5101:3-3-15 **In-person assessments and level of care review process for medicaid covered long term care services.**

(A) The purpose of this rule is to set forth the in-person assessment process and level of care review process for individuals who are seeking medicaid payment for long term care services.

"Level of care review", as used in this rule, is a determination of an individual's physical, mental and social/emotional status to determine whether the individual requires either an intermediate level of care, or skilled level of care. The level of care (LOC) shall be determined as a result of an in-person assessment conducted by the Ohio department of ~~human services (ODHS)~~job and family services (ODJFS), or its designee, if an in-person assessment is required or requested prior to admission to a medicaid certified nursing facility, or by a paper review process for those individuals for whom an in-person assessment is not required or requested prior to admission to a medicaid certified nursing facility. Level of care review is conducted pursuant to paragraph 1902(a)(30(A) of the Social Security Act as amended and includes those activities necessary to safeguard against unnecessary utilization. "NF services" are those services available in facilities, or parts of facilities, certified as nursing facilities by the Ohio department of health (ODH). Individuals who are determined to require an intermediate LOC or skilled LOC may be appropriate for admission to a NF. The LOC process is also the mechanism by which vendor payment to a NF is initiated. Some individuals must also undergo preadmission screening (PAS) as outlined in rule ~~5101:3-3-151~~ 5101:3-3-15.1 of the Administrative Code.

The evaluation of an individual's LOC needs determines the facility type for which medicaid vendor payment can be made. An intermediate LOC or skilled LOC is necessary for NF admission. Except as provided for in paragraph (G) of this rule, medicaid vendor payment can be initiated to a NF only when the individual's LOC determination is intermediate LOC or skilled LOC. The term "skilled level of care", as used in this rule, has no relationship to the provision of either skilled nursing services under the rules governing private duty nursing set forth in Chapter 5101:3-8 of the Administrative Code, or skilled care as defined under the medicare program provisions of the Social Security Act as amended.

(B) Definitions:

(1) ~~"CDHS"~~"CDJFS" means county department of ~~human services~~job and family services.

(2) "Delayed in-person assessment" is an in-person assessment of an individual which delays the determination of whether home and community-based services are an appropriate alternative to a continued stay in a NF. Such an assessment is begun prior to NF admission, but is not completed until after

admission to the NF. Delayed in-person assessments must be completed within one hundred eighty days of the individual's first admission to a NF. The decision to delay the conclusion of the assessment is based on a partial assessment that may consist of only a paper review of a level of care request, or may be based on an incomplete in-person assessment.

(3) "ICF-MR" means intermediate care facility for the mentally retarded. An "ICF-MR" is a long term care facility certified to provide services to individuals with mental retardation or a related condition who require active treatment as defined at 42 CFR 483.440,dated October 1, 2007. In order to be eligible for vendor payment in an ICF-MR, an individual must be determined by ~~ODHS~~ODJFS, or its designee, to be in need of an ICF-MR/DD LOC as outlined in rule 5101:3-3-07 of the Administrative Code.

(4) "In-person assessment" means a process that includes a face-to-face assessment with the individual performed by staff of ~~ODHS~~ODJFS, or its designee, who are registered nurses or licensed social workers with prior education, experience or training in the field of geriatric long term care as approved by ~~ODHS~~ODJFS or its designee prior to providing services, who meet the requirements of paragraph (d) of 42 CFR 432.50, dated October 1, 2007 and who are certified by ~~ODHS~~ODJFS or its designee. The purpose of the in-person assessment is to review and discuss directly with the individual and, to the extent possible, with the individual's informal care givers and/or representative, the individual's care needs and preferences, and to access information necessary to complete a level of care determination.

(5) "ILOC" means intermediate level of care. An "ILOC" is a determination by ~~ODHS~~ODJFS or its designee that an individual's care needs meet the criteria specified in rule 5101:3-3-06 of the Administrative Code.

