Ohio Administrative Code

Rule 5160-3-14 Process and timeframes for a level of care determination for nursing facility-based level of care programs.

Effective: April 2, 2021

(A) This rule describes the processes and timeframes for a level of care determination, as defined in rule 5160-3-05 of the Administrative Code, for a nursing facility (NF)-based level of care program, as defined in rule 5160-3-05 of the Administrative Code.

(1) The processes described in this rule will not be used for a determination for an ICF-IID-based level of care, as defined in rule 5160-3-05 of the Administrative Code.

(2) A level of care determination may occur face-to-face, by a desk review, or by telephone, as defined in rule 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 5160-3-15, 5160-3-15.1, 5160-3-15.2, 5122-21-03, and 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 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) 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 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 5160-1-19 of the Administrative Code.

(B) Level of care request.

(1) In order for ODM or its designee (hereafter referred to as ODM) 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 included and completed on the ODM 03697, "Level of Care Assessment" (rev. 7/2014) or alternative form, as defined in rule 5160-3-05 of the Administrative Code, and any necessary supporting documentation is submitted with the ODM 03697 or alternative form, as described in paragraphs (B)(2) to (B)(4) of this rule.

(2) Necessary data elements on the 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) Certification on the ODM 03697 or alternative form.

(a) A certification means a signature from a physician as defined in rule 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 ODM 03697 or alternative form. ODM will allow an electronic signature for the certification or standard cerification via mail.

(b) A certification must be obtained within thirty calendar days of submission of the ODM 03697 or alternative form.

(c) Exceptions to the certification:

(i) When an individual resides in the community and ODM determines that the individual's health and welfare is at risk and that it is not possible for the submitter of the 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 ODM 03697 or alternative form, a verbal certification is acceptable.

(ii) ODM must obtain a certification within thirty days of the verbal certification.

(4) Necessary supporting documentation with the ODM 03697 or alternative form when the individual is subject to a preadmission screening process:

(a) A copy of the ODM 03622, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 8/2014) and ODM 07000, "Hospital Exemption from Preadmission Screening Notification" (rev. 7/2014), as applicable, in accordance with rules 5160-3-15.1 and 5160-3-15.2 of the Administrative Code; and

(b) Any preadmission screening results and assessment forms.

(C) Process when ODM receives a complete level of care request.

(1) When ODM determines that a level of care request is complete, ODM 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 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 5160:1-2-01 and 5160:1-6-03.1 of the Administrative Code, the county department of job and family services (CDJFS) will determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(D) Process when ODM receives an incomplete level of care request.

(1) When ODM determines that a level of care request is not complete, ODM will:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete ODM 03697 or alternative form.

(b) Specify the necessary information the submitter must provide on or with the 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 ODM within fourteen calendar days.

(i) When the submitter provides a complete level of care request to ODM within the fourteen-calendar day timeframe, ODM will perform the steps described in paragraph (C) of this rule.

(ii) When the submitter does not provide a complete level of care request to ODM within the fourteen-calendar day timeframe, ODM may deny the level of care request and document the denial in the individual's electronic record maintained by ODM.

(2) In accordance with rules 5160:1-2-01 and 5160:1-6-03.1 of the Administrative Code, the CDJFS 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) 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 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) 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) 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) 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 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) ODM makes an adverse level of care determination, as defined in rule 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) 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 ODM verifies that the individual does not have a current NF-based level of care.

(e) 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 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 ODM 03697 or alternative form at the time of the level of care request.

(G) Level of care validation.

ODM may conduct a level of care validation, as defined in rule 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.