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ABOUT ASCEND

Ascend Management Innovations (formerly Ascend Management Innovations) originated in 1998 as a pioneer in designing innovative healthcare management solutions for programs serving individuals with complex diagnostic profiles. Since 2000, Ascend has been partnering with state agencies to provide individualized assessment services for individuals with mental health and/or intellectual and developmental disabilities. We specialize in incorporating evidence-based practices into public sector healthcare management through a combination of information technologies, quality improvement and management initiatives, service oversight, provider training, and management of healthcare datasets.

Ascend aims to make a difference in the lives of persons with disabilities by providing superior assessment services that effectively capture the individual’s personal needs and goals and enrich the person-centered planning process. Ascend’s leadership team offers extensive experience in managing assessment services. Together with the contract staff and independent contractors, Ascend is able to provide individualized, comprehensive assessments to identify areas of focus to best meet the individual’s needs.

Have Questions?

For questions about AssessmentPro, including system access, password assistance, etc. please email PASRR@fssa.in.gov.

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

For more information about Ascend, please visit our website at www.ascendami.com.

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ABOUT interRAI HC

The interRAI Suite offers a wide range of assessment instruments developed to assess the needs of people with chronic illness or disability. The interRAI Home Care (HC) assessment is specifically designed to evaluate the individual’s medical needs. The interRAI HC is a person-centered and comprehensive assessment that focuses on maximizing the person’s functioning and quality of life by capturing his or her strengths and preferences, and addressing health needs. The information can then be used as part of an interdisciplinary service planning process that ensures the person receives the most appropriate services to meet his or her needs.
The interRAI HC assessment process involves an interview with the individual, and his or her caregivers to gather information about the person’s everyday needs.

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ABOUT interRAI HC in INDIANA

The Indiana Family and Social Services Administration (FSSA) has selected the interRAI HC as the standardized assessment tool to determine whether or not a person seeking admission to, or residing in a nursing facility (NF), meets NF Level of Care (LOC).

To better understand the role of the interRAI HC in Indiana, it is helpful to first understand Preadmission Screening and Resident Review (PASRR). PASRR refers to a section in the Code of Federal Regulations that sets the requirements for State healthcare programs. PASRR regulations set the minimum standards for the rights and care of individuals receiving care in a Medicaid-certified NF setting. These regulations require that all persons be screened for the presence of mental illness (MI), intellectual disability (ID), and/or related conditions (RC) before going into a Medicaid-certified NF. PASRR also serves to identify 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, service needs must be identified and included 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.

How is the interRAI HC used?

The interRAI HC is an assessment that is administered with anyone seeking admission to a Medicaid-certified NF. This assessment is used to identify the person’s medical and behavioral health needs and then determine whether person’s needs can be met in the community with the appropriate supports and services in place, or whether he or she requires the level of care provided in a nursing facility.

Long-term care services in Indiana are a collaboration of the IN Division of Aging, the IN Division of Disability and Rehabilitative Services, and the IN Division of Mental Health and Addiction. These agencies are overseen by the Indiana FSSA. The Division of Aging (DA) is the authority overseeing Level I and Level of Care (LOC). The Indiana Division of Disability and Rehabilitative Services (DDRS) is the agency serving individuals with intellectual and developmental disabilities. The Indiana Division of Mental Health and Addiction (DMHA) is the agency serving individuals with mental health disabilities.

If the person is currently being treated in a hospital setting, the hospital provider will complete the short form interRAI HC Level of Care screen (LOC), or “short form LOC.” If the person is in a community
setting, such as his or her home or an assisted living setting, the local Area Agency on Aging (AAA) will complete the full interRAI HC LOC screen, or “long form LOC.” In addition, AAA providers will also conduct long form LOC screens for individuals who do not appear to meet NF level of care. The nursing facility (NF) provider will complete the long form LOC for residents who become Medicaid active, are in need of continued NF care beyond the approved length of stay, or experience a significant change in condition. The provider will submit the completed interRAI HC to Ascend for clinical review. Providers can monitor the progress of screens for any individual in their facility 24/7. To ensure efficient screening processes, providers are expected to actively monitor AssessmentPro and respond promptly to communications from Ascend reviewers.

**Ascend’s role in IN long-term care services**

Ascend 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™, Ascend’s web-based PASRR screening and tracking services.

In addition, Ascend’s Project Support Specialist (PSS) assists with answering non-clinical questions. The PSS helps answer provider questions about workflow, timelines, etc.; provides direction to providers as needed; and routes technical questions about the website to the State’s technical assistance provider or to Ascend’s IT team as needed. Questions should be directed to PASRR@fssa.in.gov and will be routed as appropriate.

Ascend’s Clinical Reviewers provide clinical review of all Level I screens that do not result in an immediate approval for NF placement, as well as interRAI HC short or long form submissions. Clinical Reviewers will clinically review all interRAI HC short forms submitted by hospital providers and a quality monitoring sampling of interRAI HC long forms submitted by AAA providers, as well as any supporting documentation, and provide the relevant persons with a written outcome, which the provider can print directly from PASRR Pro-I™. Clinical Reviewers may also contact submitters within AssessmentPro to seek clarification or additional information in order to make an appropriate determination for the individual. Providers can also begin a screen and save the screen without submitting it, creating a “draft screen” that is accessible for up to 72 hours. This allows providers to return to the draft screen to make corrections, and/or upload documentation before submitting the screen. Providers can also withdraw draft and submitted screens when a screen is no longer necessary (e.g. the individual expires, discharges to a community setting, admits to a NF that is not Medicaid-certified, etc.).

Please note all screens are subject to quality review by one of Ascend’s 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.ascendami.com/ami/Providers/YourState/IndianaPASRRUserTools.aspx.

The federal PASRR regulations can be found at 42 CFR 483 Part C.

