5160-3-14 **Nursing facility-based level of care assessment and determination process for adults.**

(A) This rule describes the processes and timeframes for an adult's level of care assessment and determination for a nursing facility-based level of care program, as defined in paragraph (B)(27) of rule 5160-3-05 of the Administrative Code.

(1) A nursing facility-based level of care is necessary for:

(a) A nursing facility to submit claims for services included in the nursing facility per diem rate, in accordance with rule 5160-3-39.1 of the Administrative Code.

(b) An adult to be enrolled on a nursing facility-based medicaid waiver program.

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

(3) The processes described in this rule shall not be used for a level of care determination for an adult on a medicaid managed care plan who is seeking a nursing facility admission.

(B) Level of care assessment for an adult seeking medicaid fee-for-service payment for a nursing facility stay.

(1) An ODM 10127 "Adult Level of Care Questionnaire" (2/2018) must be completed and submitted along with any necessary supporting documentation to the PASSPORT administrative agency (PAA). The PAA will review the completed ODM 10127 and supporting documentation and will make a level of care determination.

(2) The nursing facility shall ensure that the preadmission screening and resident review (PASRR) requirements have been met in accordance with rules 5160-3-15, 5160-3-15.1 and 5160-3-15.2 of the Administrative Code.

(a) In order for the Ohio department of medicaid (ODM) to authorize payment to a nursing facility, the adult must have received a non-adverse PASRR determination and subsequent nursing facility-based level of care determination.

(i) ODM cannot authorize payment to the nursing facility before the effective date of the PASRR determination.

(ii) The level of care effective date cannot precede the effective date of the PASRR determination date.

(b) 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 5160-3-39.1 of the Administrative Code.

(3) A level of care effective date may precede the date that an ODM 10127 is submitted to the PAA.

(4) Supporting documentation to be submitted with the ODM 10127 may include, but is not limited to:

(a) Minimum data set (MDS);

(b) Discharge summary;

(c) Medical history and physical; and

(d) PASRR forms or other PASRR documentation.

(5) When the PAA receives an incomplete ODM 10127 or insufficient supporting documentation, the PAA shall:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete ODM 10127 or insufficient supporting documentation and specify the necessary information the submitter must provide.

(b) Notify the submitter that the level of care will be denied if the PAA does not receive the necessary information within fourteen calendar days.

(i) When the submitter provides the necessary information within the fourteen calendar day timeframe, the PAA shall proceed with the level of care determination process.

(ii) When the submitter does not provide the necessary information within the fourteen calendar day timeframe, the PAA shall deny the level of care.

(C) Desk review level of care determination.

(1) The PAA shall complete a desk review level of care determination, as defined in paragraph (B)(14) of rule 5160-3-05 of the Administrative Code, within

one business day from the date of receipt of the ODM 10127 when an adult is seeking admission or re-admission to a nursing facility from an acute care hospital or hospital emergency room.

(2) The PAA shall complete a desk review level of care determination within five calendar days from the date of receipt of the ODM 10127 when:

(a) An adult is seeking admission to a nursing facility and is requesting medicaid fee-for-service payment for the nursing facility stay.

(b) An adult who resides in a nursing facility is requesting to change from a non-medicaid payor to medicaid fee-for-service payment for the continued nursing facility stay

(c) An adult who resides in a nursing facility is requesting to change from medicaid managed care to medicaid fee-for-service payment for the continued nursing facility stay.

(d) An adult is transferring from one nursing facility to another nursing facility.

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

(1) The PAA shall complete a face-to-face level of care assessment, as defined in paragraph (B)(15) of rule 5160-3-05 of the Administrative Code, within two business days from the date of a request when:

(a) An adult is receiving adult protective services, as defined in rule 5101:2-20-01 of the Administrative Code.

(b) An adult appears to meet level of care criteria solely on the basis of a need for twenty-four hour support in order to prevent harm due to a cognitive impairment, in accordance with paragraph (B)(3) of rule 5160-3-08 of the Administrative Code.

(2) The PAA shall complete a face-to-face level of care assessment within ten calendar days from the date of the request when:

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

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

(c) A desk review level of care determination results in an adverse level of care determination, as defined in paragraph (B)(5) of rule 5160-3-05 of the Administrative Code. A registered nurse shall conduct a face-to-face level of care assessment to verify the level of care outcome.

(d) The PAA determines that there is insufficient of inconsistent information provided during the desk review level of care determination process.

(E) Delayed face-to-face visit.

(1) The PAA shall complete a delayed face-to-face visit, as defined in paragraph (B)(13) of rule 5160-3-05 of the Administrative Code, within ninety calendar days after the PAA conducts a desk review level of care determination.

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

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

(b) An adult, medicaid authorized representative, or other representative of the 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 rule 5160-3-15.2 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 a medicaid home and community-based waiver.

(F) Level of care validation.

The PAA shall complete a level of care validation, as defined in paragraph (B)(21) of rule 5160-3-05 of the Administrative Code, within one business day from the date of receipt of the ODM 10127 for:

(1) An adult who is enrolled on a nursing facility-based medicaid waiver program 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 and bed-hold days are exhausted in accordance with rule 5160-3-16.4 of the Administrative Code.

(G) Level of care determination for an adult seeking enrollment on a nursing facility-based medicaid waiver program.

(1) In accordance with rules 5160-46-02, 5160-58-02.2, 5160-31-03, and 5160-33-03 of the Administrative Code, a nursing facility-based level of care is one criterion required for enrollment on a nursing facility-based medicaid waiver program.

(2) A qualified assessor shall conduct a face-to-face level of care assessment using the ODM 10125 "Adult Comprehensive Assessment Tool (ACAT)" (2/2018).

(3) When the ODM 10125 and all required fields within the ODM 10125 are completed, ODM or its designee shall make a level of care determination.

(4) When a licensed social worker or licensed independent social worker performs the face-to-face level of care assessment resulting in an adverse level of care determination, a registered nurse shall conduct a subsequent face-to-face level of care assessment to verify the level of care outcome.

(H) Issuing notice for level of care determinations.

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

(2) When the PAA makes a level of care determination based upon a level of care assessment submitted in accordance with paragraph (B) of this rule, the PAA shall issue documentation of the level of care determination outcome(s) to the submitter of the ODM 10127.

(3) In accordance with Chapter 5160:1-2 of the Administrative Code, the county department of job and family services shall determine medicaid eligibility.

(4) In accordance with division 5101:6 of the Administrative Code, ODM shall issue proper notice and hearing rights.

Replaces: 5160-3-14

Effective:

Five Year Review (FYR) Dates:

WITHDRAWN ELECTRONICALLY

Certification

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