

**LAKESHORE REGIONAL ENTITY**  
**Pre-Admission Screening/Annual Resident Review as Required by OBRA of 1987**  
**(OBRA PAS/ARR)**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Definition or Description of Service**

- a. To evaluate Individuals for eligibility for nursing facility services, and review for continued need of the service. Staff in this program complete Pre-Admission Screenings (PAS) and Annual Resident Reviews (ARR), as well as appeal notifications for nursing home placements.
- b. This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as well as the MDHHS OBRA Operations Manual.

**2. Practice Principles**

- a. The Pre-Admission Screening and Annual Resident Review process is mandated by the Omnibus Budget Reconciliation Act of 1987. The process determines who is eligible to live in a Medicaid-funded nursing facility.
- b. Pre-Admission Screening Level I screening is required for all Individuals seeking to enter a nursing facility and its purpose is to identify Individuals who may have a mental illness or intellectual disability or related condition.
- c. The PAS Level II screening is used to assess Individuals who are identified as having a mental illness, developmental disability, or related condition to determine the need for nursing facility services, specialized services, and/or mental health services.
- d. OBRA PAS/ARR ensures only people with significant needs are placed in the restrictive nursing facility environment.

**3. Credentialing Requirements** *Refer to current Medicaid Provider Manual for updated requirements*

- a. Professional staff must possess certification or license appropriate to the service they provide, as identified within the MDHHS OBRA Manual.
- b. Provider will assure that licensed professional staff are licensed and/or registered in the State of Michigan to provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
- c. Providers of OBRA PAS/ARR services must meet the staff qualifications as defined by the MDHHS Michigan PIHP/CMHSP Provider Qualification per Medicaid Services and HCPCS/CPT Codes.
- d. Provider shall maintain a copy of training records for each staff person for review if requested by the Payor, the LRE, or an external review team.
- e. Providers of services must:
  - i. Be at least 18 years of age.
  - ii. Be able to prevent transmission of any communicable disease from self to others in the environment where they are providing supports.
  - iii. Be able to communicate expressively and receptively in order to follow individual plan requirements and Individual-specific emergency procedures, and report on activities performed. Understanding and skill must be documented.
  - iv. Be in good standing with the law as outlined in the MDHHS/PIHP contract.
  - v. Be able to perform basic first aid and emergency procedures.

#### 4. Service Requirements

- a. Provider, utilizing formats acceptable to CMHSP, shall document the progress toward the goals and objectives set forth in the individual plan of service (IPOS) of the Individual(s) served under this agreement, per CMHSP-required standards. Provider also shall promptly notify the Supports Coordinator/Case Manager, in writing, when it believes an Individual's IPOS or ancillary plan(s) is/are in need of revision or modification because of any of the following:
  - i. An Individual has achieved an objective set forth in the IPOS or ancillary plan(s);
  - ii. An Individual has regressed or lost previously attained skills; or,
  - iii. An Individual has failed to progress toward identified objectives despite consistent effort to implement the IPOS.
- b. Provider shall ensure coordination of care occurs between the Individual's primary health care physician and Medicaid Health Plan, as appropriate. Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment and as specified in an Individual's IPOS.
- c. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed.
- d. The Individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the Individual.
- e. Services must adhere to all requirements set forth in the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services and Nursing Facilities chapters of the Medicaid Provider Manual and the MDHHS OBRA Operations Manual.
- f. PAS/ARR services may be provided to an Individual as long as he/she meets the minimum requirements, as defined in Medical Necessity Criteria within the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual.
- g. Provider will do the following:
  - i. Complete assessment within 14 days of referral date.
  - ii. Complete Preadmission Screening (PAS) and Annual Resident Review (ARR) screenings as mandated by the Omnibus Budget Reconciliation Act of 1987.
  - iii. Complete Level II assessments to clinically evaluate the Individual's need for both nursing home and mental health services. Level II assessments shall be completed by a psychiatrist, a psychologist, a nurse, and clinician/social worker, as indicated.
  - iv. Provide consultation and training to nursing facility staff.
  - v. Refer Individuals needing mental health treatment or other services to the appropriate agency/agencies.
  - vi. Identify Individual needs in the pertinent domains that support person-centered treatment in the nursing facility.
  - vii. Forward evaluations and recommendations to MDHHS for final determination following the required MDHHS process.
  - viii. Adapt PAS/ARR assessments to the cultural background, language, ethnic origin, and means of communication used by the Individual being evaluated.
  - ix. Ensure that PAS/ARR evaluations involve:
    - (1) The person being evaluated
    - (2) The person's legal representative, if one has been designated under State law, and,
    - (3) The person's family, if available, when the person or his/her legal representative agrees to family participation.
  - x. Ensure that the data relied on to make a determination will minimally include the following:

- xi. Evaluation of physical status (including results of a physical examination, diagnoses, current treatments and medications, medical and drug history, and nutritional status).
  - xii. Evaluation of mental status including a psychosocial assessment, a psychiatric evaluation (if the person is believed to have a mental illness), and a psychological assessment of intellectual functioning.
  - xiii. A functional assessment (including assessment of the person's ability to engage in activities of daily living, to self-medicate, and to self-monitor health status), and, in addition, for persons who are believed to have a developmental disability or a related condition, assessments in the areas of vocational skills, education development, communication, independent living skills, and sensory or motor development.
- h. Forward evaluations and recommendations to MDHHS for final determination.
  - i. Explain the evaluation and the MDHHS determination to the Individual and the Individual's legal representative within **five (5) days**.
  - j. Provide a copy of the evaluation and the MDHHS determination letter and explain the appeal rights to the Individual and his/her legal representative. It is strongly encouraged, that this information be provided face-to-face to the person evaluated or the legal representative. Any appeal notification activity shall be documented and be part of the clinical assessment.
  - k. Notify the attending physician, nursing facility and discharging hospital of the results of the evaluation and the MDHHS determination in writing within **five (5) days** of the review. Retain a copy of this notification in the Individual's record.
  - l. Provider will maintain documentation for all orientation and continuing education, which shall include areas as needed to provide high quality services.
  - m. Maintain agreements with nursing homes describing roles and responsibilities in the PAS/ARR assessment process for Individuals entering or residing in the nursing home.
  - n. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the Individual. Provider shall be responsive to the particular needs of Individuals with sensory or mobility impairments, and provide necessary accommodations.
  - o. Provider shall complete service documentation and records that meet the PIHP/CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the PIHP, CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third-party payers.

## 5. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

## 6. Eligibility Criteria/Access Requirements/Authorization Procedures

- a. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the person-centered planning process to determine and document medical/clinical necessity for the requested service.
- b. Waiver eligibility requires verification of no change in waiver status.
- c. The [Lakeshore Region Guide to Services](http://www.lsre.org) provides a summary of service eligibility, access to services, and service authorization. This document is located on the Lakeshore Regional Entity website at [www.lsre.org](http://www.lsre.org). Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.