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PASRR OVERVIEW

Background

PASRR stands for Preadmission Screen and Resident Review. PASRR began in the 1980s as part of an initiative to improve nursing facility care. In 1987, the Omnibus Reconciliation Act of 1987 (OBRA-87), known as the Nursing Home Reform Act, was enacted. The purpose of OBRA-87 is to protect individual rights, improve quality of care, and improve quality of life of those who need nursing facility care.

A portion of this Act, known as PASRR, clarifies the role that nursing facility providers have in addressing behavioral health needs of nursing facility residents. The goal of PASRR is, in part, to:

- Identify individuals 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. Known as the Level I, this is a short screen that seeks to answer the question: “Does this person have a known or suspected serious mental illness, an intellectual disability and/or a related condition?” If the answer is no, then the person may be admitted to a nursing facility if he or she meets 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 him or her into a Medicaid-certified nursing facility prior to admission.

- Determine services and supports persons with MI/ID/RC need. The PASRR Level II evaluation process identifies the rehabilitative or specialized services that the person requires. Nursing facilities are responsible for planning for and delivering—or arranging for the delivery—of all rehabilitative services that are identified through the PASRR Level II evaluation process.

- Determine the most appropriate setting for persons with MI/ID/RC. There are two main considerations in determining appropriateness: what is the least restrictive setting necessary that also meets the person’s needs.
In *Olmstead v. L.C.* (1999), the US Supreme Court deemed mental illness to be a form of disability protected under the Americans with Disabilities Act. The Supreme Court held that persons with mental disabilities have the right to live in the community rather than in an institution when it is the person’s wish to live in the community and the State’s treatment professionals have deemed community-based services appropriate for the individual’s needs. Additionally, the Supreme Court held that unjust segregation based on a disability is discrimination.

**Federal Requirements of PASRR**

The PASRR program is mandated by the Centers for Medicare and Medicaid (CMS) and ensures that persons with MI/ID/RC receive the appropriate placement and services necessary to meet their needs. The PASRR evaluation process identifies persons who have a diagnosis of MI/ID/RC and identifies the services and supports necessary to meet the individual’s needs.

When a person with MI/ID/RC is approved for nursing facility admission, the nursing facility providers must address both the medical and behavioral needs of residents.

The PASRR process must be completed prior to admission, and whenever an individual experiences a significant change in condition, referred to as a Status Change review.

**Who is evaluated through PASRR?**

*Persons with Serious Mental Illness (SMI)*

PASRR is designed to identify individuals with a serious mental illness. The Level I screen gathers information about the individual’s mental health diagnoses, the person’s symptoms and the intensity/severity of symptoms, and the degree to which the condition/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 disorders, obsessive compulsive disorder and any other disorder which could lead to a chronic disability which is not a primary diagnosis of dementia.
• **Duration:** significant life disruption or major treatment episodes within the past two years and due to the disorder. This *does not necessarily mean that the individual was hospitalized.* This might include, for example, a person whose mental illness exacerbated to the extent that critical resource adjustments (such as increased case management services, increased monitoring, etc.) would have been indicated (*regardless of whether they were identified or delivered*). Examples of the types of intervention needs which may have occurred, regardless of whether or not services were delivered, include (but are not limited to):
  - Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization, inpatient psychiatric hospitalization, crisis unit placement) within the past two years; or
  - A major psychiatric episode; or
  - A suicide attempts or gestures; or
  - Other concerns related to maintaining safety.

• **Disability:** referred to as *Level of Impairment* in regulatory language, disability is characterized by active behavioral health symptoms within the preceding six month period which significantly interfere with the individual’s ability to interact interpersonally, concentrate, follow through with goals or needs, and/or adapt effectively to change. Simply, this means that the individual has experienced chronic or intermittent symptoms over the preceding 6 months which have impacted his or her life.

How would a person with a first time episode of serious depression be assessed under these criteria?

To answer that, let’s first look at the data. Current studies identify a range of anywhere from 19%-55% of persons in NF populations who experience mental disorders. Data also tells us that elders are the most likely to attempt suicide and to use lethal means to accomplish suicide than any other population. Although persons living in NFs are less likely to attempt suicide through violent means, they have high levels of suicidal ideation. Moreover, many of these persons die from indirect suicide than from direct suicidal behavior (through self-destructive behaviors such as refusing to eat or refusing life-sustaining medications).

While PASRR does not target persons who have a brief episode of depression, if the depression is more severe than—or lasts longer than—a typical grief reaction, it is important that you provide sufficient information for Ascend’s clinicians to determine whether treatments should be identified through the PASRR process to address and improve the individual’s symptoms. As a general guideline, if an individual experiences a depressive episode which lasts longer than three months, this could be considered as a sign of a potential first-time episode of serious depression.

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**Persons with Intellectual Disability**

Intellectual Disability (ID) is defined in the *Diagnostic and Statistical Manual, Fifth Edition* as a disorder that includes intellectual and adaptive functioning limitations with an onset in the developmental period (childhood or adolescence), prior to age 22. Intellectual disability may be associated with other
conditions, such as a genetic syndrome, or traumatic brain injury (TBI) sustained during the developmental period. Three criteria must be met:

- 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 level of severity of an individual’s intellectual disability is based on adaptive functioning in three domains—Conceptual domain, Social domain, and Practical domain—and is classified in one of four ranges: Mild, Moderate, Severe and Profound.

One key challenge for conducting evaluations is confirming that lowered cognitive levels are developmentally related, and do not result from other medical causes (e.g., stroke, TIA, accidents, or injuries) during adulthood. Because formalized testing was less normative in rural areas for elderly individuals with ID, a responsibility of the evaluation process is to research developmental information and medical history to confirm developmental onset if that has not been done previously.

