LTC User Guide for Preadmission Screening and Resident Review (PASRR) for Nursing Facilities
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Learning Objectives

After reading this Long Term Care (LTC) PASRR/NFSS User Guide, you will be able to:

• Understand the Preadmission Screening and Resident Review (PASRR) process.
• Understand the Interdisciplinary Team (IDT) Meeting requirements and the PASRR Specialized Services (PSS) information.
• Understand the process for requesting specialized services using the NFSS form.
• Understand how to update forms - and the consequences of doing so.
• Identify NFSS form statuses.
• Understand and respond to alerts.
• Recognize how to prevent Medicaid waste, abuse, and fraud.
• Understand that complying with Health Insurance Portability and Accountability Act (HIPAA) is YOUR responsibility. You should seek legal representation when needed, and consult the manuals or speak to your Texas Medicaid & Healthcare Partnership (TMHP) Provider Representative when you have questions.
• Identify additional resources.
Preadmission Screening and Resident Review (PASRR)

PASRR is a review process that is federally mandated, requiring that all individuals seeking Medicaid-certified Nursing Facility (NF) admissions are screened for Mental Illness, Developmental Disability (Related Condition), or Intellectual Disability (Mental Retardation), regardless of funding source or age.

An individual being admitted through the Preadmission process (that is not Exempted Hospital Discharge, Expedited Admission or negative for PASRR eligibility) should not be admitted to the NF until a PASRR Level 1 (PL1) Screening Form and PASRR Evaluation (PE) have been submitted on the LTC Online Portal by the LA. Additionally, a PASRR Evaluation (PE) must also be submitted after a PL1 with positive PASRR eligibility for an individual already admitted into the facility as Exempted Hospital Discharge or Expedited Admission. Finally, the NF must certify if they can or cannot meet the needs of the individual if the PE is positive.

The information on the hard copy of the PL1 Screening Form, which is completed by the Referring Entity (RE) and given to the LA or NF, is submitted directly on the LTC Online Portal and assigned a Document Locator Number (DLN) when successfully admitted. To check on status information, providers can use FSI or Current Activity to access the PL1 Screening Forms and the associated PEs that were submitted for their facility.

The PE is used to perform an evaluation to confirm or deny the suspicion of MI, ID or DD documented on the PL1 Screening, determine if the NF is the appropriate placement for the individual, and determine whether the individual could benefit from specialized services. The PE can only be performed face-to-face by the Local Authority (LA), and must be initiated within 72 hours from the first notification to perform the PE, and submitted on the LTC Online Portal within seven calendar days from the first notification to perform the PE.

If the individual is PASRR Negative based on the PE, a letter will be provided to the individual/LAR. If the individual does not agree with this result, then the individual/LAR can contact the Evaluator at the LA stated on the letter. A Fair Hearing can be requested. More information on Fair Hearings can be found in the “Medical Necessity and the MN Determination Process” section of this User Guide.

If an individual is discharged to acute inpatient care for less than 30 days and is re-admitted to the same NF, it is not necessary to submit a new PL1 Screening Form unless the first PL1 has been updated as discharged.

Overview of PASRR Admission Processes

There are four different PASRR processes: Exempted Hospital Discharge, Expedited Admission, Preadmission, and Negative PASRR Eligibility. In order to decide which admission process to follow, the RE must first determine if there is a suspicion of PASRR eligibility. If there is a suspicion of PASRR eligibility, then one of the first three processes can be followed. If there is no suspicion of positive PASRR eligibility, then the Negative PASRR Eligibility process is followed. Below are flowcharts explaining the different processes at a high-level.
1. The Exempted Hospital Discharge process starts when a Referring Entity (RE) performs the PL1 and determines if the individual is eligible for Exempted Hospital Discharge Admission. The criterion for an admission under Exempted Hospital Discharge is the individual is not expected to remain in the NF more than 30 calendar days.

2. If the individual does not meet the criterion for Exempted Hospital Discharge, then the RE follows the Expedited Admission Process or the Preadmission Process.

3. If the individual **does** meet the Exempted Hospital Discharge criterion, then:
   a. The RE sends the PL1 Screening Form to the admitting NF with the individual.
   b. The NF submits the PL1 Screening Form on the LTC Online Portal immediately upon receipt.

**NOTE:** If the NF attempts to submit the MDS LTCMI without first submitting the PL1 Screening Form, the LTCMI will not be accepted. In the case of Preadmission PL1, the PE must also be submitted and MN determined prior to submitting the MDS LTCMI.

4. If the individual is discharged from the NF prior to 30 calendar days from the admission date, the NF indicates the discharge on the PL1 Screening Form.
   a. If the individual is still in residence at the NF after 30 calendar days from the admission date, then:
   b. The LTC Online Portal alerts the LA to perform a PE.
   c. The LA initiates face-to-face contact for the PE within 72 hours of notification.

5. The LA submits the PE on the LTC Online Portal within seven calendar days of notification by the LTC Online Portal. Authorization for payment to the LA for completion of the PE is set-up as a result of successful submission of the PE on the LTC Online Portal.
6. If the PE is positive, the NF reviews the PE, including recommended specialized services, and certifies on the PL1 Screening Form if they are Able or Unable to serve the individual.

7. If the NF is Unable to serve the individual, the NF must notify the LA, and the LA will coordinate placement into another NF or an alternate setting.

8. If the NF is Able to serve the individual, the NF will conduct the IDT with required participants.

9. The NF requests specialized services using the NFSS form.

**NOTE:** For more information about certification, see the “Certification of the NF’s Ability to Serve the Individual” section of this User Guide.

### Expedited Admission Process

1. Referring Entity performs the PL1 Screening and screens for Expedited Admission using the following seven categories:

<table>
<thead>
<tr>
<th>Category #</th>
<th>Category Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Convalescent Care</td>
<td>Individual is admitted from an acute care hospital to an NF for convalescent care with an acute physical illness or injury which required hospitalization and is expected to remain in the NF for greater than 30 days.</td>
</tr>
</tbody>
</table>
2. If the individual does not meet Expedited Admission or the Exempted Hospital Discharge criteria, then the RE follows the Preadmission process (described in a subsequent diagram).

3. If the individual does meet Expedited Admission criteria, then the RE sends the PL1 Screening Form to the admitting NF along with the individual.

NOTE: If the NF attempts to submit the MDS LTCMI without first submitting the PL1 Screening Form, the LTCMI will not be accepted. In the case of Preadmission PL1, the PE must also be submitted and MN determined prior to submitting the MDS LTCMI.

4. The LA is required to perform a PE based on the Expedited category:
   a. If the Expedited Admission category is 1, 2, or 3, the LTC Online Portal will create an Alert for the LA to complete the PE once the PL1 Screening Form is successfully submitted on the LTC Online Portal by the NF.
   b. If the Expedited Admission category is 4 or 5, the LTC Online Portal creates the Alert seven calendar days after the NF admission date.
   c. If the Expedited Admission category is 6, then the LTC Online Portal creates an Alert 14 calendar days after the NF admission date.
   d. If the Expedited Admission category is 7, the LTC Online Portal will alert the LA to perform a PE when the MDS indicates the individual is no longer comatose.

5. Once notified by an Alert, the LA initiates the face-to-face contact for the PE within 72 hours of notification by the LTC Online Portal.

6. The LA will submit the PE on the LTC Online Portal within seven calendar days of notification. Authorization for payment to the LA for completion of the PE is determined as a result of successful submission of the PE on the LTC Online Portal.

7. The NF reviews the PE, including recommended specialized services, and certifies on the PL1 Screening Form if they are Able or Unable to serve the individual.

8. If the NF is Unable to serve the individual, the NF must notify the LA, and the LA will coordinate placement into another NF or an alternate setting.

<table>
<thead>
<tr>
<th>Category #</th>
<th>Category Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Terminal Illness</td>
<td>Individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. An individual’s medical prognosis is documented by a physician’s certification, which is kept in the individual’s medical record maintained by the NF.</td>
</tr>
<tr>
<td>3</td>
<td>Severe Physical Illness</td>
<td>An illness resulting in ventilator dependence or diagnosis such as chronic obstructive pulmonary disease, Parkinson’s disease, Huntington’s disease, amyotrophic lateral sclerosis, congestive heart failure, which result in a level of impairment so server that the individual could not be expected to benefit from specialized services.</td>
</tr>
<tr>
<td>4</td>
<td>Delirium</td>
<td>Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.</td>
</tr>
<tr>
<td>5</td>
<td>Emergency Protective Services</td>
<td>Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the NF not to exceed seven days.</td>
</tr>
<tr>
<td>6</td>
<td>Respite</td>
<td>Very brief and finite stay of up to a fixed number of days to provided respite to in-home caregivers to whom the individual with MI or IDD is expected to return following the brief NF stay.</td>
</tr>
<tr>
<td>7</td>
<td>Coma</td>
<td>Severe illness or injury resulting in inability to respond to external communication or stimuli, such as coma or functioning at brain stem level.</td>
</tr>
</tbody>
</table>
9. If the NF is **Able** to serve the individual, the NF will conduct the IDT with required participants.

10. The NF requests specialized services using the NFSS form.

**NOTE:** For more information about certification, see the “Certification of the NF's Ability to Serve the Individual” section of this User Guide.

**Preadmission Process**

1. The Preadmission Process starts when there is an NF admission from an RE in the community (such as from home, a group home, psychiatric hospital, jail, etc.) that is not Expedited Admission, Exempted Hospital Discharge, or the individual is negative for PASRR eligibility. The RE may require assistance from the LA to complete the PL1 Screening Form. The NF is not allowed to submit Preadmission PL1s.

2. Because the PL1 Screening is positive:
   a. The RE faxes the PL1 Screening Form to the LA (this notification starts the 72 hour timer).
   b. The LA submits the PL1 Screening Form on the LTC Online Portal system immediately upon receipt.
   c. The LA initiates face-to-face contact for the PE within 72 hours of notification by the RE (See step 3a for notification).
   d. The LA submits the PE on the LTC Online Portal within seven calendar days of notification by the RE (See step 3a for notification). Authorization for payment to the LA for completion of the PE is set-up as a result of successful submission of the PE on the LTC Online Portal.

3. If the PE is positive, the NF reviews the PE, including recommended specialized services, and certifies on the PL1 Screening Form Section D if they are Able or Unable to serve the individual.

**Note:** If the NF attempts to submit the MDS LTCMI before the Preadmission PL1 Screening Form and PE have been submitted, and before MN determination has been made if the PE was positive for PASRR eligibility, then the LTCMI will not be accepted. For more information about certification, see the “Certification of the NF’s Ability to Serve the Individual” section of this User Guide. For more information about LTCMI Rejections, see the “LTCMI Rejections” section of the LTC User Guide for Nursing Facilities.
4. If the NF is **Unable** to serve, the NF must notify the LA, and the LA will coordinate placement of the individual into another NF or alternate placement by working with the RE and the other identified NFs listed on the PL1 Screening Form. The LA updates the PL1 Screening Form with the “Admitted To” date once the individual is placed.

5. If the NF is **Able** to serve the individual, the NF admits the individual on the PL1 by clicking on the “Admitted to NF” button on the yellow Form Actions bar and entering the date of admission, and the NF will conduct the IDT with required participants.

6. The NF requests specialized services using the NFSS form.

**Negative PASRR Eligibility Process**

In the Negative PASRR Eligibility process (meaning PL1 fields in PASRR Screening Section C0100. Mental Illness, C0200. Intellectual Disability, and C0300. Developmental Disability are all “No”) the RE or the NF (when it’s an NF to NF transfer) will perform the PL1. The NF that admits the individual will submit the PL1 on the LTC Online Portal immediately upon receipt.

If the PL1 Screening is negative:

1. The RE sends the PL1 Screening Form to the admitting NF with the individual.

2. The NF admits the individual and upon admission submits the PL1 Screening Form on the LTC Online Portal.

*Note:* If the individual is PASRR Negative, based on a PL1 Screening, then existing procedures for nursing home admissions are followed. A PE is not performed unless requested by HHS, DSHS, an NF, or the individual/LAR.

Detailed instructions for the PL1 Screening Form can be found online at: [https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-forms-instructions](https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-forms-instructions).

**How to Submit a PASRR Level 1 Screening Form**

1. Log in to the LTC Online Portal. PL1 Screening Forms should not be submitted by a third-party software vendor.

2. Click the **Submit Form** link located in the blue navigational bar.

3. Type of Form: Choose **PL1: PASRR Level 1 Screening** from the drop-down box.

4. Vendor Number: Choose the submitter Vendor Number/Provider Number from the drop-down box.

5. Click the “Enter Form” button.

6. Enter all required information as indicated by the red dots. Remember that the individual must be admitted under Exempted Hospital Discharge or Expedited Admission for submission of the PL1 Screening Form by an NF, and indicated accordingly, and that a negative PL1 can also be submitted. Field C0300 contains a hyperlink to ICD codes to assist in documenting Developmental Disability.

7. From here, you have two choices:
   a. Click the “Submit Form” button to submit the screening form.
b. Click the “Save as Draft” button to store the screening form for future completion, but not submit it. The screening form does not have to be complete to save the draft. Note that drafts are only available for 60 days.

8. To print the submitted PL1 for your records, open the PL1 and click the “Print” button located on the yellow Form Actions bar.

**Note:** If the screening form is successfully submitted, a DLN will be assigned and the LTC Online Portal will show a message stating “Your form was submitted successfully.” If there are errors, they will be displayed in a box at the top of the screen. These errors will need to be resolved before the screening form will be successfully submitted. Once all errors are resolved, click the “Submit Form” button again to submit the screening form.

The LTC Online Portal will halt the submission of a PL1 which does not include PASRR condition(s) identified on the latest PE by displaying an error message. The error message will state the PASRR condition of the latest PE and will allow the submitter to update the PL1 and resubmit.

This will occur with all scenarios including Change of Ownership (CHOW) and transfers.

If a previous PL1 Screening Form is found, and the Date of Assessment is the same as the previously submitted screening form, the new screening form will not be accepted. If a previous PL1 Screening Form is found, and the Date of Assessment is prior to the Date of Assessment on the new screening form, the new screening form will continue to process, and the old screening form will be inactivated. A PL1 (and sometimes a PE) are required prior to the submission of the MDS LTCMI Admission Assessment.

After a positive PL1 Screening is submitted and the LA has completed the PE, the NF submitting the form must check the LTC Online Portal to see if the associated PE is also positive. If it is, the NF must certify on the source
PL1 that it is willing and able to serve the individual, or unable to serve the individual (based on the services indicated on the associated PE). For more information about certification, see the “Certification of the NF’s Ability to Serve the Individual” section of this User Guide.

Certification of the NF’s Ability to Serve the Individual

A Nursing Facility must certify that it can or cannot provide required specialized services to an individual. When the PE is positive and a PL1 Screening Form is set to Pending Placement in NF - PE Confirmed, Individual Placed in NF - PE Confirmed, or Negative PASRR Eligibility status, NFs identified in Section D of the PL1 Screening Form must certify that the NF has reviewed the recommended specialized services on the PE and determined whether or not the individual can be served by selecting the “Able to Serve the Individual” button or the “Unable to Serve the Individual” button located on the yellow Form Actions bar. Additionally, the NF will receive an alert to certify on a PL1 when a positive PE is submitted.

Note: When a PL1 has an associated negative PE, the buttons to certify will not be displayed.

1. Locate the PL1 Screening Form using FSI or Current Activity.
2. There are two choices:
   
a. To certify the ability to serve the individual, click the “Able to Serve the Individual” button located in the yellow Form Actions bar. Click the “OK” button when the pop-up window appears.

![Message from webpage](image1)

or

b. To certify that the NF does not have the ability to serve the individual, click the “Unable to Serve the Individual” button located in the yellow Form Actions bar. Click the “OK” button when the pop-up window appears.