(6) "Individual" means a medicaid recipient or person with pending medicaid eligibility who is making application to a NF or ICF-MR; or is applying for home and community-based services (HCBS) waiver enrollment; or is applying for ~~optional state supplement (OSS)~~ residential state supplement program (RSS) funded placement; or is seeking long term care services (as defined in paragraph (B)(8) of this rule) but has not yet made application for a particular type of service or service setting.

(7) "LTCF" means a medicaid certified long term care facility as defined in rule ~~5101:3-1-49~~5101:3-3-01 of the Administrative Code.

(8) "Long term care services" are those medicaid funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative,

and/or personal care services which may be provided to eligible individuals.

(9) "Nursing facility (NF)" means any long term care facility (excluding ICFs-MR), or part of a facility, currently certified by the ~~Ohio department of health~~ODH as being in compliance with the nursing facility standards and medicaid conditions of participation. Any reference to "NF-LOC" means an ILOC or SLOC.

(10) "PAS" means preadmission screening and refers to that part of the preadmission screening and ~~annual~~ resident review ~~(PASARR)~~(PASRR) process mandated by section 1919(e)(7) of the Social Security Act, as amended, which must be met prior to any new admission to a NF (as defined in rule ~~5101:3-3-151~~5101:3-3-15.1 of the Administrative Code). PAS includes determinations regarding whether individuals who have serious mental illness (SMI) and/or MR/DD require the level of services provided by a NF. Those determinations must be based on the same LOC criteria as are set forth in Chapter 5101:3-3 of the Administrative Code. However, the PAS process is distinct from the LOC review process.

(11) "Physician" means a doctor of medicine or osteopathy who is licensed to practice medicine.

(12) "Primary diagnosis" has the same meaning as in rule ~~5101:3-3-151~~5101:3-3-15.1 of the Administrative Code.

(13) "Psychologist" means a degreed psychologist who has been licensed by the Ohio board of psychology to practice psychology in the state of Ohio.

(14) "RSS" means the residential state supplement program as defined in rule 173-35-01 of the Administrative Code.

~~(14)~~(15) "SLOC" means skilled level of care. A "SLOC" is a determination by ~~ODHS~~ODJFS or its designee that an individual's care needs meet the criteria set forth in rule 5101:3-3-05 of the Administrative Code.

~~(15)~~(16) "Representative" means a person acting on behalf of an individual who is applying for or receiving medical assistance. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on the individual's behalf.

(C) Paragraphs (C)(1) to (C)(5) of this rule specify those individuals who are exempt from participation and those who are required to participate in the in-person assessment process conducted by ~~ODHS~~ODJFS or its designee. ~~ODHS~~ODJFS or

its designee shall base its determination regarding the need to conduct an in-person assessment on information contained on the individual's ~~ODHS 3697~~JFS 03697 "level of care assessment" (Rev.4/03), or other authorized form, as specified in paragraph (H) of this rule.

(1) For individuals who are residing in an acute care hospital and are seeking admission or readmission to a medicaid certified nursing facility bed:

(a) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are exempt from the in-person assessment requirement in the hospital prior to admission to a NF, and are exempt from a delayed in-person assessment later in the NF, unless the paper review indicates that a NF LOC would be denied. In the case of a probable denial, the provisions set forth in paragraph (H)(5) of this rule apply and the in-person assessment is required.

(i) Individuals with care needs that clearly exceed the combination of services available to the individual from home and community-based service waivers and available informal care givers (as defined in ~~Chapters~~ Chapter 5101:3-31 ~~and 5101:3-39~~ of the Administrative Code), and who have no rehabilitation potential and a poor prognosis based upon the medical judgement of the individual's physician.