If the individual with ID/RC also has a diagnosis of dementia, it is important to document as clearly as possible the extent of the dementia. If the dementia is progressed, s/he may be found to be appropriate for NF care by virtue of the progression of the dementia condition. In order to determine progression of dementia, it is critical that information be gathered to reflect the individual’s pre-morbid state (e.g., what was the individual’s functioning before the onset of dementia versus his/her current functioning?). Generally, that information is best obtained from family or other caregivers who have known the individual well. Confirmation that a dementia diagnosis is primary may require substantiation by neurocognitive testing, CT scan, MRI, etc. Refer to section 1.3.1b Dementia Exemption for more information.

Persons with a Related Condition (RC)

Related Condition (RC) is a federal term referring to conditions where service or treatment needs are similar to those of individuals with intellectual disability. The evaluation for this population must specifically incorporate information sufficient to confirm substantial limitations in three or more major areas of life activity, in addition to confirmation of developmental onset of the condition (prior to age 22) as specified under §435.1009.

Individuals with a related condition have service or treatment needs similar to individuals with intellectual disability. RC is defined as a severe, chronic disability that meets all of 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.
1.0 PASRR LEVEL I 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.). Level I screens are submitted via PASRR Pro-I, Ascend’s web-based Level I tool in AssessmentPro.

A Level I screen is required:

- Before admission to any Medicaid-certified nursing facility (this includes 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 the conclusion of an assigned time-limited stay for individuals with MI and/or ID/RC who are expected to need to stay beyond the approved amount of time, requiring a Level II evaluation.

NOTE: Mental status change referrals must be submitted 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/initial LI or Level II.
- A newly prescribed psychotropic medication for mental illness. For PASRR purposes, a psychotropic medication for a medical condition (i.e. regulating sleep, appetite, etc.) does not trigger a new Level I or need for a Level II.
- A significant increase in or newly exhibited mental health symptoms (depression, anxiety, hallucinations, refusal to eat, etc.).

It is important to note that the Medicaid certification of the nursing facility, not the payment method of the individual, determines whether PASRR is required. If an individual is seeking admission into a Medicaid-certified nursing facility, regardless of whether they are paying for their stay with Medicaid/Medicare or private payment, they MUST receive a PASRR Level I screen, and if applicable a Level II evaluation, completed prior to admission and whenever a resident experiences a significant change in status, therefore 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:

- Experiences a significant change in condition,
- Requires a continued NF stay beyond the approved end date of a categorical determination or exemption, along with a LOC screen, in order to initiate the required onsite Level II (regardless of the individual’s pay source),
- Is admitted to their facility from out of state, or
- Requires an updated Level I screen because of a change in medication, diagnoses, etc. Although the screen may not be associated with a Level II condition, if the existing Level I screen is no longer accurate, you must submit a new Level I.

AssessmentPro allows any authorized user in your facility to begin and enter a screen; however, only a qualified provider may submit a screen. The healthcare professional submitting the Level I and/or LOC screen is attesting that the information is accurate to the best of their knowledge and they are accepting full responsibility for the submitted content.

When you begin a Level I screen in PASRR Pro-I, you will be guided through a series of questions that gather information about the person’s medical and behavioral diagnoses, history, current symptoms and any other relevant details. Most Level I screens will receive an instant decision at the time of submission, which will allow the provider to immediately receive and print the outcome determination. However, if there is information provided on the Level I screen indicating that the person has or may have a Level II condition, PASRR Pro-I will automatically queue the Level I to an Ascend clinician who will review the information, possibly request additional information that may be needed to get a better understanding of the individual’s needs, and provide an outcome determination.

1.2.1 Draft Screens and Turnaround Time

AssessmentPro will save draft screens for a temporary period. Level I draft screens are saved for 72 hours. Once a draft screen has expired, you can no longer return to it and your work will not be saved. A new screen is required. Refer to Section 4.2.2 Draft Screen Expiration of this manual for more information.

Level I screens are sent to Ascend’s clinical review queue in date/time order.
If a screen requires clinical review, you will typically receive a Level I outcome within 6 business hours from the time all necessary information is received to complete the review. If Ascend’s Clinical Reviewer requests additional information, the review is placed on hold, at which time the clock stops calculating until all information has been received and the review can be completed. The turnaround time resumes calculating once the information requested has been received. It is essential that you monitor the Action Required queue regularly for feedback/questions from the clinician so you can respond and promptly provide any additional clarification or upload any requested documentation. Responding promptly to requests for information will make the Level I screening process more efficient. **If you do not respond to a request for additional information within 10 business/14 calendar days, the Level I and/or LOC screen will be cancelled.** A new Level I must be submitted and a determination must be rendered before the individual can be admitted to a Medicaid-certified NF.

### 1.3 Level I Outcomes

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

- No Level II Required
- Level II Negative, No Status Change
- Level II Positive, No Status Change
- Exempted Hospital Discharge
- Emergency Categorical
- Respite Categorical
- Refer for Level II Onsite
- Withdrawn
- Cancelled

If the information provided in the Level I screen indicates that the person does not have a possible MI, ID, and/or RC condition, the screen will result in an automatic approval. If the information provided indicates that the individual has, or may have a MI, ID, and/or RC condition, then the referral will be queued to an Ascend clinician for review.

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1.3.2 Negative Level I and Emergency Admissions

Effective 7/1/16, IN will no longer apply a non-Level II emergency admission provision. Refer to the process outlined below:

For those seeking to enter the nursing facility placement from home or a 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 individual requires a Level II, contact the appropriate agency for the individual’s disability type to complete the Level II evaluation.

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

If the individual does not require a Level II and is not Medicaid active, the individual may enter the nursing facility once a negative Level I outcome has been issued in AssessmentPro.

Due to the tight time frames, you will receive a determination within six hours (during normal business hours) once all required information is received by Ascend.

