

5160-3-14

Process and timeframes for a level of care determination for nursing facility-based level of care programs.

- (A) This rule describes the processes and timeframes for a level of care determination, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, for a nursing facility (NF)-based level of care program, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code.
- (1) The processes described in this rule ~~shall~~will not be used for a determination for an ICF-~~MRIID~~-based level of care, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code.
- (2) A level of care determination may occur face-to-face ~~or~~, by a desk review, or by telephone, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, and is one component of medicaid eligibility in order to:
- (a) Authorize medicaid payment to a NF; or
- (b) Approve medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program.
- (3) An individual who is seeking a NF admission is subject to both a preadmission screening and resident review (PASRR) process, as described in rules ~~5101:3-3-14~~5160-3-15, ~~5101:3-3-15.1~~5160-3-15.1, ~~5101:3-3-15.2~~5160-3-15.2, 5122-21-03, and ~~5123:2-14-01~~5123-14-01 of the Administrative Code, and a level of care determination process.
- (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 the Ohio department of ~~job and family services~~ (~~ODJFS~~)medicaid (ODM) to authorize payment to a NF, the individual must have received a non-adverse PASRR determination and subsequent NF-based level of care determination.
- (i) ~~ODJFS~~ODM may authorize payment to the NF effective on the date of the PASRR determination.
- (ii) The level of care effective date cannot precede the date that the PASRR requirements were met.
- (iii) If a NF receives medicaid payment from ~~ODJFS~~ODM or its designee for an individual who does not have a NF-based level of care, the NF is subject to the claim adjustment for overpayments process

described in rule ~~5101:3-1-19~~5160-1-19 of the Administrative Code.

(B) Level of care request.

- (1) In order for ~~ODJFS~~ODM or its designee (hereafter referred to as ~~ODJFS~~ODM) to make a level of care determination, ~~ODJFS~~ODM must receive a complete level of care request. A level of care request is considered complete when all necessary data elements are included and completed on the ~~JFS-03697~~ODM 03697, "Level of Care Assessment" (rev. ~~4/2003~~7/2014) or alternative form, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, and any necessary supporting documentation is submitted with the ~~JFS-03697~~ODM 03697 or alternative form, as described in paragraphs (B)(2) to (B)(4) of this rule.
- (2) Necessary data elements on the ~~JFS-03697~~ODM 03697 or alternative form:
 - (a) Individual's legal name;
 - (b) Individual's medicaid case number, or a pending medicaid case number;
 - (c) Date of original admission to the facility, if applicable;
 - (d) Individual's current address, including county of residence;
 - (e) Individual's current diagnoses;
 - (f) Date of onset for each diagnosis, if available;
 - (g) Individual's medications, treatments, and required medical services;
 - (h) A description of the individual's activities of daily living and instrumental activities of daily living;
 - (i) A description of the individual's current mental and behavioral status; and
 - (j) Type of service setting requested.
- (3) ~~Physician certification~~Certification on the ~~JFS-03697~~ODM 03697 or alternative form.
 - (a) A ~~physician~~ certification means a signature from a physician; as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, nurse practitioner as defined in Chapter 4723. of the Revised Code, or physician assistant as defined in Chapter 4730. of the Revised Code and date on the

~~JFS 03697~~ODM 03697 or alternative form. ODM will allow an electronic signature for the certification or standard certification via mail.

- (b) A ~~physician~~ certification must be obtained within thirty calendar days of submission of the ~~JFS 03697~~ODM 03697 or alternative form.
- (c) Exceptions to the ~~physician~~ certification:
 - (i) When an individual resides in the community and ~~ODJFS~~ODM determines that the individual's health and welfare is at risk and that it is not possible for the submitter of the ~~JFS~~ODM 03697 or alternative form to obtain a physician, nurse practitioner, or physician assistant signature and date at the time of the submission of the ~~JFS~~ODM 03697 or alternative form, a verbal ~~physician~~ certification is acceptable.
 - (ii) ~~ODJFS~~ODM must obtain a ~~physician~~ certification within thirty days of the verbal ~~physician~~ certification.
- (4) Necessary supporting documentation with the ~~JFS 03697~~ODM 03697 or alternative form when the individual is subject to a preadmission screening process:
 - (a) A copy of the ~~JFS~~ODM 03622, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. ~~11/2010~~8/2014) and ~~JFS~~ODM 07000, "Hospital Exemption from Preadmission Screening Notification" (rev. ~~11/2010~~7/2014), as applicable, in accordance with rules ~~5101:3-3-15.1~~5160-3-15.1 and ~~5101:3-3-15.2~~5160-3-15.2 of the Administrative Code; and
 - (b) Any preadmission screening results and assessment forms.
- (C) Process when ~~ODJFS~~ODM receives a complete level of care request.
 - (1) When ~~ODJFS~~ODM determines that a level of care request is complete, ~~ODJFS~~ODM shall~~will~~:
 - (a) Issue a level of care determination.
 - (b) Inform the individual, and/or the sponsor and the authorized representative, as applicable, about the individual's PASRR results.

