



Accessing the Long Term Care System in Maine

Long Term Care Medical Eligibility, Pre-Admission Screening & Resident Review, Acquired Brain Injury & Other Related Conditions

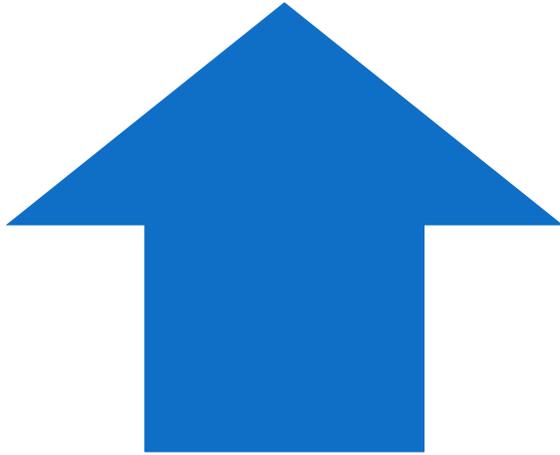
Agenda

- Introduction to Goold Health Systems, a Change Healthcare company
- MaineCare Application Process
- Referrals
- Long Term Care Medical Eligibility (MED)
- Pre-Admission Screening & Resident Review (PASRR)
- Acquired Brain Injury (ABI)
- Other Related Conditions (ORC)
- Resources & Training
- Q & A

Goold Health Systems, a Change Healthcare company

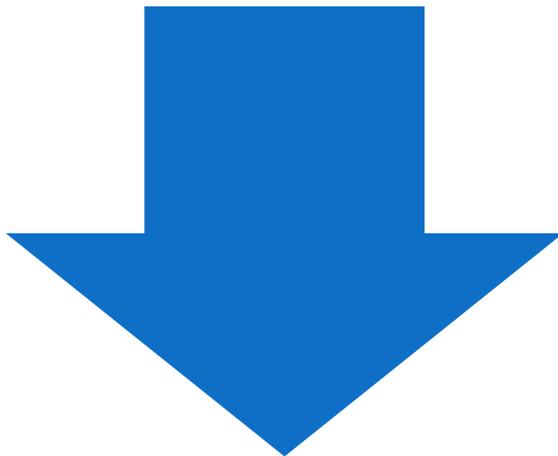
- Assessing Services Agency (ASA) for the Maine Department of Health & Human Services (DHHS), in partnership with the Office of Aging and Disability Services (OADS)
- Goold administers long-term care assessments for elderly and disabled individuals over 18 years of age
- Conduct face-to-face assessments using DHHS MeCare application and/or other DHHS approved forms
- Educate consumers about support services in an individual's home, the community or a nursing facility (NF)

ASA Benefits



Increase consumer participation in selecting a long-term care program

Identify caregiver needs and address caregiver burnout



Reduce cost through greater emphasis on rehabilitation and health promotion

Reduce the number of unnecessary admissions to nursing facilities

Assessment Programs

- Long Term Care Medical Eligibility (MED)
- Pre-Admission Screening & Resident Review (PASRR)
- Acquired Brain Injury (ABI)
- Foster Care Level of Care (FCLoC)
- Katie Beckett

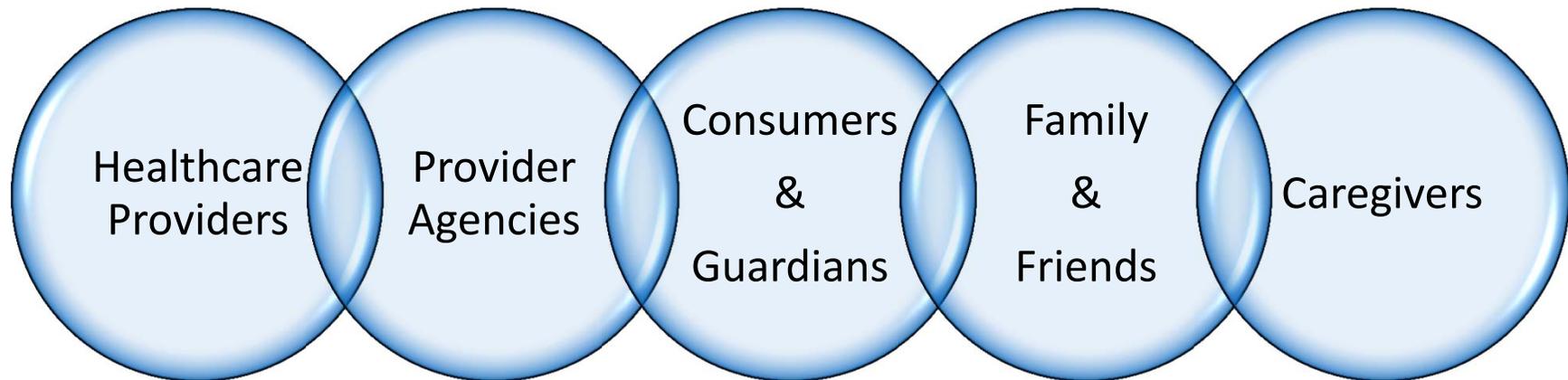
MaineCare Application Process



Once MaineCare is approved, the next step is a medical eligibility assessment

Referrals

Who can submit a referral?



Where can I find referral forms?



Maine Assessing Services Agency Maine Department of Health & Human Services (DHHS)

Received by: fax phone

REFERRAL FORM MEDICAL ELIGIBILITY DETERMINATION

1. REFERRAL DATE	Month Day Year	20. REFERRAL SOURCE	1. Nursing Facility 2. Consumer 3. Family member 4. Hospital 5. OIAS 6. Residential Care 7. Provider agency 8. Community agency 9. Advocacy agency 10. Physician 11. Other state agency 12. Other
2. APPLICANT NAME	First: (MI) Last:	21. LOCATION AT	1. Hospital Campus 5. Nursing Home
3. BIRTH DATE	Month		
4. GENDER	1. Male		
5. MARITAL STATUS	1. Never married 2. Married		
6. CITIZENSHIP	1. U.S. Citizen		
7. PRIMARY LANGUAGE	0. English 2. 1. French 3.		
7A. INTERPRETER REQUIRED	0-No		

Contact a local Department of Health and Human Services office for an application.