Providers can submit screens in AssessmentPro at any time, including nights and weekends. However, a determination may not be issued until the next business day. If the admitting NF accepts the new resident prior to the determination being issued, the NF provider should note that the outcome could potentially be reversed once a clinician has reviewed the screen during normal business hours; therefore the NF who accepts the individual must be aware they are admitting him at risk until Ascend reviews the screen and issues the determination.

1.4 PASRR Level II Exemptions

Certain circumstances allow individuals who have MI/ID/RC to be exempt from PASRR or to be admitted to a NF through an abbreviated Level II evaluation process.

An exemption means that certain situations or conditions, while also meeting criteria for Level II evaluation, are federally exempted from the need to have a full Level II evaluation prior to NF admission.

The exemptions that may be applied in IN are:

- Exempted Hospital Discharge, and
- Dementia Exemption.

Copies of specific medical documents may be requested by the Ascend reviewer in order to make an accurate determination; however, all requests for an exempted hospital discharge require a history &
Exemptions may be applied only to individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.

For additional details, refer to section 3.3.1 Exemption and Categorical Admissions.

1.4.1 Exempted Hospital Discharge (EHD)

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

- Is discharging from a medical hospital to a nursing facility after receiving medical (non-psychiatric) services, and
- Requires short-term treatment of **30 calendar days or less**, in a NF for the same condition for which the individual was hospitalized.

In order to apply the EHD decision:

- The individual must **meet both criteria** listed above, and
- **The hospital provider must** complete a Level I screen and upload a current H&P to the individual’s Level I Screen in AssessmentPro. NOTE: A LOC is not required when requesting an EHD.

When an individual is approved for NF admission under an EHD, **the admitting facility must** submit an **updated Level I and new LOC** before the conclusion of the 30-calendar-day approval if it is determined that the individual requires a continued stay beyond the 30 calendar days for medical reasons. It is important to be aware that a full onsite Level II must also be completed. Be proactive in assessing the individuals’ needs, and if they will need to continue their stay, submit your screen well in advance of the approval end date to ensure that a determination is issued and the NF is compliant with state and federal requirements.

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

1.4.2 Dementia Exemption

Certain persons with dementia are *excluded* from PASRR when a dementia condition is present. The **dementia exclusion** applies to:

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

Where co-morbid dementia and mental illness are present, the decision as to whether dementia is primary is more complex than simply deciding if the dementia is currently the most prominent diagnosis. The complexity occurs in ensuring that the symptoms of dementia are clearly more advanced than those of the co-occurring behavioral health condition. That is, the dementia is advanced to the degree that the co-occurring mental illness is not likely ever again to be the primary focus of treatment.

Because serious mental illnesses and dementia both exhibit similar types of executive functioning impairments and personality change, the progression of the dementia is a key focus of the screening process. As a part of the Level I process, Ascend will be determining if dementia is the sole diagnosis or primary over a secondary mental illness diagnosis.

The provider submitting the Level I must include information that clearly supports the dementia is primary over the mental health diagnosis. When co-occurring diagnoses are present, federal guidelines are very strict that an exemption cannot occur unless sufficient evidence is present which clearly confirms the progression of the dementia as primary. Providers should upload any supporting documentation that provides evidence that dementia is primary over SMI to the person’s Level I screen. Examples of supporting documentation include neurocognitive test results, a series of Mini Mental Status Exams (MMSEs), H&P outlining the progression, etc.

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

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1.5 PASRR Level II Categorical Decisions

Federal PASRR regulations allow for some PASRR decisions to be issued through an abbreviated Level II process because the person meets conditions for certain categories, exempting them from having a Level II evaluation prior to NF admission. These decisions are known as categorical PASRR decisions. When an individual meets criteria for one of these categories, it means that for that individual, decisions can be made to determine that nursing home admission is appropriate and/or to determine that specialized services are not needed, as appropriate for the category.

As with exemptions, categorical decisions may be applied only for individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.
For additional details, refer to section 3.3.1 Exemption and Categorical Admissions.

There are two types of categorical Level II determinations that may be applied in Indiana:

- **Provisional Emergency Situations**
- **Respite Situations**

**1.5.1 Provisional Emergency Situations**

The Provisional Emergency categorical may be applied when an individual has a Level II condition (MI, ID, or RC) and:

- There is a sudden unexpected and urgent need for placement (typically) (e.g., loss of a caregiver, loss of a residence, suspicion of abuse/neglect, etc.),
- The individual meets Adult Protective Services (APS) or Child Protective Services (CPS) criteria, and
- A lower level of care is not available and/or appropriate.

For individuals age 18 and over, an APS report is made to the APS hotline (800.992.6978). For individuals under the age of 18, a CPS report is made to the CPS hotline (800.800.5556). All reports must include the information listed below. After business hours, reports may be left on voicemail.

- Name of person making report;
- Name, address, and phone number of facility from which report is being made;
- Individual’s name;
- Individual’s address, to include 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 abuse, neglect, and/or exploitation is suspected; and
- Indicate the APS or CPS report is for the APS or CPS 7-calendar-day emergency admission.

Provisional Emergency Situations allow for up to 7 calendar days in a NF. If the individual needs more than 7 calendar days in the NF, a new Level I and LOC screen, and new Level II when applicable, must be completed prior to the approval end date. The NF provider is responsible for submitting a new Level I and LOC screen in AssessmentPro.

When a provider requests a Provisional Emergency categorical during normal business hours, be sure the provider includes the following documentation, as available:

- Identifying demographic information including individual’s name, address, and current location,
☐ Description of the reason for the emergency request (change in individual’s condition and/or the situation warranting emergency placement and the current APS or CPS involvement/intervention),
☐ Name of APS or CPS personnel contacted & date of contact,
☐ History & Physical,
☐ 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,
☐ PASRR Level I 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, such as during evenings or weekends. In these cases, the screen will be queued to a Clinical Reviewer on the next business day. If a NF provider admits an individual before a determination is rendered in PASRR Pro-I, they must do so with the understanding that the screen may result in a denial once it is reviewed by an Ascend clinician.