![Message from webpage](image2)

3. The following confirmation screen will appear:

![Message from webpage](image3)

4. The corresponding field in Section D of the PL1 Screening Form (D0100N) will be systematically updated to show either “0. No” or “1. Yes”

**Note:** Once a positive PE has been submitted by the Local Authority from a Preadmission PL1, the NF has 90 days to certify Able to Serve the Individual or Unable to Serve the Individual. If after 90 days, none of the NFs listed on the PL1 Screening Form in Section D have indicated an ability to serve and admit the individual, then a new PL1 Screening Form must be submitted by the LA.

**Note:** Although it is technically possible to make updates to the PL1 right up to when the LA submits the PE, it is not recommended to do so, as it may cause mismatches in data between the two forms. These mismatches are often not easily correctable, and should be avoided if at all possible. For more information about the PASRR admission processes, see the “Overview of PASRR Processes” section of this User Guide.
PASRR Level 1 Screening Updates

NF Providers must submit PL1 Screening Form updates directly on the LTC Online Portal. Only users with appropriate security permissions can submit updates. In the case of a Preadmission PL1, which is submitted by an LA, only the LA can perform updates. Therefore, the NF should contact the LA so it can perform the update. Also in the case of a Preadmission PL1, the admitting NF must certify and admit the individual on the PL1 before they can update it for deceased and discharged residents.

The PL1 Screening Form cannot be updated if the status is set to Form Inactivated or PL1 Inactive. The PL1 Screening Form can be updated for the demographic information only until an associated PE has been successfully submitted. The “Update Form” button will not be available on the PL1 during a PE initiation and submission. Updates to a PL1 will not occur when changing an individual's information during the associated PEs submission (the PL1 must be updated before the PE is initiated; otherwise, the two forms will be incorrectly sequenced, and the PL1 will not be able to be updated).

For deceased or discharged individuals, the PL1 can be updated at any time, even after a PE has been submitted. This update will change the status of the PL1 to PL1 Inactive. No parent/child form is created when an update to a PL1 is submitted. The History trail shows the fields that have been updated by listing the new and previous values.

Available Fields

The following fields on the PASRR Level 1 Screening can be updated. After updating, you must click the “Submit Form” button to save the changes you have made. Updates to the individual's demographic information do not change the PL1 status. However, when updating fields B0650 (Individual is deceased or has been discharged?) and B0655 (Deceased/Discharge Date) on the PL1 Screening Form, the status of the PL1 Screening Form does change. By updating these fields, the PL1 will be set to status PL1 Inactive. Fields B0650 and B0655 are the only PL1 updated fields with this effect.

The following fields on the PE can be updated until one of the MI/IDD Completion PTIDs is set to status Invalid/Complete, Processed/Complete, or PCS Processed/Complete anywhere in the PTID history. Because NFs do not have access to the PE, the NF will need to contact the LA and ask them to make these updates.

Fields updated on the PE are also automatically updated on the associated PL1. The ability to update some fields is based on security permissions. The LMHA/LBHA cannot update IDD Date of Assessment and the LIDDA cannot update the MI Date of Assessment. Other fields may also be unavailable based on Vendor/Provider Number combination.
PL1 History Trail

Every PL1 Screening Form will have a History trail. After opening a PL1 form, scroll to the bottom. The History trail will display a list of every processing status that has been held by the document along with any appropriate details. Any notes added by a user, alerts that have been generated, and fields that have been updated will also be located in the History trail.

Error Messages

The LTC Online Portal will validate the PASRR condition entered on the PL1 against the latest PE, if any. If the unsubmitted PL1 includes an incorrect PASRR condition, the LTC Online Portal will display the following error message:

“The previously submitted PE is positive for <PASRR Condition(s) of Latest PE>. Correct the PL1 to include <PASRR Condition(s) of Latest PE> and re-submit.”

Below is an example of a typical error message:

The following errors must be fixed before the form will submit:

- Other Type of Entity is a required field.
- Current Location Name is a required field.
- Current Location Street Address is a required field.
- Current Location City is a required field.
- Current Location State is required field.
- Current Location ZIP Code is a required field.
- Current Location Phone Number is a required field.
- Date of Last Physical Examination is a required field.
- Certification of Signature is a required field.
- Referring Entity Signature Date is a required field.
PASRR Evaluation (PE)

The PASRR Evaluation (PE) is a face-to-face assessment performed with the individual and/or the Legally Authorized Representative (LAR). The PE is always performed when the PASRR Level 1 (PL1) Screening indicates that a person is suspected of having a positive PASRR condition with a “Yes” in at least one of the fields in Section C (C0100, C0200, and/or C0300). The PE verifies PASRR eligibility of the individual and lists any recommended specialized services. Nursing Facilities review the PE to determine if they are able or unable to serve the individual’s needs. If a PL1 indicates a negative PASRR condition, a PE may also be performed upon request from the state or a Nursing Facility.

A PE is performed regardless of the individual’s Medicaid status. This includes individuals who already have Medicaid, pending Medicaid approval, and those who have not applied for Medicaid or may not be eligible.

Over time, there can be multiple PL1s and multiple PEs for an individual. By linking the active PE to the active PL1, it is always possible to determine which one is the active PL1 and PE.

Only Local Authorities can perform and submit the PE. The Nursing Facility or the Referring Entity must contact the Local Authority to perform a PE once the PL1 is completed and it indicates a suspicion that the individual is PASRR Positive. The Local Authority initiates face-to-face contact for PE within 72 hours of notification by the Referring Entity.

Here are a few things to remember:

• PEs are always done when a PL1 is positive.
• PEs can be requested by the state or a Nursing Facility, even if the PL1 is negative.
• The PE must be completed prior to admission to the Nursing Facility if the admission type is Preadmission.
• PEs can only be updated by the LA that submitted the PE.
• A PE is performed on individuals with a positive PL1 regardless of their Medicaid status:
  – Medicaid
  – Non-Medicaid
  – Pending Medicaid
• Nursing Facilities can access PE forms for informational purposes only on the LTC Online Portal by using FSI and Current Activity. NFs can print PE forms that are accessible to them.

Local Authorities, Nursing Facilities, and Referring Entities work together to ensure both the PL1 and the PE are completed.

Dually Diagnosed Individuals

Dually diagnosed individuals are individuals who show signs of both Mental Illness (MI) and Intellectual and Developmental Disability (IDD), MI and Intellectual Disability (ID), or MI and Developmental Disability (DD). There are two sections on one PASRR Evaluation and two payments for the PASRR Evaluation if performed by separate Local Authorities.

When two Local Authorities are involved, then the Local Authority that initiates submitting a PASRR Evaluation is responsible for completing common sections of the PASRR Evaluation. All sections of the PASRR Evaluation are common except Section B and Section C. Section B is specific to IDD and is for LIDDAs to use while Section C is specific to MI and is for LMHAs/LBHAs to use. Upon submission by the submitting Local Authority, the PASRR Evaluation will be set to status Pending Form Completion. The other Local Authority must complete the evaluation.
using the same PE, and should not initiate a new PE.

The PASRR Evaluation is not considered complete until both sections (MI and IDD) are completed when the person is dually diagnosed. A system-generated alert is sent to the Local Authority responsible if only one part of the PASRR Evaluation is completed.

**Using Form Status Inquiry (FSI) to Identify Residents with Specific PASRR Conditions**

Nursing Facilities can use FSI to identify residents with specific PASRR conditions. This can assist NFs in identifying the number of residents in the facility who are IDD only, MI only, IDD and MI, or PASRR Negative.

The LTC Online Portal will:

- Derive and store the PASRR condition of NF residents, as indicated by the latest active PASRR Evaluation (PE)* for the resident at the time of the most recent MDS LTCMI submission. (*An active PE is one that is not set to status Pending Form Completion or Form Inactivated).
- Provide the capability to export the resident-based search results to Microsoft Excel.
- Provide a capability to search for residents in the facility based on their PASRR condition, by selecting an option from the drop-down box in the FSI.
- Display a list of residents when searching by a PASRR condition listed in the “PASRR Eligibility Type” drop-down box of the FSI. This function is different because all other searches will display forms or assessments in the Search Results section.

To use FSI this way you must select MDS 3.0: Minimum Data Set (Comprehensive) or MDSQTR 3.0: Minimum Data Set (Quarterly) from the FSI “Type of Form” drop-down box.

1. Click the **Search** link on the blue navigational bar.
2. Choose **Form Status Inquiry** from the drop-down menu.
3. Type of Form: Choose one of the following options from the drop-down box:
   - MDS 3.0: Minimum Data Set (Comprehensive)
   - MDSQTR 3.0: Minimum Data Set (Quarterly)
4. Vendor Number: Choose the submitter Vendor Number/Provider Number from the drop-down box.
5. From the “PASRR Eligibility Type” drop-down box choose one of the following:
   1. IDD Only
   2. MI Only
   3. IDD and MI
   4. Negative
6. Click the “Search” button. The search will return all current residents who meet the search criteria. Current residents are determined by fields “B0650. Individual is deceased or has been discharged?,” “B0655. Deceased/Discharged Date” of the PL1 as well as the latest 3618/3619 submission. For this search, the “From” and “To” dates are disabled and will default to the current date as both the start and end date once a “PASRR Eligibility Type” is selected from the drop-down menu.
Interdisciplinary Team (IDT) Meeting

The IDT tab on the PL1 is where information about the IDT meeting and Specialized Services Review is captured. It is the responsibility of the NF to facilitate and invite to the IDT meeting the NF’s Registered Nurse (RN), the applicable Local Authority (LA), and the individual or the individual’s legally authorized representative (LAR). LA is an umbrella term that encompasses both Local Intellectual & Developmental Disability Authorities (LIDDAs) and Local Mental Health Authorities (LMHAs) /Local Behavioral Health Authorities (LBHAs). Fields on the PE will dictate who needs to attend the IDT meeting. When PE fields B0100 or B0200 are “1. Yes” the LIDDA is required to attend. When PE field C0800 is “1. Yes” the LMHA/LBHA is also required to attend.

The IDT meeting is held at the NF and must be convened within the first 14 calendar days of the resident’s admission to the NF, provided a positive PE is in place. Completion of the PASRR Evaluation (PE) and participation in the IDT meeting requires the NF to provide the LA staff with access to the resident and the resident’s records.

It is the responsibility of the LA to participate in the IDT meeting to finalize the recommended specialized services indicated on the submitted PE. The LA does not have to be physically present at the meeting; participation by telephone is permissible.

LIDDAs are required to provide a service coordinator and service coordination to a Medicaid-eligible Nursing Facility resident with Intellectual or Developmental Disability (IDD) or with a dual IDD/ Mental Illness (MI). LIDDAs must also organize a quarterly service planning team (SPT) and facilitate service planning related to specialized services, community living options, and transition to community living. The service planning is separate and distinct from service planning conducted by Nursing Facility staff. The service planning team meeting organized by the LIDDA is documented on the PSS form.
The IDT meeting is necessary to finalize and document the specialized services the resident will receive from both the NF and the LIDDAs and/or LMHAs/LBHAs. All finalized specialized services must be documented by the NF in the resident's Comprehensive Care Plan and initiated within 20 days (for an NF) or 30 days (for an LA) after the date that the services are agreed to in the IDT meeting. The NF has three business days from the date of the IDT meeting to submit it on the LTC Online Portal via the PL1, “IDT” tab. The LIDDAs and LMHAs/LBHAs have five business days from the date of the IDT meeting to confirm their attendance and agree to the services documented for the IDT meeting submitted on the LTC Online Portal.

If the initial IDT or Specialized Services Review meeting was not submitted on the LTC Online Portal and held within the last year by the current NF, the MDS Long Term Care Medicaid Information (LTCMI) is rejected. Upon rejection of the LTCMI, the error message will read: “An Interdisciplinary Team (IDT) meeting submission is not found on the LTC Online Portal, or it was found but the IDT meeting date is more than one year ago. An IDT meeting submission is required before the MDS LTCMI can be submitted. You may save the LTCMI and submit after the IDT is submitted.” The NF will be able to save the LTCMI and submit it after successful submission of the IDT or Specialized Services Review meeting.

The LTC Online Portal will not reject the MDS LTCMI for missing an IDT meeting submission under the following circumstances:

- The PL1 is inactive (resident has been transferred, or deceased, or discharged).
- A positive PE for this individual at this NF was not found on the LTC Online Portal.
- The resident is in the Hospice Program (Service Group 8) as of the current date or the MDS Assessment Effective Date (Service Group 8). Indication of Hospice will be checked both in the MDS (Section O and LTCMI) and Claims Management System.

**IDT Meeting Steps**

1. The meeting must occur within the first 14 calendar days of admission to the NF.
2. The NF must inform the RN, LA, and the individual (or the LAR) of the date and time of the meeting (The LA and LAR can participate in the meeting via telephone; physical presence is not required).
3. The finalized Specialized Services delivered by the LA and NF should be included in the residents Comprehensive Care Plan.
4. All NF Specialized Services must be initiated within 20 business days after the date of the IDT meeting. The LA has 30 business days after the date of the IDT meeting to initiate services.
5. When a LIDDA is invited to an IDT meeting and fails to attend, the NF should notify the HHSC IDD Services/PASRR Section via email: PASRR.Support@hhsc.state.tx.us.
6. When an LMHA/LBHA is invited to an IDT meeting and fails to attend, the NF should notify DSHS PASRR via email: PASRR.MentalHealth@hhsc.state.tx.us.

**Submitting an IDT Meeting**

Once the NF has conducted the IDT meeting, the NF has three business days from the date of the IDT meeting to submit it on the LTC Online Portal. Enter the IDT meeting information as required. Many of the fields are conditionally required, meaning that depending on the information entered in a field, other fields may become required fields.

1. Upon successful completion of a PL1 and a PE indicating positive PASRR eligibility, click the “Create IDT” button displayed on the PL1 on the yellow Form Actions bar.
2. The Nursing Facility must complete all required fields (as indicated by a red dot next to the field) on all sections of the IDT screen. Field G0500 has two questions that must be completed: “G0500A. Are Specialized Services indicated at this time?” and “G0500B. Was there a discussion of the Individual’s need for habilitation therapies (OT, PT, ST)?” The IDT Confirmation section will be completed by the LA staff that attended the meeting. Nursing Facility required fields are disabled for the LA.
3. Once completed, the Nursing Facility will submit the form by clicking the “Submit Form” button on the bottom right of the screen.

4. The following confirmation message will be displayed upon successful submission of the NF portion of the IDT: “The IDT has been successfully submitted by the NF and is now pending confirmation by the LA/LMHA.”

5. An IDT History trail will be displayed at the bottom of the IDT tab and will display a History of all the successfully submitted Initial IDT or Specialized Services Review meetings. The History will display “Date of IDT Meeting (MM-DD-YYYY)” as links in chronological order from most recent date of IDT meeting to oldest date of IDT meeting. Each IDT will display as a collapsible link and contain the History of that IDT meeting.
6. By clicking the “Update IDT” button, NFs will have the ability to update a successfully submitted IDT until it is confirmed by the LA staff that attended the meeting.

Authorization Request for PASRR Nursing Facility Specialized Services (NFSS)

The NFSS form allows NF personnel to request NF specialized services on behalf of the individual via the LTC Online Portal. It allows requests to be submitted for specialized services for individuals with Intellectual Disabilities (ID), Developmental Disabilities (DD), Intellectual and Developmental Disabilities (IDD) or dual diagnoses of Mental Illness (MI)/IDD. Specialized Services (SS) cannot be requested on this form for individuals with MI only, who are under 21 years of age, have a negative PE, or who are not Medicaid-eligible. The form also allows NF providers to:

- Upload all required and supporting documentation directly to the portal as electronic attachments.
- Save drafts of PASRR NFSS forms prior to completing.
- Print out the completed form, or draft.
- Save time with pre-populated fields.

The NFSS form allows the NF to request multiple specialized services on a single form for a resident. The services can be selected from three types:

- Customized Manual Wheelchair (CMWC);
- Durable Medical Equipment (DME); or
- Habilitative Therapies.

Providers can only request one type of service per form. For example, if the NF needs to request four DME items and three Habilitative Therapies, this request must be submitted on two separate NFSS forms, one for the therapies and one for the DME items.

