Manual.
- Providers should review the timely filing policy for more detailed information. The Timely Resubmission policy is outlined in Section 204 of the Medicaid/PeachCare for Kids ® (Part I) Policies and Procedures Manual, Chapter 200.

Timely Filing

Timely Filing is as soon as possible, but no later than six months from the month of service.

Failure to file a claim so that it is received within six months after the month in which service was rendered and/or failure to obtain prior approval or precertification when required will result in the denial of the claim.

This means that the timely submission and resubmission processes requires:

- 1) The original claim to be submitted within 180 days or 6 months from date of service.
- 2) A claim that was denied for missing or erroneous information be resubmitted to correct the misinformation within three months from the month of the date of service or when the denial occurred; whichever is later.

Remember, it is your responsibility to keep your claims timely.

Timely Filing

(continued)

- Failure to file a claim so that it is received within six months after the month in which service was rendered and/or failure to obtain prior approval or precertification when required will result in the denial of the claim.
- All claim submissions and adjustments to denied claims are to be completed according to policy by 365 days.
- Other timely submission and resubmission system edits will remain in GAMMIS according to GA Medicaid policy (i.e., there is no time limit for adjusting a claim that reverses payment back to the Department).

The Timely Resubmission policy outlined in Section 204 of the Medicaid/PeachCare for Kids® (Part I) Policies and Procedures Manual, Chapter 200 will still be enforced to include this new one year or 365 days guideline.

QMB Medicaid Recipients

QMB Medicaid recipients are not required to apply for Nursing Home(NH) Medicaid. However, Medicaid will pay second, after Medicare, to cover the QMB recipient's Medicare coinsurance and deductibles.

Please note: After the first 100 days in a benefit period, QMB recipients will be responsible for all costs for each day thereafter.

Since many applicants enter Nursing Homes from swing beds (SNF), some of the 100 days may be used prior to being admitted to the NH.

If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay anything on the claim.

QMB Medicaid Recipients

(continued)

When a QMB recipient is admitted to a nursing facility under Medicare SNF care, the nursing facility will complete a Form DMA-59, Sections I, II and III and fax it directly to the DCH at (404) 463-2538.

The DCH will add the appropriate data for these individuals to GAMMIS so the Medicare cross-over claims will process correctly.

Contact the ABD Medicaid Help Desk at ABDHelpDesk@dhr.state.ga.us if you have any questions.

Common Edits/Audits

- ❖ 3001: PA/PRECERT NOT ON FILE and
- ❖ 3011: DOS NOT WITHIN PA/PRECERT EFFECTIVE DATES
- ❖ 2031: HOSPICE CLAIM SPANS MEMBER HOSPICE SEGMENTS – HDR
- ❖ 4450: MEMBER HAS ELECTED TO RECEIVE HOSPICE SERVICES and
- ❖ 2581: MEMBER HAS ELECTED TO RECEIVE HOSPICE SERVICES-HDR
- ❖ 2110: MEMBER INELIGIBLE ON DATE OF SERVICE
- ❖ 1087: MEMBER NOT ELIGIBLE FOR NH ON DOS – DENY and
- ❖ 1088: MEMBER NOT ELIGIBLE FOR NH ON DATES OF SERVICE
- ❖ 1088: PROVIDER NOT AUTHORIZED BY NH SPAN - DENY
- ❖ 0141: TOTAL ACCOMMODATION UNITS NOT EQ STMT FROM/TO DOS and
- ❖ 2191: COVERED DAYS CONFLICT WITH HDR FROM AND TO DATES

Note: Facilities should remain vigilant in tracking not only completeness and accuracy of member charts, but also weekly Remittance Advices.

DMA-520 Claim Inquiry Guidelines

- Only one DMA-520 form may be used per inquiry. All data fields must be completed.
- For new inquiries, a Contact Tracking Number (CTN) will be provided. Please use this CTN and Claim ICN to track your appeal request.
- For previously submitted inquiries, the status will be provided along with the option to electronically upload supporting documentation.
- If the CTN status is CLOSED, you will not be able to upload supporting documentation.

Initial Provider Review DMA-520 Form (Gainwell)

- DMA-520 Must be submitted via the GAMMIS Web Portal at: www.mmis.georgia.gov .
 - Claim must complete the payment cycle.
 - Search for your Denied ICN.
 - Select DMA-520 option.
- DMA-520 appeal request must be requested within **30 days** of the claim's denial or adverse action.

(Blue DMA-520 Option will appear if timely)



DMA-520/Administrative Review

- Initial General Claim Denial Review
- Gainwell Technologies reviews all DMA-520 forms
- LOGON ID
- Submitted using your denied ICN; Select the DMA-520 option via the Web Portal

DMA-520/Administrative Review

DCH Administrative Review

- Search for your Denied ICN indicated when your initial DMA-520 was submitted
- Select DMA-520; Status will be closed
- Select Administrative review

(When submitting an administrative review, DMA-520 Response denial letter must be on hand and attached to your appeal).

