1.2.1. IN LCAR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual

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About Maximus

Since 1975, Maximus has pioneered innovative healthcare management solutions for programs that serve people with complex diagnostic profiles. Since 2000, Maximus has partnered with state agencies to assess people with mental illness and intellectual and developmental disabilities. We incorporate evidence-based practices into public sector healthcare management by combining information technologies, quality improvement and management initiatives, service oversight, provider training, and management of healthcare datasets.

Maximus' assessment process captures each person's needs and goals helping facility staff plan services and supports in a person-centered way.

We combine our leadership team's experience with project staff and independent contractors who comprehensively assess people and identify services that will best meet their needs.

OUR MISSION: Making a *difference* by providing INNOVATIVE healthcare products and services.

Have Questions?

For questions about AssessmentPro including system access and password assistance: email PASRR@fssa.in.gov, phone the help desk at 833.597.2777, or fax number 877.431.9568.

For clinical questions about a specific person or assessment, use the **Communicate with clinical reviewer** feature within AssessmentPro.

For more information about Maximus, visit our website at www.maximusclinicalservices.com

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ABOUT interRAI HC

Products from interRAI assess people who have chronic illnesses and disabilities. The interRAI Home Care (HC) assessment focuses on a person's medical needs. It records the person's strengths and preferences so an interdisciplinary team can plan the best services to meet their needs. The interRAI HC assessment gathers this information through interviews with the person and their caregivers.

About interRAI HC in Indiana

The Indiana Family and Social Services Administration (FSSA) uses the interRAI HC as its standardized assessment tool for deciding if a person seeking continued stay in a nursing facility (NF) or newly seeking an NF stay meets the state's criteria for level of care (LOC).

InterRAI and PASRR

To understand interRAI HC's role in Indiana, it helps to understand Preadmission Screening and Resident Review (PASRR).

PASRR is a federal mandate that sets the minimum standards for the rights and care of people receiving care in a Medicaid-certified NF. These regulations require that all persons be screened for the presence of mental illness (MI), intellectual disability (ID), and related conditions (RC) before going into a Medicaid-certified NF.

PASRR also identifies the least restrictive setting that meets the person's needs. If the setting is determined to be a NF (either for a short or long-term stay), the PASRR must identify services that the facility must include in the care planning process.

States may design long-term care programs that *exceed* these federal standards, but all long-term programs must at least meet the federal requirements. Refer to PASRR Overview for more information.

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How is the interRAI HC used?

The interRAI HC is administered to anyone seeking admission to a Medicaid-certified NF. The assessment identifies the person's medical and behavioral health needs and then determines if the community's supports and services can meet the person's needs or if the person needs a level of care that only a NF can provide.

The IN Division of Aging (DA), the IN Division of Disability and Rehabilitative Services (DDRS), and the IN Division of Mental Health and Addiction (DMHA) collaborate to administer long-term care services. The Indiana FSSA oversees these agencies. DA oversees Level I and LOC. DDRS serves people with intellectual and developmental disabilities. DMHA serves people with mental health disabilities.

If a hospital is treating the person, the hospital provider will complete the short form interRAI HC LOC, or "short form LOC." If the person is in a community setting, like their home or an assisted living setting, the local Area Agency on Aging (AAA) will complete the full interRAI HC LOC screen ("long form LOC"). AAA providers will also do long form LOC screens for people who do not appear to meet NF level of care. The NF provider will complete the short form LOC for residents who become Medicaid active, need to continue NF care beyond the approved length of stay, or experience a significant change in condition. The provider will submit the completed interRAI HC to Maximus for clinical review. Providers can monitor the progress of screens for any person in their facilities 24/7. To ensure efficient screening processes, providers should actively monitor AssessmentPro and respond promptly to communications from Maximus reviewers.

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Maximus' role in IN long-term care services

Maximus provides and maintains a web-based assessment platform that hospitals, NF, and AAA providers use to complete the federal PASRR Level I screen and the NF level of care screen. This platform, known as AssessmentPro™, offers PASRR Pro-I™, LOC Pro™, and PathTracker™, which provides Maximus' web-based PASRR screening and tracking services.

Maximus' Program Support Staff (PSS) can answer non-clinical questions about things like workflow and

timelines. They can provide direction to providers as needed and route technical questions about the website to the State's technical assistance provider or to Maximus' IT team as needed. Questions should be directed to PASRR@fssa.in.gov and will be routed as appropriate.

Maximus' Clinical Reviewers *clinically review* all Level I screens that do not result in an immediate approval for NF placement. They also review interRAI HC short and long form submissions. They review supporting documentation and all LOC forms from hospitals and monitor a sample of interRAI HC long forms from AAA providers. Clinical Reviewers also write an outcome that the provider can print directly from PASRR Pro-I™ and give to the assessed person. Clinical Reviewers may also use AssessmentPro to ask submitters to clarify or add information. Providers can also begin a screen and save it without submitting it. Doing this creates a "draft screen" that the provider can access for up to 72 hours. This lets providers return to the draft screen to correct it and to upload documentation before submitting the screen. Providers can also withdraw draft and submitted screens (for example, when a person dies, discharges to a community setting, or admits to a NF that is not Medicaid-certified).

Please note all screens are subject to quality review by one of Maximus' Clinical Reviewers.

Additional Resources

To access trainings, frequently asked questions, and other helpful resources about PASRR, Level of Care, and AssessmentPro, visit the Indiana PASRR User Tools page at https://www.Maximusami.com/ami/Providers/YourState/IndianaPASRRUserTools.aspx.

You can find the federal PASRR regulations at 42 CFR 483 Part C.

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PASRR Overview

Background

PASRR stands for **P**re**a**dmission **S**creen and **R**esident **R**eview. PASRR began in the 1980s as part of an initiative to improve nursing facility care. In 1987 congress enacted the Omnibus Reconciliation Act of 1987 (OBRA-87), also known as the Nursing Home Reform Act. OBRA-87 protects individual rights, improves the quality of care and the quality of life for people who need nursing facility care.

A portion of this Act, known as PASRR, clarifies the role that nursing facility providers have in addressing their residents' behavioral health needs. PASRR:

- Identifies people who have or might have a serious mental illness (SMI), intellectual disability (ID), or a condition related to intellectual disability [referred to as related condition (RC)], based on the information available through a **Level I**. The Level I is a short screen that tries to answer this question: "Does this person have a known or suspected serious mental illness, an intellectual disability, or a related condition?" If the answer is *no*, then the nursing facility may admit the person if they meet the State's criteria for nursing facility level of care. If the answer is *yes* or *maybe*, further evaluation is required before

the person can go into the nursing facility. Per federal requirements, every person who is seeking admission to a Medicaid-certified NF must be screened for the presence of an MI, ID or RC condition before the provider can admit them into a Medicaid-certified nursing facility.

