

Below you will find the frequently asked questions for the multi-location Onsite Provider Training conducted 10/18/2016 – 10/21/2016. Answers to these questions were based on knowledge and policy as of 10/18/2016. Due to policy and programming changes these answer may change in the future.

Q: Is it true, Psychiatric ARNP can now be used to deliver the Specialized Service of “Ongoing psychiatric care”?

A: Yes, it is true the Specialized Service of “ongoing psychiatric care” can now be delivered by a Psychiatrist or Psychiatric ARNP. However, please note this does not mean that if an individual enters a Nursing Facility and already has an established relationship with a psychiatric provider, that the individual now should see the Psychiatric ARNP ordinarily used by the Nursing Facility. Continuity of previous/established care should always be our goal if appropriate and practically available.

Q: What is the turnaround time for Level II evaluations?

A: Ascend is contracted with the State of Iowa to complete Level II evaluations in five calendar days.

As of October 31, 2016, the annual average turnaround time for Level II evaluations is **5.08 days**. The average turnaround time for the most recent quarter was **3.94 days**. The turnaround time for October was **3.72 days**.

The Level II evaluation process first involves the Ascend Independent Contractor who interviews the individual, the family members (if available), and facility staff members, completes the Level II evaluation and submits it to Ascend. Next, the Ascend Quality Coordinator reviews all supporting documents, the Level II evaluation, and composes the Summary of Findings Report and includes the services and supports for that individual.

Q: How can we know when Ascend Independent Contractors or Assessors will be completing assessments?

A: It has always been required that the Independent Contractor make every effort to interview one or more individuals involved in the care of the individual and, if applicable, the individual’s Legal Guardian to coordinate and schedule a time to see the individual. Effective October 3, 2016, Ascend requires all Independent Contractors to submit an attestation with the completed assessment of individuals. This attestation will include the following elements:

- The Ascend Client ID number (CID) for the individual to be assessed
- Date and time the Independent Contractor contacted the facility to make the appointment to complete the onsite assessment
- Name and title of the facility representative with whom the Independent Contractor spoke
- Date and times the Independent Contractor began and ended the onsite assessment

- Names and titles of the facility representatives consulted during or as part of the assessment
- The Independent Contractor signature, and
- The signature of a representative from the facility.

Q: Why is "lawn care" on every Level II PASRR? Does my Nursing Facility have to teach a person to mow the grass?

A: The goal of the PASRR Level II process is to identify the most appropriate setting (nursing facility, community, inpatient care, etc.) for an individual with a PASRR disability, and to identify the specific services and supports an individual will need in that setting to attain the highest practicable physical, mental, and psychosocial well-being. Additionally, evaluation of potential placement or discharge to a community setting is required by PASRR law [CFR 42 483.132 (a)(1) and 483.132 (a)(5)]. To ensure that an individual with a mental health or intellectual disability is always treated in the least restrictive and most integrated possible setting, every PASRR Level II Summary of Findings will identify services and supports a person may need if or when he/she is discharged to the community.

Some individuals' PASRR determinations may state that the individual is appropriate for nursing facility level of care for a specific short period of time, with the expectation that he/she should be given every possible opportunity to discharge to a lower level of care. Services that a person needs to be successful in the community are listed in the section "Community Placement Supports to Enhance Community Transition and Placement." The nursing facility is responsible for ensuring that these services and supports are arranged as a part of the discharge planning process, and are in place for the individual upon discharge to the community.

If lawn care is among the identified community placement supports, and if the individual is going to a place where there is a lawn that will need to be cared for, the nursing facility is not expected to ensure delivery of lawn care services while the individual is a resident of the NF, but must ensure that these services will be in place when he/she leaves the facility. If "lawn care" is identified as a service the individual will need to be successful in the community, the nursing facility should work with the individual, his/her support circle, and community resources to ensure this service/support is set up at the individual's place of residence when he/she is discharged home.

Although it is not the expectation that these community placement supports be delivered while a person is a resident of the nursing facility, some community placement supports may require referrals and evaluations to be completed while the individual is still a resident of the NF to ensure that the service/support is in place by the time the individual discharges to the community. The overall intent of this section of the Summary of Findings is to identify what services and supports the nursing facility needs to arrange for the individual, as a part of the discharge planning process, in order to maximize their potential to be successful in the community.

Finally, many PASRR determinations will not have an expiration date and are therefore not time limited. The Summary of Findings will still identify services the individual may need in order to be successful in the community. The intention is to identify, at the time of the PASRR assessment, what community placement supports an individual will need, if he/she were to discharge to the community. If there is a change in the

individual's discharge potential, the nursing facility is expected to review the identified community placement supports, incorporate them in the discharge planning process, and ensure they are in place by the time the individual discharges to the community.

Q: What do I do if families have questions about PASRR?

A: If the Individual or family members with access to HIPAA protected information have questions about their PASRR, they can contact Ascend. Ascend's contact information is listed on every PASRR Summary of Findings Report. The Iowa Helpdesk can be reached via email at iowapasrr@ascendami.com or via phone at (877) 431-1388 ext. 3403. If the Helpdesk is unable to address the question(s), they will connect the individual with someone who can.

Q: I've spoken with an Ascend clinician about a PASRR outcome. Now I want to request a reconsideration. How can I make this request and what are the next steps?

A: If you believe that additional information should have been considered during the time of the PASRR evaluation, you may make a written request for reconsideration. A reconsideration will take into account any additional information that was available at the time of the PASRR evaluation, but was not considered by Ascend for the review.

Anybody who has authorized access to the Summary of Findings Report may request a reconsideration. A reconsideration may be requested within ten calendar days of the PASRR date. Information on how to request reconsideration is contained in every PASRR Summary of Findings Report.