- (c) Notify the individual, and/or the sponsor and the authorized representative, as applicable, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, of the level of care determination.
- (d) When there is an adverse level of care determination, inform the individual, the sponsor, and the authorized representative, as applicable, about the individual's hearing rights in accordance with division 5101:6 of the Administrative Code.
- (2) In accordance with rules ~~5101:1-38-01~~5160:1-2-01 and ~~5101:1-39-23~~5160:1-6-03.1 of the Administrative Code, the county department of job and family services (CDJFS) ~~shall~~will determine medicaid eligibility and issue proper notice and hearing rights to the individual.
- (D) Process when ~~ODJFS~~ODM receives an incomplete level of care request.
- (1) When ~~ODJFS~~ODM determines that a level of care request is not complete, ~~ODJFS~~ODM shallwill:
- (a) Notify the submitter that a level of care determination cannot be issued due to an incomplete ~~JFS 03697~~ODM 03697 or alternative form.
- (b) Specify the necessary information the submitter must provide on or with the ~~JFS 03697~~ODM 03697 or alternative form.
- (c) Notify the submitter that the level of care request will be denied if the submitter does not submit the necessary information to ~~ODJFS~~ODM within fourteen calendar days.
- (i) When the submitter provides a complete level of care request to ~~ODJFS~~ODM within the fourteen--calendar day timeframe, ~~ODJFS~~ODM shallwill perform the steps described in paragraph (C) of this rule.
- (ii) When the submitter does not provide a complete level of care request to ~~ODJFS~~ODM within the fourteen--calendar day timeframe, ~~ODJFS~~ODM may deny the level of care request and document the denial in the individual's electronic record maintained by ~~ODJFS~~ODM.
- (2) In accordance with rules ~~5101:1-38-01~~5160:1-2-01 and ~~5101:1-39-23~~5160:1-6-03.1 of the Administrative Code, the CDJFS ~~shall~~will determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(E) 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 a complete level of care request when:
- (a) ~~ODJFS~~ODM determines that an individual is seeking admission or re-admission to a NF from an acute care hospital or hospital emergency room.
 - (b) A CDJFS requests a level of care determination for an individual who is receiving adult protective services, as defined in rule 5101:2-20-01 of the Administrative Code, and the CDJFS submits a ~~JFS-03697~~ODM 03697 or alternative form at the time of the level of care request.
- (2) A desk review level of care determination is required within five calendar days from the date of receipt of a complete level of care request when:
- (a) ~~ODJFS~~ODM determines that an individual who resides in a NF is requesting to change from a non-medicaid payor to medicaid payment for the individual's continued NF stay.
 - (b) ~~ODJFS~~ODM determines that an individual who resides in a NF is requesting to change from medicaid managed care to medicaid fee-for-service as payment for the individual's continued NF stay.
 - (c) ~~ODJFS~~ODM determines that an individual is transferring from one NF to another NF.

(F) Face-to-face level of care determination. ODM will allow telephonic, video conference or desk review in lieu of a face-to-face, unless the individual's needs require a face-to-face visit. ODM will conduct face-to-face visits for all adverse level of care determinations as described in paragraph (F)(1)(b) of this rule.

- (1) A ~~face-to-face~~ level of care determination is required within ten calendar days from the date of receipt of a complete level of care request when:
- (a) An individual or the authorized representative of an individual requests a face-to-face level of care determination.
 - (b) ~~ODJFS~~ODM makes an adverse level of care determination, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, during a desk review level of care determination. When a desk review results in an adverse level of care determination, a face-to-face assessment will follow to verify the findings of the desk review.

- (c) ~~ODJFS~~ODM determines that the information needed to make a level of care determination through a desk review is inconsistent.
 - (d) An individual resides in the community and ~~ODJFS~~ODM verifies that the individual does not have a current NF-based level of care.
 - (e) ~~ODJFS~~ODM determines that an individual has a pending disenrollment from a NF-based HCBS waiver due to the individual no longer having a NF-based level of care.
- (2) A ~~face-to-face~~ level of care determination is required within two business days from the date of a level of care request from a CDJFS for an individual who is receiving adult protective services when the CDJFS does not submit a ~~JFS 03697~~ODM 03697 or alternative form at the time of the level of care request.

~~(G) Delayed face-to-face visit:~~

- ~~(1) A delayed face-to-face visit, as defined in rule 5101:3-3-05 of the Administrative Code, is required within ninety calendar days after ODJFS conducts a desk review level of care determination for an individual as described in paragraphs (E)(1)(a), (E)(1)(b), and (E)(2)(a) of this rule.~~
- ~~(2) The following are exceptions to the delayed face-to-face visit:~~
 - ~~(a) An individual as described in paragraphs (E)(2)(b) and (E)(2)(c) of this rule.~~
 - ~~(b) An individual who declines a delayed face-to-face visit.~~
 - ~~(c) An individual who has had a long-term care consultation, in accordance with Chapter 173-43 of the Administrative Code, since the individual's NF admission.~~
 - ~~(d) An individual who has had an in-person resident review, in accordance with Chapter 5101:3-3 of the Administrative Code, since the individual's NF admission.~~
 - ~~(e) An individual 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.~~

~~(H)~~(G) Level of care validation.

~~ODJFS~~SODM may conduct a level of care validation, as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code, 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) An individual who is enrolled on a NF-based HCBS waiver and is seeking admission to a NF.
- (2) An individual who is a NF resident and is seeking readmission to the same NF after a hospitalization.

Effective:

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Certification

Date

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