- Determine services and supports any person with MI/ID/RC need. The PASRR **Level II** evaluation identifies the rehabilitative or specialized services that the person needs. ***Nursing facilities must plan for and deliver or arrange for the delivery of all rehabilitative services that the PASRR Level II identifies.***
- Determine the most appropriate setting for any person with MI/ID/RC. Assessors should consider two factors: what is the least restrictive setting necessary that also meets the person's needs. In its *Olmstead v. L.C. (1999)* decision, the US Supreme Court found that the Americans with Disabilities Act protects mental illness as a form of disability. The Supreme Court also held that people with mental disabilities have the right to live in the community instead of in an institution when the person wants to live in the community and when the State's treatment professionals have deemed community-based services appropriate for the person's needs. Additionally, the Supreme Court held that unjust segregation based on a disability is discrimination.

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Federal Requirements of PASRR

The Centers for Medicare and Medicaid Services (CMS) require PASRR assessments. These PASRR assessments must:

- Identify people with SMI, ID, or RC
- Determine the appropriate placement for those people and identify the services they need

Nursing facility providers must address both the medical and behavioral needs of any resident with SMI, ID, or RC. The PASRR process must be completed before a person admits and when a person's status significantly changes, which is referred to as a Status Change review.

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Who is evaluated through PASRR?

Persons with Serious Mental Illness (SMI)

The Level I screen gathers information about people with SMIs. This information includes the person's mental health diagnoses, their symptoms and intensity, and how much the condition and its symptoms have impacted the person's life and well-being.

The federal definition for SMI is:

- ***Diagnosis:*** Of a major mental illness, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, psychotic disorder, panic disorder, obsessive compulsive disorder and **any other disorder** that could lead to **a chronic disability** that is not a primary diagnosis of dementia.

- ***Duration:*** A significant life disruption or major treatment episode during the past two years because of the disorder. **A disruption or major treatment episode includes hospitalization but is not limited to it.** A disruption might include needing more services (like case management) because the condition intensified **regardless of whether the services were identified or delivered**. More example scenarios that reveal intervention needs include:
    - Psychiatric treatment more intensive than outpatient care (like partial hospitalization, inpatient psychiatric hospitalization, or crisis unit placement) within the past two years
    - A major psychiatric episode
    - A suicide attempt or suicidal gestures
    - Other safety concerns
- ***Disability:*** Referred to as *Level of Impairment* in regulatory language, disability is characterized by active behavioral health symptoms within the preceding six-month period that significantly interfere with the person's ability to:
    - Interact interpersonally
    - Concentrate
    - Follow through with goals or needs
    - Adapt effectively to change

In other words, the person's symptoms have impacted their life over the past 6 months.

Using these criteria, how would we assess a person with a first-time episode of serious depression?

To answer that, let us first look at the data:

19%-55% of people in nursing facilities have mental disorders. Elders attempt and accomplish suicide more often than anyone else.

While people living in nursing facilities attempt *violent* suicide less often, they think *more* often about suicide. Many of these people die from *indirect* suicide by refusing to eat or take medicine. This data means that the people whom PASRR assesses have a high risk for suicide.

PASRR does not target people with a brief episode of depression. Having said that, these facts demand caution. If someone's depression is more severe than or lasts longer thana typical grief reaction, give Maximus' clinicians enough information to decide if PASRR should identify treatments to improve the person's symptoms.

As a general guideline, if a person's depressive episode lasts longer than three months, it may be a first-time episode of **serious** depression.

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Persons with Intellectual Disability

The *Diagnostic and Statistical Manual, Fifth* Edition defines intellectual disability (ID) as a disorder with intellectual and adaptive functioning limitations that begins during childhood or adolescence, prior to age 18. Intellectual disability may be associated with other conditions, such as a genetic syndrome, or traumatic brain injury (TBI) sustained during the developmental period. A person's condition must meet three criteria to be ID. The person must show:

- Deficits in intellectual functioning (reasoning, abstract thinking, learning, etc.)
- Deficits in adaptive functioning that require ongoing support (social skills, relating to others, personal independence, etc.)
- Deficit onset during the developmental period

The intellectual disability's severity rests on adaptive functioning in three domains: the conceptual domain, social domain, and practical domain. Healthcare professionals can classify severity in one of four ranges: mild, moderate, severe, and profound.

Good evaluations tease out how and when lower cognition began. Lower cognition may have started during the developmental phase or if a medical issue (like a stroke, transient ischemic attack, or an accident or injury)

caused it later in life.

Figuring this out is complicated. Decades ago, formal IQ testing happened less frequently, especially in rural areas. Because of this, PASRR evaluations often must research developmental information and medical history to uncover when symptoms began.

The dementia exemption does not apply to persons diagnosed with intellectual disability or related condition.

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Persons with a Related Condition (RC)

Federal code refers to conditions that affect people like intellectual disabilities as “Related Conditions” (RC). PASRR evaluations for people with RC must confirm that the condition limits three or more major areas of life activity. They also must confirm that the condition began before age 22 (see §435.1009).

People with RC have needs like people who have intellectual disabilities. RC is defined as a severe, chronic disability that meets the following conditions:

- Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness, found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to ID and requires treatment or services similar to ID
- Is present prior to age 22
- Is expected to continue indefinitely
- Results in substantial functional limitations in three or more of the following major life activities:
    - Self-care
    - Understanding and use of language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for independent living; Diagnosis alone is not a qualifier for a RC.

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1. PASRR Level I (LI) Screening Process

1.1. Who receives a Level I?

A Level I screen is required for **all** individuals seeking admission to a Medicaid-certified nursing facility, regardless of how the person is paying for their stay (i.e., Medicare/Medicaid, private insurance, etc.). Providers submit Level I screens through PASRR Pro-I, Maximus’ web-based Level I tool in AssessmentPro. A Level I screen is required:

- Before admission to any Medicaid-certified nursing facility (this includes Program of All-Inclusive Care to the Elderly (PACE) participants seeking admission to any Medicaid-certified nursing facility)

- For residents of a Medicaid-certified nursing facility who have experienced a significant change in mental status that suggests the need for a first-time Level I review, a subsequent Level I review, or updated PASRR Level II evaluation
- Before a time-limited stay ends for people with MI and/or ID/RC who need to stay after approved stay expires, requiring a Level II evaluation

The Nursing Facility's Medicaid certification, not the person's payment method, determines if PASRR is required. If a person tries to admit to a Medicaid-certified nursing facility, regardless of whether they are paying for their stay with Medicaid/Medicare or private payment, the person MUST have a PASRR Level I screen, and if applicable a Level II evaluation, before admitting and whenever a resident's status significantly changes, requiring a Level II evaluation.

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1.2. Who submits a Level I screen?

Hospital, AAA, and NF providers are responsible for submitting Level I screens. Typically, the provider of record will submit the Level I screen. If the person is in a hospital setting, the hospital provider will submit the Level I screen; if the person is in the community, the AAA or NF provider can submit the screen. The NF provider is responsible for submitting the Level I screen for anyone in their facility who:

- Has a significant change in mental status,
- Needs to stay in the NF after the approved end date of a categorical determination or exemption. The NF must also submit a LOC screen to initiate the required onsite Level II (regardless of the individual's pay source),
- Is admitted to their facility from out of state, or
- Needs an updated Level I screen because of a change in medication, diagnoses, etc. The screen may not be associated with a Level II condition, but if the existing Level I screen is no longer accurate, you must submit a new Level I.