- DCH (Department of Community Health) Review
- Administrative reviews (no turn around time limit)

DMA-520/Administrative Review

- You will receive notification via e-mail from DoNotReply@gammis.com to let you know there is a response from the submitted DMA-520.

Georgia DCH Email Request -	
Email Link:	Click here to access the GAMMIS web portal.
From:	State of Georgia DCH
Reference Provider ID:	REF000790451
CTN:	14765752-1
Details:	<p>This link was sent on 10/23/2017 12:37:25 PM</p> <p>You will need to have a valid user name and password to access the letter on the DCH website.</p> <p>Once authenticated on the GAMMIS Web portal, navigate to the "Reports" menu, then select "Letters". Choose the letter CTM-1934-O:PSCC Claim Status Letter from the list and click the search button. Letters are sorted by date, so select the letter with the date of 10/23/2017 .</p> <p>Notice: Online letters may not be available for viewing for up to one business day.</p>



2nd Level/Administrative Reviews (DCH – Provider Review)

- The Department offers any provider the opportunity to request an administrative (2nd level) review associated with a DMA-520 Inquiry form [Claim denial for payment or proposed adverse action (i.e. untimely filing, procedure code invalid)]. It must be submitted electronically through the Georgia Medicaid Management Information System (GAMMIS – www.mmis.georgia.gov)
- Must be requested/received timely within **30 days** of the date of the proposed adverse action notification. (**The blue Administrative review option will appear if timely.**)
- Once the status of your DMA-520 shows as “CLOSED,” the option to request an Administrative/2nd Level review will appear.

2nd Level/Administrative Review

- To initiate the Administrative Review, click on the Administrative Review button and the Administrative Review Form will open.
 - The information from the DMA-520 Claim Inquiry Form will auto populate.
 - Make sure that the Contact Information is entered.
 - Add information in the Written Explanation box to explain the reason for the administrative review.
 - Submit your on-line request and a new CTN will be assigned.
 - The CTN status will be “OPEN” and you will have the option to upload supporting attachments/documentation.
-
- **The DCH does not have a time limit to respond to Administrative Reviews**

DMA-520 / Eligible for an Appeal

[Refresh session] You have approximately 19 minutes until your session will expire. Thursday, July 17, 2014

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy

Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | Reports | Trade Files

Home Search (Void, Adjust) New Dental Claim New Institutional Claim New Professional Claim


User Information - Provider ?

[Provider Billing Manuals](#)

re-submit cancel

Professional Claim ?

Adjudication Information

ICN/TCN	<input type="text"/>	DMA520 Inquiry 	Claim Status	DENIED
RA Date	06/25/2014		Total Paid Amount	\$0.00

Billing Information

Rendering Provider ID	<input type="text"/>	Release of Information*	Y - SIGNED STMT PERMITTING RELEASE
Rendering Taxonomy	<input type="text"/>	Related Causes Code 1	<input type="text"/>
Member ID*	<input type="text"/>	Related Causes Code 2	<input type="text"/>
Last Name*	<input type="text"/>	Accident State	<input type="text"/>
First Name, MI*	<input type="text"/>	Accident Date	<input type="text"/>
Date of Birth*	<input type="text"/>	Admit Date	<input type="text"/>
Gender*	F - Female	Discharge Date	<input type="text"/>

DMA-520 / Administrative Review

- The DMA-520 Attachment upload panel allows the user to add documents to inquiries.
- The browse button permits the user to choose a file to upload for the associated provider inquiry.
- The upload attachment button uploads the selected file for the associated provider inquiry.
- You have to hit the submit button prior to uploading attachment.

Attachment Description	File Name	Date Created
07/14/2014 - Provider Inquiry Form - DCN: [redacted]	uploadAttachment.pdf	7/14/2014 12:24:43 PM

Upload

2nd Level / Administrative Review

- To review the status of your request, search for your Denied ICN, select DMA-520 Inquiry and then select Administrative Review.
- Once your request has been processed you will receive an e-mail notifying you that there is a letter with the response for the request.

Policy Information and Updates

- **Check for Updates Frequently.** Refer to the Provider Message Center on the secure side of the GAMMIS website for the most up-to-date information concerning policy changes, as well as upcoming workshops.
- Refer to Provider Notices under the Provider Information tab on GAMMIS for Provider Communication messages.
- **Check Quarterly Updates** in the Nursing Facility Part II Policy Manual on GAMMIS.

(Please always refer to your Policies and Procedures for Medicaid PeachCare for Kids ® Part I manual for additional information regarding policy.)