Augusta: 35 Anthony Ave., Augusta 04333
1-800-452-1926
Bangor: 396 Griffin Road, Bangor 04401
1-800-432-7825
Biddeford: 208 Graham St., Biddeford 04005
1-800-322-1919
Calais: 392 South St., Calais 04619
1-800-622-1400
Caribou: 30 Skyway Drive, Unit #100, Caribou 04736
1-800-432-7366



Katie Beckett Benefit:

PASRR LEVEL I SCREEN DETERMINATION FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY, AND OTHER RELATED CONDITIONS



IF YOU NEED ASSISTANCE WITH COMPLETING THIS FORM OR HAVE GENERAL QUESTIONS ABOUT PASRR, PLEASE CALL GOOLD HEALTH SYSTEMS AT 1-800-609-7893

All Level II Assessment decisions or deferral/waiver of a Level II Assessment must be made by Goold Health Systems, a designee of the Maine Department of Health & Human Services (DHHS).

PLEASE SUBMIT ALL PAGES, INCLUDING THE SIGNED ATTESTATION ON PAGE 4.

1. SUBMITTING HOSPITAL/AGENCY INFORMATION	
HOSPITAL/AGENCY NAME	DATE
FAX NUMBER	PHONE NUMBER
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM	
2. CONSUMER INFORMATION	

Help with Referrals



Maine Assessing Services Agency
Maine Department of Health & Human Services (DHHS)

PASRR LEVEL I SCREEN USER GUIDE

DETERMINATION FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY,
AND OTHER RELATED CONDITIONS



PASRR Overview and FAQ: <http://assessmaine.com/pasrr>

APPLICANT NAME: *The consumer's name*

1. SUBMITTING AGENCY

HOSPITAL/AGENCY NAME

DATE

FAX NUMBER

BACKGROUND INFORMATION

This referral form will collect some of the applicant's demographic information as well as pertinent information to assist in the assessment process. This information will be forwarded to the RN assessor and certain items will need to be verified at the time the assessment is completed. Consumers need to give permission to release information contained in this section to be shared with other providers. **For a referral to be considered complete and timely by the assessing services agency, the shaded areas MUST be completed by provider agencies, hospitals or nursing facilities. If information required is not completed, delays in completion of the assessment may occur and may result in payment issues for the provider.**

- 1. REFERRAL DATE:** This date establishes a common reference point to indicate the start of the assessment process based on the date this referral was forwarded to the assessing services agency. For the month and day of the referral, enter two digits each, using zero (0) in the first box for a 1-digit month or day, use four digits for the year.
- 2. APPLICANT NAME:** Print applicant's legal name clearly, using capital letters for first name, middle initial and last name.

Submitting a Referral

- **Option 1**

- Call 800-609-7893
- An Intake Specialist will assist you in making the referral

- **Option 2**

- Fax a complete referral form
 - LTC/ABI: 800-368-0965 or 207-430-4601
 - PASRR: 844-884-5577
- An Intake Specialist will call the appropriate contact with any questions

Complete Referrals

- Intake Specialists pre-screen all referrals to ensure that only appropriate referrals are entered into MeCare
- Accurate pre-screens depend on:
 - Referral with all required fields complete
 - Required documents
 - Supporting paperwork
 - Other pertinent information

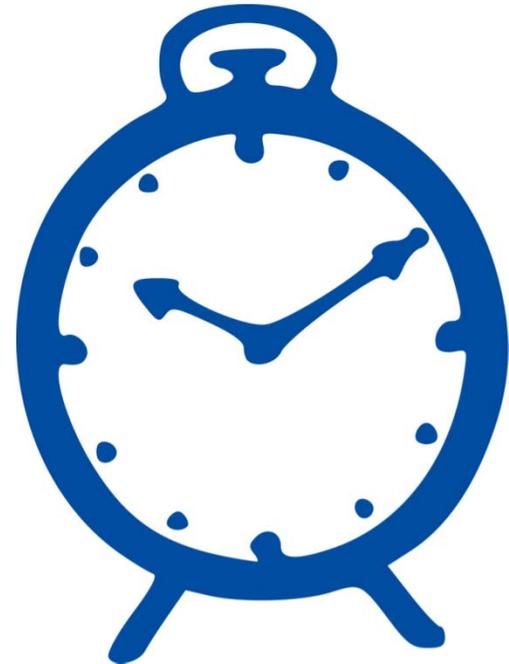
Long Term Care

Long Term Care

- Assessments for elderly and disabled individuals over 18
- Referral from a medical service provider, family member or individual consumer
- Measures individual needs and results in a list of options, based on medical eligibility, for services available to the individual
- Support services in the home, community or a nursing facility

LTC Assessment Timelines

- From date of complete referral
 - 5 days to complete most assessments
 - 24 hours to complete hospital assessments
- Daily referral deadlines
 - Hospitals: 4:00 p.m.
 - Other sources: 3:00 p.m.
- Exceptions
 - Psychiatric hospital admission
 - PASRR is involved



Waivers Requiring MED

- MED determines an individual's functional eligibility for services under the waiver
- **Acquired Brain Injury**
 - Individuals who have sustained an acquired brain injury
- **Other Related Conditions**
 - Cerebral Palsy or Epilepsy; or
 - Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities
 - LTC advisory, no Plan of Care (POC) developed

LTC Referral Forms

- Referral Form

http://assessmaine.com/sites/default/files/uploaded_files/Referral-Form-Rev2-112114.pdf

- Referral Form Instructions

http://www.maine.gov/dhhs/oads/docs/ref_instruct.pdf

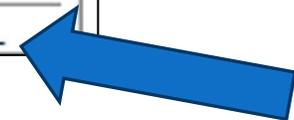
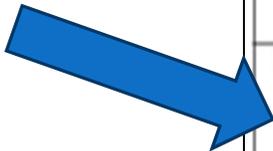
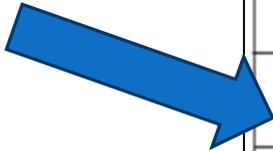
– Link available on assessmaine.com

Complete Referral Forms

- A referral is considered complete when all of the required fields are completed by the submitter
- Incomplete referrals may cause delays in completion of the assessment and may result in payment issues for the provider