AssessmentPro lets any authorized user in your facility begin and *enter* a screen, but only a qualified provider may *submit* a screen to Maximus. The healthcare professional submitting the Level I or LOC screen is attesting that the information is accurate to the best of their knowledge. The **submitter accepts full responsibility** for the submitted content.

When you start a Level I screen, PASRR Pro-I will guide you through questions about the person's medical and behavioral diagnoses, history, and current symptoms. PASRR Pro-I will usually decide the Level I's outcome immediately, which means you can instantly print the outcome determination. But, if the Level I indicates that the person may have a Level II condition, PASRR Pro-I will automatically queue the screen I to a Maximus clinician who will review it, possibly request more information, and decide its outcome.

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1.2.1. Submitting Level I for Mental Status Change

If a NF resident's behavioral or mental status **significantly changes**, the NF must submit a new Level I to report the change through the PASRR process. This applies to people who have a known Level II condition **and** to people with a previous negative Level I. NFs must submit mental status change referrals within 14 days of the significant change event. Examples of a mental status change event include:

- A new mental health diagnosis that is not listed on previous LI or Level II.
- A new psychotropic medication for mental illness. For PASRR purposes, a psychotropic medication for a medical condition (like for regulating sleep or appetite) does **not** trigger a new Level I or need for a Level II.
- A significant increase in existing symptoms or new symptoms (like depression, anxiety, hallucinations, or refusal to eat).

1.2.2. Draft Screens and Turnaround Time

AssessmentPro will save draft Level I screens for 72 hours. Once a draft screen has expired, you cannot return to it. You will lose your work, and you will need to start a new screen. Refer to Section 4.2.2. Draft Screen Expiration of this manual for more information.

PASRR Pro-I puts Level I screens in Maximus' clinical review queue in chronological order.

If a screen needs a clinical review, AssessmentPro will usually notify you of its outcome within 6 business hours from when Maximus receives all the information we need to complete the review. If Maximus' Clinical Reviewer requests more information, the Clinical Reviewer will put the assessment on hold. Our turnaround clock's time stops ticking until we receive all the information we need. You should check the ***Action Required*** queue regularly for feedback and questions from our clinicians so you can respond and promptly upload any requested documentation or answer questions. Responding promptly to requests for information will expedite the Level I screening process. **If you do not respond to a request for more information in 10 business days or 14 calendar days, AssessmentPro will cancel the Level I or LOC screen.** You will need to submit a new Level I, and we must render a decision *before* the person can admit to a Medicaid-certified NF.

> ✓ **Be sure to frequently monitor the screens you have submitted in Assessment Pro.**
>
> The ***Action Required*** queue will alert you to any requests for information or other clarification to complete an accurate and expedient screen.

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1.3. Level I Outcomes

The possible outcomes for a Level I screen in Indiana are:

- Cancelled – Expired – Information Not Received
- Cancelled Type 2

- Custom Categorical
- Emergency Categorical
- Respite Categorical
- Terminal Illness Categorical
- Exempted Hospital Discharge
- Convalescent Categorical
- Level 1 Negative No Status Change
- Level 1 Positive No Status Change
- No Level II Required, No SMI/ID/RC
- No Level II Required, Situational Symptoms
- Refer for Level II DBR
- Refer for Level II Onsite
- Refer for Level II Onsite (via Quality Review)

If the Level I screen indicates that the person does **not** have a possible MI, ID, and/or RC condition, PASRR Pro-I will automatically approve the person for NF placement. If the Level I indicates that the person has, or may have a MI, ID, and/or RC, then the PASRR Pro-I will queue the referral to a Maximus clinician for review.
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1.3.1. Negative Level I and Emergency Admissions

Effective 07/01/2016, IN will no longer apply a non-Level II emergency admission provision. Refer to the process outlined below:

For people wanting to enter a nursing facility from their homes or another community-based setting, the submitter (nursing facility, AAA, or hospital emergency department/observation bed unit) will log in to AssessmentPro (www.assessmentpro.com) to complete the Level I screen to determine if a Level II is required.

If the person does not require a Level II *but is Medicaid active*, then the provider will also complete the LOC assessment. Maximus will issue the Level I and LOC determinations.

If the person does not need a Level II *and is **not** Medicaid active*, the person can enter the nursing facility after AssessmentPro has issued a Level I outcome.

Due to the tight time frames, you will receive a determination within six hours (during normal business hours) after Maximus receives all required information.

Providers can submit screens in AssessmentPro at any time, including nights and weekends. However, Maximus may not issue a determination until the next business day. Admitting people before Maximus has finished the PASRR is a risk because the Maximus Clinical Reviewer may not approve NF placement.

1.4. PASRR Dementia Exclusion

PASRR excludes some people with dementia. This **dementia exclusion** applies to:

- **People with a sole diagnosis of dementia,** or
- **People with a primary dementia with a secondary MI diagnosis**

When a person has co-morbid dementia and mental illness, deciding which condition is *primary* takes more than deciding if the dementia is *currently* the most prominent. The dementia's symptoms *must be more advanced than* the co-occurring behavioral health conditions. Or in other words, the dementia has advanced so much that the co-occurring mental illness will never become the primary focus of treatment again, and the person would not benefit from specialized services.

Because serious mental illness and dementia both impair executive functioning and change personality, the screening process focuses on dementia's *progression*. As a part of the Level I, Maximus will determine if dementia is the sole diagnosis or primary over a secondary mental illness diagnosis.

> ✓ **When you request a dementia exclusion**, you must prove that the person's treatment primarily focuses on dementia, because it has progressed. For Maximus to approve, your request must include documents that prove this.

The provider submitting the Level I must include information that clearly supports that the dementia is primary over any mental health diagnosis. When diagnoses co-occur, federal guidelines dictate that **an exemption cannot happen unless enough evidence clearly confirms the progression of the dementia as primary.** Providers should upload any documents to the person's Level I screen that support the dementia's primacy over an SMI. Examples of supporting documents include neurocognitive test results, a series of Mini Mental Status Exams (MMSEs), or an History & Physical (H&P) outlining the progression.

For information on weekend and after-hours dementia exemption Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

1.5. PASRR Exempted Hospital Discharge

In some situations, federal code exempts people with MI, ID, or RC from PASRR or lets them admit to a NF through an abbreviated Level II evaluation process. The term **exemption** describes some of these situations.

The **Exempted Hospital Discharge (EHD)** decision is a *short-term* exemption from the PASRR process for a person with known or suspected MI, ID, or RC who:

- Received acute inpatient treatment in a medical hospital and is discharging from the hospital to a nursing facility after receiving medical (non-psychiatric) services, and
- Needs short-term treatment of **30 calendar days or less** in a NF for the same condition the person was hospitalized for. Emergency Department discharges to the nursing facility do not qualify for the EHD decision.