MAKING HEALTH CARE BETTER



Leigh Hamilton, RN, PAUM Manager

What Does PASRR Stand For?



Pre-Admission Screening and Resident Review

Purpose

To ensure that nursing facility applicants and residents with mental illness and/or intellectual disability are:

- *Identified
- *Admitted or remain in a NF only if they can be appropriately serviced in the NF
- *Provided with needed MI/ID services, including specialized services, if needed

Why?

- To prevent inappropriate treatment or placement of individuals with mental illness, intellectual disability, and related conditions
- To identify mental health needs of individuals placed in Nursing Facilities

Players and Process

- Alliant Health Solutions - Level I- “Identification Process” (flagging the patient)
- Beacon - Level II - Evaluation of placement and service needs
- MH Services - Mental health-Specialized services



Program Goals

- *Reduce/prevent unnecessary psychiatric hospitalizations
- *Reduce unnecessary use of psychotropic meds
- *Provide optimal and effective treatment efficiently while minimizing costs
- *Lessen or eliminate the debilitating symptoms of mental illness each resident experiences and to minimize and prevent recurrent acute episodes of the illness
- *Improve functioning in adult social roles and activities
- *Enhance the quality of life of PASRR residents



PASRR Process Flow

-Provider submits Level I



-Level I processed by computer automation or by PASRR Staff Reviewer for completeness, premature admit, duplicates



-If approved, pre-cert number given via Medical Review Portal or provider can call Alliant



-If not approved for admission, PA pends for staff review



PASRR Process Flow

-If triggers a Level II referral, OBRA form completed by Reviewer



-Next, Beacon contacts provider and gets medical records and performs assessment as needed. (They have 7 business days once get referral to complete assessment)



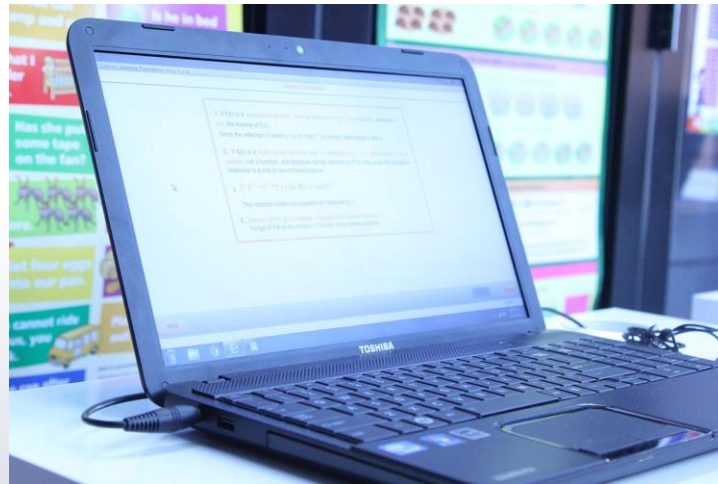
-Beacon sends a copy of decision to referring facility and to the individual



-If Mental Health Services are needed, the NF contacts a mental health provider.

Where Do I find PASRR Level I Application Form and Guidelines for PASRR?

Nursing Facility Service Manual, Section 800 Prior Approval/Admission Procedures and Appendix H. See Appendix F for Level I application form.



Reviewing PASRRs

1. Review Technical Rules
2. Review for Mental Illness/DD/Dementia



Technical Rules

- ▶ Duplicate Request
- ▶ MD Signature Date
- ▶ Less than 30 day admit
- ▶ Severe Physical Illness
- ▶ Where did the patient come from?
- ▶ Premature Admit



Review for Mental Illness/DD/Dementia

- ▶ Mental Illness
- ▶ Dementia
- ▶ DD/ID
- ▶ Hx of Mental Illness



Automatic Denials

-Automatic Denial:

Does the individual applying for admission, directly from hospital discharge, require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days? **YES**

-No precert is needed if resident will be staying LESS THAN 30 DAYS in the facility.



Less Than 30 Day Admit

DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE

Contact Information			
Contact First Name :	[REDACTED]	Contact Last Name :	[REDACTED]
Name of Contact Facility :	[REDACTED]	Contact Facility Type :	[REDACTED]
Phone :	[REDACTED]	Fax :	[REDACTED]
Address :	[REDACTED]	City :	[REDACTED]
		Title of Contact Person :	SOCIAL WORKER
		Date Level I Requested :	04/30/2018
		E-mail :	[REDACTED]
		State / Zip :	[REDACTED]

Nursing Facility Information	
Has the patient been admitted to the nursing facility?	No
Name of Nursing Facility Patient Admitted To :	[REDACTED]
Date of Admission to Nursing Facility :	[REDACTED]
Does the individual applying for admission, directly from hospital discharge , require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days ?	YES
Nursing Facility Provider ID :	[REDACTED]

Automatic Approval Examples

*Only 1. was answered Yes. All others No.