The NFSS form has 17 tabs that include detailed sections for provider and individual information, and sections that allow providers to fill out information for the specific types of service requested. The tabs include:

- Resident/NF
- CMWC/DME Assessment
- CMWC Request
- Gait Trainer
- Orthotic Device
- Car Seat/Travel Restraint
- Mattress
- Positioning Wedge
- Prosthetic Device
Completing and Submitting the NFSS Form

In order to generate, access and submit NFSS forms on the LTC Online Portal, certain user permissions are required. Only NF users (not LA or MCO users) can submit or update these forms. An NF user (though not an “Admin Only” user) must have either a “PL1 Submitter” or “PL1 Viewer” user permission and the “NFSS Submitter” permission. The system validation will prevent “Admin Only” users from generating or opening an NFSS form.

To submit a new NFSS form, the provider can gain access to the NFSS Form only from a completed, active PL1 Screening Form. The NFSS is launched from the PL1 utilizing the ‘Initiate NFSS’ button found in the yellow Form Actions bar. The button will only appear when fields B0100 or B0200 are ‘1. Yes’ on the PASRR Evaluation.

1. Log onto the LTC Online Portal and navigate to the Form Status Inquiry screen.
2. From the Type of Form drop-down box, choose **PL1: PASRR Level 1 Screening**.

3. Choose the appropriate Vendor Number from that drop-down box.

4. Enter the date range in which the PL1 was submitted. The default date range is 30 days.
5. Enter the DLN of the PL1, Medicaid Number, SSN, or Last/First Name of the individual for which SS needs to be requested.

6. Click the “Search” button. The system will then display the search results.

7. Click “View Detail” for the appropriate PL1.
8. “Initiate NFSS” button will be displayed in the yellow Form Actions bar. Click “Initiate NFSS.”
9. The individual’s demographic information (completed during the PL1 Screening Form Submission process) will auto-populate. Confirm that the legally authorized representative’s information is correct if present on the Resident/NF tab of the NFSS form. If the LAR information on the NFSS form is incorrect, the NF should correct it.
10. To begin requesting SS on this form, scroll to the ‘Type of Service Requested’ section at the bottom of the Resident/NF tab.

11. Identify the type of SS for which you are requesting authorization in A2000.

   a. If you select “1. Customized Manual Wheel Chair (CMWC)” in A2000, the A2100 drop-down field becomes enabled and required. Selecting “1. CMWC Assessment Only” from the A2100 drop-down list will result in only the CMWC/DME Assessment tab being enabled for data entry. The rest of the form will
be disabled. Selecting “2. CMWC” from the A2100 drop-down list will result in the CMWC/DME Assessment tab being enabled for data entry. When data is entered on the CMWC/DME Assessment tab, then the CMWC Request tab becomes enabled for data entry.” The rest of the form will be disabled.

b. If you select “2. Durable Medical Equipment (DME)” in A2000, the A2200 drop-down field becomes enabled and required. Selecting “1. DME Assessment Only” from the A2200 drop-down list will result in only the CMWC/DME Assessment tab being enabled for data entry. The rest of the form will be disabled. Selecting “2. DME” from the A2200 drop-down list will enable and require the check boxes in A2210. Click on the check boxes of all applicable equipment. When data is entered on the CMWC/DME Assessment tab, then the tab(s) associated to the check boxes that you clicked on in A2210 become enabled for data entry. The rest of the form will be disabled.
c. If you select “3. Habilitative Therapies” in A2000, the check boxes in A2300 become enabled and required. Click on the check boxes of all applicable therapies. The assessment tabs associated to the therapies you clicked on in A2300 become enabled for data entry. The service tabs associated to the therapies you clicked on in A2300 become enabled upon data entry if the therapy type is not for an assessment only. The rest of the form will be disabled.
12. Scroll to the top of the form and select the appropriate tab. The selections made in the ‘Type of Service Requested’ section on the Resident/NF tab will enable the associated tabs on the NFSS form for data entry. Complete the required fields as indicated by the red dots. For instructions, refer to the NFSS Item-by-Item Guide located on the PASRR Forms and Instructions section of the HHS website at https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-forms-instructions.

13. To submit the form, click the “Submit Form” button located at the bottom right hand side of the page.

14. After successfully submitting and closing, the Portal will issue a DLN for the NFSS form. The DLN can then be entered into FSI to find the form.

**Required Certification for DME/CMWC**

For DME and CMWC requests, the NFSS form must include uploaded MSRP catalog pricing. The supplier must furnish information that verifies the prices listed on the Itemized MSRP List for each of the items listed. The catalog pricing for the item must indicate the item is priced at an amount that is the same as, or less than, the MSRP.

The applicable CMWC-related forms listed below need to be submitted in conjunction with the NFSS form if listed in the “Upload Attachments” section:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page
- PASRR NF Specialized Services (NFSS) - CMWC Supplier Acknowledgment and Signature Page
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification

The applicable DME-related forms listed below need to be submitted in conjunction with the NFSS form if listed in the “Upload Attachments” section:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page
- PASRR NF Specialized Services (NFSS) - DME Supplier Acknowledgment and Signature Page
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification

Refer to “Upload Attachments” later in this guide for more information on uploading the forms.
Additionally, for any approved DME item or CMWC in “Pending NF Receipt” status, the NF must certify by entering data into the required fields on the NFSS form that the item has been received and meets the needs of the individual. In addition, a receipt certification attachment must be uploaded into the LTC Portal after the item has been delivered. The signature by the therapist on this attachment certifies that the item meets the needs of the resident as specified in the assessment. It also indicates, by the administrator’s signature, that the item was delivered and received by the nursing facility. Failure to submit this receipt confirmation will delay or prevent the facility’s reimbursement.

**Important Features and Functions of the NFSS form**

1. The “Authorization” section as seen on each of the tabs (except Resident/NF and Auth Summary) includes:
   a. PTID
   b. Status
   c. Action drop down menu
   d. Reason Code
   e. If Other text box
   f. Date of Assessment
   g. Other data fields may be available dependent upon the specialized services type e.g., Begin Date, End Date, or Total Approved Price.
2. PTID Status Change Page displays when the “Confirm” button is clicked. Submitters can change the status by clicking “Change Status,” or reject the status change by clicking “Cancel.” Information entered in the message text area will display as a note in the PTID history.

3. Upload Attachments
   a. The NFSS form allows you to upload required and supporting documentation as electronic attachments directly to the LTC Online Portal. This can be done in the “Upload Attachments” section located in all the tabs except Resident/NF and Auth Summary. As previously mentioned, an icon on each tab will indicate the required document(s) which are available as templates for easy download and completion for subsequent upload to the portal. The submitter will click on this icon and download the page/attachment, obtain the appropriate signatures or information and upload the page/attachment back to the appropriate request/
PTID by clicking on the “Click Here to Upload Documents” button. This will open up the user's browser to locate the saved files. The PTID history will also show the date, time, and name of successfully uploaded attachments. Up to 10 files can be uploaded at any time. Files cannot exceed 10mb per file. Supported file types are PDF, Image (JPG, TIF, and PNG), MS Word, MS Excel, and RTF.

b. To remove an attachment, the “Delete” button is displayed and enabled once the attachment is successfully uploaded and PTID is not approved or denied. Once PTID gets approved or denied, the “Delete” button will no longer be available.

4. Submitters have the ability to add notes on the NFSS form on the Long Term Care Online Portal (LTCOP). The NFSS form allows the user to add a note using either the “Add Note” button on the yellow Form Actions bar above the Resident/NF tab or by using the “Add Note” button located on each PTID action bar located below the attachment section.
5. For convenience, each section of the service tabs are collapsible.

6. The “Auth Summary” tab is available to help NFs monitor the status of a request for SS and when multiple services are requested on one form using the PTID. Each assessment and service has its own PTID and the NF can follow the status of each PTID through the various stages. This page is read-only so any actions that need to be taken based on the status must be done in the Authorization section of the specified tab.

7. For those services that a resident receives on a recurring basis, such as therapies, the submitter can use the “Populate” button on the NFSS form to populate data from a previously approved assessment into a new NFSS service request. The Populate button is available only on Service PTID tabs. It populates data only on the Assessment PTID tab. This populated information can be edited to update assessment information, alleviating the need for the submitter to key in all assessment information again.

8. “Update” PTID Action, located above the “Authorization” section, allows the user the ability to update a submitted NFSS form and record a history of changes on the LTCOP. Refer to the "Updates" section in this document for more information on how to use this function.
History Trail

Every NFSS form will have a Form History that is located at the bottom of each tab. This history shows the different statuses the form processes through during submission and workflow and validation processes. Forms that do not pass all the validations will not be submitted to the PASRR Reviewer’s workflow.

Additionally, a PTID will be created for each assessment or service successfully submitted with an NFSS form. The PTID History is similar to the Form History, but is created to track each assessment or service authorization associated with the form as it moves through all the required statuses. Once an NFSS form is submitted, the user can check both the Form History and the PTID History by referring to the assessment or service tab of the NFSS form.

When a PTID is in the “Pending Denial” status, the NF must check the PTID history for specific information on what additional information HHSC staff is requesting in order to continue processing the PTID request. The NF must set the PTID status back to “Pending State Review” or the timer will run out and issue a system-generated denial.

Printing the PASRR Specialized Services (PSS) Form

As there is only an initial IDT and subsequent annual Specialized Services Review meeting requirement for PASRR individuals, it is important for NFs to be familiar with requirements for service planning team (SPT) meetings and the documentation on the PASRR Specialized Services (PSS) form.

The PSS form is how Local Intellectual and Developmental Disability Authorities (LIDDA) and Local Mental Health Authorities (LMHA)/Local Behavioral Health Authorities (LBHA) document PASRR specialized services information on the LTC Online Portal.
The PSS form is initiated from a positive PE where the individual’s PASRR condition is IDD or Dual (IDD and Mental Illness [MI]). Only LIDDAs will have the capability to initiate and submit PSS forms. Nursing Facilities can access PSS forms for informational purposes only on the LTC Online Portal by using FSI and Current Activity. NFs can print PSS forms that are accessible to them.

To efficiently facilitate the required quarterly LIDDA SPT meetings and the NF’s quarterly comprehensive care plan meetings, it is advantageous to schedule these required meetings to occur at the same time. While the same participants are necessary for both meetings, the discussion and documentation of agreed upon SS are documented in two separate places.

The LA documents the list of agreed upon PASRR specialized services and are the only entries onto the PSS form. The NF documents the PASRR specialized services, along with other NF PASRR support activities and services the resident requires, on their comprehensive care plan that resides in the resident’s chart.

Use FSI to search for a submitted PSS form.

1. Choose **PSS: PASRR Specialized Services** from the Type of Form drop-down box. The “From Date” and “To Date” are required fields.

   Nursing Facilities may narrow their search by using the Reason Code drop-down box to choose one of the following options:
   - Change in Medical Condition
   - Change in Service
   - Deceased
   - Discharged
   - Refusal of Service Coordination
   - Transfer
   - Transition

2. Click the “Search” button. Remember, Nursing Facilities can access PSS forms for informational purposes only. NFs can print PSS forms that are accessible to them.
Medical Necessity and the MN Determination Process

For the PASRR Preadmission process, TMHP is responsible for reviewing successfully submitted PEs to determine Medical Necessity (MN) for PASRR Positive individuals. The initial MDS assessment will inherit the MN determination from the PE, if the MDS assessment effective date is within 30 days (plus or minus) of the date of assessment of the PE. For other MDS submissions, including all other admission types (Expedited, Exempted Hospital, and PASRR Negative individuals), TMHP is responsible for reviewing submitted MDS assessments to determine MN. The MDS LTCMI will be rejected while waiting for the MN determination on a positive PE initiated from a Preadmission PL1.

Definition of Medical Necessity

40 TAC §19.101 (75) states:

Medical Necessity is the determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the Medicaid claims administrator contracted with HHS makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses.

40 TAC §19.2403(e) states:

A recipient may establish permanent medical necessity status after completion date of any MDS assessment is approved for medical necessity no less than 184 calendar days after the recipient’s admission to the Texas Medicaid Nursing Facility Program.
General Qualifications for Medical Necessity Determinations

40 TAC §19.2401 states:

Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

(1) The individual must demonstrate a medical condition that:

(A) is of sufficient seriousness that the individual’s needs exceed the routine care, which may be given by an untrained person; and

(B) requires licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical or nursing services that:

(A) are ordered by the physician;

(B) are dependent upon the individual’s documented medical conditions;

(C) require the skills of a registered nurse or licensed vocational nurse;

(D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and

(E) are required on a regular basis.

Note: Medical Necessity is not the only prerequisite to qualify for Medicaid eligibility.
Manual Medical Necessity Determination on PASRR Evaluation

To expedite processing, TMHP automatically checks submitted evaluations with a Medicaid Number to determine if the individual already has Permanent MN (PMN). If the individual has PMN, the MN is automatically approved. The History trail will state “Individual has permanent MN.”

For individuals who do not have PMN, TMHP systems automatically review specific criteria on the PE. If the criteria are appropriately met, MN is automatically approved. The History trail will state “Medical Necessity Approved for the individual based on PASRR Evaluation.” If MN could not be determined automatically, then the PE will then be sent to a nurse for manual MN review. The status will be set to Pending Review on the FSI search results, and the last message showing in the History trail will be “The Form has failed Auto MN Approval.”

The flowchart below provides a high-level overview of the process used for manual MN determination for a Preadmission PASRR Positive individual. Providers can use the LTC Online Portal to check the status of MN determination.

1. Submissions for individuals who do not have PMN or do not pass auto-MN are reviewed by the TMHP nurse for MN determination within five business days of successful submission of the positive PE initiated from a Preadmission PL1.
2. Once reviewed, the submission is either approved (meeting MN) or placed in a Pending Denial (need more information) status for up to 21 calendar days. FSI or Current Activity can be used to view the status of MN determination whether the PE is set to status Approved, Denied, or Pending Denial (need more information).

3. The LA must either add additional information clarifying nursing/medical needs through the “Add Note” feature or by calling TMHP and speaking with a TMHP nurse.

4. If the TMHP nurse determines that MN has been met, the PE is approved.

5. If the TMHP nurse still cannot determine any licensed nursing need after additional information has been provided, the PE is sent to the TMHP physician for MN determination.

6. If the TMHP physician determines that MN has been met, the PE is approved.

7. If MN is denied by the TMHP physician, notification of denied MN is sent to the individual in a letter.

8. The individual’s physician may submit additional information within 14 business days of the date on the denial letter by faxing additional medical information to the TMHP LTC department (40 TAC §19.2407). Or, the LA may provide additional information by using the Add Note feature of the PE on the LTC Online Portal or by calling and speaking with a TMHP nurse. The individual’s PE and the additional (or new) medical information will be reviewed by the TMHP nurse and either approved or sent to the TMHP physician for a second MN determination. The TMHP physician will either approve the PE or uphold the original decision to deny.

9. If the LA or individual’s physician does not provide additional information clarifying nursing/medical needs within 21 calendar days of Pending Denial (need more information), the PE is sent to the TMHP physician for review, and the steps 5-9 will apply.

10. The individual may initiate the appeal process when notified by TMHP that medical necessity was denied by the TMHP physician. If a hearing is requested, additional information may be submitted at any time by the NF, LA, or by the individual’s physician either via telephone call to the TMHP nurses or via fax.

Note: The Long Term Care Medicaid Information (LTMCI) can be rejected when MN has not been performed on a Preadmission PE. Submitters are responsible for checking the status of their submitted forms, assessments, screenings, and evaluations using FSI or Current Activity and supplying additional information, if needed.

Request for Fair Hearing

A fair hearing is an informal, orderly, and readily available proceeding held before an impartial health and human services enterprise hearing officer. At the hearing, an individual/applicant (appellant), or their representative, including legal counsel, may present the case as they wish to show that any action, inaction, or agency policy affecting the case should be reviewed. It’s important to note that a denial of a request for authorization of NFSS (on the NFSS form) is through the HHSC PASRR Unit, and not TMHP.