For Maximus to apply the EHD decision:

- The person must **meet both criteria** listed above, and
- The hospital provider must:
  - Complete a Level I screen,
  - NF to submit a Level of Care within 48 hours of admission. Hospitals no longer have to complete LOC preadmission.
  - Upload a current H&P to the person's Level I in AssessmentPro

A Maximus Clinical Reviewer may request more documents to decide the Level I's outcome. **All** requests for an exempted hospital discharge require an H&P. To expedite an EHD request, upload the H&P when you submit the screen.

When Maximus approves someone for an EHD NF admission, **the admitting facility must** submit an **updated Level I and new LOC** before the 30-calendar-day approval ends if the person will need to stay longer for medical reasons. The admitting facility needs to submit a LOC within 48 hours utilizing the admission date as the assessment reference date (ARD). You should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days before the approval ends so that Maximus can complete a full Level II PASRR determination by that date. Doing that will keep your NF compliant with state and federal requirements.

Maximus only applies exemptions to people with stable symptoms who do not threaten themselves or others.

For information on weekend and after-hours EHD Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

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1.6. PASRR Level II Categorical Decisions

Federal PASRR regulations allow for an abbreviated Level II process for people who fall into certain **categories** that exempting them from a Level II evaluation before they admit to a NF. We call these **categorical** PASRR decisions.

If someone has a confirmed or suspected PASRR disability and meets criteria for one of these categories, it means that providers can request, or Maximus clinicians can decide if that person is appropriate for a nursing facility and if they do not need specialized services.

As with exemptions, Maximus only applies categorical decisions for people with stable behavioral symptoms who do not pose a threat to themselves or others. For more details, refer to section 3.2.1. Exemption and Categorical Admissions. Maximus may potentially apply four categorical Level II determinations in Indiana:

- **Provisional Emergency Categorical**
- **Respite Categorical**
- **Terminal Categorical**

- **Convalescent Categorical**

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1.6.1. Provisional Emergency Categorical

Maximus may grant a Provisional Emergency categorical when a person has a Level II condition (MI, ID, or RC) **and** the person:

- Suddenly, unexpectedly, and urgently needs placement (typically because of losing a caregiver, losing a home, or suspected abuse or neglect)
- Cannot receive a lower level of care

If the person reports abuse, neglect, or you suspect it, you must report to the Adult Protective Services (APS) hotline by dialing 800.992.6978 or completing a report online https://aps-govcloud.my.site.com/APSOnlineReport/s or through the Department of Child Service (DCS) hotline at 800.800.5556. After business hours, you may leave reports on voicemail. Your report must contain the following:

- Name of the person making the report,
- Name, address, and phone number of the facility from which you are making a report,
- Individual's name,
- Individual's address, including the city and county (may be the facility where the individual will reside),
- Individual's phone number (may be the facility where the individual will reside),
- Description of why you suspect abuse, neglect, or exploitation is suspected, and
- Indicate the APS or Child Protective Services (CPS) report is for the APS or CPS 7-calendar-day emergency admission.

Both 455 IAC I-2-2, which governs APS, and IC-31-34-1, which governs DCS, define abuse and neglect. Neglect includes self-neglect.

Provisional Emergency categoricals allow for up to 7 calendar days in a NF. If the person needs more than 7 calendar days, the NF must submit a new Level I and LOC screen in AssessmentPro **before** the approval ends.

If you request a Provisional Emergency categorical during normal business hours, include the following:

- The person's demographic information, including their name, address, and current location,
- The reason for the emergency request (a condition's change or the situation warranting APS or CPS involvement),
- Name of APS or CPS personnel contacted & date of contact if indicated,
- History & Physical (H&P),
- Primary and secondary diagnoses (include medical and/or mental health diagnoses),

- Prescribed medications w/ dosage, frequency, and reason for prescribed,
- Description of ADL impairment,
- Any family and/or community services the individual is receiving,
- Name of any family member or legal representative who is knowledgeable about the individual's needs and situation,
- Level I screen,
- Level of Care screen,
- History of recent hospitalizations or other inpatient care, including treatments received and reason for treatment, and
- Any other information needed to make a placement decision.

Providers may need to request a Provisional Emergency categorical outside of normal business hours like during evenings or weekends. When this happens, AssessmentPro will queue the screen to a Clinical Reviewer on the next business day. If you admit a person to your NF before PASRR Pro-I or Maximus issues a decision, you should know that a Maximus clinician may deny placement.

You may have limited documentation for emergency request referrals during evenings or weekends, particularly for people living in the community. At a minimum, you should upload the following information with the screen:

- Identifying demographic information, including the person's name, address, and current location
- The reason for the emergency request (how the person's condition has changed, why the person needs emergency placement, and the current APS or CPS involvement/intervention)
- The name of APS or CPS personnel contacted and date of contact.
- If indicated, Providers should submit any available documentation with the referral.

After looking at the referral, Maximus' Clinical Reviewer will use PASRR Pro-I to request any extra information which you can submit during normal business hours.

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus will complete a full onsite Level II. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen before the approval ends so that Maximus can issue a PASRR determination by that date. Doing that will keep your NF compliant with state and federal requirements.

For information on weekend and after-hours provisional emergency Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

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1.6.2. Respite Categorical

The Respite categorical is available for people in the community. Community settings include a person's home, Emergency/observation room, and assisted living and residential care facilities. Hospital admissions,

nursing facilities and psychiatric facilities **are not** community settings. The respite categorical lets a person stay in a nursing facility for 30 calendar days to give relief to family members or caregivers. The respite categorical can apply when a person has a Level II condition (MI, ID, or RC), and:

- Lives in the community, and
- Is expected to return to the community from the NF

Respite categoricals only let a person **stay in a nursing facility for 30 calendar days per calendar quarter. If the person stays 15 calendar days or more, 30 calendar days must pass before they can admit again.**

For Maximus to apply the Respite Categorical:

- The person must **meet the criteria** listed above, and
- The provider must:
    - Complete a Level I screen,
    - Level of care screen prior to nursing facility admissions
    - Upload a current H&P to the person's Level I in AssessmentPro

You may need to request a respite categorical outside of normal business hours like during evenings or weekends. When this happens, AssessmentPro will queue the screen to a Clinical Reviewer the next business day. If you admit a person to your NF before PASRR Pro-I or Maximus issues a decision, you should know that a Maximus clinician may deny placement.

Providers should submit any available documentation with the referral. After looking at the referral, Maximus' Clinical Reviewer will use PASRR Pro-I to request any extra information which you can submit during normal business hours.

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus will complete a full onsite Level II. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days prior to the approval end date so that Maximus can issue a PASRR determination by that date. Doing that will keep your Nursing Facility compliant with state and federal requirements.

For information on weekend and after-hours Respite Categorical Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

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1.6.3. Terminal Illness Categorical

The Terminal Illness categorical is available when a person has a medical condition, that when running its normal course, would have a life expectancy of 6 months or less. The person must be psychiatrically stable and does not present a risk of harm to self or others.