1. Does the individual have a primary (Axis I) diagnosis of dementia?	Yes
The type of dementia, due to:	
Alzheimer's Disease :	Yes
Vascular Changes :	No
HIV :	No
Head Trauma :	No
Huntington's Disease :	No
Creutzfeldt-Jakob (ABE) :	No
Pick's Disease :	No
Parkinson's Disease :	No
Other :	No
Other Diagnosis if known :	
Date of Onset if known :	
If 'Other' is selected, please explain.	
If No, is there presenting evidence to indicate :	
Undiagnosed Condition:	
Suspected Diagnose:	
2. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from *specialized services?	No

* Specialized Services under Georgia's PASRR Program are services in combination with nursing facility services results in the implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities which necessitates supervision by trained mental health personnel and is directed

Automatic Approval Examples

All NO's

1. Does the individual have a primary (Axis I) diagnosis of dementia?		No
The type of dementia, due to:		
Alzheimer's Disease :	No	Vascular Changes : No
HIV :	No	Head Trauma : No
Huntington's Disease :	No	Creutzfeldt-Jakob (ABE) : No
Pick's Disease :	No	
Parkinson's Disease :	No	Other :
Other Diagnosis if known :		Date of Onset if known :
If 'Other' is selected, please explain.		
If No, is there presenting evidence to indicate :		
Undiagnosed Condition :	No	Suspected Diagnose : No
2. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from *specialized services?		No
* Specialized Services under Georgia's PASRR Program are services in combination with nursing facility services results in the implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities which necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, Skills training with Rehab supports & therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.		
Specified the Physical Illness :		
Coma, Functioning at a Brain Stem Level :	No	Congestive Heart Failure : No
Chronic Obstructive Pulmonary Disease :	No	Ventilator Dependence : No
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) :	No	Delirium : No
Parkinson's Disease :	No	Huntington's Disease : No
Other :	No	Date of Onset if known :
If 'Other' is selected, please explain.		
Physical illness likely to continue ?		No
Likely to interfere with mental/cognitive capacity/function ?		No
3. Does the individual have a terminal illness as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less?		No
Diagnosis if known :		Date of Onset if known :
4. Does the individual have a Primary Diagnosis of Serious Mental illness, developmental disability or related condition?		No
If Yes, specify the mental illness :		
Schizophrenia, Paranoid Type :	No	Schizophrenia, Disorganized Type : No
Schizophrenia, Catatonic Type :	No	Schizophrenia, Undifferentiated Type : No
Schizophrenia, Residual Type :	No	Bipolar Disorder : No
Depressive Disorder :	No	Somatiform Disorder : No
Other Mental Disorder if known :	No	Anxiety Disorder : No
Substance Use Related Disorder :	No	Date of Onset if known :
Comments :		

Premature Admit

Physician Information			
Physician's Name on DMA-6 :	<input type="text"/>	Office or Hospital : Hospital	Phone <input type="text"/>
Address 1 :	<input type="text"/>	Address 2 :	City : Fayetteville
State:	GA	Zip :	30214 County: Fayette
Physician Signed?	Yes	Date Signed :	04/17/2018
DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE			
Contact Information			
Contact First Name :	<input type="text"/>	Contact Last Name :	<input type="text"/> Title of Contact Person : AD
Name of Contact Facility :	<input type="text"/>	Contact Facility Type :	<input type="text"/> Date Level 1 Requested : 04/30/2018
Phone :	<input type="text"/>	Fax :	<input type="text"/> E-mail : <input type="text"/>
Address :	<input type="text"/>	City :	Newnan State / Zip : GA 30263
Nursing Facility Information			
Has the patient been admitted to the nursing facility?	Yes	Date of Admission to Nursing Facility :	04/17/2018
Name of Nursing Facility Patient Admitted To :	<input type="text"/>	Nursing Facility Provider ID :	<input type="text"/>
Does the individual applying for admission, directly from hospital discharge , require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days ?			No

Why do PASRRs Pend?

- *MD signature greater than 30 days from the date of admission OR the date the PASRR was submitted
- *Answered YES to mental illness, Dementia, DD/ID, or one of the last questions under functional limitations
- *Possible duplicate (checks all PASRR within last 90 days)
- *Patient has already been admitted to a Nursing Facility

Helpful hints

*Dementia only → APPROVE

*Alzheimer's only → APPROVE

*Dementia (not Alzheimer's) + Mental Illness/ID or DD → REFER To Beacon

*Mental Illness only → REFER To Beacon

*Intellectual Disability (ID) or Dev Disability (DD) only → REFER To Beacon

*Answer YES to 2. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from *specialized services? → APPROVE

Other Helpful Hints

- Add Medicaid ID always, if available
- If DOB or SSN is incorrect in GAMMIS, DFCS is the only agency that can correct
- If no Medicaid ID on PASRR, can change any demographics
- Use the Change Request Link on the Medical Review Portal



Other Helpful Hints

- Does the individual applying for admission, directly from a hospital discharge, require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days?
- If provider answers YES and then submits a new PASRR within a week or so, the originally denied PA needs to be changed to approved.
- Provider has up to 40 days to get the denied PASRR changed to Approved, otherwise a new PASRR needs to be submitted for pay date purposes.