Providers may have limited documentation during evening and weekend referrals for an emergency request, particularly for an individual who is currently living in the community. At a minimum, providers should upload the following information with the screen:

☐ Identifying demographic information including individual’s name, address, and current location,
☐ Description of the reason for the emergency request (change in individual’s condition and/or the situation warranting emergency placement and the current APS or CPS involvement/intervention), and
☐ Name of APS or CPS personnel contacted & date of contact.

Providers should submit any available documentation at the time of submission. Upon review, Ascend’s Clinical Reviewer will request any additional information as needed via PASRR Pro-I. The provider should be able to access any additional documentation during normal business hours.

If an individual needs to stay at the NF beyond the approval end date, the provider is responsible for submitting a new Level I and LOC screen in AssessmentPro, and a full onsite Level II must be completed. As with PASRR exemptions, be proactive in assessing the needs of the individual, and if the resident will need to continue his or her stay, submit your combined Level I/LOC screen well in advance of the approval end date to ensure that a determination is issued and the NF is compliant with state and federal requirements.
1.5.2 Respite Situations

The Respite categorical is available for individuals who reside with an in-home caregiver. It allows up to 30 calendar days of NF admission to provide relief to the family/caregiver. The Respite categorical may be applied when an individual has a Level II condition (MI, ID, or RC), and:

- The individual resides in the community with an in-home caregiver, and
- The individual is expected to return home from the NF.

Respite approvals allow for NF stays up to 30 calendar days per calendar quarter, with 30 calendar days between stays of 15 calendar days or more. In order to apply the Respite categorical decision:

- The individual must meet both criteria listed above, and
- The provider must upload a current H&P to the individual’s Level I Screen.

When a provider requests a Respite categorical during normal business hours, be sure the provider includes the following documentation, as available:

- Identifying demographic information including individual’s name, address, and current location,
- 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,
- PASRR Level I 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 Respite categorical outside of normal business hours, such as during evenings or weekends. In these cases, the screen will be queued to a Clinical Reviewer on the next business day. If a NF provider admits an individual before a determination is rendered in PASRR Pro-I, they must do so with the understanding that the screen may result in a denial once it is reviewed.
Providers may have limited documentation during evening and weekend referrals for a Respite categorical request, particularly for an individual currently living in the community. At a minimum, providers should upload the following information with the screen:

- Identifying demographic information including individual’s name, address, and current location, and
- Description of the reason for the Respite request.

Providers should submit any available documentation at the time of submission. Upon review, Ascend’s Clinical Reviewer will request any additional information as needed via PASRR Pro-I. The provider should be able to access any additional documentation during normal business hours.

If an individual needs to stay at the NF beyond the approval end date, the provider is responsible for submitting a new Level I and LOC screen in AssessmentPro, and a full onsite Level II must be completed. As with PASRR exemptions, be proactive in assessing the needs of the individual, and if the resident will need to continue his or her stay, submit your combined Level I/LOC screen well in advance of the approval end date to ensure that a determination is issued and the NF is compliant with state and federal requirements.

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

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1.6 Level I Outcome Letters

Providers have access to print outcome letters via AssessmentPro 24 hours a day. Letters must be maintained in the person’s record and must accompany the individual should he or she transfer to a different NF.

All outcome letters (approvals and denials) will include a notice of the individual/guardian’s right to appeal the decision.

Table 1: Level I Outcome Letter Distribution

<table>
<thead>
<tr>
<th>Level I Outcome</th>
<th>Referral Source Provides:</th>
<th>Ascend Provides:</th>
<th>Admitting NF—print via Assessment Pro</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual—printed via AssessmentPro</td>
<td>Legal Guardian—printed via AssessmentPro</td>
<td>Referral Source—printed via AssessmentPro</td>
</tr>
<tr>
<td>No Level II Required</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Level II Negative, No</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Status Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Level II Positive, No</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Status Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exempted Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Categorical</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Respite Categorical</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Refer for Level II</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Onsite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer for Level II</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DBR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cancelled</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
2.0 LEVEL OF CARE SCREENING OVERVIEW

2.1 What is the purpose of the LOC screen?

The Level of Care (LOC) screen is an evaluation to determine the most appropriate setting to meet an individual’s medical & behavioral needs. The LOC screen identifies whether or not a person requires the level of care provided in a skilled or intermediate nursing facility, and if appropriate for NF admission, how much time the individual is expected to need (i.e. short- or long-term approval).

2.2 Submitting a Level of Care (LOC) screen

2.2.1 Provider role in LOC screening process

Hospital, NF, and AAA providers play an essential role in serving individuals seeking nursing facility services. Your timely, accurate, and comprehensive submissions will ensure that the LOC screening process is efficient and effective, thus getting the services and supports that individuals need in place quickly.

Your specific action depends on your provider setting (hospital, nursing facility, or AAA). The following table identifies the LOC submission requirements by provider type.