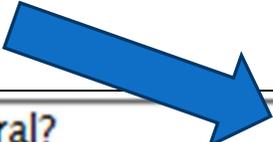
Inaccurate Demographics

1.	REFERRAL DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Month Day Year
2.	APPLICANT NAME	First: _____ (MI) _____ Last: _____
3.	BIRTH DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Month Day Year
4.	GENDER	1. Male 2. Female <input type="checkbox"/>
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced <input type="checkbox"/>
6.	CITIZENSHIP	1. U.S. Citizen 2. Legal alien 3. Other <input type="checkbox"/>
7.	PRIMARY LANGUAGE	0. English 1. French 2. Spanish 3. Other _____ 4. to 87.- See instructions <input type="checkbox"/>
7A.	INTERPRETER REQUIRED	0-No 1-Yes 2-Notknown <input type="checkbox"/>
8.	RACE/ETHNICITY (Optional)	1-Am Indian/Alaskan 2-Asian 3-Black 4-Hispanic/Latino 5-White 6-Other _____ 7-Hawaiian/Pacific Isl <input type="checkbox"/>
9.	RESIDENCE ADDRESS	Street _____ City/Town _____ Cnty _____ State _____ Zip _____ Phone (____) _____



Missing Information

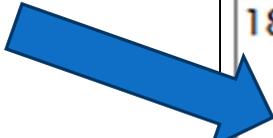
15.	REFERRAL INFORMATION	Is consumer aware of this referral? 0-No 1-Yes	<input type="checkbox"/>
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16.	VISUAL/ HEARING	a. Visual Impairment	0-No	1-Yes	<input type="checkbox"/>
		b. Hearing Loss	0-No	1-Yes	<input type="checkbox"/>
17.	COGNITION/ BEHAVIOR	a. Cognitive Impairment	0-No	1-Yes	<input type="checkbox"/>
		b. Behavioral Problems	0-No	1-Yes	<input type="checkbox"/>




18.	ADVANCED DIRECTIVES (For only those items with supporting documentation)	<i>(Check all that apply.)</i>			
		a. Living will	a	f. Feeding restrictions	r
		b. Do not resuscitate	b	g. Medication restrictions	g
		c. Do not hospitalize	c	h. Other _____	h
		d. Organ donation	d	i. NONE OF ABOVE	i
		e. Autopsy request	e		



Physician

28.	PHYSICIAN	Name _____ Address _____ _____ Telephone _____
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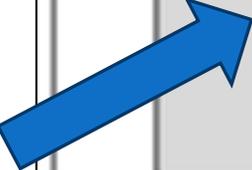
Legal Guardians

- If Box 14 = 1, then Box 29 must contain full contact information for the guardian

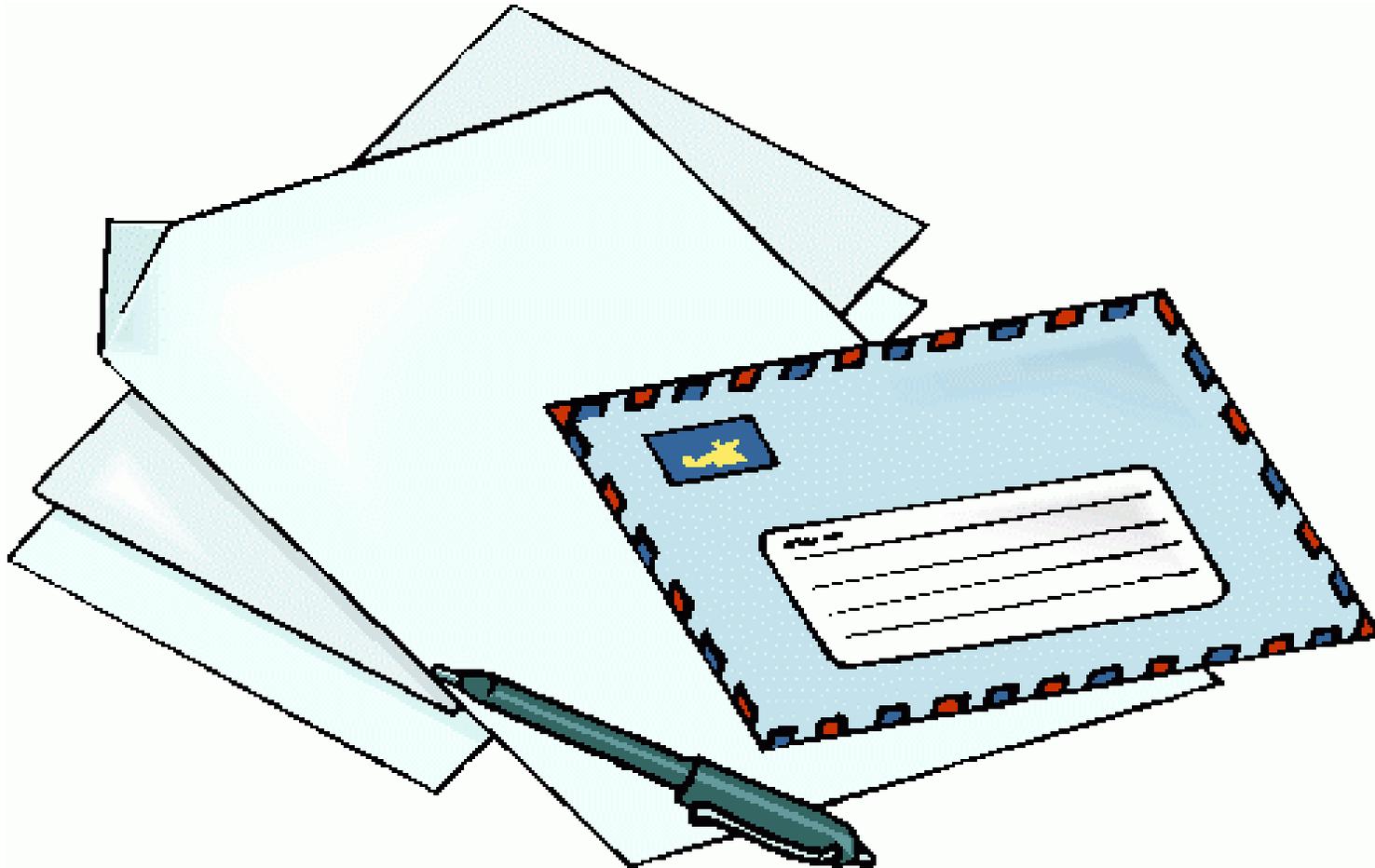
14.	LEGAL GUARDIAN	Does consumer have a legal guardian? 0-No 1-Yes 2-Not known	<input checked="" type="text" value="1"/>
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29.	EMERGENCY OR FAMILY CONTACT	Name _____ Address _____ _____ Relationship _____ Telephone _____ Legal Guardian <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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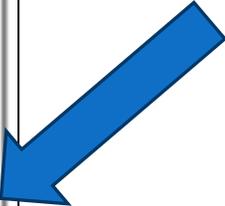