Billing Issues

- *Make sure provider is billing correct date
- *Check for end dates in GAMMIS (May need to resave and resend to GAMMIS)
- *Make sure billing for Level II vs Level I if PA was referred
- *Make sure Medicaid ID attached if patient has Medicaid



Let's Review

Request Information

Assessment Number : [REDACTED] [EDIT](#) Request Date : 05/07/2018 Status : **Pending** [CSA Rules](#)

Member Medicaid ID : [REDACTED] Member Name : [REDACTED] Age : 86y 9m

Member SSN : [REDACTED]

[Add a PASRR-Related Phone Call](#)
[Add / Search Non-PA Call\(s\)](#)

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

[Browse...](#) [Attach File](#)

Attached Files

File	Type	Code	Document Name	Size	User	Date	
PreadmissionScreeningNew.pdf	Attached By Nurse			50 KB	RROBILLARD	5/7/2018 10:58:16 AM	DELETE

GHP Decision : Reviewer Name : GHP Decision Date :

Request Submitted Via : Reason for Withdrawn :

Premature Admission :

OBRA Decision : OBRA Number : OBRA Decision Date :

Modified By : RROBILLARD Modified Date : 5/7/2018 10:58:16 AM Created By : RROBILLARD

Comments / Messages :

[Send L1 to HP again](#)

[Save Request](#) [Return To Search Results](#)

Why is it pending?

Request ID: [Redacted] Status: Pending

Physician Information

Physician's Name on DMA-6: [Redacted] Office or Hospital: Office Phone: 7707747688
Address 1: [Redacted] Address 2: [Redacted] City: Snellville
State: GA Zip: 30078 County: Gwinnett
Physician Signed? Yes Date Signed: 05/02/2018

DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE

Contact Information

Contact First Name: [Redacted] Contact Last Name: [Redacted] Title of Contact Person: Medical Records Director
Name of Contact Facility: [Redacted] Contact Facility Type: Nursing Facility Date Level 1 Requested: 05/07/2018
Phone: [Redacted] Fax: [Redacted] Email: [Redacted]
Address: [Redacted] City: Cumming State / Zip: [Redacted]



Nursing Facility Information

Has the patient been admitted to the nursing facility? Yes Date of Admission to Nursing Facility: 05/02/2018
Name of Nursing Facility Patient Admitted To: CHESTNUT RIDGE NURSING & REHAB CENTER Nursing Facility Provider ID: [Redacted]
Does the individual applying for admission, directly from hospital discharge, require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days? No



Member Information

Member ID: [Redacted]
Last Name: [Redacted] First Name: [Redacted] Middle Initial: L
Social security Number: [Redacted] Date of Birth: [Redacted] Gender: M
Current Location of Applicant: Residential / Nursing facility
If 'Other' is selected for Applicant's Current Location, please explain. If 'Home' is selected, please list address, contact person, contact phone number.

All that apply to the Applicant/Resident: (DO NOT HAVE TO PROCEED IF PHYSICIAN HAS CERTIFIED THAT NF SERVICES ARE FOR 30 DAYS OR LESS)

New admission:	Yes	Readmission to NF from Psychiatric Hospital:	No	Readmission to NF from Acute Hospital:	No
Respite care, less than 30 days:	No	Transfer from Residential to NF:	No	Transfer between NF's:	No
Emergency, Requiring Protective Services:	No	Out of State Resident(OOS):	No	Significant Status Change:	No
Referral from ID/DD Agency/DBHDD:	No	Other:	No		

Premature admission

Questions?



PASRR Level II Training

Opening Remarks

Welcome and Introductions

Who is the Georgia Collaborative?

Objectives for PASRR Training

Questions

Thank you

PASRR Team

Melissa Travers, LPC

Supervisor, Clinical Services, PASRR
Georgia Collaborative, ASO

Two Administrative Staff
Eight Clinicians and RNs



The Georgia Collaborative ASO



- The Right Service
- In the Right Amount
- For the Right Individuals
- At the Right Time

Mission of the Georgia Collaborative

We help people live their lives to the fullest potential. The Georgia Collaborative makes our mission possible through effective partnerships with DBHDD, individuals and providers.