Table 2: LOC Submission Requirements by Provider Type

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>SUBMISSION TYPE:</th>
<th>SUBMISSION METHOD:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Providers</strong></td>
<td>Level I screens</td>
<td>Electronic</td>
</tr>
<tr>
<td></td>
<td>Short-form LOC for the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o All individuals who have a positive Level I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o All individuals who are using Medicaid as the pay source for the NF stay (e.g. switching from Medicare to Medicaid)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Waiver participants without a valid/current LOC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Preadmission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Status Change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 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)]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Categorical criteria met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Provisional emergency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Respite</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROVIDER TYPE</td>
<td>LOC SUBMISSION REQUIREMENTS</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Facility Providers    | • Level I screens  
                        • Short form LOC for:  
                        o Preadmission  
                        o 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  
                        o Emergency or Categorical criteria met  
                        ▪ Provisional emergency situation  
                        ▪ Respite situation  
                        • Long form LOC assessment for:  
                        o Status Change—regardless of pay source  
                        o 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.  
                        o LOC only when Medicaid becomes individual’s pay source for NF stay. |
| AAA Providers         | • Submit the full LOC assessment for:  
                        o At-home preadmission screening  
                        o Referrals from Ascend 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. |
3.0 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 do not require a LOC screen unless they need continued NF care lasting longer than the approved 30 calendar days. Refer to section 1.4.1 Exempted Hospital Discharge (EHD) for information on EHD decisions. All other Level II decisions—including APS Emergency, Respite, and Dementia exemption decisions—require a LOC prior to admission.
- All PACE participants who do not have a valid/current LOC on record.
- All Waiver recipients 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:
- When there is a significant change in **medical** condition (medical “status change”) indicating the person has experienced:
  - 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: when there is a significant change in **medical** condition (medical “status change”) indicating the person has experienced:
- For all PACE participants annually, and more often as needed as medical needs change (e.g. a medical status change)
  - 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:** Status change referrals must be submitted within 14 days of the significant change event.
Examples:

A new LOC is **not** required if:

- A resident’s medical condition improves to the point that NF care is no longer required. The NF should proceed with discharge. (A new LOC could be completed as part of discharge planning if the individual refuses to leave the facility and action is taken to discharge).
- 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.

A new LOC is **required** 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.

You may refer to the [IN Level I/LOC Frequently Asked Questions](#) for additional information on when to submit an LOC screen.

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### 3.1.1 LOC and Waiver Recipients

If the provider (hospital, NF, case manager, or AAA) is aware the NF applicant is a current Medicaid Waiver recipient, follow the PASRR Process described below.

The provider of care will:

1. Submit the Level I in AssessmentPro prior to NF admission.
2. If the Level I is negative, and the individual has a valid/current LOC approved through the Waiver, proceed with NF admission. A new LOC is not required. The waiver case manager must provide the admitting NF with a copy of the approved Waiver LOC.
3. If the Level I indicates that the individual requires 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.
   a. If the individual requires a Level II and has a valid/current LOC approved through the Waiver, a new LOC is not required.
   b. If the individual requires a Level II and DOES NOT have a valid/current LOC approved through the Waiver, submit a LOC in AssessmentPro. A decision from BOTH the LOC and the Level II must be issued prior to admission.
The admitting facility will:

1. Enter the admission date in PathTracker upon admission to their NF.
2. Print notification letter from within AssessmentPro.
3. Update PathTracker with the individual’s discharge date.

Once the admission date is entered, AssessmentPro will alert the Division of Aging to complete the Medicaid LOC data entry process. The Waiver Case Manager must complete all required Waiver paperwork per the Waiver procedures regarding the individual’s Waiver status.

If the provider (hospital, NF, case manager, or AAA) is NOT aware the NF applicant is a current Medicaid Waiver recipient, follow the PASRR Process described below.

The provider of care will:

1. Submit the Level I and LOC in AssessmentPro to determine whether the person requires a Level II (indicated by the Level I outcome) and NF eligibility (indicated by the LOC outcome) prior to entering the NF admission. It is the provider’s responsibility to ensure that the PASRR process is completed prior to the individual’s admission to the NF.

The admitting facility will:

1. Enter the admission date in PathTracker upon admission to their NF, if approved for NF LOC.
2. Update PathTracker with the individual’s discharge date.

Once the admission date is entered, AssessmentPro will alert the Division of Aging to complete the Medicaid LOC data entry process. The Waiver Case Manager must complete all required Waiver paperwork per the Waiver procedures regarding the individual’s Waiver status.

If the individual is currently receiving non-nursing facility LOC Waiver services and is seeking NF placement, follow the process described below:

The provider of care will:

1. Submit a Level I and LOC in AssessmentPro.

The admitting facility will:

1. Enter the admission date in PathTracker upon admission to their NF.
2. Print notification letter from within AssessmentPro.
3. Update PathTracker with the individual’s discharge date.

Once the admission date is entered, AssessmentPro will alert the Division of Aging to complete the Medicaid LOC data entry process. The Waiver Case Manager must complete all required Waiver paperwork per the Waiver procedures regarding the individual’s Waiver status.
For all preadmissions, it is the provider of care’s responsibility to ensure that the PASRR process is completed prior to the individual’s admission to the NF.

3.1.2 Required Documentation

A History and Physical (H&P) is required with all LOC screens. Federal regulations requires that the H&P be no more than a year old; however, it is best practice to submit an H&P that is an accurate representation of the individual’s current conditions, symptoms, medications, and treatments/interventions.

Providers are encouraged 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 (MARs), sections A, C, G, & H of the current/most recent Minimum Data Set (MDS), Certified Nursing Assistant (CNA) flow sheets, and/or behavioral therapy notes, nursing notes, progress notes, Occupational Therapy (OT)/Physical Therapy (PT) notes, etc.

Monitor the Action Required queue regularly for requests for additional information from Ascend’s 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 screens for a temporary period. LOC draft screens are saved for 72 hours. Once a draft screen has expired, you can no longer return to it and your work will not be saved. A new screen is required. Refer to Section 4.2.2 Draft Screen Expiration of this manual for more information.

LOC screens are sent to Ascend’s clinical review queue in date/time order.

