5160-3-14 **Adult assessment and determination process for nursing facility-based level of care programs.**

(A) This rule describes the processes and time frames for an adult 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 approve medicaid payment for:

(a) A nursing facility stay; or

(b) 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 an adult seeking medicaid payment to a nursing facility.

(1) An adult 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 the ODM to authorize payment to a nursing facility, the adult 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 the PAS requirements were met.

(iii) If a nursing facility receives medicaid payment from ODM for an adult 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 the ODM 10127 "Adult Level of Care Questionnaire" (7/2016) and any necessary supporting documentation is submitted.

(3) Supporting documentation to be submitted when an adult 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 10127 when:

(a) ODM determines that an adult is seeking admission or re-admission to a nursing facility from an acute care hospital or hospital emergency room.

(b) A county department of job and family services (CDJFS) requests a level of care determination for an adult who is receiving adult protective services, as defined in rule 5101:2-20-01 of the Administrative Code, 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 level of care assessment when:

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

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

(c) ODM determines that an adult is transferring from one nursing facility to another nursing facility.

(D) Face-to-face level of care assessment.

(1) A face-to-face level of care assessment is required within two business days from the date of the request for a level of care assessment when:

(a) The request is from a CDJFS for an adult who is receiving adult protective services when the CDJFS does not submit an ODM 10127 at the time of the level of care request.

(b) The adult seeking a nursing facility-based level of care appears to meet level of care criteria solely on the basis of a need for twenty-four hours support in order to prevent harm due to a cognitive impairment.

(2) 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:

(a) An adult or the authorized representative of an adult requests a face-to-face level of care assessment.

(b) An adult resides in the community and ODM verifies that the adult does not have a current nursing facility-based level of care.

(c) 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).

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

(e) A level of care validation is necessary and ODM determines the adult has a pending disenrollment from an HCBS waiver due to the adult 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 assessment for an adult.

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

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

(b) An adult who declines a delayed face-to-face visit.

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

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

(e) An adult 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) An adult who is enrolled on a nursing facility-based HCBS waiver and is seeking admission to a nursing facility.

(2) An adult 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 an adult 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) The electronic system approved by ODM; or

(2) ODM 10125 "Adult Comprehensive Assessment Tool (ACAT)" (7/2016).

(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 adult, 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 adult.

(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, an additional 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 adult, and the authorized representative, as applicable, about the adult's hearing rights in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-3-14

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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