Medicare Denial Letter



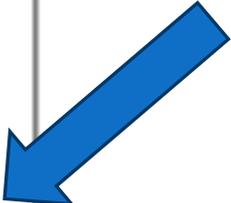
First Non-SNF Date

26.	PROGRAM ASSESSMENT REQUESTED <i>(Choose only one.)</i>	<ul style="list-style-type: none">1. Long Term Care Advisory2. Adult Day Services3. OES Homemaker4. MaineCare Day Health I, II, III5. Consumer Directed PA I, II, III6. Home Based Care7. Phys. Dis. HCBS8. Elderly HCBS9. Adults w/ Disability HCBS10. PDN - Level I, II, III, VIII11. Adult Family Care Home12. Extended PDN - Level V13. NF Assessment14. 20-day Medicare/MaineCare15. Medicare to MaineCare16. 20-day copay to NF MaineCare	<ul style="list-style-type: none">17. 30-day Community MaineCare NF18. Advisory to MaineCare Update19. Adv. Medicare to Private Pay NF20. Continuing Stay Review21. Extraordinary Circumstances to NF22. Katie Beckett23. NF PDN24. Independent Housing25. BI - Brain Injury NF26. MaineCare Home Health27. PDN Medication Services28. PDN Venipuncture Only29. Consumer Directed HBC30. Assisted Living31. Residential Care
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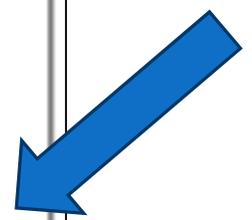
20-day Copay Assessment

26.	PROGRAM ASSESSMENT REQUESTED <i>(Choose only one.)</i>	1. Long Term Care Advisory 2. Adult Day Services 3. OES Homemaker 4. MaineCare Day Health I, II, III 5. Consumer Directed PA I, II, III 6. Home Based Care 7. Phys. Dis. HCBS 8. Elderly HCBS 9. Adults w/ Disability HCBS 10. PDN - Level I, II, III, VIII 11. Adult Family Care Home 12. Extended PDN - Level V 13. NF Assessment 14. 20-day Medicare/MaineCare 15. Medicare to MaineCare 16. 20-day copay to NF MaineCare	17. 30-day Community MaineCare NF 18. Advisory to MaineCare Update 19. Adv. Medicare to Private Pay NF 20. Continuing Stay Review 21. Extraordinary Circumstances to NF 22. Katie Beckett 23. NF PDN 24. Independent Housing 25. BI - Brain Injury NF 26. MaineCare Home Health 27. PDN Medication Services 28. PDN Venipuncture Only 29. Consumer Directed HBC 30. Assisted Living 31. Residential Care
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Conflicting Dates - Hospitals

26.	PROGRAM ASSESSMENT REQUESTED <i>(Choose only one.)</i>	<input type="checkbox"/> 1. Long Term Care Advisory <input type="checkbox"/> 2. Adult Day Services <input type="checkbox"/> 3. OES Homemaker <input type="checkbox"/> 4. MaineCare Day Health I, II, III <input type="checkbox"/> 5. Consumer Directed PA I, II, III <input type="checkbox"/> 6. Home Based Care <input type="checkbox"/> 7. Phys. Dis. HCBS <input type="checkbox"/> 8. Elderly HCBS <input type="checkbox"/> 9. Adults w/ Disability HCBS <input type="checkbox"/> 10. PDN - Level I, II, III, VIII <input type="checkbox"/> 11. Adult Family Care Home <input type="checkbox"/> 12. Extended PDN - Level V <input checked="" type="checkbox"/> 13. NF Assessment <input type="checkbox"/> 14. 20-day Medicare/MaineCare <input type="checkbox"/> 15. Medicare to MaineCare <input type="checkbox"/> 16. 20-day copay to NF MaineCare	<input checked="" type="checkbox"/> 17. 30-day Community MaineCare NF <input type="checkbox"/> 18. Advisory to MaineCare Update <input type="checkbox"/> 19. Adv. Medicare to Private Pay NF <input type="checkbox"/> 20. Continuing Stay Review <input type="checkbox"/> 21. Extraordinary Circumstances to NF <input type="checkbox"/> 22. Katie Beckett <input type="checkbox"/> 23. NF PDN <input type="checkbox"/> 24. Independent Housing <input type="checkbox"/> 25. BI - Brain Injury NF <input type="checkbox"/> 26. MaineCare Home Health <input type="checkbox"/> 27. PDN Medication Services <input type="checkbox"/> 28. PDN Venipuncture Only <input type="checkbox"/> 29. Consumer Directed HBC <input type="checkbox"/> 30. Assisted Living <input type="checkbox"/> 31. Residential Care
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Pre-Screen Process

- An Intake Specialist asks the person a series of questions to determine if the person appears eligible to have an assessment
- Assessment prescreen
 - Demographic information
 - Services received in last 60 days
 - Physical help needed with personal care
 - Help needed with homemaker tasks
 - Nursing needs
 - Income and assets information

MED Assessment

- Appointment set up by scheduling team or RN
- RN needs to see medications, MaineCare card, Medicare card, Social Security card, and guardianship papers, if applicable
- RN asks questions about income and assets
- Assessment information entered into laptop
- RN leaves eligibility letter, program choice letter, hearing rights, copy of Release of information (ROI) if requested, Plan of Care (POC)