(ii) Individuals who resided in a NF for one hundred eighty days or more prior to the hospital admission and are either seeking readmission to the same NF following a hospitalization during which the individual exhausted all available paid leave days (see rule ~~5101:3-3-59~~5101:3-3-16.4 of the Administrative Code for an explanation of paid leave days); or are transferring from one NF to another following an intervening hospital stay regardless of whether all available paid leave days have been exhausted (see rule ~~5101:3-3-59~~5101:3-3-16.4 of the Administrative Code for an explanation of paid leave days).

(iii) Individuals who have a contractual or statutory right to have their care provided indefinitely by a NF that provides continuing care as defined in Section 173.13 of the Revised Code, or a home for the aged as defined in Section 5701.13 of the Revised Code.

(b) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are not required to participate in an in-person assessment in the hospital prior to admission to a NF, but the

requirement for the assessment is delayed until the person has resided in the NF for a period not to exceed one hundred eighty days from the date of the individual's first NF admission. A LOC determination shall be made prior to the NF admission regardless of whether the in-person assessment has been completed or delayed.

(i) Individuals who are new NF applicants who have prognoses for improvement and rehabilitation potential of fair or better, based upon the medical judgement of the individual's physician.

(ii) Individuals who are new NF applicants who have a discharge plan of NF stay of one hundred eighty days or less.

(iii) Individuals who are previous NF residents who did not participate in an in-person assessment prior to or during their NF stay, who are returning to a NF in which they resided for less than one hundred eighty days immediately preceding the hospitalization, and who have a discharge plan for a NF stay of one hundred eighty days or less.

(iv) Individuals who are not covered by paragraphs (C)(1)(a) to (C)(1)(b)(iii) of this rule, and those for whom the department or its designee cannot complete the assessment prior to admission to a NF in accordance with the applicable schedule specified in paragraph (D)(1) of this rule.

(c) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are required to participate in an in-person assessment in the hospital, prior to the NF admission. A LOC determination shall be made prior to the NF admission.

(i) Individuals who are not determined to be in any of the categories contained in ~~paragraphs~~ paragraph (C)(1)(a) or (C)(1)(b) of this rule.

(ii) Individuals for whom ~~ODHS~~ ODJFS or its designee has determined, based on a review of the ~~ODHS 3697~~JFS 03697 or other authorized form, that the individual appears not to be eligible for an intermediate LOC (defined in rule 5101:3-3-06 of the Administrative Code) or a skilled LOC (defined in rule 5101:3-3-05 of the Administrative Code).

(iii) Individuals for whom the information needed by ~~ODHS~~ODJFS or its designee to make a LOC determination is inconsistent or incomplete.

(iv) Individuals who have requested, or their authorized representative has requested, an in-person assessment.

(2) For individuals who are current NF residents, not currently authorized for vendor payment, and who are seeking medicaid vendor payment of their NF stay:

(a) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are exempt from an initial in-person assessment, and exempt from a later delayed assessment, unless the review of the ~~ODHS 3697~~JFS 03697, or MDS+ and doctors orders, indicates that a NF LOC would be denied. In the case of a probable denial, the provisions set forth in paragraph (H)(5) of this rule apply and the in-person assessment is required.

(i) Individuals who have been in the NF for one hundred eighty days or longer.

(ii) Individuals with care needs that clearly exceed the combination of services available to individuals from home and community-based service waivers and available informal care givers (as defined in ~~Chapters~~ Chapter 5101:3-31 ~~and 5101:3-39~~ of the Administrative Code), and have no rehabilitation potential and a poor prognosis, based upon the medical judgement of the individual's physician.

(iii) Individuals who have a contractual or statutory right to have their care provided indefinitely by a NF that provides continuing care as defined in Section 173.13 of the Revised Code, or a home for the aged as defined in Section 5701.13 of the Revised Code.

(b) Individuals determined by ~~ODHS~~ODJFS or its designee to have been in the NF for less than one hundred eighty days and have prognoses for improvement with rehabilitation potentials of fair or better, based upon the medical judgement of the individual's physician, are not required to participate in an in-person assessment prior to LOC determination. In such cases, the requirement for the assessment is delayed until the person has resided in the NF for a period not to exceed one hundred

eighty days from the date of the individual's first NF admission.