All terminal illness categorical requests seeking nursing facility care require the following documents.

- History & Physical within 12 months
- Level I screen

- Level of Care screen
- **And one** of the following documents:
    - Hospice certification (this document can be found on the Indiana FSSA website) **or**
    - Physician's documentation stating a terminal illness or life expectancy of 6 months or less is present

Providers should submit any available documentation with the referral. After looking at the referral, Maximus' Clinical Reviewer will use PASRR Pro-I to request any extra information which you can submit during normal business hours.

For information on weekend and after-hours terminal illness categorical Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

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1.6.4. Convalescent Categorical

The Convalescent categorical is a *short-term* exemption from the PASRR process for a person with known or suspected MI, ID, or RC who:

- Received acute inpatient treatment in a medical hospital and is discharging from the hospital to a nursing facility after receiving medical (non-psychiatric) services, and
- Needs short-term treatment between **31 to 60 calendar days** in a NF for the same condition in which the person was hospitalized. Emergency Department discharges to the nursing facility do not qualify for the Convalescent situations.
- Are psychiatrically stable and does not present a risk of harm to self or others

For Maximus to apply the Convalescent categorical:

- The person must **meet the criteria** listed above, and
- The hospital provider must:
    - Complete a Level I screen,
    - Level of care screen prior to nursing facility admissions, and
    - Upload a current H&P within the past 12 months to the person's Level I in AssessmentPro

If a person needs to stay at the Nursing Facility after the approval ends, you must submit a new Level I and LOC screen in AssessmentPro and Maximus will complete a full onsite Level II. Like with PASRR exemptions, you should proactively assess people's needs. If they need to stay longer, submit your screen 7-10 business days prior to the approval end date so that Maximus can issue a PASRR determination by that date. Doing that will keep your Nursing Facility compliant with state and federal requirements.

For information on weekend and after-hours Convalescent Categorical Level I screens, see section 3.3. Weekend, Holiday, & After-Hour Screenings of this manual.

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1.7. Level I Outcome Letters

You can print outcome letters from AssessmentPro 24 hours a day. You must keep each person's letter in their record, and the letter must accompany the person if they transfer to a different NF.

All outcome letters (both approvals and denials) will include a notice of the individual's or guardian's right to appeal the decision. See Table 1: Level I Outcome Letter Distribution on next page.

Table 1: Level I Outcome Letter Distribution

Level I Outcome	Referral Source Provides:			Maximus Provides:	Admitting NF - print via Assessment Pro
	Individual - printed via AssessmentPro	Legal Guardian - printed via AssessmentPro	Referral Source - printed via AssessmentPro	Primary Care Physician - via mail	
Emergency Categorical	X	X	X	X	X
Respite Categorical	X	X	X	X	X
Terminal Categorical	X	X	X	X	X
Exempted Hospital Discharge	X	X	X	X	X
Convalescent Categorical	X	X	X	X	X
No Level II Required	X	X		X	X
Level II Negative, No Status Change	X	X		X	X
Level II Positive, No Status Change	X	X		X	X
Refer for Level II DBR	X	X		X	
Refer for Level II Onsite	X	X		X	
Withdrawn	X	X		X	
Cancelled	X	X		X	

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2. Level of Care (LOC) Screening Overview

2.1. What is the purpose of the LOC screen?

The Level of Care (LOC) screen evaluates the most appropriate setting to address a person's medical and behavioral needs. The LOC screen decides if a person needs a skilled or intermediate nursing facility's level of care and how much time the person will need there.

2.2. Submitting a Level of Care (LOC) screen

2.2.1. Provider role in LOC screening process

Submitting a complete and prompt level of care screen to Maximus tees up the right services and supports for the person. To consider a screen complete, Maximus needs different information depending on who submits it (a nursing facility, hospital, or AAA). The below table lists what we need by provider type.

Table 2: LOC Submission Requirements by Provider Type

PROVIDER TYPE	LOC SUBMISSION REQUIREMENTS	
	SUBMISSION TYPE:	**SUBMISSION METHOD:**

Hospital Providers	• Level I screen
	• Short-form LOC for the following:
	  ○ All individuals who have a positive Level I
	  ○ All individuals who are using Medicaid as the pay source for the NF stay (e.g., switching from Medicare to Medicaid)
	  ○ Status Change
	  ○ Out-of-State individuals [in IN hospital whose Level I did not result in an automatic approval (requires both a LOC screen and Level II evaluation)]
	  ○ Categorical criteria met
	  ○ Provisional emergency
	  ○ Respite
	  ○ Terminal
	  ○ Convalescent
		• Electronic

Nursing Facility Providers	• Level I screens
	• Short form LOC for:
	  ○ Preadmission
	  ○ Out-of-State individuals - if individual requires a Level II, must also complete LOC; otherwise, LOC will be completed once Medicaid becomes the individual's pay source for the NF stay
	  ○ Emergency or Categorical criteria met
	  ▪ Provisional Emergency
	  ▪ Respite
	  ▪ Terminal
	  ▪ Convalescent
	  ○ Status Change, regardless of pay source
	• Long form LOC assessment for:
	  ○ Continued Stay - applies when the individual requires NF care beyond the approval end date. If the person has MI/ID/RC, a new LOC **and** Level I are required. If the person does not have MI/ID/RC, only LOC is required.
	  ○ Conversion to Medicaid
		• Electronic

AAA Providers	• Submit the full LOC assessment for:
	  ○ At-home preadmission screening
	  ○ Referrals from Maximus for potential LOC denials
		• Electronic where internet access is available.
		• If no internet access is available, the paper interRAI HC is completed onsite, then transferred to the electronic version once internet access is regained.

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3. The LOC Process and Decisions

3.1. When is a LOC screen required?

For NF applicants, a LOC screen is required for:

- Medicaid recipients who are seeking admission to a Medicaid-certified NF and are using Medicaid as their pay source, regardless of the length of the NF stay, and
- All Level II candidates (indicated by the Level I Screen outcome), regardless of pay source. ***Note:*** *Individuals who meet criteria for an Exempted Hospital Discharge also require a LOC screen.* Refer to section 1.5. Exempted Hospital Discharge (EHD) for information on EHD decisions. All other Level II decisions, including APS Emergency, Respite, Terminal Illness, Convalescent, and Dementia exemption decisions, require a LOC prior to admission.
- All PACE participants who do **not** have a valid/current LOC on record.

For NF residents**,** a LOC screen is required:

- As residents become Medicaid-active and will be using Medicaid as the pay source for nursing facility stay; Medicaid Aid categories that do not cover nursing facility per diem include:
  - E - family planning,
  - G - qualified disabled working individual,
  - I - qualified individual – 1,
  - J - special low-income Medicaid beneficiary (SLIMB),
  - K - qualified individual – 2,
  - L - qualified Medicare beneficiary (QMB), and
  - R - room and board assistance (RBA).
- When there is a significant change in ***medical*** condition (medical “status change”), indicating the person has experienced:
  - a medical decline and may require a higher level of care,
  - a behavioral/psychiatric episode resulting in an exacerbation of symptoms and may require alternative services and/or supports.
- For all PACE participants annually, and more often as needed as medical needs change (e.g., a medical status change)

Note: A new LOC screen for medical status change referrals must be submitted within 14 days of the significant change event.