The individual, the individual’s responsible party, or in the case of no responsible party, the LA, Director of Nursing (DON), or the NF administrator may request a fair hearing on behalf of the individual within 90 days from the effective date of the decision or from the notice of adverse action date, whichever is later, by calling TMHP at 1-800-626-4117, Option 5. When an individual receives a letter that indicates denied MN and the right to request a fair hearing, the individual (or LAR) must request a fair hearing within ten days of the date of the letter for Medicaid payment to continue until the fair hearing decision. Medicaid payment will only continue if the individual was already receiving services. If the individual requests a fair hearing later than ten days of the date of the letter, Medicaid payment will not be made for days past day ten. The individual can request a fair hearing up to 90 calendar days after the date of the letter.
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Form 4803, Acknowledgement and Notice of Fair Hearing, serves as a notice of the fair hearing. It is sent to the appellant to acknowledge the receipt of a request for a hearing and to set a time, date, and place for the hearing. Form 4803 will be sent to all known parties and required witnesses at least ten calendar days in advance of the hearing.

The fair hearing is held at a reasonable place and time. They are normally scheduled in the order in which requests are received and are usually held via teleconference.

Appellants may present their own case, or bring a friend, relative, or attorney to present their case. Health and Human Services enterprise does not pay attorney fees. Appellants may request additional time to prepare for their case by contacting the hearing officer.

Appellants may request an interpreter at no cost. However, appellants must notify the hearing officer at least two days before the hearing if they are going to require an interpreter.

Before and during the hearing, appellants and their representatives have the right to examine the documents, records, and evidence that HHS will use. To see medical evidence before the hearing, the appellant must make a written request to the hearing officer. The appellant may bring witnesses and present facts and details about the case. The appellant may also question or disagree with any testimony or evidence that is presented by the department.

Appellants have the right to know all the information the hearing officer examines in making the decision. The laws and policies which apply to the appellant’s case and the reasons for HHS’ action will be explained.

The hearing officer will issue a final written order. The decision by the hearing officer is HHS’ final administrative decision. If the appellant believes the hearing officer did not follow applicable policy and procedures, the appellant can submit a request for administrative review within 30 days of the date of the decision. The appellant submits the request for administrative review to the hearing officer, who will forward the request to the appropriate legal office for review.

The appellant may have to pay back any overpayments HHS made to the appellant because the appellant did not supply correct and complete information or was overpaid while waiting for the hearing decision.

**MDS set to status PE MN Denied**

If the Preadmission PE is denied MN, then the MDS is set to status PE MN Denied. When the MDS is in this status, the “Check MN on PE” button will be displayed under the Workflow Actions section of the yellow Form Actions bar.

1. Locate the MDS assessment using FSI.
2. Click the “Check MN on PE” button on the yellow Form Actions bar.
3. If the MN determination on the PE has been overturned, the Change Status confirmation page will be displayed. The NF can enter text to be added to the History trail and click the “Change Status” button.

4. The MDS assessment will be set to status **Approved**.

If the MN determination on the PE has not been overturned, the NF will see the following message:

**Note:** When MN on PE has not been overturned, the NF may be able to find more information by viewing the History trail of the PE, or by contacting the LA.
Validations Requiring Provider Monitoring

Documents process through several validations before reaching status **SAS Request Pending**. The following will outline the various statuses which require close monitoring by the provider to ensure timely processing.

1. **PL1: Awaiting PE** results in an alert being sent by the LTC Online Portal to the LA notifying the LA to complete the PE. Until the LA submits the PE, an NF cannot certify able to serve the individual or unable to serve the individual. If the PE is successfully submitted, it continues to the next validation:

   - **Pending Placement in NF - PE Confirmed** - If the PE is positive for PASRR eligibility, the NF must view the PE, and certify able to serve the individual or unable to serve the individual on the PL1. The admitting NF must also enter the date they admitted the individual by clicking on the "Admitted to NF" button and completing the required information.

   - **Individual Placed in NF - PE Confirmed** - The individual has been admitted to a Nursing Facility and a PE has been successfully submitted for the individual. If the PE is positive for PASRR eligibility, the NF must certify able to serve the individual or unable to serve the individual on the PL1.

2. **All Applicable Form Types: Medicaid ID Pending** validation results in either:

   - **ID Confirmed** – If confirmed, it continues to next validation.

   - **Medicaid ID Pending** – In this status, validation attempts will occur nightly until eligibility is found, the request is canceled, or until six months has expired, whichever comes first.

   - **ID Invalid** – If the form is in this status, the provider must verify Medicaid number, SSN, Medicare number, and the first four letters of the last name for accuracy. They must match what is on the individual's Medicaid card (if they have one). However, the last name cannot contain spaces or special characters (e.g., hyphen).

     › If this information is accurate, the provider may contact TMHP to see what their options are regarding form resubmittal.

     › If this information is different, the incorrect information will need to be corrected and the form resubmitted.

   - **Med ID Check Inactive** – In this status, the Medicaid ID validation was attempted nightly for six months and either failed or the request was canceled.

**Note:** Updateable fields vary by form type. See the “Updates” section of this User Guide.
3. All Applicable Form Types: Pending Medicaid Eligibility validation will result in either:
   - Medicaid Eligibility Confirmed – If confirmed, it continues to next validation.
   - Pending Medicaid Eligibility – In this status, validation attempts will occur nightly until eligibility is found, the request is canceled, or until six months has expired, whichever comes first.
     › If Medicaid Eligibility has already been established, the provider may contact TMHP to see what their options are regarding form resubmittal.
     › After Medicaid Eligibility has been established, the provider must allow 14 days for the systems to interface. AFTER 14 days, the provider may call TMHP to see what their options are regarding form resubmittal.
   – ME Check Inactive - In this status, the Medicaid Eligibility validation was attempted nightly for six months and failed, so the request was canceled. If the request is canceled, it is because the form was updated or inactivated and the status changes to those statuses, instead of ME Check Inactive.

4. All Applicable Form Types: Pending Applied Income validation will result in either:
   - Applied Income Confirmed – the form will process to “SAS Request Pending.”
   - Pending Applied Income - In this status, validation attempts will occur nightly until applied income is found, the request is canceled, or until six months has expired, whichever comes first.
     › If Applied Income has already been established, the provider may contact TMHP to see what their options are regarding form resubmittal.
     › After Applied Income has been established, the provider must allow 14 days for the systems to interface. AFTER 14 days, the provider may call TMHP to see what their options are regarding form resubmittal.

Note: An Applied Income check will be performed for all NFSS forms submitted on the LTC Online Portal.

   – AI Check Inactive - In this status, the Applied Income validation was attempted nightly for six months and failed, so the request was canceled.

5. MDS, PE, NFSS PTID: Pending Denial - MN is pending denial or NFSS PTID is pending additional information.

6. NFSS: Pending NF Receipt- CMWC or DME is pending receipt and certification by the NF.

7. NFSS: Pending State Review - PTID is Pending Review by HHS PASRR Reviewer.

8. PE, NFSS PTID: Pending Fair Hearing - Fair Hearing has been requested by the resident/NF

9. NFSS: Pending State Confirmation - PTID is Pending Confirmation by HHS PASRR Reviewer of the CMWC or DME item received by the NF.

10. NFSS: Pending MD/DO License Verification - MD/DO credentials are pending verification.

Note: The NFSS form has a TOTAL of 30 days to pass through all validations.

Note: Detailed diagrams illustrating the Medicaid Eligibility Verification Workflows can be found in Appendix A and B of the LTC User Guide for General Information, Online Portal Basics, and Program Resources.
The example below shows an NFSS form that flows successfully:

```
<table>
<thead>
<tr>
<th>Form Submitted</th>
<th>8/24/2017 3:45:51 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Pending</td>
<td>8/24/2017 3:45:53 PM</td>
</tr>
<tr>
<td>ID Confirmed</td>
<td>8/24/2017 3:45:54 PM</td>
</tr>
<tr>
<td>Pending Medicaid Eligibility</td>
<td>8/24/2017 3:45:54 PM</td>
</tr>
<tr>
<td>Medicaid Eligibility Confirmed</td>
<td>8/24/2017 3:45:55 PM</td>
</tr>
<tr>
<td>Pending Applied Income</td>
<td>8/24/2017 3:45:55 PM</td>
</tr>
<tr>
<td>Applied Income Confirmed</td>
<td>8/24/2017 3:45:55 PM</td>
</tr>
</tbody>
</table>
```

The example below shows status **ID Invalid**, indicating that the assessment failed Medicaid ID validation:

```
ID Invalid  6/1/20  12:55:02 PM
6/1/20  12:55:02 PM
TMHIP : Medicaid ID is not valid
```

The example below shows how the SAS Request Pending on an approved therapy service PTID.

```
<table>
<thead>
<tr>
<th>PTID Submitted</th>
<th>4/11/2018 2:00:04 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending State Review</td>
<td>4/11/2018 2:26:30 PM</td>
</tr>
<tr>
<td>Approved</td>
<td>4/11/2018 2:27:56 PM</td>
</tr>
<tr>
<td>SAS Request Pending</td>
<td>4/11/2018 2:27:56 PM</td>
</tr>
</tbody>
</table>
```