(c) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are required to participate in an in-person assessment in the NF prior to the LOC determination.

(i) Individuals who are not determined to be in any of the categories of paragraph (C)(2)(a) or (C)(2)(b) of this rule.

(ii) Individuals for whom ~~ODHS~~ODJFS or its designee has determined, based on a review of the ~~ODHS 3697~~JFS 03697, that the individual appears not to be eligible for an intermediate LOC (as defined in rule 5101:3-3-06 of the Administrative Code) or a skilled LOC (as defined in rule 5101:3-3-05 of the Administrative Code).

(iii) Individuals for whom the information needed by ~~ODHS~~ODJFS or its designee to make a LOC determination is inconsistent or incomplete.

(iv) Individuals who have requested, or their authorized representative has requested, an in-person assessment.

(3) For individuals who are current NF residents who are currently authorized for vendor payment of their NF stay and are transferring to another NF without an intervening hospital stay:

(a) Individuals determined by ~~ODHS~~ODJFS or its designee to be in any of the following categories are exempt from an initial in-person assessment, and exempt from a later delayed assessment, unless the review of the ~~ODHS 3697~~JFS 03697 or MDS+ and doctor's orders indicates that a NF LOC would be denied. In the case of a probable denial, the provisions set forth in paragraph (H)(5) apply and the in-person assessment is required.

(i) Individuals who have resided in a NF for one hundred eighty days or more prior to the date of transfer.

(ii) Individuals who have resided in a NF for less than one hundred eighty days but have already participated in an in-person assessment.

(iii) Individuals with care needs that clearly exceed the combination of services available to individuals from home and community-based service waivers and available informal care givers (as defined in ~~Chapters~~ Chapter 5101:3-31 ~~and 5101:3-39~~ of the Administrative Code), and have no rehabilitation potential and a poor prognosis, based upon the medical judgement of the individual's physician.

(b) Individuals determine by ~~ODHS~~ ODJFS or its designee to have resided in a NF for less than one hundred eighty days who have not participated in an in-person assessment prior to or during the current NF stay, and who have prognoses for improvement with rehabilitation potentials of fair or better, based upon the medical judgement of the individual's physician, are not required to participate in an in-person assessment prior to LOC determination. The requirement for the in-person assessment may be delayed until the individual has accrued a total combined NF residency period not to exceed one hundred eighty days from the date of the first NF admission.

(c) Individuals determined by ~~ODHS~~ODJFS or its designee to have resided in a NF for less than one hundred eighty days who have not participated in an in-person assessment prior to or during the current NF stay, and who do not meet the criteria set forth in ~~paragraphs~~paragraph (C)(3)(a) or (C)(3)(b) are required to participate in an in-person assessment conducted by ODHS or its designee prior to the LOC determination.

(4) Individuals who have a contractual or statutory right to have their care provided indefinitely by a NF that provides continuing care as defined in Section 173.13 of the Revised Code, or a home for the aged as defined in Section 5701.13 of the Revised Code, are exempt from the in-person assessment requirement prior to admission to the NF portion of the ~~CCRC~~continuing care retirement community (CCRC) or home for the aged, and are exempt from a delayed in-person assessment, unless the paper review indicates that a NF LOC would be denied. In the case of a probable denial, the provisions set forth in paragraph (H)(5) of this rule apply and the in-person assessment is required.

(5) All individuals who are residing in settings other than those specified in paragraphs (C)(1) to (C)(4) of this rule, who are seeking admission to a medicaid certified nursing facility, shall be required to participate in an in-person assessment conducted by ~~ODHS~~ODJFS or its designee prior to admission to the NF. ~~ODHS~~ODJFS or its designee shall determine whether the individual is eligible for an intermediate LOC or skilled LOC (as defined

in rules 5101:3-3-05 and 5101:3-3-06 of the Administrative Code). If the in-person assessment cannot be completed prior to the NF admission, a delayed in-person assessment shall be conducted in the NF within one hundred eighty days of admission. A LOC determination shall be made prior to the NF admission regardless of whether the in-person assessment has been completed or a delayed in-person assessment must be completed.