Overview and Objectives

PASRR: What, Who, Purpose

PASRR Process Overview

PASRR Level II Workflow

PASRR Denial/Appeal Process

Review of PASRR Level II forms

What is PASRR?

What does PASRR stand for?

Pre
Admission
Screening and
Resident
Review

Why complete the PASRR process?

- To prevent inappropriate treatment or placement of Individuals with mental illness, intellectual disability and related conditions
- To identify mental health needs of Individuals placed in Nursing Facilities



PASRR Answers 2 Important Questions

Does the Individual have medical conditions that justify placement in a Skilled Nursing Facility?

Does the Individual have a Severe Mental Illness and/or IDD/DD that requires specialized services?

Please note:

- A person with only mental health/behavioral needs cannot be approved for Skilled Nursing Facility placement.
- Homelessness does not qualify a person for SNF placement.
- Persons who need supervision and/or assistance with medication administration should be served in the least-restrictive environment. This may include group homes, intensive residential programs, or other community placement.

PASRR Partners

Alliant Health Solutions- Level I “Identification Process”
 (“flagging” patient)



Beacon- Level II- Evaluation of placement and service needs





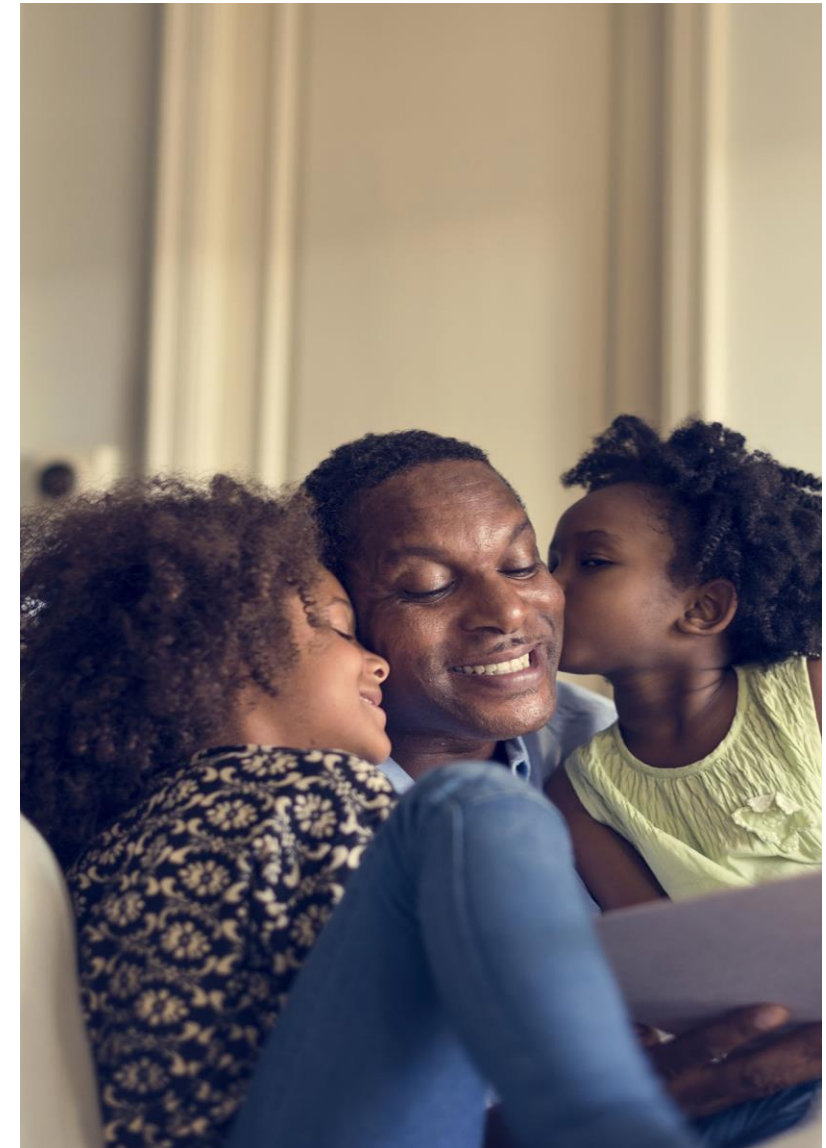
Purpose of PASRR

To ensure nursing facility applicants and residents with mental illness and/or intellectual disability are:

Identified

Admitted or remain in a nursing facility only if they can be appropriately serviced in the nursing facility

Provided with needed MI/ID services, including specialized services, if needed



Importance of PASRR

- PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes and in the least restrictive settings possible
- PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care

PASRR Process

- **Level I:** The PASRR process requires that all applicants to a Medicaid-certified Nursing Facility receive a **Level I** preliminary assessment to determine whether they might have a mental illness, intellectual disability, or related condition. If one of these conditions is identified, a referral will be made for a **Level II** assessment
- **Level II:** The outcome of this **Level II** evaluation confirms the need for placement in a skilled nursing facility and provides a set of service recommendations for providers to use in developing an individualized plan of care

PASRR Workflow of Level II Submissions

Step 1

GMCF/Alliant contacts the Collaborative if there is evidence of a SMI, IDD/DD, or related condition to start Level II

Step 2

The Collaborative will request medical records from the facility to be submitted within 24 hours. A review of the records will begin within 48 hours of referral.