The following example shows a PTID that has gone through the standard process.

```
<table>
<thead>
<tr>
<th>Form Submitted</th>
<th>4/11/2018 2:00:04 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Pending</td>
<td>4/11/2018 2:00:09 PM</td>
</tr>
<tr>
<td>ID Confirmed</td>
<td>4/11/2018 2:00:16 PM</td>
</tr>
<tr>
<td>Pending Medicaid Eligibility</td>
<td>4/11/2018 2:00:16 PM</td>
</tr>
<tr>
<td>Medicaid Eligibility Confirmed</td>
<td>4/11/2018 2:00:16 PM</td>
</tr>
<tr>
<td>ME Check Inactive</td>
<td>5/14/2018 12:19:58 PM</td>
</tr>
</tbody>
</table>
```

```
### PTID History

<table>
<thead>
<tr>
<th>Event</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTID Submitted</td>
<td>8/24/2017 3:43:50 PM</td>
</tr>
<tr>
<td>8/24/2017 3:43:52 PM</td>
<td>TMHP : No previous Occupational Therapy for this resident and contract number can be found within the last year to populate the Occupational Therapy data.</td>
</tr>
<tr>
<td>Pending State Review</td>
<td>8/24/2017 3:43:57 PM</td>
</tr>
<tr>
<td>8/24/2017 3:43:57 PM</td>
<td>TMHP : The Service has been sent for State review.</td>
</tr>
<tr>
<td>Approved</td>
<td>8/24/2017 4:04:53 PM</td>
</tr>
<tr>
<td>8/24/2017 4:04:53 PM</td>
<td>TMHP : The request for therapy services has been approved by the State PASRR reviewer.</td>
</tr>
<tr>
<td>SAS Request Pending</td>
<td>8/24/2017 4:04:53 PM</td>
</tr>
<tr>
<td>8/24/2017 4:04:53 PM</td>
<td>TMHP : The request is being processed by DADS. Please allow 2-4 business days for the next status change.</td>
</tr>
<tr>
<td>Processed/Complete</td>
<td>8/25/2017 5:11:21 AM</td>
</tr>
</tbody>
</table>
Alerts

Alerts are notices to a user to perform an action related to a PL1 Screening or PE, an NFSS form, to confirm IDT meetings, or when a Resident Review is needed. A Resident Review takes place when an LA is notified to perform a PE on a resident of an NF. The notification is normally generated as an automatic Alert in the LTC Online Portal, although the request could come as a manually-generated Alert in the LTC Online Portal from HHS, DSHS or the NF. The LTC Online Portal creates alerts automatically when an action needs to take place. Nursing Facility users can also create alerts to be sent to the LA using the LTC Online Portal.

The Alerts screen should be accessed on a daily basis via the LTC Online Portal to meet time frames associated with the Alert.

Alert Descriptions

<table>
<thead>
<tr>
<th>Alert</th>
<th>Communication to the Local Authority (Outgoing Alerts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct PL1 Screening</td>
<td>The recipient of the alert must submit a PL1 for the individual within 7 calendar days of the Alert date. This alert can only be generated manually using the “Create Alert” button on the Alerts page. The NF can send it to the LA, or the PASRR Units can send it to the NF or the LA.</td>
</tr>
<tr>
<td>Conduct PASRR Evaluation - First Notification</td>
<td>The LA must submit a PASRR Evaluation for the individual within 7 calendar days of the first notification. This is the first notice to the LA.</td>
</tr>
<tr>
<td>Conduct PASRR Evaluation - Second Notification</td>
<td>The LA must perform and submit a PASRR Evaluation within 7 calendar days of this notification. This alert is triggered if it has been more than 7 calendar days since the date of the alert of the first notification. If the LA has already performed the PASRR Evaluation but has not entered it on the LTC Online Portal, the LA should submit the PASRR Evaluation immediately.</td>
</tr>
<tr>
<td>Complete IDD Section on the PASRR Evaluation</td>
<td>The IDD Section of the PASRR Evaluation has not been submitted on the LTC Online Portal. The LIDDA responsible for the IDD Section of the PASRR Evaluation should complete the IDD Section. This alert is triggered for a dual PE because only one side has been completed thus far.</td>
</tr>
<tr>
<td>Complete MI Section on the PASRR Evaluation</td>
<td>The MI Section of the PASRR Evaluation has not been submitted on the LTC Online Portal. The LMHA/LBHA responsible for the MI Section of the PASRR Evaluation should complete the MI Section. This alert is triggered for a dual PE because only one side has been completed thus far.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alert</th>
<th>Communication received by the Nursing Facility (Incoming Alerts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFSS Request - Approved</td>
<td>A requested specialized service for the resident has been approved. It has been determined by a review of the information submitted that the requested item/service meets medical necessity.</td>
</tr>
<tr>
<td>NFSS Request - Denied</td>
<td>A requested specialized service for the resident has been denied.</td>
</tr>
<tr>
<td>NFSS Request - Pending Denial</td>
<td>A requested specialized service for the resident cannot be processed at this time. Submit any requested information by the due date, or the request will be denied and a new request will need to be submitted.</td>
</tr>
</tbody>
</table>
Provider Action Required

Provider Action Required. (Applies to rejection errors found within the form and PTID history trail. Once a form or PTID is set to Provider Action Required status, the provider must take action before that particular form or PTID can continue.)

PL1 Needs Certification - First Notification

A positive PASRR Evaluation has been submitted. The Nursing Facility must review the PE, including PASRR recommended Specialized Services, and certify on the PL1 Screening form whether “Able to Serve the Individual” or “Unable to Serve the Individual” by clicking the corresponding button on the yellow “Form Actions” tool bar and confirming the selection on the pop up screen by clicking “OK.” The Nursing Facility also needs to schedule and conduct the IDT meeting.

PL1 Needs Certification - Second Notification

This is the second notice that a positive PASRR Evaluation has been submitted. The Nursing Facility must review the PE, including PASRR recommended Specialized Services, and certify on the PL1 Screening form whether “Able to Serve the Individual” or “Unable to Serve the Individual” by clicking the corresponding button on the yellow “Form Actions” tool bar and confirming the selection on the pop up screen by clicking “OK.” The Nursing Facility also needs to schedule and conduct the IDT meeting.

Alert System-Generated Communication sent to HHS PASRR Unit (Outgoing Alerts)

NF Unable to Serve

- If a Nursing Facility has certified on the PL1 Screening Form that they are unable to serve the individual and the NF has already admitted the individual into the facility, an Alert is sent to HHS PASRR Unit by the LTC Online Portal. This Alert will appear in the list of Outgoing Alerts for the NF.
- NF contacts LA to advise of their inability to serve the individual, allowing the LA to begin coordination of placement into another facility.

Accessing Alerts

Follow the steps below to access the Alerts screen.

2. Click “providers” on the green bar located at the top of the screen.
3. Click “Long Term Care” on the yellow bar.
4. Click the “Log In to LTC Online Portal” button on the blue bar.
5. Enter your User name and Password. Click the “OK” button. The Form Status Inquiry (FSI) page will display by default.
6. Click the Alerts link located on the blue navigational bar.

The Alerts screen displays. A list of incoming and outgoing alerts are displayed. The alert list only contains alerts for your Vendor/Provider numbers. Alerts are shown for the last 30 days from the current date. Alerts older than 30 days from the current date are not available.

v 2018 0730
Alerts can be sorted by clicking the column header of the Alerts list. Alerts can be deleted. Once deleted, they can not be retrieved.

The Alert Subject column provides a brief description of the alert. Click the Alert Subject link to see the alert detail.

The alert detail describes what needs to be done. It also provides information about the individual and a link to the current PL1 Screening Form, PE or the NFSS form.

7. Click the “Return to Alerts Page” button at the top of the page to return to the Alerts list.
Creating Alerts

Nursing Facility users can create alerts to be sent to the LA.

1. Click the Alerts link located on the blue navigational bar.
   
   The Alerts screen displays.

2. Click the “Create Alert” button.

3. Choose the Vendor/Provider No. from the drop-down box.

4. Choose the Alert Subject from the drop-down box. Each alert includes a standard message to the recipient.
   
   Nursing Facility users can create the following alerts:
   
   - Conduct PASRR Evaluation - First Notification
   - Conduct PASRR Evaluation - Second Notification
   - Complete IDD Section on the PASRR Evaluation
   - Complete MI Section on the PASRR Evaluation
   - Conduct PASRR Level 1 Screening

5. Enter the PL1 Screening Form DLN or PE DLN, if applicable.

6. Enter the Vendor No. and Provider No. for the LA to whom the alert will be sent.

7. Enter the individual's required information if the NF is asking the LA to submit a PL1.

8. Click the “Send Alert” button. The Create Alert window will close and you will be returned to the Alerts page.
Deleting Alerts

You can delete Alerts from your Alerts page, but the Alert will not be deleted from the Alerts page of whomever the Alert was sent to.

Deleted alerts cannot be restored, and alerts will automatically be deleted after 30 days. Once an alert is deleted, it cannot be retrieved. When you have completed the action requested on an alert, you may want to delete the alert.

1. Select the alert you wish to delete by clicking the box in the “Select” column next to the applicable alert. You can select multiple alerts.

2. Click the “Delete Alert” button above the alert list.

3. A confirmation message is displayed. Click the “OK” button to delete the alert, click the “Cancel” button if you do not want to delete the alert.

Provider Workflow Rejection Messages for the NFSS Form

Below are the rejection messages providers will receive as a result of an error occurring during the nightly batch processing. The messages are in order of message number.

The table contains three columns:

1. **Provider Message.** This is the system message that will be displayed in form and PTID History trail.
2. **Form/Assessment.** What form and assessment can receive this message?
3. **Suggested Action.** Instructions for resolving the issue listed in the system message.
### Specific Instructions

<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| GN-9101 – GN-9105: This form cannot be processed because the individual’s Applied Income is not available to the authorization system. Contact the HHS Eligibility Worker to update the individual’s Applied Income. Once the Applied Income has been updated, this form can be resubmitted. | 3618, 3619, MDS, NFSS | The recipient’s applied income is not available to the authorization system.  
- Pull a MESAV for the recipient covering the date requested on the form or assessment.  
  Note: If the recipient does not already have Service Authorizations for your contract, this information will not be available on the MESAV.  
- If the MESAV does not show an Applied Income for the dates of the form or assessment, contact the Texas Health and Human Services Commission (HHS) Eligibility Worker to update the Applied Income records.  
  - Once the Applied Income has been updated, resubmit the rejected form or assessment. If the recipient is already established in your facility, you may monitor the MESAV for updated Applied Income.  
- If the MESAV does show an Applied Income for the dates of the form or assessment, resubmit the rejected form or assessment. |
| GN-9106: This form cannot be processed because HHS does not have Long Term Care Financial Eligibility for this individual and timeframe. Contact the HHS Eligibility Worker or SSI office. | 3618, 3619, MDS, NFSS | The recipient’s Medicaid eligibility is not available to the authorization system.  
- Pull a MESAV for the recipient covering the date requested on the form or assessment.  
  Note: If the recipient does not already have Service Authorizations for your contract, this information will not be available on the MESAV.  
- If the MESAV does not show Long Term Care Financial Eligibility for the dates of the form or assessment, contact the HHS Eligibility Worker or Supplemental Security Income (SSI) office to update the Financial Eligibility records.  
  - Once the Financial Eligibility has been updated, resubmit the rejected form or assessment. If the recipient is already established in your facility, you may monitor the MESAV for updated Financial Eligibility.  
- If the MESAV does show Financial Eligibility for the dates of the form or assessment, resubmit the rejected form or assessment. |
| GN-9248: This form cannot be processed due to one or more invalid Diagnosis Codes. Correct the Diagnosis Codes and resubmit. | MDS, NFSS | The submitted Primary International Classification of Diseases (ICD) Diagnosis Code is not valid.  
- Modify the Primary Diagnosis Code on the LTCMI section as needed and resubmit the rejected assessment.  
- If the Primary Diagnosis Code on the LTCMI section is valid, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
| GN-9254: This form cannot be processed because the provider is not authorized to provide services on the effective date of the form. Correct the effective date as needed. For 3619 admissions, resubmit once the Medicare contract is effective in the system. | All | The provider's contract is either not in effect as of the effective date of the form or assessment, or the provider is not authorized to bill for the type of services covered by the form or assessment.  
- Review the facility contract to determine if the contract is in effect and authorizes the type of services covered by the form or assessment.  
- If the effective date of the form or assessment is wrong, modify the form or assessment and resubmit the rejected form or assessment.  
- If the contract is not yet in effect, resubmit the rejected form or assessment once the service code is effective in the system. For 3619 admissions, resubmit the rejected form once the Medicare contract is effective in the system. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| PS-3001: This therapy assessment cannot be processed because the submitted Provider No. is not valid as of the Date of Assessment. Correct the therapy Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No. | NFSS (Therapy Assessment) | The Therapy Date of Assessment is outside the provider’s contract dates.  
- Confirm the Date of Assessment for the rejected therapy assessment and submit a correction of the date as needed.  
- If the date is correct, but the form is under the incorrect contract, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting to inactivate the form. Then submit a new NFSS form with the proper contract.  
- If there is not an active contract for the Date of Assessment, the submission will have to be held until the contract has been approved. |
| PS-3003: This CMWC/DME assessment cannot be processed because the submitted Provider No. is not valid as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No. | NFSS (CMWC/DME Assessment) | The CMWC/DME Date of Assessment is outside the provider’s contract dates.  
- Confirm the Date of Assessment for the rejected CMWC/DME assessment and submit a correction of the date as needed.  
- If the date is correct, but the form is under the incorrect contract, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting to inactivate the form. Then submit a new NFSS form with the proper contract.  
- If there is not an active contract for the Date of Assessment, the submission will have to be held until the contract has been approved. |
| PS-3004: This CMWC/DME item cannot be processed because the submitted Provider No. is not valid as of the Therapist’s Certification Date. Correct the CMWC/DME Therapist’s Certification Date or contact the HHS IDD PASRR Unit to inactivate this service, then submit a new NFSS form with the correct Provider No. | NFSS (CMWC/DME item) | The CMWC/DME Therapist’s Certification Date is outside the provider’s contract dates.  
- Confirm the Therapist’s Certification Date for the rejected CMWC/DME item and submit a correction of the date as needed.  
- If the date is correct, but the form is under the incorrect contract, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting to inactivate the form. Then submit a new NFSS form with the proper contract.  
- If there is not an active contract for the Therapist’s Certification Date, the submission will have to be held until the contract has been approved. |
| PS-3005: This therapy assessment cannot be processed because the submitted Provider No. is not valid for the requested service as of the Date of Assessment. Correct the therapy Date of Assessment or submit when the service becomes effective for the Provider No. | NFSS (Therapy Assessment) | The therapy Date of Assessment is outside the provider’s contract dates for the requested service.  
- Confirm the therapy Date of Assessment and submit a correction of the date as needed.  
- If the requested service is not active on the contract for the Date of Assessment, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting assistance. The submission will have to be held until the contract has been updated to include the requested service. |
| PS-3007: This CMWC/DME assessment cannot be processed because the submitted Provider No. is not valid for the requested service as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit when the service becomes effective for the Provider No. | NFSS (CMWC/DME Assessment) | The CMWC/DME Date of Assessment is outside the provider’s contract dates for the requested service.  
- Confirm the CMWC/DME Date of Assessment and submit a correction of the date as needed.  
- If the requested service is not active on the contract for the Date of Assessment, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting assistance. The submission will have to be held until the contract has been updated to include the requested service. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| PS-3008: This CMWC/DME item cannot be processed because the submitted Provider No. is not valid for the requested item as of the Therapist's Certification Date. Correct the CMWC/DME Therapist's Certification Date or submit when the item becomes effective for the Provider No. | NFSS (CMWC/DME item) | The CMWC/DME Therapist's Certification Date is outside the provider's contract dates for the requested item.  
• Confirm the CMWC/DME Therapist's Certification Date and submit a correction of the date as needed.  
• If the requested item is not active on the contract for the Therapist's Certification Date, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting assistance. The submission will have to be held until the contract has been updated to include the requested item. |
| PS-3009: This therapy assessment cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Date of Assessment. Correct the therapy Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (Therapy Assessment) | There is no Daily Care Service Authorization that covers the therapy Date of Assessment.  
• Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the therapy Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
• If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it and resubmit.  
• If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  – If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  – If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  – Once the covering 3618 admission and MDS assessment have processed, resubmit the therapy assessment.  
• If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| PS-3011: This CMWC/DME assessment cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (CMWC/DME Assessment) | There is no Daily Care Service Authorization that covers the CMWC/DME Date of Assessment.  
- Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the CMWC/DME Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
- If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it and resubmit.  
