5160-3-10 **Child assessment and determination process for nursing facility-based level of care programs.**

(A) This rule describes the processes and timeframes for a child's level of care assessment and determination for a nursing facility-based level of care program.

(1) The processes described in this rule shall not be used for a determination of a developmental disabilities level of care.

(2) A level of care determination may occur face-to-face or by a desk review, as prescribed in paragraphs (C) through (E) of this rule, and is one component of medicaid eligibility in order to:

(a) Authorize medicaid payment to a nursing facility; or

(b) Approve medicaid payment of a nursing facility-based home and community-based services (HCBS) waiver or other nursing facility-based level of care program.

(B) Level of care assessment for a child seeking medicaid payment to a nursing facility.

(1) A child who is seeking a nursing facility admission is subject to a preadmission screening (PAS) process using the Ohio Department of Medicaid (ODM) 03622, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 8/2014) or via the ODM approved electronic system, as described in rules 5160-3-15, 5160-3-15.1, 5122-21-03, and 5123:2-14-01 of the Administrative Code, and a level of care assessment.

(a) The preadmission screening process must be completed before a level of care determination or a level of care validation can be issued.

(b) In order for ODM to authorize payment to a nursing facility, the child must have received a non-adverse PAS determination and subsequent nursing facility-based level of care determination.

(i) ODM may authorize payment to the nursing facility effective on the date of the PAS determination.

(ii) The level of care effective date cannot precede the date that the PAS requirements were met.

(iii) If a nursing facility receives medicaid payment from ODM for a child who does not have a nursing facility-based level of care, the nursing facility is subject to the claim adjustment for overpayment process described in rule 5160-1-19 of the Administrative Code.

(c) ODM or its designee (hereafter referred to as ODM) shall validate

completion of the PAS and that all preadmission screening and resident review (PASRR) requirements were met.

(2) In order to make a level of care determination, ODM must receive a complete level of care request. A level of care request is considered complete when all necessary data elements are completed by a qualified assessor using one of the following assessment tools and any necessary supporting documentation is submitted.

(a) Linking Ohioans to independence, services and supports (LOTISS);

(b) ODM 10128 "Child Level of Care Questionnaire" (7/2015).

(3) Supporting documentation to be submitted when a child is requesting medicaid payment to a nursing facility may include, but is not limited to:

(a) Minimum data set (MDS) details;

(b) Discharge summary;

(c) Medical history and physical; and

(d) Any preadmission screening results and assessment forms.

(C) Desk review level of care determination.

(1) A desk review level of care determination is required within one business day from the date of receipt of the most current version of the ODM 10128 when ODM determines that the child is seeking admission or re-admission to a nursing facility from an acute care hospital or hospital emergency room.

(2) A desk review level of care determination is required within five calendar days from the date of receipt of a level of care assessment when:

(a) ODM determines that a child who resides in a nursing facility is requesting to change from a non-medicaid payor to medicaid payment for the child's continued stay.

(b) ODM determines that a child who resides in a nursing facility is requesting to change from medicaid managed care to medicaid fee-for-service as payment for the child's continued stay.

(c) ODM determines that a child is transferring from one nursing facility to another nursing facility.

(D) A face-to-face level of care assessment is required within ten calendar days from the date of the request for a level of care assessment when:

(1) A child or the authorized representative of a child requests a face-to-face level of care assessment.

(2) A child resides in the community and ODM verifies that the child does not have a current nursing facility-based level of care.

(3) An adverse level of care determination is issued upon completion of a desk review level of care assessment. In this instance the face-to-face level of care assessment must be completed by a registered nurse (RN).

(4) ODM determines that the information needed to make a level of care determination through a desk review is inconsistent.

(5) A level of care validation is necessary and ODM determines the child has a pending disenrollment from an HCBS waiver due to the child no longer having a nursing facility-based level of care.

(E) Delayed face-to-face visit.

(1) A delayed face-to-face visit is required within ninety calendar days after ODM conducts a desk review level of care determination for a child.

(2) The following are exceptions to the delayed face-to-face visit:

(a) A child as described in paragraphs (C)(2)(b) and (C)(2)(c) of this rule.

(b) A child who declines a delayed face-to-face visit.

(c) A child who has had a long-term care consultation, in accordance with Chapter 173-43 of the Administrative Code, since the child's nursing facility admission.

(d) A child who has had an in-person resident review, in accordance with Chapter 5160-3 of the Administrative Code, since the child's nursing facility admission.

(e) A child who is receiving care under a medicaid care management system that utilizes a care management, case management, or care coordination model, including but not limited to case management services provided through an HCBS waiver.

(F) A level of care validation may be conducted in lieu of a face-to-face level of care determination within one business day from the date of a level of care request for:

(1) A child who is enrolled on a nursing facility-based HCBS waiver and is seeking admission to a nursing facility.

(2) A child who is a nursing facility resident and is seeking readmission to the same nursing facility after a hospitalization.

(G) In order to make a level of care determination for a child seeking medicaid HCBS waiver services, ODM must receive a complete level of care request. A level of care request is considered complete when all necessary data elements are completed by a qualified assessor during a face-to-face visit using one of the following assessments and any necessary supporting documentation is submitted.

(1) Linking Ohioans to independence, services and supports (LOTISS); or

(2) ODM 10126 "Child Comprehensive Assessment Tool (CCAT)" (7/2015).

(H) When a level of care assessment is submitted, upon completion of all required fields:

(1) ODM will issue a level of care determination.

(2) ODM shall notify the child, and/or his or her authorized representative, as applicable, of the level of care determination.

(3) In accordance with Chapter 5160:1-2 of the Administrative Code, the CDJFS shall determine medicaid eligibility and issue proper notice and hearing rights to the child.

(I) Adverse level of care determination.

(1) When a licensed social worker (LSW), or licensed independent social worker (LISW), performs any nursing facility-based level of care assessment resulting in an adverse level of care determination, a secondary assessment must be performed by an RN to verify the assessment outcome.

(2) When there is an adverse level of care determination, ODM shall inform the child, and the authorized representative, as applicable, about the child's hearing rights in accordance with division 5101:6 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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