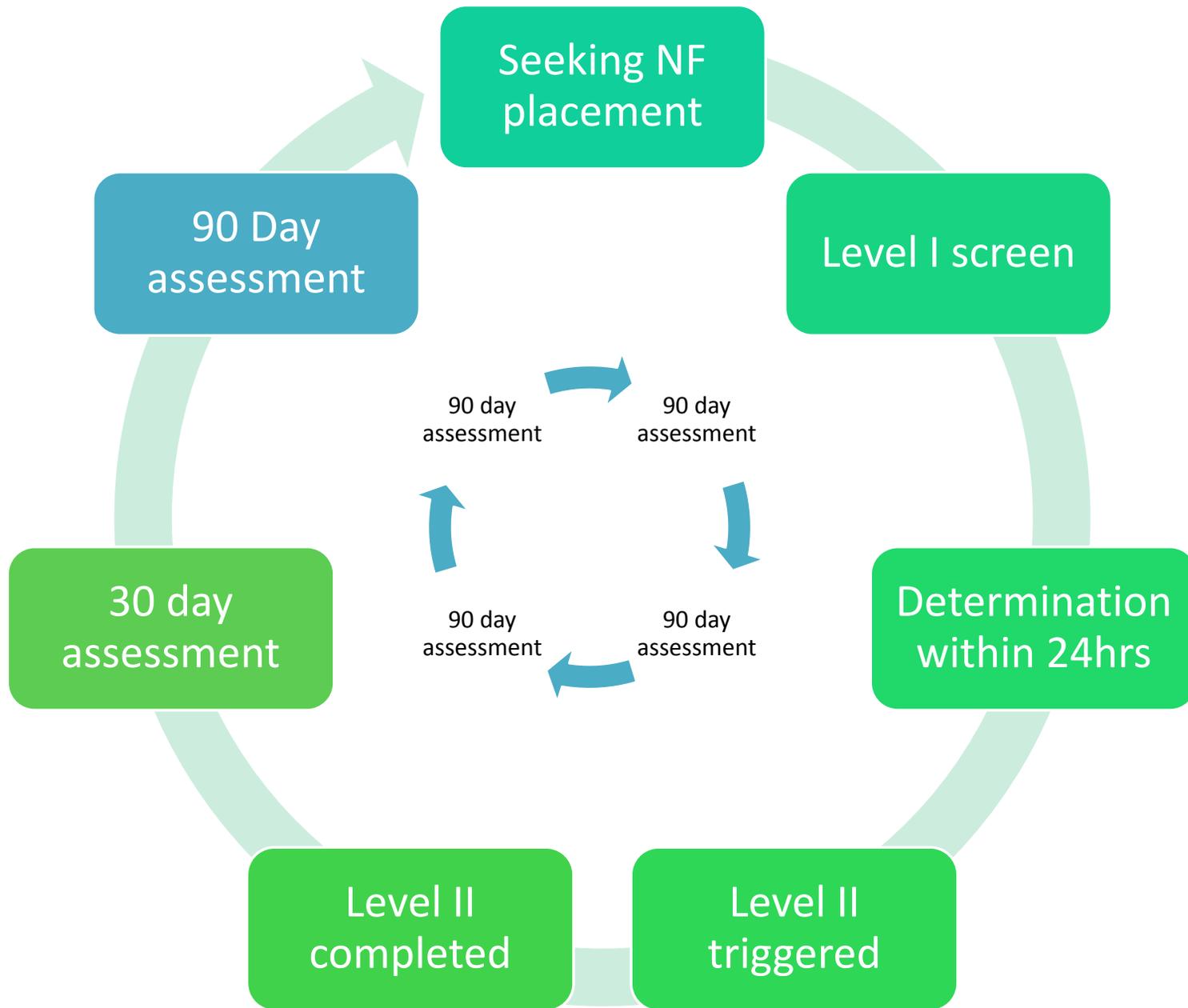
Pre-Admission Screening & Resident Review

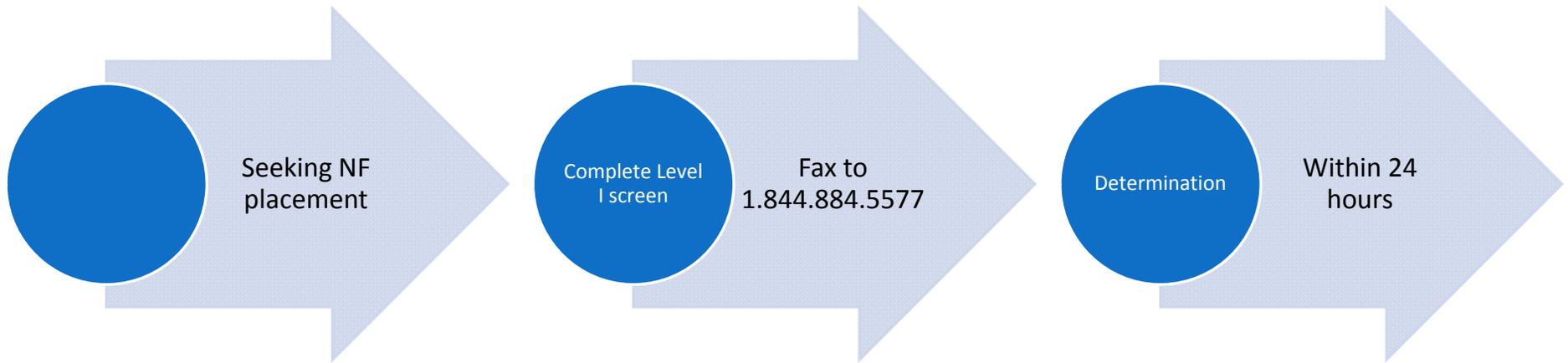
PASRR Introduction

- Goold has been completing PASRR assessments since April 2014
- Dedicated PASRR team
- Average statistics
 - 60 Level I Screens processed daily
 - 3 Level IIs triggered daily over past month
 - 4 Level II assessments completed per week
 - 9 90-day reviews completed per week

PASRR

- Applies to all persons seeking admission to a Nursing Facility (NF)
- Level I screens
- Level II assessments
- 90 Day review





Seeking NF
placement

Complete Level
I screen

Fax to
1.844.884.5577

Determination

Within 24
hours

PASRR Assessment Timelines

- Daily Level I submission deadline
 - 3:00 p.m., Monday-Friday
 - 24 hours to issue determination
- PASRR Level II
 - 7-9 business days
- 30-Day review
- 90-Day assessment



PASRR Referral Forms

- Level I screen- fillable form
 - Link available on assessmaine.com

- Level I user guide
 - Link available on assessmaine.com

PASRR I Screen

PASRR LEVEL I SCREEN

DETERMINATION FOR MENTAL ILLNESS, INTELLECTUAL DISABILITY,
AND OTHER RELATED CONDITIONS



IF YOU NEED ASSISTANCE WITH COMPLETING THIS FORM OR HAVE GENERAL QUESTIONS ABOUT PASRR, PLEASE CALL GOOLD HEALTH SYSTEMS AT 1-800-609-7893

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PLEASE SUBMIT ALL PAGES, INCLUDING THE SIGNED ATTESTATION ON PAGE 4.