Ascend’s Clinical Reviewers will complete reviews within 6 business hours from the time all necessary information is received. If Ascend’s Clinical Reviewer requests additional information, the review is placed on hold, at which time the clock stops calculating until all information has been received and the review can be completed. The turnaround time resumes calculating once the information requested has been received. It is essential that you monitor the Action Required queue regularly for feedback/questions from the clinician so you can respond and promptly provide any additional clarification or upload any requested documentation. Responding promptly to requests for information will make the LOC screening process more efficient. If you do not respond to a request for additional information within 10 business/14 calendar days, the Level I and/or LOC screen will be cancelled. A new LOC screen must be submitted and a determination must be rendered before the individual can be admitted to a Medicaid-certified NF.
3.1.4 Clinical Review & Outcomes

For all **short form LOC screens**, an Ascend 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 30, 60, 90, or 120 calendar days),
- **Approved for Short-Term Intermediate Nursing Facility** (with a specified duration of 30, 60, 90, or 120 calendar days),
- **Approved for Long-Term Skilled Nursing Facility** (120+ days),
- **Approved for Long-Term Intermediate Nursing Facility** (120+ days), or
- **Denied for Nursing Facility** (this decision requires further evaluation as described below).

For PACE participants, an Ascend 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** (120+ days),
- **Approved for Long-Term Intermediate Nursing Facility** (120+ days), or
- **Denied for Nursing Facility** (this decision requires further evaluation as described below).

**NOTE regarding potential NF LOC denials**: Ascend will not make determinations for an individual who does not appear to meet LOC. When this occurs, Ascend’s Clinical Reviewer will select the **Denied for Nursing Facility** outcome, and the screen will be queued to a local AAA provider, who will conduct an onsite LOC assessment. AssessmentPro will send an email notification alerting the AAA provider of the new referral.

The AAA will:

1. Log into LOC Pro.
2. Monitor the LOC Referrals queue. This queue contains all LOC Pro screens that have been reviewed by an Ascend clinician and determined to be potential denials.
3. Schedule the onsite assessment.
4. Conduct the onsite long form LOC. If there is no internet access at the assessment location, the AAA provider will complete a paper long form LOC, and then enter the assessment responses in AssessmentPro once secure internet access is regained.
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 Ascend **within 5 business days**.
8. Complete onsite LOCs for all preadmission LOCs **within 3 business days**.
For all long form LOC screens, the system will generate an approval for individuals who meet NF LOC criteria. When an individual meets LOC criteria, LOC Pro will issue approvals as follows:

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

For all long form LOC automatic approvals (issued via AssessmentPro), the NF provider will enter a Length of Stay decision. When the NF provider views the automatic approval outcome, AssessmentPro will prompt the provider to enter an approved length of stay of Short-Term for a duration of 30, 60, 90, or 120 calendar days, or Long-Term (120+ days).

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 individual and his or her 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 individual/guardian’s right to appeal the decision.

Ascend is responsible for mailing letters to an individual’s primary care physician. The following table describes the LOC outcome letter distribution:

Table 3: LOC Outcome Letter Distribution

<table>
<thead>
<tr>
<th>Level of Care Outcome</th>
<th>Attachments</th>
<th>Referral Source Provides:</th>
<th>Ascend Provides:</th>
<th>Admitting NF—print via Assessment Pro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved for Skilled Nursing Facility (30-120 days)</td>
<td>LOC Screen &amp; Appeal Rights</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Approved for Intermediate Nursing Facility (30 – 120 days)</td>
<td>LOC Screen &amp; Appeal Rights</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Approved for Skilled Nursing</td>
<td>LOC Screen &amp; Appeal rights</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Outcomes of *Denied for Nursing Facility* is issued by the AAA provider via AssessmentPro. Providers will access these outcomes in AssessmentPro, as with Ascend-issued outcomes.

**NOTE:** If an individual is receiving both a Level I and LOC screen together, both outcomes will be included in a single letter. You will not need to print separate letters for these screens unless they are completed at separate times.

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### 3.2 Transfers and Out-of-State Referrals

#### 3.2.1 Inter-facility Transfers

No additional screen is required if an individual changes location, as long as the individual was not discharged to a *lower* level of care. This means that if an individual who has been approved through PASRR for NF admission is either:

1) transferred from one IN NF to another IN NF, or
2) transferred from an IN NF to a hospital and back to the same or another IN NF,

no additional screen is required *unless* there has been a significant change in condition, the individual has discharged to a lower level of care (e.g. community placement) and needs to return to the same or different NF, or the approved length of stay is nearing expiration.

NF providers will be able to update discharges, transfers, and admissions in PathTracker, a service within AssessmentPro for tracking persons with Level II conditions. As long as there has been no change in mental health status or medical care needs, a Level I/LOC is good indefinitely.

If a person experiences a Status Change, a new Level I is required before transferring to a new NF. If the individual has a Level II condition or found to have a Level II condition via the Status Change review, a Level I and LOC is required in order to refer for a Level II evaluation.
If a person discharges from a NF to a lower level of care, such as a community placement, and then needs to return to the same or different NF, a new Level I is required. If the individual has a Level II condition (regardless of pay source) or is an active Medicaid recipient and is using Medicaid as the pay source for the NF stay, a new Level I and LOC are required.

### 3.2.2 Out of State Transfers

If an out-of-state resident is currently being treated in an IN hospital and is seeking admission to an IN Medicaid-certified NF, the hospital provider must submit a Level I screen. If a Level II is required, the hospital provider must also submit a short-form LOC. For individuals who do not require a Level II, the LOC must be completed by the IN NF provider if/when the individual becomes IN Medicaid-active and elects to use Medicaid as the pay source for the NF stay.

If an individual is a resident of another state, is in an out-of-state facility, and is seeking admission to an IN NF, then the IN NF provider completes the Level I. If a Level II is required, the IN NF provider will also complete a short-form LOC. If a Level II is not required, the IN NF provider will complete a long-form LOC if/when the individual becomes IN Medicaid-active and elects to use Medicaid as the pay source for the NF stay.

If an individual is an IN resident and is IN Medicaid-active, is currently at an out-of-state NF and is seeking a transfer to an IN NF and is using Medicaid as the pay source, then the IN NF provider must submit a Level I, and if a Level II is required, 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 start, resume, submit, or withdraw requests for screens; add, remove, and manage users; monitor the status of a screen; upload documentation, and any other system functions.

