Pre-Admission Screening and Resident Review

All persons seeking admission to a Medicaid certified nursing home are required to complete a preadmission screen (PAS/Level I) prior to admission and send it to LDH's Office of Aging and Adult Services (OAAS). Those identified as suspected of having a mental illness are referred by OAAS to the Office of Behavioral Health (OBH)-Pre-Admission Screening and Resident Review (PASRR) for a Level II determination.

OBH-PASRR refers all enrollees for an independent evaluation to their respective MCO if a face-to-face evaluation was deemed necessary to determine the enrollee's need for nursing home admission and services. MCOs shall adhere to the contract requirements related to the staffing and implementation of the PASRR Level II evaluation process.

In accordance with PASRR operations, MCOs must submit the PASRR Level II evaluation to OBH-PASRR for a final determination. Complete and thorough Level II evaluations should be submitted to OBH-PASRR and should include the following information:

- A comprehensive history and physical that includes complete medical history; review of all bodily systems; specific evaluations of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes; and in the case of abnormal findings which are the basis of nursing home placement, additional evaluations conducted by appropriate specialists.
- A comprehensive drug history including current or immediate past use of medications that could mask symptoms or mimic mental illness, side effects or allergies.
- A psychosocial evaluation.
- A comprehensive psychiatric evaluation including a complete psychiatric history; evaluation of intellectual functioning, memory functioning and orientation; description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence of content of delusions); and hallucinations.
- Records that speak to the reason for nursing home placement, including documentation to support categorical determinations (i.e., terminal illness, severe physical illness, or any illness where the individual is not likely to benefit from a specialized behavioral health service).
- If there is an indication of dementia within the records, include corroborative testing or other information available to verify the presence of progression of the dementia (i.e., dementia work up, Comprehensive Mental Status Exam).

MCOs should ensure the appropriate linkage of individuals referred through the PASRR Level II process to case management and services regardless of the final determination of placement into a nursing facility, in accordance with processes outlined within the **DOJ Compliance Guide**. Additionally, the MCOs shall maintain appropriate records and utilize the LDH-identified templates.

HOSPITAL SERVICES

A hospital is defined as any institution, place, building, or agency, public or private, whether for profit or not, maintaining and operating facilities, 24-hours a day, seven days a week, having 10 licensed beds or more. The hospital must be properly staffed and equipped for the diagnosis, treatment and care of persons admitted for

overnight stay or longer who are suffering from illness, injury, infirmity, or deformity or other physical or mental conditions for which medical, surgical, and/or obstetrical services would be available and appropriate.

An inpatient or outpatient hospital may be the service location for many of the services that are described within the *Services* section of this Manual. Unless otherwise detailed within the *Hospital Services* subsection, the MCO shall refer to the guidelines and requirements for those specific services as provided within this Manual.

The MCO must ensure that hospitals participating in its network meet all applicable certification and licensing requirements issued by the state in which they are located. The LDH Health Standards Section (HSS) is the only licensing authority for hospitals in the state of Louisiana.

As described in the Contract, the MCO's rate of reimbursement shall be no less than the published Medicaid FFS rate in effect on the date of service or that is contained on the weekly procedure file sent to the MCO by the fiscal intermediary, or its equivalent, unless mutually agreed to by both the MCO and the provider in the provider agreement. The MCO shall also make directed payments to qualified hospitals in accordance with the Contract, rule, and the **State Directed Payment Program Manual**.

General Policies

Inpatient vs. Outpatient Services

- The MCO must ensure that inpatient services are not reimbursed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. The following requirements apply:
  - All outpatient services except outpatient therapy performed within 24 hours of an inpatient admission shall be included on the inpatient claim.
  - All outpatient services except outpatient therapy performed within 24 hours before an inpatient admission and 24 hours after the discharge shall be included on the inpatient claim. This includes outpatient services that are either related or unrelated to the inpatient stay.
  - If an inpatient in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.
- If an enrollee is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided the enrollee is not admitted as an inpatient.
- Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee is to be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for enrollees who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered a number of factors. Admissions of particular enrollees are not covered or non-covered solely on the basis of the length of time the enrollee actually spends in the hospital.
- The MCO will reimburse up to 48 hours when medically necessary for an enrollee to be in an outpatient status. This time frame is for the physician to observe the enrollee and to determine the need for further

RESOURCES

MANUALS AND GUIDES

Links to manuals and guides referenced in this Manual are provided below. Additional MCO resources are posted on the LDH website [link].

- Chisholm Compliance Guide and MCO User Manual
- Crisis Response System Companion Guide
- DOJ Agreement Compliance Guide
- Financial Reporting Guide
- Louisiana Quality Management Strategy for the Louisiana Medicaid Managed Care Program (Quality Strategy)
- Marketing and Member Education Companion Guide
- Medicaid 834 Benefit and Enrollment EDI Transaction Set Companion Guide (834 Systems Companion Guide)
- Medicaid Services Manual
- Provider Network Companion Guide
- Quality Companion Guide
- Reinstatement and Implementation of LAHIPP Third Party (TPL) Claims Payment
- State Directed Payment Program Manual
- System Companion Guides

FEE SCHEDULES

Louisiana Medicaid FFS fee schedules are posted on www.lamedicaid.com [link].

FORMS AND TEMPLATES

Most forms referenced in this Manual may be located at www.lamedicaid.com [link].

Additional forms referenced in this Manual may be located using the following links:

- Denial and Partial Denial Notice Templates