1. SUBMITTING HOSPITAL/AGENCY INFORMATION	
HOSPITAL/AGENCY NAME	DATE
FAX NUMBER	PHONE NUMBER
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM	
2. CONSUMER INFORMATION	

DHHS Manual

- Persons authorized to screen
 - Hospital discharge planners
 - Licensed social workers
 - Registered professional nurses
 - Psychologists
 - Physicians
 - Licensed NF staff
- The screen must be completed and signed by the same person

Level I
determination

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graph TD; A[Level I determination] --> B[Letter issued]; A --> C[30 Day waiver]; A --> D[+ Level II]
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Letter issued

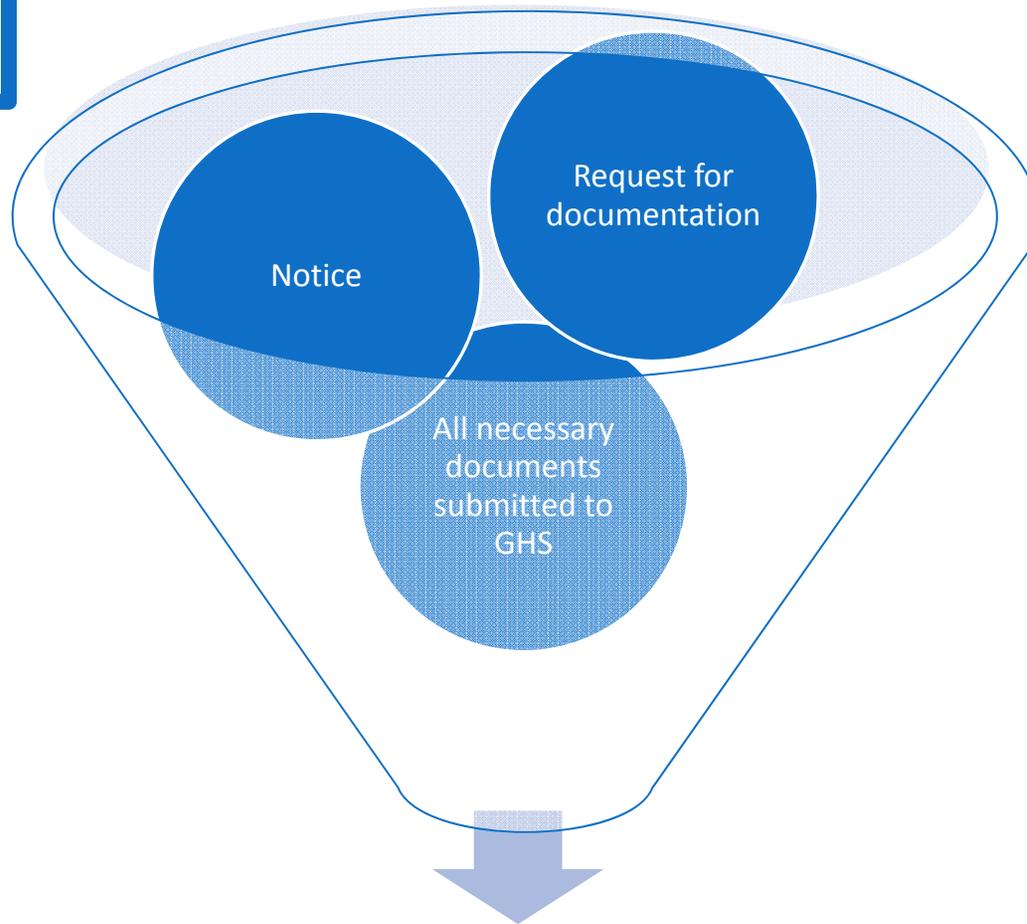
30 Day waiver

+ Level II

Level I
determination
letter issued

Level I determination		
Letter issued	Final Determination	30 Day Waiver issued
No determination made- no letter	Dementia Waiver	Dementia Waiver SNF stay \geq 30 days
No PASRR Criteria- Dementia only	Does not meet criteria	
No PASRR Criteria- Discharge to Swing Bed	Insufficient Documentation	
No PASRR Criteria-No MI, ID, or ORC diagnosis	Terminal Illness Waiver	

Level II
Assessment
is triggered



Level II can begin upon receipt
of all requested documents

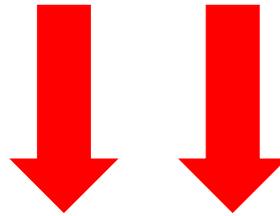
Request for documentation



All of the following chart documents are required to be faxed to GHS at 844.884.5577 BEFORE the assessment may proceed:

<input type="checkbox"/>	Signed Informed consent with Guardianship/POA documentation
<input type="checkbox"/>	<p>A current comprehensive history and physical (H&P) examination, which includes the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Motor Functioning <input type="checkbox"/> Sensory functioning <input type="checkbox"/> Gait <input type="checkbox"/> Deep tendon reflexes <input type="checkbox"/> Cranial nerves <input type="checkbox"/> Abnormal reflexes <input type="checkbox"/> Additional evaluations conducted by appropriate specialists, in the case of abnormal findings which are the basis for a NF placement
<input type="checkbox"/>	<p>The Minimum Data Set (MDS) – If in a Nursing Facility (NF)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Section A (Including A1500, A1510, A1550 from the Annual MDS) <input type="checkbox"/> Section C <input type="checkbox"/> Section E <input type="checkbox"/> Section G <input type="checkbox"/> Section I <input type="checkbox"/> Section N
<input type="checkbox"/>	<p>A current comprehensive psychiatric evaluation, which includes the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Psychiatric history <input type="checkbox"/> Evaluation of intellectual functioning <input type="checkbox"/> Memory functioning <input type="checkbox"/> Orientation <input type="checkbox"/> Description of current attitudes and overt behaviors <input type="checkbox"/> Affect and mood <input type="checkbox"/> Suicidal and/or homicidal ideation <input type="checkbox"/> Paranoia and degree of reality testing, presence and content of delusions, and hallucinations
<input type="checkbox"/>	Medication Administration Records (MAR's)
<input type="checkbox"/>	Treatment Administration Records (TAR's)
<input type="checkbox"/>	Flowsheets for Activities of Daily Living (ADL's). An accurate functional assessment is extremely important in determining a consumer's appropriate placement.
<input type="checkbox"/>	Intellectual Disability (ID) testing; IQ & Adaptive testing (For consumers with ID only)

Request for documentation



All of the following chart documents must be prepared and present at the time of the assessment:

<input type="checkbox"/>	Hospital admission/ER history from any medical hospitalization within the last year
<input type="checkbox"/>	Crisis Unit admit/discharge summary from the past year
<input type="checkbox"/>	Medication changes in the past 6 months
<input type="checkbox"/>	Psychosocial Summary that includes the consumer's past and present living arrangements, describing successes and failures, and medical and support systems
<input type="checkbox"/>	Social History, including Social Service and Discharge Planning documentation including the consumer's past community successes and failures, description of previous community placements, and relevant discharge planning notes including current attempts at community placement
<input type="checkbox"/>	Initial psychiatric assessments
<input type="checkbox"/>	Psychiatric hospital admit/discharge summary from any stay within the last two years
<input type="checkbox"/>	Psychiatric progress notes
<input type="checkbox"/>	Behavioral Tracking
<input type="checkbox"/>	Mental Health Treatment Plan (ISP or PCP)
<input type="checkbox"/>	Consultation reports
<input type="checkbox"/>	Assistive Technology use
<input type="checkbox"/>	Recent ACT notes if active with services, or discharge summary
<input type="checkbox"/>	Recent CIS notes if active with services, or discharge summary
<input type="checkbox"/>	Social Service notes that include a description of the consumer's specific needs relating to nursing home placement and their desire for nursing home admission, problematic symptoms and behaviors, and the ADL and IADL needs of the consumer

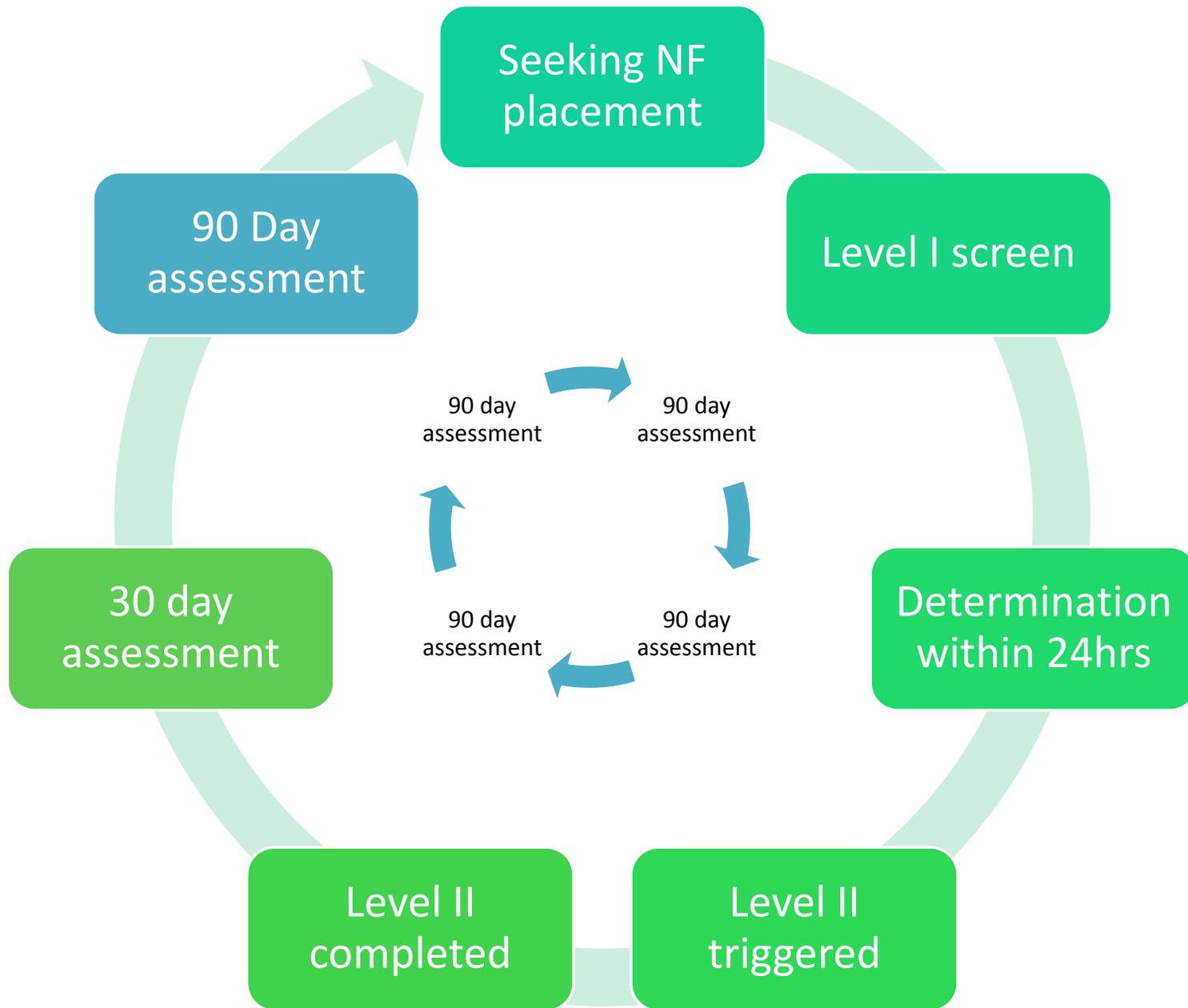
For PASRR Level II CIC Assessments please only send evaluations and records completed since the previous PASRR Level II Assessment.

PASRR Level II Process

- May involve a Level of Care Medical Eligibility Determination (MEDxx)
- Conducted onsite
- Face-to-face interview with consumer, guardian and any caregivers
- Review of medical records

Result

- The consumer cannot be admitted to a NF without a Level I screen and determination letter
- If the Level I determination triggers a Level II assessment, the Level II must be completed prior to admission to the NF
- The admitting NF must agree to meet the needs of the consumer
- Results will be provided 7-9 days from the date of receipt of the complete referral packet



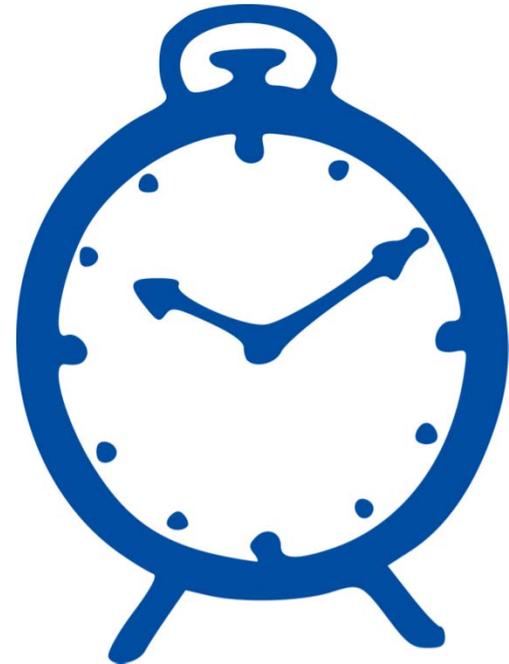
Acquired Brain Injury

Acquired Brain Injury

- An insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection
- Not degenerative or congenital
- Can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning
- Can result in the disturbance of behavioral or emotional functioning
- Can be either temporary or permanent
- Can cause partial or total functional disability or psychosocial maladjustment

ABI Assessment Timelines

- From date of complete referral
 - 5 days
- Daily referral deadline
 - 3:00 p.m.