Please send a written request for reconsideration (via email at iowapasrr@ascendami.com or fax at (877) 431-9568) that includes the following information: (1) The reason for requesting the reconsideration and (2) any additional documentation that was available prior to the date of the PASRR Summary of Findings Report and was not considered during the review.

Once the request is received and approved for reconsideration by Ascend, the expected turnaround time is five calendar days.

Just as with any other PASRR, requesting a reconsideration does not guarantee that you will receive the desired outcome.

Q: Where can I find information on how to complete a compliant care plan?

A: Go to PASRR.com, the Iowa PASRR Provider's page. The first three links under "Provider Tools," include Iowa's care planning guidelines, and instructions, as well as the tool itself. The use of the tool designed for use by Iowa providers is not mandatory. Whether you choose to utilize the tool or not, we believe the guidance and instructions will be very useful for you in the development of compliant care plans.

Q: I have questions about ServiceMatters? How do I get these questions answered?

A: Questions about all technical aspects of ServiceMatters, including confirmation of submission, extension requests and system usage, should be directed to the Iowa Helpdesk at iowapasrr@ascendami.com or (877) 431-1388 ext. 3403. Questions about ServiceMatters Technical Assistance should be directed to Tammy Kasperzick (877) 431-1388 ext. 3288. Please be aware that most ServiceMatters questions will be answered during the extensive Technical Assistance provided in writing during and after the ServiceMatters Technical Assistance call. Also, feel free to invite other NF staff to the Technical Assistance Call so they can benefit from the technical assistance. Ascend will schedule only one Technical Assistance call to review each Individual involved in the ServiceMatters process.

Q: What if the individuals' PCP or guardian states that the identified specialized service is not needed?

A: If a well-informed and well-qualified professional with current knowledge of the individual and their PASRR disability believes that any particular PASRR identified service may not be needed or appropriate at the current time, please complete the Care Plan reflecting this determination by the disability expert and it will be reviewed during the ServiceMatters process.

Q: What can be submitted during ServiceMatters review that qualifies as a treatment record to document delivery of PASRR identified Specialized Services (SS)?

A: Detailed electronic health record documents that show treatment occurred, with dates and providers indicated, a form utilized by the NF and completed by the specialized service provider outlining when the individual was seen, medications, what kind of review occurred at the appointment, and next appointment, if applicable, or copies of the Individual's actual treatment records.

Q: I had a resident that came with Nebraska PASRR. Do I need to redo an Iowa PASRR?

A: This would be out of compliance with Iowa PASRR. Iowa NFs may not accept a person with a PASRR from another state unless that other State's Medicaid program is going to pay for the NF stay of the individual. If the sending state is going to be the payer, then we don't want that individual in Iowa's PASRR system and they should not be in PathTracker Plus. If, however, this is an Iowa resident, then the NF must obtain an Iowa PASRR prior to admission.

Q: If a resident has received a Level I negative screen for Level II, but I notice that it may be incorrect and the resident has a diagnosis of depression, do I need to do another Level I?

A: You may consult with Ascend first if you have questions, but a new PASRR screen will be needed in most cases.

Q: What happens when there is a discrepancy in the information accessed from ASCEND? For example, a PASRR that does not accurately reflect details about the resident due to age being incorrect?

A: Please contact the Ascend Iowa Help Desk at 1-877-431-1388, extension 3403 to discuss any corrections that may be needed.

Status Change Questions

Q: What is a Status Change and when should I submit a new Level I to Ascend?

A: Please refer to MDS 3.0 for guidelines that specify “When a Significant Change Should Result in Referral for a PASRR Level II Evaluation.” Within this guidance, there are some excellent examples of circumstances in which a referral for a status change is warranted. These examples are provided for individuals with an identified Level II condition, and for individuals for whom a Level II condition has not been identified.

Excerpt from MDS 3.0:

Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:

Note: this is not an exhaustive list

- *A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.*
- *A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.*
- *A resident who experiences an improved medical condition—such that the resident’s plan of care or placement recommendations may require modifications.*
- *A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.*
- *A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.*
- *A resident whose condition or treatment is or will be significantly different than described in the resident’s most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with a SCSA.)*

Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:

Note: this is not an exhaustive list

- *A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).*
- *A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.*
- *A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.*

The guidance presented by Ascend during recent trainings included illustrative examples regarding events that might signal a status change, such as hospitalizations or transfer to hospice. These examples expand upon and DO NOT REPLACE the guidance provided by MDS.

After consulting the MDS 3.0 guidelines for reporting a significant change in status, if you still have questions, please reach out to the Iowa PASRR Helpdesk.

Q: Sometimes a resident is already admitted to a NF and then later is admitted to Hospice. Does this need to be indicated on a new PASRR?

A: A new PASRR is not required simply due to the change in level of care or movement into hospice care. However, any time an individual meets the criteria for a status change PASRR, or has circumstances that have a significant potential to impact their behavioral health, then a new PASRR is needed. Please see the [MDS 3.0 Chapter 2 \(Status Changes\)](#) on PASRR.com for further detail about when to submit a PASRR status change to Ascend.

Q: If an individual has a new diagnosis for mental health, does he or she need to have a new PASRR?

A: It depends on the seriousness of the new diagnosis and the potential for it to impact overall health, behavior, and functioning. See the Provider Manual for guidance.

System-Specific Questions

Q: Does the inbox display per user or facility?

A: The inbox displays for the facility.

Q: If an individual is coming from home, how do I complete a Level I if I cannot admit them into the system until they are in the facility?

A: Submitting a PASRR on someone and adding them as a resident of your NF in PathTracker are two different things. You can complete the PASRR without admitting them as a resident of your NF. If they subsequently become a resident of your NF, then you enter an admission notice.