(D) ~~ODHS~~ODJFS, or its designee, shall perform an in-person assessment, determine that the assessment should be delayed, or determine that the assessment is not required according to the following schedule:

(1) For hospitalized individuals, not later than one of the following:

(a) One working day after the individual or the individual's representative submits either an oral or written request to ~~ODHS~~ODJFS or its designee for an assessment and/or level of care determination.

(b) A later date requested by the individual or the individual's representative.

(2) In the case of an emergency, not later than one calendar day after the individual or the individual's representative submits either an oral or written request to ~~ODHS~~ODJFS or its designee for an assessment and/or LOC determination. An individual with an emergency need shall be determined by ~~ODHS~~ODJFS or its designee and shall include, but not be limited to, any individual identified by a ~~CDHS~~CDJFS adult protective services worker, and any individual in a hospital emergency room who is likely to require NF admission.

(3) In all other cases, not later than one of the following:

(a) Five calendar days after the individual or the individual's representative submits either an oral or written request to ~~ODHS~~ODJFS or its designee for an assessment and/or LOC determination.

(b) A later date requested by the individual or the individual's representative.

(E) At the conclusion of every in-person assessment and at a time not later than the time the assessment is required to be performed according to paragraph (D) of this rule, the department or its designee shall provide the individual written notice of the determination, in accordance with Chapter 5101:6-2 of the Administrative Code. Notice shall also be provided to the individual's representative, if any. If an in-person assessment was required for any reason other than to comply with the

provisions of paragraph (H)(5) of this rule and it is the conclusion of the assessors, based on the program eligibility criteria set forth in rules 5101:3-1-01, ~~5101:1-17-16~~5101:1-17-02, and ~~Chapters~~ Chapter 5101:3-31 ~~and 5101:3-39~~ of the Administrative Code as well as on service availability, that home and community-based services are a viable option for the individual, ~~ODHS~~ODJFS or its designee shall develop a plan, in consultation with the individual and the individual's representative, to allow the individual and the individual's representative to make an informed decision from among the available home and community-based service alternatives. If the plan is accepted by the individual, ~~ODHS~~ODJFS or its designee shall implement the plan not later than one working day after the plan is agreed to unless the individual's health and safety will not be jeopardized by, and the individual agrees to, a later implementation date.

(F) LOC review is required for all individuals who are:

(1) Seeking admission or readmission to a medicaid certified NF except for individuals seeking readmission to a medicaid certified NF who have not exhausted available paid leave days (see rule ~~5101:3-3-03~~5101:3-3-16.4 of the Administrative Code for requirements regarding available leave days).

(2) Currently residing in a NF and are now seeking medicaid vendor payment for their NF stays.

(3) Seeking enrollment for HCBS waivers other than the individual options waiver ~~or the OBRA waiver~~.

(G) Under the circumstances in paragraphs (G)(1), (G)(2), and (G)(3) of this rule, vendor payment shall be continued or reinstated when a change in institutional setting is sought.

(1) Individuals who are current NF residents receiving medicaid vendor payment who wish to transfer to another NF must submit a completed ~~ODHS 3697~~JFS 03697 form or, if transferring without an intervening inpatient hospital stay, the most recent MDS+ completed for the individual by the sending NF and physician's orders for the individual's care at the time of admission to the receiving NF, not later than the day of transfer to the new NF, as specified in paragraphs (H)(1) and (H)(2) of this rule, to initiate payment to the new NF effective from the date of admission. For those individuals who are long term residents, as defined in rule ~~5101:3-3-15~~5101:3-3-15.1 of the Administrative Code, and who have chosen to remain in a NF and receive specialized services in the NF, a copy of the ~~PASARR~~PASRR determination and documentation related to the individual's choice to remain in the NF setting must accompany the request for a level of care review.