Here are some examples of when to submit and not submit a new level of care based on these requirements.

You **must** submit a new level of care if:

- The resident was admitted with long term approval, medical status has improved, and they are refusing to leave the facility (as above)

- A short-term approval (including EHD or Categorical approvals) is coming to an end and the resident has medical needs to support continued stay

Do **not** submit a new level of care if:

- A resident's medical condition improves and they do not need a nursing facility anymore. The nursing facility must discharge the person. You may complete a level of care during discharge planning if the person refuses to leave the facility
- A new medical diagnosis is added which does not impact the current length of stay.
- A resident is medically hospitalized or has an ER visit and returns to the NF.
- NF to NF transfers (with or without an intervening hospital stay) provided there is a current approved LOC already established.

Refer to the IN Level I/LOC Frequently Asked Questions for more information on when to submit a level of care screen.

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3.1.1. LOC and Waiver Recipients

If a nursing facility applicant received an HCBS Medicaid waiver, in particular, Aging & Disabled (A&D) or Traumatic-Brain Injury (TBI) waiver, follow the below process:

Note: This excludes BDDS Community waivers for MFP/CIH.

- Submit the Level I in AssessmentPro before the person admits to a nursing facility
- If the Level I is negative and the person has a valid and current LOC approved through the Waiver, submit a short-form LOC, and upload the approved waiver within the LOC as a document
- If the Level I indicates the person needs a Level II, complete all steps for the Level II process. Refer to Section 3.4. Refer for Level II Outcome for instructions on getting started.
- If the person needs a Level II and has a valid and current LOC approved through the waiver, submit a short-form LOC, and upload the approved waiver within the LOC as a document.
- If the person needs a Level II and does **not** have a valid and current LOC approved through the waiver, submit a LOC in AssessmentPro. The LOC decision will be determined within the Level II outcome and must be issued prior to admission.
- If you do not submit a LOC through AssessmentPro, the Medicaid system will automatically update.

The admitting facility will:

- Enter the admission date in PathTracker after the person admits to their nursing facility
- Print notification letter from AssessmentPro.
- Update PathTracker with the person's discharge date.

If you are not sure if a nursing facility applicant is a current Medicaid waiver recipient, follow the below process:

- Submit the Level I and LOC in AssessmentPro. AssessmentPro and Maximus will decide if the person is eligible for a nursing facility before the they admit. **Note:** You are responsible for checking that the PASRR process is finished before any person admits to a nursing facility

The admitting facility will:

- Enter the admission date in PathTracker after the person admits to their nursing facility, if approved for NF LOC.
- Update PathTracker with the person's admission date.

After the nursing facility enters the admission date, the automation to CORE is processed.

If the person is receiving non-nursing facility LOC waiver services and is seeking nursing facility placement, follow the process described below:

- Submit a short-form LOC in AssessmentPro.
- Upload a copy of the current waiver to the documents section within the submitted LOC.

The admitting facility will:

- Enter the admission date in PathTracker after the person admits to their nursing facility
- Print notification letters from AssessmentPro.
- Update PathTracker with the person's discharge date.

Once the nursing facility enters the admission date, the automation to CORE is processed.

For all preadmissions, it is the provider of care's responsibility to ensure that the PASRR process is completed before the person admits to a nursing facility.

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3.1.2. Required Documentation

You must submit a **History and Physical (H&P)** for each level of care screen. Federal regulations require that the H&P be no more than a year old. As a best practice, you should submit an H&P that accurately represents the person's current condition, symptoms, medications, and treatments and interventions.

Maximus encourages providers to upload any additional documentation that will help provide a complete and accurate picture of the person's needs at the time of submission. Examples of supporting documents include medication administration records (or MARs), sections A, C, G, & H of the current or most recent minimum data set (MDS), certified nursing assistant (CNA) flow sheets, and notes like behavioral therapy notes, nursing notes, progress notes, occupational therapy notes, and physical therapy notes.

Monitor the ***Action Required*** queue regularly for requests for additional information from Maximus' reviewers. If specific information or documentation is needed, the system will alert you through this queue. You will then be able to open the individual's screen and upload any additional documents.

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3.1.3. Draft Screens and Turnaround Time

AssessmentPro will save draft level of care screens for 72 hours. Once a draft screen has expired, you cannot return to it. You will lose your work, and you will need to start a new screen. Refer to Section 4.2.2. Draft Screen Expiration of this manual for more information.

AssessmentPro queues level of care screens to Maximus' Clinical Reviewers in chronological order. If a screen needs a clinical review, AssessmentPro will usually notify you of its outcome within 6 business hours from when Maximus receives all the information we need to complete the review. If Maximus' Clinical Reviewer requests more information, the Clinical Reviewer will put the assessment on hold. Our turnaround clock's time stops ticking until we receive all the information we need. You should check the ***Action Required*** queue regularly for feedback and questions from our clinicians so you can respond and promptly upload any requested documentation or answer questions. Responding promptly to requests for information will expedite the Level I screening process. **If you do not respond to a request for more information in 10 business days or 14 calendar days, AssessmentPro will cancel the Level I or LOC screen.** You will need to submit a new level of care screen, and we must render a decision *before* the person can admit to a Medicaid-certified NF.

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3.1.4. Clinical Review & Outcomes

For all LOC screens, except screens from AAAs, a Maximus Clinical Reviewer will conduct a clinical review of the screen and supporting documentation, and issue one of the following outcomes:

- *Approved for Short-Term Skilled Nursing Facility* (with a specified duration of 90 calendar days OR 7, 30, or 60 calendar days for an individual with an accompanying PASRR with a categorical outcome), Hold for level II,
- *Approved for Short-Term Intermediate Nursing Facility* (with a specified duration of 7, 30, 60, or 90 calendar days), Hold for level II,
- *Approved for Long-Term Skilled Nursing Facility,* Hold for level II,
- *Approved for Long-Term Intermediate Nursing Facility,* or Hold for level II, or
- *Denied for Nursing Facility* (this decision requires further evaluation as described below).

For PACE participants, a Maximus Clinical Reviewer will conduct a clinical review of the screen and supporting documentation, and issue one of the following outcomes:

- *Approved for Long-Term Skilled Nursing Facility*,
- *Approved for Long-Term Intermediate Nursing Facility,*
- *Out-of-State Document Based Review (DBR), which has a specified duration of 90 days, or*
- *Denied for Nursing Facility* (this decision requires further evaluation as described below).

Note: Regarding potential NF LOC denials: Maximus will not make determinations for an individual who

does not appear to meet level of care. When this happens, Maximus' Clinical Reviewer will select the *Denied for Nursing Facility* outcome, and the screen will queue to a local AAA provider who will conduct an onsite assessment. AssessmentPro will email the AAA provider a notification for the new referral.