- If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  - If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  - If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  - Once the covering 3618 admission and MDS assessment have processed, resubmit the CMWC/DME assessment.  
- If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
| PS-3012: This CMWC/DME item cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Therapist's Certification Date. Correct the CMWC/DME item Therapist's Certification Date or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (CMWC/DME item) | There is no Daily Care Service Authorization that covers the CMWC/DME item Therapist's Certification Date.  
- Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the CMWC/DME item Therapist's Certification Date. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
- If a covering Daily Care Service Authorization is found and the Therapist's Certification Date is incorrect, update it and resubmit.  
- If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  - If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  - If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  - Once the covering 3618 admission and MDS assessment have processed, resubmit the CMWC/DME item.  
- If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| **PS-3013**: This therapy assessment cannot be processed because a different Provider No. for the same Vendor No. has a Daily Care Service Authorization as of the Date of Assessment. Adjust the therapy Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No. | NFSS (Therapy Assessment) | This therapy assessment has been submitted using the incorrect Provider Number. The facility has had a Change of Ownership and the therapy assessment needs to be submitted using the Provider No. that was active on the therapy Date of Assessment.  
- Confirm the Date of Assessment for the rejected therapy assessment and submit a correction of the date as needed.  
- If the date is correct, but the form is under the incorrect contract, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting to inactivate the form. Then submit a new NFSS form with the proper contract.  
- If there is not an active contract for the Date of Assessment, the therapy assessment will have to be held until the contract has been approved. |
| **PS-3015**: This CMWC/DME assessment cannot be processed because a different Provider No. for the same Vendor No. has a Daily Care Service Authorization as of the Date of Assessment. Adjust the CMWC/DME Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No. | NFSS (CMWC/DME Assessment) | This therapy assessment has been submitted using the incorrect Provider Number. The facility has had a Change of Ownership and the therapy assessment needs to be submitted using the Provider No. that was active on the therapy Date of Assessment.  
- Confirm the Date of Assessment for the rejected therapy assessment and submit a correction of the date as needed.  
- If the date is correct, but the form is under the incorrect contract, contact HHS IDD PASRR Unit at 855-435-7180 and leave a message requesting to inactivate the form. Then submit a new NFSS form with the proper contract.  
- If there is not an active contract for the Date of Assessment, the therapy assessment will have to be held until the contract has been approved. |
| **PS-3017**: This therapy assessment cannot be processed because the individual is enrolled with a different provider as of the Date of Assessment. Correct the therapy Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (Therapy Assessment) | There is a Daily Care Service Authorization for a different provider that covers the therapy Date of Assessment.  
- Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the therapy Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
- If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it and resubmit.  
- If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  - If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  - If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  - Once the covering 3618 admission and MDS assessment have processed, resubmit the therapy assessment.  
- If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| PS-3019: This CMWC/DME assessment cannot be processed because the individual is enrolled with a different provider as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (CMWC/DME Assessment) | There is a Daily Care Service Authorization for a different provider that covers the CMWC/DME Date of Assessment.  
- Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the CMWC/DME Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
- If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it and resubmit.  
- If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  - If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  - If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  - Once the covering 3618 admission and MDS assessment have processed, resubmit the CMWC/DME assessment.  
- If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
| PS-3020: This CMWC/DME item cannot be processed because the individual is enrolled with a different provider as of the Therapist’s Certification Date. Correct the Therapist’s Certification Date or submit the necessary 3618 admission form and/or MDS assessment. | NFSS (CMWC/DME item) | There is a Daily Care Service Authorization for a different provider that covers the CMWC/DME Therapist’s Certification Date.  
- Pull a MESAV and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the CMWC/DME Therapist’s Certification Date. If the 3618 admission and MDS assessment for the recipient have not processed you will not have services authorized.  
- If a covering Daily Care Service Authorization is found and the Therapist’s Certification Date is incorrect, update it and resubmit.  
- If a covering Daily Care Service Authorization is not found, review the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.  
  - If the 3618 admission is not processed, determine why the form rejected. Correct the current 3618 admission, or inactivate the rejected 3618 and submit a new 3618 admission.  
  - If the 3618 is processed, determine if there is an associated MDS assessment. If the MDS failed to process, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI and submit it.  
  - Once the covering 3618 admission and MDS assessment have processed, resubmit the CMWC/DME item.  
- If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, contact HHS LTC Provider Claims Services at 512-438-2200, Option 1, for assistance. |
<table>
<thead>
<tr>
<th>Provider Message (Displayed in History)</th>
<th>Form/Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS-3022: This CMWC/DME item cannot be processed because the individual was not at least 21 years of age as of the Therapist’s Certification Date. Correct the Therapist’s Certification Date or contact HHS MEPD for assistance correcting the individual’s Birth Date in their records.</td>
<td>NFSS (CMWC/DME item)</td>
<td>The recipient was not at least 21 years of age as of the Therapist’s Certification Date.  • If the Birth Date is incorrect on the form, contact the individual or their Legally Authorized Representative (LAR) and ask them to contact HHS MEPD to request that the error be corrected in the system. Resubmit the CMWC/DME item after the individual or LAR has confirmed that the information has been corrected by HHS.</td>
</tr>
<tr>
<td>PS-3044: This therapy assessment cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the Date of Assessment.</td>
<td>NFSS (Therapy Assessment)</td>
<td>• Correct the therapy Date of Assessment or submit the necessary MDS Assessment.</td>
</tr>
<tr>
<td>PS-3045: This therapy service must be manually processed by HHSC.</td>
<td>NFSS (Therapy Assessment)</td>
<td>• Email the IDD PASRR Unit: <a href="mailto:PASRR.Support@hhsc.state.tx.us">PASRR.Support@hhsc.state.tx.us</a>) for assistance.</td>
</tr>
<tr>
<td>PS-3046: This CMWC/DME assessment cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the CMWC/DME Date of Assessment.</td>
<td>NFSS (CMWC/DME Assessment)</td>
<td>• Correct the CMWC/DME Date of Assessment or submit the necessary MDS assessment.</td>
</tr>
<tr>
<td>PS-3047: This CMWC/DME item cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the Therapist’s Certification Date.</td>
<td>NFSS (CMWC/DME Item)</td>
<td>• Correct the CMWC/DME item Therapist’s Certification Date or submit the necessary MDS assessment.</td>
</tr>
</tbody>
</table>

**Note:** For Response Codes PS-3044, PS-3046 and PS-3047, contact provider claims services for additional assistance.
Updates

Updates can be made to certain fields on the PL1 Screening Form and NFSS form. NF Providers must submit PL1 Screening Form and NFSS Form updates directly on the LTC Online Portal. Only users with appropriate security permissions can submit updates.

**Note:** The Update Form button will not be displayed in the yellow Form Actions bar on any form that cannot be updated. This includes submission of these forms by a third-party software vendor for your facility. PL1 Screening Forms cannot be submitted by a third-party software vendor.

**PASRR Level 1 Screening Updates**

The PL1 Screening Form cannot be updated if the status is *Form Inactivated* or *PL1 Inactive*. The PL1 Screening Form can be freely updated until an associated PE has been successfully submitted. After the successful submission of the PE, only fields B0650 and B0655 can be updated. Updates to a PL1 will not occur if the LA changes an individual’s information during the initiation of an associated PE.

The status of a PL1 Screening Form does not usually change upon submission of an update, and no parent/child form is created. The History trail shows the fields that have been updated, listing the previous and new values.

**Fields that can be updated on the PL 1 without changing the form status:**

- A0600. Date of Assessment
- B0100A. First Name
- B0100B. Middle Initial
- B0100C. Last Name
- B0100D. Suffix
- B0200A. Social Security No.
- B0200B. Medicare No.
- B0300. Medicaid No.
- B0400. Birth Date
- B0600. Gender
- B0700A. Previous Residence Type
- B0700B. Other Residence Type (enabled only if “5. Other” is selected in B0700A)
- B0700C. Street Address
- B0700D. City
- B0700E. State
• B0700F. ZIP Code
• B0700G. County of Residence
• B0800A. Relationship to Individual
• B0800B. Other Relationship to Individual (enabled only if “6. Other” is selected in B0800A)
• B0800C. First Name
• B0800D. Middle Initial
• B0800E. Last Name
• B0800F. Suffix
• B0800G. Phone Number
• B0800H. Street Address
• B0800I. City
• B0800J. State
• B0800K. ZIP Code

**Fields that can be updated on the PL1 which will cause the form to be set to status PL1 Inactive:**

• B0650. Individual is deceased or has been discharged?
• B0655. Deceased/Discharged Date (enabled only after a selection is made in B0650)

**Note:** These two fields B0650 and B0655 are completed if the individual leaves the facility or passes away. The information for these two fields can be entered by the PL1 submitter or the admitting NF at any time before or after a PE is initiated from the PL1 (in the case of a Preadmission PL1, only the LA can update these fields). Both fields must be completed before the status of the PL1 will be changed to PL1 Inactive.

### Making Updates to the PASRR Level 1 Screening

1. Log in to the LTC Online Portal.
2. Click the **Search** link in the blue navigational bar.
3. Choose **Form Status Inquiry** from the drop-down menu.
4. Search for the PL1 Screening Form using the individual’s SSN, Medicaid Number, First and Last Name, or DLN and enter a date range for “From Date” and “To Date.” The date fields are required.
5. Click the “Search” button.
6. Click the **View Detail** link.
7. Click the “Update Form” button.
8. Complete only the fields needing updates.

9. Click the “Submit Form” button. A history note, detailing the changed fields, is added to the PL1 Screening Form.
NFSS Form Updates

A successfully submitted NFSS form can be updated using the “Update” button. This button will appear in the PTID Authorization section of a successfully submitted NFSS form if the PTID is in one of the following statuses:

- **PTID Submitted**
- **Pending MD/DO License Verification (Only for Service PTIDs)**
- **Pending State Review**
- **Pending Denial**

Making Updates to the NFSS form

1. Log in to the LTC Online Portal.
2. Click the **Search** link in the blue navigational bar.
3. Choose **Form Status Inquiry** from the drop-down menu.
4. Search for the NFSS form using the appropriate Vendor Number.
5. Enter the “From Date” and “To Date” in which the NFSS form was submitted. The date fields are required.
6. Enter the DLN, Medicaid Number, SSN, or Last/First Name of the individual for which SS needs to be requested.
7. Click the “Search” button.
8. Click the **View Detail** link.
9. The NFSS form will open on the Resident/NF tab.
10. To locate the “Update” button, click on the appropriate tab and scroll to the Authorization section.
11. Click the “Update” button in the PTID Authorization section of the NFSS form.

As previously mentioned, the submitter can make updates to the form fields on the assessment or service tabs until the point that HHSC takes action on the request by changing the status to **approved** or **denied**. Once HHSC changes the status, the submitter can make no further updates to the form fields; however, attachments (signature pages, acknowledgment, and receipt certification pages, etc.) can still be uploaded and attached to the specific NFSS form.
12. Complete only the fields needing updates.

13. Click the “Submit Form” button.

**Note:** If the update is successfully submitted, the LTC Online Portal will show “Update was successful.” If there are errors, they will be displayed in a box at the top of the screen. These errors will need to be resolved before the update will be successfully submitted. Once all errors are resolved, click the “Submit Form” button again to submit the update.

14. The form remains open after the update was successfully submitted. You may perform other tasks or click on the “Unlock Form” button to close the form.
Inactivations

PASRR Level 1 Screening Inactivations

There is no Inactivate Form button on a PL1 Screening Form. If a new PL1 Screening Form is submitted for an individual with an existing PL1 Screening Form, the previous PL1 Screening Form and any associated PE will be inactivated automatically. Upon submission of this new PL1 Screening Form, a message will appear prompting you to confirm inactivation of the previous PL1 Screening Form and associated PE.

Another way to inactivate a PL1 (either before or after the PE is submitted) is to enter a deceased or discharged date. See the PASRR Level 1 Screening Updates instructions in the Updates section of this User Guide.

Note: If an inactivation is needed for an NFSS form, contact the HHS PASRR Unit for assistance.
Medicaid fraud: “An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

**How to Report Waste, Abuse, and Fraud**

Reports may be made through the following website: [https://oig.hhsc.texas.gov/report-fraud](https://oig.hhsc.texas.gov/report-fraud). This website also gives instructions on how to submit a report, as well as how to submit additional documentation that cannot be transmitted over the Internet. The website also provides information on the types of waste, abuse, and fraud to report to OIG.

If you are not sure if an action is waste, abuse, or fraud of Texas Medicaid, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a telephone number for Recipient Fraud and Abuse reporting **1-800-436-6184**.
HIPAA Guidelines and Provider Responsibilities

Providers must comply with the Health Insurance Portability and Accountability Act (HIPAA). It is YOUR responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals or speak to your TMHP Provider Representative when you have questions.
Resource Information

Types of Calls to Refer to TMHP

Call TMHP at 1-800-626-4117, Option 1, about the following:

- NF forms completion – including PASRR Level 1 Screening Form and NFSS form.
- Rejection codes on the forms and PTIDs.
- Management of the Provider Action Required status.
- If the Medicaid, Social Security, or Medicare number and the name match the individual’s Medicaid ID card and the form is set to status ID Invalid, call TMHP to see what their options are regarding form resubmittal.
- PASRR Level 1 Screening Form submission error messages and the NFSS Form and PTID error messages.
- PASRR Level 1 Screening Form and PASRR Evaluation status questions.

Call TMHP at 1-800-626-4117, Option 2, about the following:

- MN Determination on PE.

Call TMHP at 1-800-626-4117, Option 3, about the following:

- TMHP LTC Online Portal and TexMedConnect account setup.

Types of Calls to Refer to HHS IDD PASRR Unit

Call HHS PASRR Unit at 1-855-435-7180 or email PASRR.Support@hhsc.state.tx.us about the following:

- Assistance or cooperation from an NF or LIDDA.
- Assistance with locating information to perform and submit the PL1 Screening Form and NFSS form.
- Assistance with locating screenings and evaluations, individuals, or additional training resources.
- Policy guidance on specialized services and therapist assessments.
- Assistance or cooperation from non-Hospital Referring Entities.
Types of Calls to Refer to HHS MI PASRR

Email HHS MI PASRR at PASRR.MentalHealth@hhsc.state.tx.us about the following:

• Assistance or cooperation from a Hospital RE or LMHA/LBHA.

Types of Calls to Refer to HHS PCS

Call HHS PCS at (512) 438-2200, Option 1, about the following:

• Denials or pending denials of individuals who have established prior permanent medical necessity, after verifying Medicaid Number, contains a nine-digit numeric rather than “+” or “N.”

• Resolution of forms in Manual Workflow (such forms have been rejected by SAS and must by reviewed by HHS PCS).

Types of Calls to Refer to a Local Authority

• For a true preadmission when an individual just arrives without paperwork at the NF when not Expedited Admission, Exempted Hospital Discharge, or Negative.

• For an individual who just arrives at the NF with a PASRR Negative Letter from the PE and needs help calling the LA.

• When the NF needs to follow up after an alert was sent to the LA to perform and submit a PE for a Resident Review.

• To invite the LA to participate in the Interdisciplinary Team (IDT) Meeting.
Helpful Contact Information

**Texas Medicaid & Healthcare Partnership (TMHP)**

General Customer Service ........................................................................................................... 1-800-925-9126
Long Term Care (LTC) Department .......................................................................................... 1-800-727-5436 / 1-800-626-4117
  - General Inquiries, MDS not in the LTC Online Portal, LTCMI questions, Claim Forms,
  - Claim Submission, R&S Report, PL1 Screening Form, and PASRR Evaluation (PE) .......... Option 1
  - Medical Necessity .................................................................................................................... Option 2
  - Technical Support .................................................................................................................. Option 3
  - Fair Hearing ............................................................................................................................ Option 5
  - LTC Other Insurance Information and Updates .................................................................... Option 6
LTC Department (fax) ..................................................................................................................... (512) 514-4223
Medicaid Hotline ......................................................................................................................... 1-800-252-8263

**Health and Human Services (HHS)** ...................................................................................... (512) 438-3011
Consumer Rights & Services Hotline ......................................................................................... 1-800-458-9858
  - Complaint for LTC Facility/Agency ...................................................................................... Option 2
  - Information About a Facility .................................................................................................... Option 4