(a) Under this circumstance, vendor payment to the new NF will be authorized back to the date of the individual's admission to the facility. ~~ODHS~~ODJFS, or its designee, shall notify the appropriate ~~CDHS~~CDJFS to begin vendor payment. Those individuals who are verified as long term residents in accordance with paragraph (G)(1) of this rule shall receive authorization for vendor payment regardless of the level of care determination. For all other individuals in this circumstance, if ~~ODHS~~ODJFS or its designee determines that the individual is no longer in need of a NF LOC, it will notify, not later than the date the determination is made, the individual, the individual's authorized representative, if any, and the NF of the adverse LOC determination and ~~ODHS's~~ODJFS's intent to terminate vendor payment. The notice shall set forth the individual's hearing rights and the time frames within which they must be exercised. ~~ODHS~~ODJFS, or its designee, may instruct the appropriate ~~CDHS~~CDJFS, as its designee, to issue this notice.

(b) If a hearing request is received in response to the notice specified in paragraph (G)(1)(a) of this rule within time frames specified in rule 5101:6-2-04 of the Administrative Code, authorization for payment will be continued, in accordance with rule 5101:6-4-01 of the Administrative Code, pending the issuance of a state hearing decision.

(c) If the individual does not submit a hearing request within the time frame specified in paragraph (G)(1)(b) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the individual of ~~ODHS's~~ODJFS's intent to terminate vendor payment.

(2) Hospitalized individuals who are current NF residents and are seeking admission to a different NF must meet the requirements in paragraphs (G)(1) to (G)(1)(c) of this rule in order to have vendor payment authorized from the date of admission. These requirements must be met regardless of whether they have exhausted paid leave days.

(3) Hospitalized individuals who are seeking readmission to the same NF after the exhaustion of paid leave days may be readmitted to that NF regardless of the results of the LOC determination if, not later than the date of readmission, the individual submits a completed ~~ODHS 3697~~JFS 03697 form to initiate vendor payment effective from the date of readmission. If the LOC determination is not ILOC or SLOC the procedures set forth in paragraphs (G)(1)(a) to (G)(1)(c) of this rule shall apply.

(H) In order to obtain an in-person assessment and/or LOC determination, the individual

or the individual's representative must submit either an oral or written request to ~~ODHS~~ODJFS or its designee. If the request for assessment and/or LOC determination is submitted in writing, it must be submitted on an ~~ODHS 3697~~JFS 03697, or an alternative form specified by ~~ODHS~~ODJFS, which has been appropriately completed, accurately reflects the individual's current mental and physical condition, and is certified by a physician. If the request is submitted orally, ~~ODHS~~ODJFS, or its designee, shall complete the ~~ODHS 3697~~JFS 03697 and seek to obtain the certification of the ~~ODHS 3697~~JFS 03697 by the physician identified by the individual for that purpose.

(1) The ~~ODHS 3697~~JFS 03697, or the ~~ODHS~~ODJFS-authorized alternative form, must to the maximum extent possible be based on information from the MDS+, and must include the following components and/or attachments:

(a) The individual's legal name; medicaid number; date of original admission to the facility, if applicable; current address; name and address of residence if current residence is a licensed or certified residential setting or hospital; and county where the individual's medicaid case is active.

(b) All of the individual's current diagnoses with the primary diagnosis specified (if so specified by the individual's physician), including medical, psychiatric and developmental diagnoses and, if available, the dates of onset.

(c) All medications, treatments, and professional medical services required.

(d) A statement regarding the individual's functional status, including an assessment of current status in self care, mobility, self-administration of medication, capacity for independent living, learning, self-direction and communication skills.