The AAA will:

1. Log in to LOC Pro.
2. Monitor the **LOC Referrals** queue. This queue contains all LOC Pro screens that have been reviewed by a Maximus clinician and determined to be a potential denial.
3. Schedule the onsite assessment.
4. Conduct the onsite long form LOC. If the assessment location has no internet, the AAA provider will complete a paper long form LOC and then enter the assessment responses in AssessmentPro once they have internet again.
5. Issue the determination in LOC Pro.
6. Issue the approved length of stay for all approval determinations.
7. Complete onsite LOCs for all potential LOC denials referred from Maximus **within 5 business days**.
8. Complete onsite LOCs for all preadmission LOCs **within 3 business days**.

If a provider receives a LOC denial for a person who has discharged from their facility, the AAA will follow the same protocol used prior to Maximus completing reviews. If there is no such protocol, the Care Manager will seek direction from their supervisor. It is acceptable for AAAs to do DBRs when either a person has already been discharged from a NF or when a person refuses to participate. These exceptions will require permission from the PASRR Director.

For all **long form LOC screens,** the system will generate an approval for individuals who meet NF LOC criteria. When a person meets LOC criteria, LOC Pro will issue approvals as follows:

- *Approved for Skilled Nursing Facility, or*
- *Approved for Intermediate Nursing Facility.*

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3.1.5. Printing & Distributing Outcome Letters

When an outcome has been issued, LOC Pro will generate letters for providers to print off and distribute to applicable persons (see Table 3: LOC Outcome Letter Distribution below).

Providers at the referring facility are responsible for printing and distributing outcome letters to the assessed person and their guardian, if applicable. Once an individual's current location has been updated in AssessmentPro, the admitting facility can also view and print the outcome letter.

All letters (approvals and denials) will include a notice of the person's or guardian's right to appeal the decision.

Maximus is responsible for mailing letters to the person's primary care physician. The following table describes the LOC outcome letter distribution:

Table 3: LOC Outcome Letter Distribution

Level of Care Outcome	Attachments	Referral Source Provides:			Maximus Provides:	Admitting NF - print via Assessment Pro
		Individual - printed via AssessmentPro	Legal Guardian - printed via AssessmentPro	Referral Source - Printed via AssessmentPro	Primary Care Physician - via mail	
Approved for Skilled Nursing Facility (30-120 days)	LOC Screen & Appeal Rights	X	X	X	X	X
Approved for Intermediate Nursing Facility (30 – 120 days)	LOC Screen & Appeal Rights	X	X	X	X	X
Approved for Skilled Nursing Facility (120+ days)	LOC Screen & Appeal rights	X	X	X	X	X
Approved for Intermediate Nursing Facility (120+ days)	LOC Screen & Appeal rights	X	X	X	X	X
Denied for Nursing Facility*	LOC Screen & Appeal Rights	X	X	X	X	X
Refer for Level II Onsite	LOC Screen & Appeal rights	X	X	X	X	X

**The AAA issues the Denied for Nursing outcome through AssessmentPro. Providers will still access these outcomes in AssessmentPro, as with Maximus-issued outcomes.*

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3.2. Transfers and Out-of-State Referrals

3.2.1. Inter-facility Transfers

So long as a person's mental health status and medical care needs stay the same, their Level I and level of care screens are indefinitely good.

Because of this, people transferring to a different facility do not need new level of care screens, unless they discharge to a lower level of care or their conditions significantly change.

This means you do not need a new screen if the person:

- Transferred **from** one nursing facility in Indiana **to** another nursing facility in Indiana
- Transferred **from** a nursing facility in Indiana **to a hospital** and **back** to any nursing facility in Indiana (including the one the person came from)

There are exceptions to this rule. You will need to complete a new level of care screen if:

- The person's condition significantly changes,
- The person discharges to **a lower level of care** (like the community) and needs to **return** to the same or different nursing facility
- The approved length of stay is about to expire

Nursing facilities can update discharges, transfers, and admissions in PathTracker, a service within AssessmentPro that tracks people with Level II conditions.

When a person's mental health status significantly changes, they must have a new Level I before transferring to a new nursing facility. If the person has a Level II condition or if the status change review uncovers a Level II condition, the person will need a Level I and a level of care screen before receiving a Level II evaluation.

If a person discharges from a nursing facility to a lower level of care, like the community, and then needs to return to the same or different nursing facility, they will need a new Level I. If the person has a Level II condition (regardless of pay source) or receives Medicaid and pays for their nursing facility stay with it, the person will need a new Level I and level of care.

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3.2.2. Out of State Transfers

If an Indiana hospital is treating an out-of-state resident and that resident wants to admit to a Medicaid-certified nursing facility in Indiana, the hospital provider must submit a Level I screen. If the person needs a Level II, the hospital provider must also submit a short-form level of care. The nursing facility in Indiana must also complete the level of care for people who do *not* require a Level II. They must do this when the person becomes Medicaid-active in Indiana and decides to use Medicaid to pay for their nursing facility stay.

If a person resides in another state, is in an out-of-state facility, and is seeking admission to an Indiana nursing facility, then the nursing facility completes the Level I. If a Level II is required, the nursing facility in Indiana will also complete a short-form LOC. If a Level II is *not* required, the nursing facility will complete a long-form LOC if the person becomes Medicaid-active in Indiana and decides to use Medicaid to pay for their nursing facility stay.

If a person is an Indiana resident, is Medicaid-active in Indiana, is at an out-of-state nursing facility, is seeking to transfer to a nursing facility in Indiana, and will pay using Medicaid, then the nursing facility in Indiana must submit a Level I, and if the person needs a Level II, a short-form LOC.

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3.3. Weekend, Holiday, & After-Hour Screenings

Providers have access to LOC Pro 24 hours a day, 7 days a week. Providers can always:

- Start, resume, submit, or withdraw requests for screen
- Add, remove, and manage users
- Monitor the status of a screen
- Upload documentation

Please note that Maximus completes clinical reviews during regular business hours: Monday-Friday, 7 AM CT (8 AM ET) to 4 PM CT (5 PM ET).

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3.3.1. Exemption & Categorical Admissions

Providers can submit screens outside of normal business hours; however, a Maximus Clinician must review all LOC assessments not from AAAs, which includes Exempted Hospital Discharges (EHDs) and Categoricals. If the person receives any outcome other than an approval outside of normal business hours, the nursing facility may admit but should note that Maximus could reverse the outcome after reviewing the screen. Any nursing facility that admits someone before Maximus reviews the screen is at risk.

For exemptions and categoricals, the approved length of stay begins the day Maximus renders an outcome and ends on the final calendar day of the approved length of stay. The outcome date will appear on each person's notification letter.

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3.3.2. Delayed Admissions

PASRR and long-term care LOC approvals are valid for 90 calendar days. Short-term stays are valid for their approval periods. If a person does not admit to the nursing facility within that timeframe, they will need a new Level I, LOC screen, and determination before admitting to a Medicaid-certified NF.