Step 3

A PASRR assessor completes a record review or face to face assessment (telephonic if out of state) as clinically necessary.

Step 4

Summary of findings with Letter of Determination are sent within 7 business days for new SNF admissions. The letter includes the authorization number needed for billing.

Step 5

If specialized services are recommended, a request for authorization should be submitted to authorize billing.

Medical Records for PASRR

- The process of submitting the DMA-613 form to GMCF/Alliant remains the same.
- Medical records should be submitted within 24 hours of referral to ensure timely review and determination.
- Failure to submit all needed records results in a cancellation which requires resubmission.
- Please limit to no more than 80 pages of records.

Medical records can
be faxed to:
855- 858-1965
or
e-mailed to:
GAPASRR@beaco
nhealthoptions.com

Documents to Submit to Beacon

- Medical history, current medications, and physical examination report (within the last year**).
- Psychological evaluation, including intelligence testing for Individuals with an intellectual disability under age 18, must be current within last 3 years** (For 18 and older, conducted as needed).
- Functional evaluation if available conducted by a qualified mental health professional.

When evaluations are not current or not available, PASRR clinical staff will contact the individual and any other applicable parties to schedule the evaluations to be completed.

PASRR Level II Referrals

- Some cases require extra research and/or face-to-face assessments.
- Special note for this Level I question: Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM-IV criteria?
 - This does not indicate the primary diagnosis/reason for admission.
 - If an individual has a fractured hip and diagnosis of schizophrenia, the mental illness must still be reported on the Level I application.

PASRR Level II Determination

Determination for those seeking new placement will be made within seven business days of receipt of the original referral

- Summary of Findings (SOF):
 - SOF are sent to the individual, representative, referring provider/facility, and/or nursing home.
 - SOF will be mailed, e-mailed, or faxed, as appropriate.

- Most Common Codes on Letters of Determination
 - Skilled Nursing Facility – Approval with specialized services.
 - Skilled Nursing Facility – Approval without specialized services.
 - Skilled Nursing Facility – Non-Approval.

List of OBRA (Omnibus Budget Reconciliation Act) Codes

- 1.0 SNF Approval SMI (PASRR)-Meets for SNF no need for SS for SMI
- 1.1 SNF Approval SMI (PASRR)-Has SMI, meets SNF LOC criteria, recommend SS for SMI
- 1.2 SNF Approval, no SMI (PASRR)-No SMI meets SNF LOC
- 2.0 SNF Denied (PASRR)-Has SMI, rec SS, considered for alternative community setting
- 2.1 SNF Denied (PASRR)-Has SMI does not meet SNF LOC should be considered for psychiatric hospitalization
- 2.2 SNF Denied (PASRR) No SMI does not meet SNF LOC
- 3.0 SNF Approval -MR/DD (PASRR)-Meets SNF LOC MR/DD-does not need SS for MR/DD
- 3.1 SNF Approval -MR/DD (PASRR)Meets SNF LOC recommend SS for MR/DD
- 3.2 SNF Approval, no MR/DD (PASRR)-No MR/DD, meets SNF LOC
- 4.0 SNF Denied -MR/DD, does not meet SNF LOC should be considered for alternative community setting with SS
- 4.1 MR/DD does not meet SNF LOC and should be considered for ICF/MR
- 4.2 SNF DENED (PASRR)-No MR/DD, does not meet SNF LOC
- 6.0 SNF DISCHARGE (PASRR)
- 7.0 SNF DECEASED (PASRR)

After Level II is Complete

- When the Level II PASRR Assessment is completed, the finalized Level II document and a Letter of Determination are sent to the referring provider.
- If the Level II is an approval, the Letter of Determination contains the authorization number the SNF needs for billing.
- SNFs utilize outside agencies with clinical and medical staff to provide specialized mental health services.
- Specialized services for IDD/DD is coordinated through the DBHDD Regional Offices.
- Authorization Requests for PASRR specialized services are submitted via the Provider Connect website.

PASRR Status Changes and Resident Reviews

- Status Changes are no longer required annually.
- Sometimes, individuals are admitted to SNFs and their behavioral conditions are unknown.
- If the SNF determines an individual has a mental health diagnosis, related condition, or IDD/DD that was not addressed in previous Level I/II, a Status Change is warranted.
- If an individual has undergone a Level II and no specialized services were recommended, but symptoms of SMI have worsened or presented, a Status Change is warranted.