(e) An assessment of the individual's current mental/behavioral status.

(f) Type of service setting for which the LOC determination is sought (NF, ~~OSS~~RSS, HCBS waiver).

(g) A statement signed and dated by a physician certifying that all information provided about the individual is a true and accurate reflection of the individual's condition.

(h) A physician certification of the individual's need for a specific level of inpatient care shall occur on or no more than fifteen days before the day

of admission. For an individual who applies for medicaid benefits while in the NF, physician certification must occur prior to the authorization of payments. The following conditions shall be met to consider the certification valid:

(i) The certification must be in writing;

(ii) The certification must be signed and dated at the same time by a physician. A rubber stamp is not acceptable. A faxed or photocopied copy of an original document containing the original signature of the physician is an acceptable submission for LOC review purposes.

(iii) The certification documentation shall be maintained in the resident's medical record in the facility where care is being provided.

(i) If the individual is required to undergo PAS, a copy of the ~~ODHS 3622~~JFS 03622 form and, where applicable in accordance with rule ~~5101:3-3-151~~5101:3-3-15.1 of the Administrative Code, the notices of all results and copies of all assessment forms, if available, must be included as attachments to the ~~ODHS 3697~~JFS 03697.

(j) For individuals who are seeking an exemption from an in-person assessment, or seeking a delayed in-person assessment, the documentation required by ~~ODHS~~ODJFS or its designee to make that determination as specified in paragraph (C) of this rule.

(2) The ~~ODHS 3697~~JFS 03697, or alternative form authorized by ~~ODHS~~ODJFS, must be sufficiently complete for a LOC determination to be made.

(a) If the individual is applying from a hospital or a nursing facility, the individual or individual's representative may submit either a verbal or written request for a LOC determination. The submission of a written request does not exempt the individual from an in-person assessment if it is required by paragraph (C) of this rule. If the individual is applying from any location other than a hospital or nursing facility, the individual or individual's representative may submit only a verbal request for a LOC determination.

(b) If a verbal request for a LOC determination is received by ~~ODHS~~ODJFS or its designee, the completion of the ~~ODHS 3697~~JFS 03697 shall be

incorporated into the in-person assessment process conducted by ~~ODHS~~ODJFS or its designee. If an in-person assessment is required or requested, ~~ODHS~~ODJFS or its designee shall make every reasonable effort to obtain all necessary information including the physician's certification. Any individual who submits a written LOC request must insure that all required components are included before submission.

(c) If ~~ODHS~~ODJFS or its designee attempts to complete the ~~ODHS 3697~~JFS 03697 but is unable to obtain all of the necessary information, or if an individual submits an incomplete ~~ODHS 3697~~JFS 03697, ~~ODHS~~ODJFS or its designee shall notify in writing the individual, the contact person indicated on the ~~ODHS 3697~~JFS 03697, the individual's representative, and the NF or other entity responsible for the submission of that LOC request, that additional documentation is necessary in order to complete the LOC review. This notice shall specify the additional documentation that is needed and shall indicate that the individual or another entity has twenty days from the date ~~ODHS~~ODJFS or its designee mails the notice to submit additional documentation or the ~~ODHS 3697~~JFS 03697 will be denied for incompleteness with no LOC authorized. In the event an individual or other entity is not able to complete an ~~ODHS 3697~~JFS 03697 in the time specified, ~~ODHS~~ODJFS or its designee shall, upon good cause, grant one extension of no more than five working days when an extension is requested by the individual or other entity.

(d) If within the periods specified in paragraph (H)(2)(c) of this rule, the individual or the individual's representative submits the required documentation, ~~ODHS~~ODJFS or its designee shall issue a LOC determination within the timelines specified in paragraph (H)(3) of this rule. A LOC determination will be issued pursuant to the criteria specified in rules 5101:3-3-05, 5101:3-3-06, 5101:3-3-07 and 5101:3-3-08 of the Administrative Code.