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3.4. Refer for Level II Outcomes

When Maximus renders the outcome *Refer for Level II*, AssessmentPro will queue the referral up for an onsite Level II assessment performed by a Maximus subcontractor or independent contractor. After the face-to-face assessment, a Maximus Clinical Coordinator will review assessment and documentation, and write a summary of findings that determines if a nursing facility is appropriate and the services and supports that the nursing facility must provide. For people who have intellectual disabilities or related conditions, Indiana's Bureau of Developmental Disability Services renders the final decision.

A Maximus psychiatrist also reviews adverse decisions for all disability types.

After the summary is finalized, AssessmentPro will automatically generate an outcome letter, which providers can print directly from the system.

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4. Important Assessment Pro General Information

4.1 Getting Started in AssessmentPro

4.1.1. User Registration & Maintenance

AssessmentPro has three levels of user access:

- AssessmentPro Access Coordinator
- Clinical User
- Non-clinical User

AssessmentPro Access Coordinators can add and remove users, approve requests for user access, update user profiles, update facility information, and do all basic user functions. Maximus recommends that facilities limit AssessmentPro administrator access to two or three users.

Clinical Users can do everything a non-clinical user can, *and* they can submit screens.

Non-clinical Users can begin screens, request permission to complete screens for additional facilities, monitor screens' progress, view the ***Action Required*** queue, upload documents, and print outcomes.

Table 4: User Roles in AssessmentPro

AssessmentPro User Role	Permissions
AssessmentPro Access Coordinator	• Highest level of access • Maximus recommends two to three staff per facility • Has the following permissions: ○ **Facility Profile:** Create, read, update, and delete ○ **User Profile:** Create, read, update, and delete for all facility users ○ **Individual Record (Demographics):** Create, read, and update for anyone with a Level I or LOC screen submitted by the facility ○ **Level I/LOC Screen:** Create, read, and update for any individual; submit for a determination ○ **Level I/LOC Outcome Documentation:** Read ○ **Referral Source Communication with Maximus Clinician:** Read and update ○ **PathTracker Records:** Create, read, update, delete (NF only)

Facility Clinical User	• Has the following permissions: ○ **Facility Profile:** Read ○ **User Profile:** Create, read, and update for self ○ **Individual Record (demographics):** Create, read, and update for anyone with a Level I or LOC screen submitted by the facility ○ **Level I/LOC Screen:** Create, read, and update for any individual; submit for a determination ○ **Level I/LOC Outcome Documentation:** Read ○ **Referral Source Communication with Maximus clinician:** Read and update ○ **PathTracker Records:** Create, read, update, delete (NF only)
Facility Non-clinical User	• Has the following permissions: ○ **Facility Profile:** Read ○ **User Profile:** Create, read, and update for self ○ **Individual Record (demographics):** Create, read, and update for anyone with a Level I or LOC screen submitted by the facility ○ **Level I/LOC Screen:** Create, read, and update for any individual; but cannot submit for a determination ○ **Level I/LOC Outcome Documentation:** Read ○ **Referral Source Communication with Maximus clinician:** Read and update ○ **PathTracker Records:** Create, read, update, delete (NF only)

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4.2. Important Information About Electronic Screening Submission

4.2.1. Multi-Facility Users

Some users are associated with multiple facilities in AssessmentPro. If you can submit screens under more than one facility, you must be sure you are submitting screens under the correct facility name. Click on the gear icon to view your current facility settings and switch facilities when you need to.

4.2.2. Draft Screen Expiration

In AssessmentPro, a draft screen is a screen someone has started but has not submitted. AssessmentPro will save a draft of your Level I or LOC screen so you can start a screen and come back to it later if you cannot finish it.

Unsubmitted Level I and level of care screens will be available for 72 hours.

Once a draft has expired, AssessmentPro will delete it, and you will need to enter a new screen. To avoid losing your work, prepare ahead of time. Gathering the person's record for reference during the screen will save you time.

Refer to the IN Level I/LOC Frequently Asked Questions for more information on using AssessmentPro and managing user and for when and how to submit Level I and LOC screens.

4.2.3. Declared States of Emergency and Widespread Outage

If Maximus or the State of Indiana Division of Aging (IN DA) declares a state of emergency or identifies an emergency situation (like a natural disaster or widespread power outages), the state and Maximus may implement an emergency admission approval. Maximus and the Division of Aging will discuss the emergency and decide if using the emergency admission approval is appropriate. The department and Maximus will officially authorize providers to deploy this process and give providers and Maximus staff instructions on both the Maximus and the IN DA websites.

Providers may only use the state of emergency admission option with prior approval. Attempting to use this option outside of prior IN DA and Maximus approval will result in non-payment to the nursing facility. You may **not** use this option because you or your facility did not register for AssessmentPro or because of routine upgrades to the system.

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5. Admission & Discharge Tracking

Nursing facilities must update all residents' admission dates in PathTracker when they admit. Nursing facilities may **not** update PathTracker until the person admits. After the admission date is entered, the system will alert the Medicaid LOC data entry process through the Division of Aging.

Providers must also update PathTracker with each PACE recipient's start date once the state determines it. After the provider enters the program start date, the system will prompt the Medicaid LOC data entry process through the Division of Aging. If the individual discontinues the PACE program, you must also update the program discharge date in PathTracker.

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6. Appeal Rights Notifications

The assessed person or guardian has the right to appeal all Level II and Level of Care decisions. All Level II and LOC outcome letters will include a notice of the person's appeal rights.

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Revision History:

Effective Date	02.02.2016	**Last Revision Date**	05.06.2025
Document Owner	IN LCAR – Program Manager		
Document Approver	IN LCAR – Program Manager		
Applies To	IN LCAR – Providers		

Rev. #	Date	Initiator	Summary of Changes
1	11.03.2020	Dawn Goodman-Martin	• Section 1.5 changed Emergency Hospital Discharge Exemption to Exempted Hospital Discharge. • Section 1.6.2 removed duplicate criteria for Respite Categorial. • Section 1.6.3 added Terminal Illness Categorical • Section 1.6.4 added Convalescent Categorical • Changed company name from Ascend to Maximus
2	02.14.2022	Jon Massie	Updated section 3.1.1 LOC and Waiver recipients to reflect current process. Changed gendered references to “They” or gender neutral pronounce throughout.
3	09.23.2022	Tammy Kasperzick	Flipped titles so the contract is first and the EM number at end
4	01.13.2023	Emily Bunty	Rebranded; changed outcome of “Cancelled Type I” to “Cancelled – Expired – Information Not Received”
5	08.01.2023	Christy Keefer	Changed long form requirements for DOA waiver to short form, reformatted
6	11.15.2023	Amanda Gordon	Updated tables, titles, headers, and footers
7	12.23.2024	Team	Updated to current process
8	03.10.2025	Christy Keefer	Updated for IN LCAR processes
9	03.21.2025	Christy Keefer	Changed ST from 180 to 90 days
10	05.06.2025	Christy Keefer	Changed APS contact from 211 to 800 number/online option