Please note that clinical review is completed during regular business hours Monday-Friday 7am CST/8am EST to 4pm CST/5pm EST.

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### 3.3.1 Exemption & Categorical Admissions

Providers are able to submit screens outside of normal business hours; however, all short form LOC assessments including Exempted Hospital Discharges (EHDs) and Categoricals must be reviewed by an Ascend clinician. If an outcome other than an approval is received and it is outside of normal business hours, the admission may occur, but providers should note that the outcome could potentially be
reversed once a clinician has reviewed the screen; therefore the NF who accepts the individual must be aware they are admitting him at risk until Ascend reviews the screen and issues the determination.

For exemptions and categoricals, the approved length of stay begins on the day of admission and ends on the final calendar day of the approved length of stay. For example, if an individual receives an EHD, the length of stay begins on the day he or she is admitted to the NF (i.e. admission date is day 1 of 30) and ends on the 30th calendar day from the admission date. Likewise, if an individual receives a Provisional Emergency approval, the length of stay begins on the date of admission (i.e. day 1 of 7), and ends on the 7th calendar day.

### 3.3.2 Delayed Admissions

LOC approvals are valid for 90 calendar days. If an individual does not admit to the nursing facility within 90 calendar days, a new Level I and LOC screen and determination are required prior to admission to a Medicaid-certified NF.

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### 3.4 Refer for Level II Outcomes

When an outcome of Refer for Level II is rendered, the submitter is responsible for notifying the appropriate mental health or intellectual disability agency representative (based on region), who will conduct the onsite Level II evaluation. Refer to the PASRR Level II Provider Contact Sheet, which is posted at [https://www.ascendami.com/ami/Providers/YourState/IndianaPASRRUserTools.aspx](https://www.ascendami.com/ami/Providers/YourState/IndianaPASRRUserTools.aspx) under Other Resources.
4.0 Important AssessmentPro General Information

4.1 Getting Started in AssessmentPro

4.1.1 User Registration & Maintenance

AssessmentPro has three types of user access: AssessmentPro Administrators, Clinical Users, and Non-clinical User. Each facility will have a limited number of staff (Ascend recommends two to three) who will have AssessmentPro Administrators access. AssessmentPro Administrators will have the ability to add and remove users, approve requests for user access, update user profiles, and update facility information in addition to all of the basic User functions.

Staff who are given Non-clinical User access will have the ability to begin screens, request permission to complete screens for additional facilities, monitor progress of screens, view the Action Required queue, upload documents, and print outcomes.

Staff who are given Clinical User access will have the ability to complete the same tasks as a Non-clinical user. They will also have the ability to submit screens.

Table 4: User Roles in AssessmentPro

<table>
<thead>
<tr>
<th>AssessmentPro User Role</th>
<th>Permissions</th>
</tr>
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</table>
| **AssessmentPro Facility Administrator** | • Highest level of access  
• Ascend recommends two to three staff per facility  
• Has the following permissions:  
  o **Facility Profile**: Create, read, update, and delete  
  o **User Profile**: Create, read, update, and delete for all facility users  
  o **Individual Record (Demographics)**: Create, read, and update for anyone with a Level I or LOC screen submitted by the facility  
  o **Level I/LOC Screen**: Create, read, and update for any individual; submit for a determination  
  o **Level I/LOC Outcome Documentation**: Read  
  o **Referral Source Communication with Ascend Clinician**: Read and update  
  o **PathTracker Records**: Create, read, update, delete (NF only) |
| **Facility Clinical User**     | • **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 Ascend clinician**: Read and update |
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 have the ability to 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 as needed.

4.2.2 Draft Screen Expiration

In AssessmentPro, a draft screen is a screen that has been started, but not yet 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 complete the screen at one time for any reason.

Level I screens that have been started but not submitted will be available for 72 hours.

LOC screens that have been started but not submitted will be available for 72 hours.

Once a draft has expired, it will be removed from the system, no information will be retained, and you will need to enter a new screen. The best way to avoid losing your work and enter screens efficiently is to prepare ahead of time. Gathering the person’s record so you can easily refer to it if there is a question you are not sure about will save you time.

You may refer to the IN Level I/LOC Frequently Asked Questions for additional information on how to use AssessmentPro, manage users, and PASRR processes such as when and how to submit Level I/LOC screens.
4.2.3 Declared States of Emergency and Widespread Outage

In the event of a declared state of emergency or situation identified by Ascend or the State of Indiana Division of Aging (IN DA) (i.e. natural disaster, widespread power outages, etc.), an emergency admission approval will be implemented. The nature of the emergency will be discussed/determined between Ascend and the Division of Aging. Together they will then determine the appropriateness for use of the emergency admission approval, and provide official authorization to deploy this process and provide specific instruction to providers and Ascend staff. Instructions and resources to complete this process will be made available when needed on both the Ascend and the IN DA websites.

The State of Emergency admission option can only be used with prior approval. The attempt to use this option outside of prior IN DA and Ascend approval will result in non-payment to the NF.

This option cannot be used due to failure to register for AssessmentPro nor will general or routine upgrades to the software system constitute a State of Emergency.

5.0 Admission & Discharge Tracking

Nursing Facility providers must update PathTracker with the admission date of all residents upon admission. PathTracker may not be updated until the actual admission occurs. After the admission date is entered, the system will alert the Medicaid LOC data entry process through the Division of Aging.

For PACE recipients, once a start date has been determined, the provider must update PathTracker with the start date. After the program start date is entered, the system will alert the Medicaid LOC data entry process through the Division of Aging. If the individual discontinues the PACE program, update the program discharge date in PathTracker.

6.0 Appeal Rights Notifications

The individual and/or guardian has the right to appeal all Level I and/or Level of Care decisions. All outcome letters will include a notice of the individual’s appeal rights.