  - Provider Self-Reported Incidents ............................................................................................ Option 5
  - Survey Documents/HHS literature ........................................................................................ Option 6
Community Services Contracts Unit Support ............................................................................. (512) 438-3550
Community Services Contracts Voice Mail (Contract Applications,
Reenrollments and Reporting Changes, such as address and telephone number) ............ (512) 438-3550
Criminal History Checks ................................................................................................................ (512) 438-2363
Facility Licensure/Certification (Reporting Changes, such as Service Area and Medical Director) .... (512) 438-2630
Home and Community Support Services Unit (Hospice Regulatory Requirements) ................. (512) 438-3161
Hospice Policy (Medicaid, Program Support, and Special Services Unit) ....................... hospice@hhs.state.tx.us
Institutional Services Contracting ................................................................................................. (512) 438-2546
Medication Aide Program ............................................................................................................. (512) 231-5800
Nurse Aide Registry ....................................................................................................................... 1-800-452-3934
Nurse Aide Training ....................................................................................................................... (512) 231-5800
NF Administrator Program ........................................................................................................... (512) 231-5800
NF Policy ....................................................................................................................................... (512) 438-3161
Regulatory Services....................................................................................................................... (512) 438-2625
  - PASRR Unit Policy Questions ................................................................................................. (855) 435-7180
Provider Claims Services Hotline............................................................................................... (512) 438-2200
  - NF and Hospice (Client Service authorizations, MESAV updates, and unable
to determine Rate Key issues) ......................................................................................................... Option 1
  - Personal Needs Allowance Payments (PNA) ........................................................................ Option 2
  - Deductions and Holds ............................................................................................................ Option 3
  - Provider Recoupment and Holds, including torts and trusts and/or annuities .................... Option 4
  - Home and Community-based Services ................................................................................ Option 5
  - TX Home Living ...................................................................................................................... Option 5
  - Rehabilitation Therapy and Specialized Services ................................................................. Option 6
Health and Human Services (HHS)
HHS Ombudsman Office Medicaid Benefits 1-877-787-8999
Medicaid Fraud 1-800-436-6184
Rate Analysis Help Line (512) 730-7404
Resource Utilization Groups (RUGs) Information
Nurse Specialist (Reconsideration & RUGs) (512) 491-2074
Texas State University RUG Training Information (512) 245-7118
Texas State University Training Online Course Questions (512) 245-7118

Informational Websites

Texas Medicaid & Healthcare Partnership (TMHP): www.tmhp.com
- HIPAA information: www.tmhp.com/Pages/TMHP/TMHP_HIPAA.aspx
- Long Term Care Division: www.tmhp.com/Pages/LTC/Ltc_home.aspx
- NF LTCMI and PASRR information is also available at: www.tmhp.com/Pages/LTC/Ltc_home.aspx
- Long Term Care Provider News Archives: www.tmhp.com/Pages/LTC/LTC_news_archives.aspx

Health and Human Services (HHS): https://hhs.texas.gov/
All HHS provider information can be found at https://hhs.texas.gov/doing-business-hhs/provider-portals.
Choose your particular provider type for available online resources:
- Consumer Rights and Services (includes information about how to make a complaint): https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
- PASRR: https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr
- Provider Letters: www.dads.state.tx.us/providers/communications/letters.cfm
- Resources for HHS Service Providers: https://hhs.texas.gov/doing-business-hhs/provider-portals
- HHS Regions: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts

Department of State Health Services (DSHS): www.dshs.state.tx.us/
- DSHS Local Mental Health Authority Search: www.dshs.state.tx.us/mhservices-search

Other
• Centers for Medicare & Medicaid Services: www.cms.gov
• Department of State Health Services: www.dshs.state.tx.us
• National Provider Identifier (NPI):
  – To obtain: https://nppes.cms.hhs.gov/NPPES
• Texas Administrative Code: www.sos.state.tx.us/tac/index.shtml
• Texas State RUG Training: www.txstate.edu/continuinged/CE-Online/RUG-Training
• Federal MDS 3.0 site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
Appendix A: PASRR Level 1 Screening and PASRR Evaluation

The PASRR Level 1 Screening is divided into seven sections labeled A through IDT. Below are images of each section. The PASRR Evaluation, Section B, is also provided below for information on where to look for the recommended specialized services to be provided/delivered by the NF.
## PASRR Level 1 Screening - Section A Tab

**Submitter Information**
- **Name**: HARBOR HOSPICE OF HOUSTON, LP
- **Address**:
  - A. Street Address: 1322 SPACE PARK DRIVE
  - B. City: HOUSTON
  - C. State: TX
  - D. ZIP Code: 770580000

- **NPI/API**: 1093004178
- **Provider No.**: 001026079
- **Vendor No.**: 2656
- **County**:

**Referring Entity Information**
- **Date of Assessment**: 
- **Screener**:
  - A. First Name
  - B. Middle Initial
  - C. Last Name
  - D. Suffix

- **Position/Title**:

- **Type of Entity**:
  - A. Type of Entity
  - B. Other Type of Entity
  - C. Physician First Name
  - D. Physician Middle Initial
  - E. Physician Last Name
  - F. Physician Suffix

**Current Location**
- **A. Name**
- **B. Street Address**
- **C. City**
- **D. State**
- **E. ZIP Code**
- **F. Phone Number**

**Date of Last Physical Examination**: 
- **Signature**
- **I certify that to the best of my knowledge this information is true and accurate.**
  - A. Certification of Signature
  - B. Signature Date
PASRR Level 1 Screening - Section B Tab

Current Status: Name:  DLN:  Username: pasrnf_ext
Form Actions:  Save as Draft  Print IDT

Section B.
Personal Information
B0100.  Individual Name
   A. First Name
   B. Middle Initial
   C. Last Name
   D. Suffix

B0200.  Social Security and Medicare Numbers
   A. Social Security No.
   B. Medicare No.

B0300.  Medicaid No.
   Enter ‘+’ if pending, ‘N’ if not Medicaid recipient

B0400.  Birth Date mm/dd/yyyy

B0500.  Age at Time of Screening

B0600.  Gender

B0650.  Individual is deceased or has been discharged?

B0655.  Deceased/Discharged Date mm/dd/yyyy

B0700.  Previous Residence
   A. Previous Residence Type
   B. Other Residence Type
   C. Street Address
   D. City
   E. State  F. ZIP Code
   G. County of Residence

B0800.  Next of Kin
   A. Relationship to Individual
   B. Other Relationship to Individual
   C. First Name
   D. Middle Initial
**PASRR Level 1 Screening - Section C Tab**

### PASRR LEVEL 1 SCREENING

**Current Status:** Name: DLN:0 Username: pasrnf_ext

**Form Actions:**
- Print
- Save as Draft
- Print IDT

#### Section C.

<table>
<thead>
<tr>
<th>C0100.</th>
<th>Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Is there evidence or an indicator this is an individual that has a Mental Illness?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C0200.</th>
<th>Intellectual Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Is there evidence or an indicator this is an individual that has an Intellectual Disability?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C0300.</th>
<th>Developmental Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Is there evidence or indicators that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability (e.g. Autism, Cerebral Palsy, Spina Bifida)?</td>
<td></td>
</tr>
</tbody>
</table>

See DADS ICD 9 related condition list: [Click Here](#)

See DADS ICD 10 related condition list [Click Here](#)

On or after 10/1/2015 use DADS ICD-10 related conditions list

#### Local Authority Information

<table>
<thead>
<tr>
<th>C0400.</th>
<th>LA - MI Provider No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0500.</td>
<td>LA - MI Vendor No.</td>
</tr>
<tr>
<td>C0600.</td>
<td>LA - MI NPI/API No.</td>
</tr>
<tr>
<td>C0700.</td>
<td>LA - IDD Provider No.</td>
</tr>
<tr>
<td>C0800.</td>
<td>LA - IDD Vendor No.</td>
</tr>
<tr>
<td>C0900.</td>
<td>LA - IDD NPI/API No.</td>
</tr>
</tbody>
</table>

[Submit Form](#)
PASRR Level 1 Screening - Section D Tab

Do100. Nursing Facilities

Enter Provider No. and Vendor No. and click lookup tool to populate NF information.

- (Hide NF Information)
  - A. Provider No.
  - B. Vendor No.
  - C. NPI
  - D. Facility Name
  - E. Street Address
  - F. City
  - G. State
  - J. NF Contact First Name
  - K. NF Contact Middle Initial
  - L. NF Contact Last Name
  - M. NF Contact Suffix
  - N. NF is willing and able to serve individual
  - O. NF Admitted the individual
  - P. NF Date of Entry
  - Q. Comments
# PASRR Level 1 Screening - Section E Tab

## Alternate Placement Preferences

### E0100. Where would this individual like to live now?
- A. Live alone with support
- B. A place where there is 24 hour care
- C. A Group home
- D. Family Home
- E. Other
- F. Other Location
- G. Unknown

### E0200. Comments about where the individual would like to live

### E0300. Living Arrangement Options
- A. By themselves
- B. With a roommate
- C. With family
- D. With a lot of friends
- E. Other
- F. Other Individual
- G. Unknown

### E0400. Comments about with whom the individual would like to live

### Alternate Placement Disposition

#### E0500. Admission Information
- A. Admitted to
- B. Admitted to Other

#### E0600. Specify Community Program
- A. Community Program
- B. Other Community Program

#### E0700. Name of ICF/IID Facility

#### E0800. Own

---

LTC User Guide for Preadmission Screening and Resident Review (PASRR) for Nursing Facilities
PASRR Level 1 Screening - Section F Tab

Section F. Admission Category

F0100. Exempted Hospital Discharge

Has the physician certified that individual is likely to require less than 30 days of NF services? (For individuals being admitted from acute care in the hospital)

F0200. Expedited Admission

Does this individual meet any of the following categories for an expedited admission into the nursing facility?

(Please select one category below)

- 0. Not Expedited Admission
- 1. Convalescent Care: Individual is admitted from an acute care hospital to an NF for convalescent care with an acute physical illness or injury which required hospitalization and is expected to remain in the NF for greater than 30 days.
- 2. Terminally Ill: Individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. An individual's medical prognosis is documented by a physician's certification, which is kept in the individual's medical record maintained by the nursing facility.
- 3. Severe Physical Illness: An illness resulting in ventilator dependence or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.
- 4. Delirium: Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.
- 5. Emergency Protective Services: Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the nursing facility not to exceed 7 days.
- 6. Respite: Very brief and finite stay of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with MI or ID is expected to return following the brief NF stay.
- 7. Coma: Severe illness or injury resulting in inability to respond to external communication or stimuli, such as coma or functioning at brain stem level.
### PASRR Evaluation - Section B Tab

Section B contains the Determination of PASRR Eligibility for IDD individuals. This section is only filled out by the LIDDA who performed the IDD evaluation.
Section B also contains the Specialized Services Determination/Recommendations for IDD. This section is completed for all individuals regardless of their Medicaid eligibility. Even though Specialized Services are recommended for all individuals, Medicaid will only reimburse for these services if the individual has Medicaid benefits.

Below this section is an area listing the specialized services which will be provided or coordinated by the Nursing Facility. Multiple specialized services can be listed. This section is called “B0600. Recommended Services Provided/Coordinated by Nursing Facility.”
Appendix B: Authorization Request for PASRR Nursing Facility Specialized Services

Following is the list of the 17 tabs on the NFSS form. The tabs in bold represent the screens included in this appendix:

- Resident/NF
- CMWC/DME Assessment
- CMWC Request
- Gait Trainer
- Orthodontic Device
- Car Seat/Travel Restraint
- Mattress
- Positioning Wedge
- Prosthetic Devide
- Standing Board/Frame
- OT Assessment
- OT Service
- PT Assessment
- PT Service
- ST Assessment
- ST Service
- Auth Summary Page
### Authorization Request for PASRR NF Specialized Services (NFSS)

**Current Status:** Unsubmitted  
**Name:** [Redacted]  
**DLN:** 0  
**Username:** [Redacted]

**Form Actions:**  
- Print  
- Save as Draft

<table>
<thead>
<tr>
<th>Residents/NF</th>
<th>CMWC/DME Assessment</th>
<th>CMWC Request</th>
<th>Gait Trainer</th>
<th>Orthotic Device</th>
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<td>OT Service</td>
<td>PT Assessment</td>
<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

#### Resident Information

**A0100. Resident's Name**
- **A. First Name:** [Redacted]
- **B. Middle Initial:** [Redacted]
- **C. Last Name:** [Redacted]
- **D. Suffix:** [Redacted]

**A0200. Social Security and Medicare Numbers**
- **A. Social Security No.:** [Redacted]
- **B. Medicare No.:** [Redacted]

**A0300. Medicaid No.:** [Redacted]

**A0400. Birth Date and Age**
- **A. Birth Date:** [Redacted]
- **B. Age at Time of Submission:** [Redacted]

#### Legally Authorized Representative (LAR) Information

**A0500. Resident's LAR Name**
- **A. First Name:** [Redacted]
- **B. Last Name:** [Redacted]

**A0600. Resident's LAR Address and Phone Number**
- **A. Street Address:** [Redacted]
- **B. City:** [Redacted]
- **C. State:** [Redacted]
- **D. ZIP Code:** [Redacted]
- **E. Phone No.:** [Redacted]

#### Nursing Facility Information

**A0700. Nursing Facility**
- **A. Provider No.:** [Redacted]
- **B. Vendor No.:** [Redacted]
- **C. NPI/API No.:** [Redacted]
- **D. Facility Name:** [Redacted]

**A0800. Nursing Facility Address**
- **A. Street Address:** [Redacted]
- **B. City:** [Redacted]
- **C. State:** [Redacted]
- **D. ZIP Code:** [Redacted]
- **E. County:** [Redacted]

**A0900. Nursing Facility Phone and FAX Number**
- **A. Phone No.:** [Redacted]
- **B. FAX No.:** [Redacted]
### LIDDA and LMHA Information

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A1000. LIDDA</td>
<td>A. Provider No.</td>
<td>B. Vendor No.</td>
</tr>
<tr>
<td>A1100. LMHA</td>
<td>A. Provider No.</td>
<td>B. Vendor No.</td>
</tr>
</tbody>
</table>

### Type of Service Requested

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>*A2000. Request Type</td>
<td>Select from only 1 category CMWC, DME, or Habilitative Therapies</td>
</tr>
<tr>
<td>A2100. CMWC Service Type</td>
<td></td>
</tr>
<tr>
<td>A2200. DME Service Type</td>
<td></td>
</tr>
<tr>
<td>A2210. Requested DME item</td>
<td>Select all that apply</td>
</tr>
<tr>
<td></td>
<td>A. Gait Trainer</td>
</tr>
<tr>
<td></td>
<td>B. Orthotic Device</td>
</tr>
<tr>
<td></td>
<td>C. Positioning Wedge</td>
</tr>
<tr>
<td></td>
<td>D. Prosthetic Device</td>
</tr>
<tr>
<td></td>
<td>E. Special Needs Car Seat or Travel Restraint</td>
</tr>
<tr>
<td></td>
<td>F. Specialized or Treated Pressure-Reducing Support Surface Mattress</td>
</tr>
<tr>
<td></td>
<td>G. Standing Board/Frame</td>
</tr>
<tr>
<td>A2300. Habilitative Therapies</td>
<td>Select all that apply</td>
</tr>
<tr>
<td></td>
<td>A. Occupational Therapy (OT)</td>
</tr>
<tr>
<td></td>
<td>B. Physical Therapy (PT)</td>
</tr>
<tr>
<td></td>
<td>C. Speech Therapy (ST)</td>
</tr>
</tbody>
</table>
# NFSS - CMWC/DME Assessment Tab

## Authorization Request for PASRR NF Specialized Services (NFSS)

**Current Status:** Unsubmitted  **Name:** [Redacted]  **DLN:** 0  **Username:** [Redacted]

### Form Actions:
- **Print**  
- **Save as Draft**

<table>
<thead>
<tr>
<th>Resident/NF</th>
<th>CMWC/DME Assessment</th>
<th>CMWC Request</th>
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<th>Orthotic Device</th>
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<td>OT Assessment</td>
<td>OT Service</td>
<td>PT Assessment</td>
<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

### CMWC/DME Assessment

**80100. Therapist’s Name**

- **A. First Name**
- **B. Last Name**

**80200. Therapist’s License**

- **A. License Type**
- **B. License No.**
- **C. License State**

**80300. Is the Therapist employed by the Nursing Facility?**

- [ ] Yes

**80400. Therapist's Employer Name**

**80500. Therapist’s Employer Address**

- **A. Street Address**
- **B. City**
- **C. State**
- **D. ZIP Code**

**80600. Therapist’s Phone and FAX Number**

- **A. Phone No.**
- **B. FAX No.**

**80700. Therapist’s Signature Date**

**80800. Date of Assessment**

**80900. Postural Control**

- **A. Head Control**
- **B. Trunk Control**
- **C. Upper Extremities**
- **D. Lower Extremities**

Select One  

[ ]
### Medical Surgical History and Plan

#### B1000. Skin Condition History

A. Is there a history of decubitus/skin breakdown?

B. If Yes, explain:

#### B1100. Current Skin Condition

A. Is there a current decubitus/skin breakdown?

B. If Yes, explain and include the wound stage and wound dimensions of each current site:

#### B1200. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g. contractures, degree of spinal curvature, etc.):

#### B1300. Describe other physical limitations or concerns (i.e. respiratory):

#### B1400. Describe any recent or expected changes in medical/physical/functional status:

#### B1500. Anticipated Surgery

A. Is surgery anticipated?

B. If Yes, indicate the expected date

C. If Yes, describe the procedure:
### Neurological Factors

**81600. Muscle Tone**

A. Indicate resident’s muscle tone:

B. Describe resident’s muscle tone:

C. Describe active movements affected by muscle tone:

D. Describe passive movements affected by muscle tone:

E. Describe reflexes present:

### Functional Assessment

**81700. Current Ambulation**

A. Ambulatory Status:

B. No. of feet

C. Is the resident dependent upon a wheelchair or walker for ambulation?

D. If yes, describe the level of dependence. If No, describe the resident’s ability to ambulate.

**81800. Ambulation Potential**

A. Indicate ambulation potential:

B. No. of years

**82000. Feeding**
### Feeding

<table>
<thead>
<tr>
<th>B2100. Feeding</th>
<th>A. Is the resident tube fed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

B. If Yes, explain:


### Dressing

<table>
<thead>
<tr>
<th>B2200. Dressing:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Education/Vocational Setting

<table>
<thead>
<tr>
<th>B2300. Current Education/Vocational Setting</th>
<th>A. Does the resident have a current education/vocational setting?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

B. If Yes, Name of education/vocational site:


C. If Yes, has a therapist from the education/vocational setting been involved in this assessment?


### Other Therapist from Education/Vocational Setting

<table>
<thead>
<tr>
<th>B2310. Other Therapist from Education/Vocational Setting</th>
<th>A. First Name</th>
<th>B. Last Name</th>