(3) The department or its designee shall not exceed the following schedule in issuing LOC determinations on behalf of individuals who are seeking admission or readmission to a medicaid certified NF:

(a) In the case of an individual applying from a hospital, one working day from the date the ~~ODHS 3697~~JFS 03697 is determined to be complete.

(b) In the case of an emergency, one calendar day from the date the ~~ODHS 3697~~JFS 03697 is determined to be complete. An individual shall be determined by ~~ODHS~~ODJFS or its designee to have an emergency need and shall include, but not be limited to, any individual identified by a

~~CDHS~~CDJFS adult protective services worker, and any individual in a hospital emergency room who likely requires NF admission.

(c) In all other cases not later than five calendar days from the date the ~~ODHS 3697~~JFS 03697 is determined to be complete.

(4) Requests for LOC determinations shall be evaluated by personnel authorized by ~~ODHS~~ODJFS whose qualifications shall include licensure as a registered nurse or social worker.

(5) A request for a NF LOC shall not be denied by ~~ODHS~~ODJFS or its designee for the reason that the individual does not need NF services until a qualified medical professional whose qualifications include being a registered nurse conducts a face-to-face assessment of the individual, reviews the medical records that accurately reflect the individual's condition for the time period for which payment is being requested; makes a reasonable effort to contact the individual's physician; and investigates and documents alternative community resources including resources available in the home and family which may be available to meet the needs of the individual. Authorized personnel other than the person who conducted the assessment shall review the assessment and make the final LOC decision.

(I) The LOC authorization process

(1) For all individuals listed in paragraph (C) of this rule who are also required to undergo PAS, the entire PAS process must be completed in accordance with rule ~~5101:3-3-15~~5101:3-3-15.1 of the Administrative Code prior to the performance of the LOC review.

(2) For all individuals who are residents of medicaid certified NFs and wish to transfer from those NFs to hospitals or to other NFs, the transferring NFs are responsible for ensuring that copies of the individual's most recent ~~PASARR~~PASRR evaluations, determinations and related documentation accompany the transferring individual.

(3) Copies of all ~~PASARR~~PASRR forms, evaluations and determinations pertaining to the individual, as well as the LOC determination, must be retained in the individual's medical record at the NF.

(4) ~~ODHS~~ ODJFS or its designee shall complete the payment authorization (~~ODHS 3670~~ JFS 09400) and shall send it, along with the ~~ODHS 3697~~JFS 03697, to the ~~CDHS~~CDJFS designated on the ~~ODHS 3697~~JFS 03697. The

CDJFS shall send a copy of the ~~ODHS 3697~~JFS 03697 and ~~ODHS 3670~~ JFS 09400 to the NF.

(5) Authorization of payment to a NF shall correspond with the effective date of the LOC determination specified on the ~~ODHS 3670~~JFS 09400. This date shall be:

(a) The date of admission to the NF if it is within thirty days of the physician's signature; or

(b) A date other than that specified in paragraph (I)(5)(a) of this rule. This alternative date may be authorized only upon receipt of a letter which contains a credible explanation for the delay from the originator of the LOC request. If the request is to backdate the LOC more than thirty days from the physician's signature, the physician must verify the continuing accuracy of the information and need for inpatient care either by adding a statement to that effect on the ~~ODHS 3697~~JFS 03697 or by attaching a separate letter of explanation; or

(c) If the individual was required to undergo PAS and failed to do so prior to admission, the effective date of the LOC determination shall be the later of the date of the PAS determination that the individual required the level of services available in a NF, or the date established in paragraph (I)(5)(b) of this rule.

Effective:

R.C. 119.032 review dates: 04/07/2008

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.204, 5111.205
Prior Effective Dates:	4/7/77, 10/14/77, 7/1/80, 8/1/84, 1/17/92 (Emer.), 4/16/92, 10/1/93 (Emer.), 12/31/93