PASRR Status Changes and Resident Reviews

- For individuals who have transferred from facility to facility, a Status Change is not required.
- A status change IS required if there is break in stay (individual discharges to home, etc.).
- If specialized psychiatric services are being provided, but there is no Level II in place, a Status Change is warranted.
- If an individual begins presenting symptoms of a Neurocognitive Condition (not Severe Mental Illness), a Status Change is not required.

PASRR Status Changes / Resident Reviews

- If an individual is receiving specialized services now has a primary diagnosis and presentation of NCD he/she is no longer eligible for specialized services via the PASRR fund. In this case, no status change is required. The psychiatric practitioner or SNF physician can document this and that specialized services are discontinued.
- Reminder: individuals may have a recommendation for specialized services (OBRA 1.1), and not receive services. He/she may receive services through a private provider or other source.
- Individuals can always choose to refuse or discontinue PASRR-funded specialized services. Make sure this is documented in the record why recommended services aren't provided.

Level II PASRR Denials

- Less than 2% of Level IIs result in a denial of placement.
- Most common reasons for a denial for SNF placement:
 - Individual does not meet medical criteria for SNF placement.
 - Individual is not psychiatrically stable to transfer to a SNF.
- Reminder: homelessness, chronic mental illness, or need for supervision do not medically justify placement in a SNF. The individual must require “monitoring and overall management of a medical condition(s) under the direction of a licensed physician.”
- If you have questions about a Level II denial or more information that wasn’t included in the records or summary, please contact Beacon before filing an appeal.

PASRR Workflow for Denials & Appeals

- In cases of denial, a first level appeal can be submitted to the Collaborative within 10 business days of the denial. Results of the appeal will be provided within seven business days of the receipt of the appeal by the Collaborative.
- A second level appeal can also be requested and should be submitted to the Collaborative within 10 business days. Results of a second level appeal will be provided within five business days by DBHDD.
- Appeals process offered for any non-approval outcomes.
- Please contact Beacon for options before submitting a denial.

PASRR Contacts

PASRR Fax:

(855)858-1965

PASRR E-mail Address:

GAPASRR@beaconhealthoptions.com

Password for e-mailed attachments: BeaconPASRR

Download PASRR Fax Cover Sheet:

www.georgiacollaborative.com

Other Contact Information

Beacon Customer Service for Georgia (Registration, Authorization, Claims)

Monday - Friday 8:00 am - 6:00 pm ET

Phone: 855.606.2725

EDI Helpdesk (ProviderConnect/Batch Technical Questions)

Monday - Friday 8:00 am - 6:00 pm ET

Phone: 888.247.9311

Email: e-supportservices@beaconhealthoptions.com

Provider Relations (General questions)

Monday - Friday 8:30 am - 5:00 pm ET

Email: GACollaborativePR@beaconhealthoptions.com

DCH Contact Information

Wylean Thomas, MCMP-II

Balancing Incentive Program & MFP
Manager

wthomas1@dch.ga.gov

Alliant Contact Information

- 678-527-3000
- 800-766-4456 Option 5

Gainwell Technologies Contact Information

Log into the GAMMIS system with your user name and password.



Gainwell Technologies Contact Information

(continued)

Contact Information ? ✕

How can we help you?

Select an Item*

Enter Category Details

How do you want to be contacted?

Contact Method* Telephone

Last Name, First Name

Phone Number, Ext

Gainwell Technologies Contact Information

(continued)

Requests Requiring PHI

NOTE: If the response to your inquiry contains protected health information (PHI) such as member or claims information, you must log into the secure web portal to submit your question and receive the response. Upon login, additional contact options related to PHI will be available.

submit cancel

Contact Information

How can we help you?

Select an Item*

Enter Category Details

How do you want to be contacted?

Contact Method*

Last Name, First Name

Phone Number, Ext

top of page

top of page

- Claim Status Inquiry
- Eligibility Inquiry
- Contact My Provider Service Rep
- Provider Enrollment
- Request a Provider Rep Visit
- ICD-10 Inquiry
- Favors Review Inquiry
- MAPIR Inquiry
- Web Registration
- Member ID Cards
- Member PCP Assignments
- Customer Service
- Complaint about a Provider
- Complaint about a Member
- Other Complaint
- Having a Technical Problem
- Other
- EDI Submission Problem
- Provider PIN Issue

Gainwell Technologies Contact Information

(continued)

Contact Information ?

How can we help you?

Select an Item* Contact My Provider Service Rep ▾

Enter Category Details

How can we help you? I Need some help with ICN 2017123456777

How do you want to be contacted?

Contact Method* Telephone ▾

Last Name, First Name DXC

Phone Number, Ext (800)766-4456



Closing

Questions and Answers