<th>C. Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Referring Physician Identifying Information

<table>
<thead>
<tr>
<th>B2400. Physician’s Information</th>
<th>A. Last Name</th>
<th>B. License State</th>
<th>C. License No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Military Spec Code  
E. Date Resident Last Seen  
F. Signature Date

G. Physician’s Additional Comments


Note: The following Physician information is required if Physician is not licensed in Texas.

<table>
<thead>
<tr>
<th>B2500. Physician’s Information</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B2600. Physician’s Address and Phone Number</th>
<th>A. Street Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. City

C. State

D. ZIP Code  
E. Phone No.
**NFSS - CMWC Request Tab**

**Authorization Request for PASRR NF Specialized Services (NFSS)**

**Current Status:** Unsubmitted  **Name:** [redacted]  **DLN:** 0  **Username:** [redacted]

**Form Actions:**  
- Print  - Save as Draft

<table>
<thead>
<tr>
<th>Resident/NF</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic Device</td>
<td>Standing Board/Frame</td>
<td>OT Assessment</td>
<td>OT Service</td>
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<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

**CMWC Request**

- **Current Seating Equipment**
  - **CO100.** Current Seating System
    - **A.** Does the resident have a current seating system?
      - [ ]
    - **B.** Describe the resident’s current seating system, including the mobility base and age of the system/base.

- **Requested Customized Seating Equipment**
  - **CO200.** Describe the seating system that is being requested and how it must be customized to meet the resident’s specific medical needs.

  **CO300.** Describe the mobility base that is being requested.

  **CO400.** Describe the medical necessity for the requested customized seating system.

  **CO500.** Describe any anticipated modifications/changes to the requested equipment within the next five years.
### Measuring Worksheet

<table>
<thead>
<tr>
<th>C0700. Measurements Completed by:</th>
<th>A. First Name</th>
<th>B. Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Title</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C0800. Measurements:</td>
<td>A. Measurement Data</td>
<td>B. Height (in inches)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Weight (in pounds)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C0900. All measurements should be recorded in inches</td>
<td>A. Top of Head to bottom of buttocks</td>
<td>G. Head width</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Top of shoulder to bottom of buttocks</td>
<td>H. Shoulder width</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Armpit to bottom of buttocks</td>
<td>I. Armpit to armpit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Elbow to bottom of buttocks</td>
<td>J. Hip width</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Back of buttocks to back of knee</td>
<td>K. Distance to bottom of left leg (popliteal to heel)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F. Foot length</td>
<td>L. Distance to bottom of right leg (popliteal to heel)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Additional Comments/Observations:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NFSS - CMWC Request Tab (continued)

supplier Information and MSRP Quote - CMWC Request

- Supplier Information
  C1500. Supplier’s Business Name
  C1600. Supplier’s Representative Completing Form
  A. First Name
  B. Last Name
  C1700. Supplier’s Address
  A. Street Address
  B. City
  C. State
  D. ZIP Code
  C1800. Supplier’s Phone and FAX Number
  A. Phone No.
  B. FAX No.

- Itemized Manufacturer’s Suggested Retail Price (MSRP) Quote
  C1900. Itemized Price Quote
  A. Number of Items to Add
  Add Additional Item

<table>
<thead>
<tr>
<th>B. Item No.</th>
<th>C. HCPCS Code</th>
<th>D. Description of Item</th>
<th>E. Item Price*</th>
<th>F. Quantity</th>
<th>G. Total Price</th>
<th>H. Approved Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ 0.00</td>
<td>0</td>
<td>$ 0.00</td>
<td>$ 0.00</td>
</tr>
</tbody>
</table>

* Item Price must be based on MSRP.

1. Total Amount of All Items Requested
   1. $ 0.00
   2. $ 0.00

2. Minus 18%
   1. $ 0.00
   2. $ 0.00

3. Grand Total
   1. $ 0.00
   2. $ 0.00

Receipt Certification

Upon receipt of a CMWC, the authorizing therapist must verify that the CMWC meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. This section to be filled out for each item requested and received.

Therapist Certification of Delivered CMWC

By signing the attachment, the therapist is certifying that the CMWC meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

C4300. Therapist’s Name
  A. First Name
  B. Last Name

C4400. Therapist’s License
  A. License Type
  B. License No.

C4500. Therapist’s Certification Date

NF Administrator Certification of Delivered CMWC

By signing the attachment, the NF Administrator is attesting that the CMWC has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

C4600. NF Administrator’s Name
  A. First Name
  B. Last Name

C4700. CMWC Received Date

C4800. NF Administrator’s Certification Date
### Upload Attachments
**Required Document**
- CMWC - Supplier Acknowledgement and Signature page
- CMWC - Receipt Certification

[Click here to Upload Documents]

Up to 10 files can be uploaded, at any time. Files cannot exceed 10mb per file. Supported file types: PDF, Image (JPG, TIF, PNG), MS Word, MS Excel, and RTF.

#### Successful Attachments

### Authorization
**G6000. CMWC Request**

<table>
<thead>
<tr>
<th>A. PTID</th>
<th>B. Status</th>
<th>C. Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D. Reason Code**
- 1. Five years has not elapsed since the date of purchase of the previous item of this type
- 2. HHSC did not receive information previously requested from the nursing facility necessary to establish eligibility for the service or item
- 3. The therapist’s assessment indicates the resident will not benefit from a customized manual wheelchair at this time
- 4. Other

**E. If Other**

**F. Date of Assessment**

**G. Total Approved Price**

$0.00

[Submit Form]
# NFSS - Gait Trainer Tab

## Authorization Request for PASRR NF Specialized Services (NFSS)

**Current Status:** Unsubmitted  **Name:** XXXXXXXXXX  **DLN:** 0  **Username:** XXXXXXXX

### Form Actions:
- Print
- Save as Draft

<table>
<thead>
<tr>
<th>Resident/NF</th>
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<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

### Gait Trainer

#### Environment and Transport - Gait Trainer

**D1000.** Environment and Transport

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is the resident's living environment accessible and safe for the use of the DME item requested?</td>
<td></td>
</tr>
<tr>
<td>B. Will the DME item need to be transported?</td>
<td></td>
</tr>
<tr>
<td>C. If Yes, describe how the DME item will be transported:</td>
<td></td>
</tr>
</tbody>
</table>

**D1100.** DME Site Accessibility

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Was a DME similar to the one requested used at this site?</td>
<td></td>
</tr>
<tr>
<td>B. If Yes, is the site accessible and safe for the use of the DME item?</td>
<td></td>
</tr>
</tbody>
</table>

**D1200.** Additional comments and observations of education/vocational therapist for this DME item:

**Current DME Item - Gait Trainer**

**D1300.** Does the resident have a current DME item or items?

**D1310.** Describe the resident’s current DME item(s) (if the item requested is a replacement), including the type and the age of the item:

**D1320.** Describe why the current DME item(s) does not meet the resident’s needs:
### LFSS - Gait Trainer Tab (continued)

#### Requested DME Item - Gait Trainer

D1400. Describe the DME item being requested:

D1410. Describe the medical necessity for the requested DME item:

D1420. Describe any anticipated modifications/changes to the DME item within the next five years:

D1430. Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other):

#### Supplier Information and MSRP Quote - Gait Trainer

**Supplier Information**

D1500. Supplier's Business Name

D1510. Supplier's Representative Completing Form

A. First Name  

B. Last Name

D1520. Supplier’s Address

A. Street Address

B. City

C. State

D. ZIP Code

D1530. Supplier’s Phone and FAX Number

A. Phone No.

B. FAX No.

**Itemized Manufacturer's Suggested Retail Price (MSRP) Quote**

D1000. Itemized Price Quote

A. Number of Items to Add

[Add Additional Item]

<table>
<thead>
<tr>
<th>B. Item No.</th>
<th>C. HCPCS Code</th>
<th>D. Description of Item</th>
<th>E. Item Price*</th>
<th>F. Quantity</th>
<th>G. Total Price</th>
<th>H. Approved Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ 0.00</td>
<td>0</td>
<td>$ 0.00</td>
<td>$ 0.00</td>
</tr>
</tbody>
</table>

* Item Price must be based on MSRP.

<table>
<thead>
<tr>
<th>I. Total Amount of All Items Requested</th>
<th>1. $ 0.00</th>
<th>2. $ 0.00</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>J. Minus 18%</th>
<th>1. $ 0.00</th>
<th>2. $ 0.00</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>K. Grand Total</th>
<th>1. $ 0.00</th>
<th>2. $ 0.00</th>
</tr>
</thead>
</table>
NFSS - Gait Trainer Tab (continued)

Receipt Certification
Upon receipt of the DME, the authorizing therapist must verify that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. This section to be filled out for each item requested and received.

Therapist Certification of Delivered Gait Trainer
By signing the attachment, the therapist is certifying that the DME meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies. An attachment must be completed for each item requested and received.

D1600. Therapist’s Name
A. First Name
B. Last Name

D1610. Therapist’s License
A. License Type
B. License No.

D1620. Therapist’s Certification Date

NF Administrator Certification of Delivered Gait Trainer
By signing the attachment, the NF Administrator is attesting that the DME has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

D1630. NF Administrator’s Name
A. First Name
B. Last Name

D1640. Gait Trainer Received Date

D1650. NF Administrator’s Certification Date

Upload Attachments
Required Document

- Gait Trainer - Supplier Acknowledgement and Signature page
- Gait Trainer - Receipt Certification

Click here to Upload Documents

Up to 10 files can be uploaded, at any time. Files cannot exceed 10mb per file. Supported file types: PDF, Image (JPG, TIF, PNG), MS Word, MS Excel, and RTF.

Successful Attachments

Authorization

A. PTID
B. Status
C. Action

D. Reason Code
- 1. Five years has not elapsed since the date of purchase of the previous item of this type
- 2. HHSC did not receive information previously requested from the nursing facility necessary to establish eligibility for the service or item
- 3. Other
- Other

E. If Other

F. Date of Assessment
G. Total Approved Price

$ 0.00

Confirm

Submit Form
# NFSS - OT Assessment Tab

## Authorization Request for PASRR NF Specialized Services (NFSS)

<table>
<thead>
<tr>
<th>Current Status: Unsubmitted</th>
<th>Name:</th>
<th>DLN: 0</th>
<th>Username:</th>
</tr>
</thead>
</table>

### Form Actions:
- Print
- Save as Draft

<table>
<thead>
<tr>
<th>Resident/NF</th>
<th>CMWC/DME Assessment</th>
<th>CMWC Request</th>
<th>Gait Trainer</th>
<th>Orthotic Device</th>
<th>Car Seat/Travel Restraint</th>
<th>Mattress</th>
<th>Positioning Wedge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic Device</td>
<td>Standing Board/Frame</td>
<td>OT Assessment</td>
<td>OT Service</td>
<td>PT Assessment</td>
<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

### OT Assessment

#### Authorization Type

- **F0100.** Occupational Therapy Authorization Type:
  - 

#### Therapist Identifying Information

1. **F0200.** Therapist’s Name:
   - A. First Name
   - B. Last Name
2. **F0300.** Therapist’s License:
   - A. License Type
   - B. License No.
   - C. License State
3. **F0400.** Is the Therapist employed by the Nursing Facility?
   - 
4. **F0500.** Therapist’s Employer Name
5. **F0600.** Therapist’s Employer Address:
   - A. Street Address
   - B. City
   - C. State
   - D. ZIP Code
6. **F0700.** Therapist’s Phone and FAX Number:
   - A. Phone No.
   - B. FAX No.
7. **F0800.** Therapist’s Signature Date

#### Date of Assessment - Occupational Therapy

- **F0900.** Date of Assessment
  - 

---
### NFSS - OT Assessment Tab (continued)

#### Therapy Assessment - Occupational Therapy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1100</td>
<td>Treating impairment or dysfunction</td>
</tr>
<tr>
<td>E1200</td>
<td>Initial Assessment/Current Level of Function and Underlying Impairments</td>
</tr>
<tr>
<td>E1300</td>
<td>Clinical Impressions</td>
</tr>
<tr>
<td>E1400</td>
<td>Reason for Skilled Services</td>
</tr>
<tr>
<td>E1500</td>
<td>Skilled Intervention Focus</td>
</tr>
</tbody>
</table>

#### Upload Attachments

**Required Document**

- Occupational Therapy - Signature page

[Click here to Upload Documents](#)

Up to 10 files can be uploaded, at any time. Files cannot exceed 10mb per file. Supported file types: PDF, Image (JPG, TIF, PNG), MS Word, MS Excel, and RTF.

**Successful Attachments**

#### Authorization

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1000</td>
<td>Occupational Therapy Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. PTID</th>
<th>B. Status</th>
<th>C. Action</th>
</tr>
</thead>
</table>

**D. Reason Code**

- 1. MNHC did not receive information previously requested from the nursing facility necessary to establish eligibility for the service or item
- 2. Other
- If Other

**F. Date of Assessment**

[Submit Form](#)
NFSS - OT Service Tab

Authorization Request for PASRR NF Specialized Services (NFSS)

Current Status: Unsubmitted
Name: [Redacted]
DLN: 0
Username: [Redacted]

Form Actions:
Print  Save as Draft

<table>
<thead>
<tr>
<th>Resident/NF</th>
<th>CMWC/DME Assessment</th>
<th>CMWC Request</th>
<th>Gait Trainer</th>
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<td>OT Service</td>
<td>PT Assessment</td>
<td>PT Service</td>
<td>ST Assessment</td>
<td>ST Service</td>
</tr>
</tbody>
</table>

OT Service

- **Therapy Treatment Plan - Occupational Therapy**
  - \$1600. Diagnosis
    - Add Diagnosis
  - \$1700. Long-Term Goals
  - \$1800. Short-Term Goals

- **Recommended Habilitation - Occupational Therapy**
  - \$1900. Recommended Habilitation
    - A. Frequency: No. of times per week
    - B. Duration: length of treatment
    - C. Intensity: No. of times per day the therapist provides treatment

- **Referring Physician Identifying Information - Occupational Therapy**
  - \$2000. Physician’s Information
    - A. Last Name
    - B. License State
    - C. License No.
    - D. Military Spec Code
    - E. Date Resident Last Seen
    - F. Signature Date

Note: The following Physician information is required if Physician is not licensed in Texas.

- \$2100. Physician’s Information
  - First Name

- \$2200. Physician’s Address and Phone Number
  - A. Street Address
  - B. City
  - C. State
  - D. ZIP Code
  - E. Phone No.
# NFSS - OT Service Tab (continued)

### Upload Attachments

**Required Document**

- [ ] Occupational Therapy - Signature page

[Click here to Upload Documents]

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### Authorization

**G2000.** Occupational Therapy

<table>
<thead>
<tr>
<th>A. PTID</th>
<th>B. Status</th>
<th>C. Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D. Reason Code**

- [ ] 1. HHSC did not receive information previously requested from the nursing facility necessary to establish eligibility for the service or item
- [ ] 2. The therapy assessment indicates the resident will not benefit from therapy at this time
- [ ] 3. Other

**E. If Other**

**F. Date of Assessment**

**G. Begin Date**

**H. End Date**

**I. Units Per Week**

[Submit Form]
# NFSS - Auth Summary Tab

![Authorization Request for PASRR NF Specialized Services (NFSS)](image)

## Auth Summary

### CMWC Authorizations

<table>
<thead>
<tr>
<th>S1000: Request Type</th>
<th>1. PTID</th>
<th>2. PTID Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. CMWC Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. CMWC Request</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DME Authorizations

<table>
<thead>
<tr>
<th>S2000: Request Type</th>
<th>1. PTID</th>
<th>2. PTID Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. DME Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Gait Trainer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Orthotic Device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Positioning Wedge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Prosthetic Device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Car Seat/Travel Restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Mattress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Standing Board/Frame</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Therapy Authorizations

<table>
<thead>
<tr>
<th>S3000: Request Type</th>
<th>1. PTID</th>
<th>2. PTID Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. OT Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. OT Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. PT Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. PT Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. ST Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. ST Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix C: Timers

<table>
<thead>
<tr>
<th>Description</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempted Hospital Discharge exceeds 30 days</td>
<td>PASRR Evaluation performed 30 days from Nursing Facility admission date.</td>
</tr>
<tr>
<td>Expedited Admission - Category 4 or 5</td>
<td>PASRR Evaluation performed seven days from Nursing Facility admission date.</td>
</tr>
<tr>
<td>Expedited Admission - Category 1, 2, or 3</td>
<td>PASRR Evaluation must be performed within 72 hours notification by Nursing Facility or LTC Online Portal Alert. Must be successfully submitted within seven calendar days from date of notification.</td>
</tr>
<tr>
<td>Expedited Admission - Category 6</td>
<td>PASRR Evaluation must be performed 14 days from Nursing Facility admission date.</td>
</tr>
<tr>
<td>PASRR Evaluation</td>
<td>Face-to-face contact initiated within 72 hours of notification by the Referring Entity, Nursing Facility or LTC Online Portal Alert. Must be successfully submitted within seven calendar days of the notification.</td>
</tr>
<tr>
<td>NF Placement Process Exhausted (PL1 Form Status)</td>
<td>90 days have passed since the PE was submitted and where none of the Nursing Facilities on Section D have certified that they are able to serve and admit the individual on the PL1 or there are 15 Nursing Facilities in this section.</td>
</tr>
<tr>
<td>MI Check Inactive (NFSS Form Status)</td>
<td>If Medicaid ID Check is unable to validate after 30 days, form moves into this status. This is a final status for the NFSS form.</td>
</tr>
<tr>
<td>ME Check Inactive (NFSS Form Status)</td>
<td>If Medicaid ID Check is unable to validate after 30 days, form moves into this status. This is a final status for the NFSS form.</td>
</tr>
<tr>
<td>AI Check Inactive (NFSS Form Status)</td>
<td>If Medicaid ID Check is unable to validate after 30 days, form moves into this status. This is a final status for the NFSS form.</td>
</tr>
<tr>
<td>Denied (NFSS PTID Status)</td>
<td>PTID will move from Pending Denial to Denied if no action is taken within 14 days for DME/CMWCs or within 7 days for therapies.</td>
</tr>
<tr>
<td>Item Not Received (NFSS PTID Status)</td>
<td>When NFSS PTID is in this status, the following note will appear in the PTID history: “365 days have elapsed since the DME or CMWC was approved. The item was not certified by the Nursing Facility.”</td>
</tr>
<tr>
<td>FH Expired (NFSS PTID Status)</td>
<td>When NFSS PTID is in this status, the following note will appear in the PTID history: “90 days have elapsed since the request was Denied.”</td>
</tr>
</tbody>
</table>
The LTC User Guide for PASRR and NFSS is produced by TMHP Training and Organizational Development Services. Contents are current as of the time of publishing and subject to change. Providers should always refer to Provider Manuals, Bulletins, and the TMHP and HHS websites for current and authoritative information.