Establishing Medical Eligibility

- ABI Checklist
- Medical Eligibility Determination
- Health & Safety
- Mayo Portland Adaptability Inventory
- Documentation from a qualified neuropsychologist and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation that the waiver services are medically necessary as described in Section 18.03-2(C)

ABI Checklist

ACQUIRED BRAIN INJURY (ABI)
 NEUROPSYCHOLOGIST/PHYSIATRIST CHECKLIST
 FOR NURSING FACILITY ACQUIRED BRAIN INJURY SERVICES



IF YOU NEED ASSISTANCE, PLEASE CALL GOULD HEALTH SYSTEMS AT 1-800-609-7893.

FAX THIS FORM TO GOULD HEALTH SYSTEMS ALONG WITH THE SIGNED PLAN OF CARE, INCLUDING TYPES AND FREQUENCIES OF THERAPIES, EXPECTED OUTCOMES, AND TIMEFRAMES.

ALL SUBMITTED PAGES MUST INCLUDE THE INDIVIDUAL'S NAME AND A NEUROPSYCHOLOGIST/PHYSIATRIST SIGNATURE.

SUBMITTING FACILITY INFORMATION				
FACILITY NAME		CURRENT DATE	ADMISSION DATE	
FAX NUMBER		PHONE NUMBER		
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM				
CONSUMER INFORMATION				
LAST NAME	FIRST NAME	M.INT.	DATE OF BIRTH	MAINECARE NUMBER
ABI POLICY CHECKLIST				
In order for services to be covered under the ABI rate of reimbursement, the assessment as described in 67.02-5(B) must be completed and a rehabilitation plan of care based upon the findings of the assessment must be in place. An assessment conducted up to no more than three (3) months prior to admission will be accepted.				
1	THE INDIVIDUAL HAS A DIAGNOSIS OF ACQUIRED BRAIN INJURY			Y <input type="checkbox"/> N <input type="checkbox"/>
2	THE INDIVIDUAL HAS RECEIVED AN ASSESSMENT BY A QUALIFIED NEUROPSYCHOLOGIST AND/OR LICENSED PHYSICIAN WHO IS BOARD CERTIFIED, OR OTHERWISE BOARD ELIGIBLE IN PHYSICAL MEDICINE AND REHABILITATION. PLEASE ATTACH ASSESSMENT.			Y <input type="checkbox"/> N <input type="checkbox"/>
3	THE INDIVIDUAL IS NOT IN A PERSISTENT VEGETATIVE STATE			Y <input type="checkbox"/> N <input type="checkbox"/>
4	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL IS ABLE TO DEMONSTRATE POTENTIAL FOR:			
CHECK ALL THAT APPLY	Physical Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
	Behavioral Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
	Cognitive Rehabilitation			Y <input type="checkbox"/> N <input type="checkbox"/>
5	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL SHOWS EVIDENCE OF:			
CHECK ALL THAT APPLY	Moderate to Severe Behavioral Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
	Cognitive Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
	Functional Disability			Y <input type="checkbox"/> N <input type="checkbox"/>
6	THE ASSESSMENT AT LEAST RESULTS IN SPECIFIC REHABILITATION GOALS, BASED UPON THE FINDINGS OF THE ASSESSMENT, DESCRIBING TYPES AND FREQUENCIES OF THERAPIES AND EXPECTED OUTCOMES AND TIMEFRAMES. PLEASE ATTACH THERAPY EVALUATIONS & RECENT PROGRESS NOTES.			Y <input type="checkbox"/> N <input type="checkbox"/>
ATTESTATION				
NEUROPSYCHOLOGIST/PHYSIATRIST SIGNATURE (REQUIRED):				



MED Assessment

- The information provided by the MED tool will be used in determining the eligibility for the Acquired Brain Injury waiver and authorizing services
- Completed at the same time as the MPAI

Health & Safety

- Evaluates cognitive, physical, and behavioral needs related to a person's brain injury
- Assesses if the person needs cueing, direct support, or a behavioral support
- Scores range from 0-1.

Neuropsychiatric Evaluation

- An assessment completed by a qualified neuropsychologist and/or a licensed physician who is Board certified, or otherwise Board eligible in Physical Medicine and Rehabilitation

Mayo Portland Adaptability Inventory

- One component of the ABI assessment process
- Helps providers measure the progress of individuals with ABI
- Valuable in the development of appropriate treatment plans

Functional Domains

- Mobility
- Cognition
- Communication
- Health and Wellness
- Self Help Skills
- Household Management
- Community, Leisure, and Vocational Skills

Resources & Training

Resources

MaineCare Benefits Manual	https://www1.maine.gov/sos/cec/rules/10/ch101.htm
Office of Aging & Disability Services	https://www1.maine.gov/dhhs/oads/
Goold Health Systems	http://assessmaine.com
Aging & Disability Resource Center	http://www.adrcmaine.org/
211 Maine	http://211maine.org/

Training Opportunities

PASRR Webinars & In-service
Training Requests:

<http://assessmaine.com/contact>

assessmaine.com

Contact

Email sent via this web form is not secure and should not be used to communicate confidential Personal Health Information (PHI). This form should be used for general topics or questions only. Please be as specific as possible and include contact information so that our team may reach out to you to provide assistance.

Your Name *

Your Organization *

Your Phone Number *

Email *

Subject *

Message *

Submit

GHS Contacts

<u>CAPIntake@ghsinc.com</u>	Reaches the LTC Intake team; questions about referrals or referral process
<u>capscheduling@ghsinc.com</u>	Reaches the LTC Scheduling team; questions about assessments that have been scheduled
<u>PASRRAdmin@ghsinc.com</u>	Reaches the PASRR administrative team; questions about process, current referrals, and pending determinations
<u>Katie.Beckett@ghsinc.com</u>	Reaches the Katie Beckett administrative team; questions about process, paperwork or scheduling

Q & A