Ohio Revised Code

Section 5165.04 Assessment to determine level of care.

Effective: September 29, 2013
Legislation: House Bill 59 - 130th General Assembly

(A) As used in this section, "representative" means a person acting on behalf of an applicant for or recipient of medicaid. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of an applicant or recipient.

(B) The department of medicaid may require each applicant for or recipient of medicaid who applies or intends to apply for admission to a nursing facility or resides in a nursing facility to undergo an assessment to determine whether the applicant or recipient needs the level of care provided by a nursing facility. The assessment may be performed concurrently with a long-term care consultation provided under section 173.42 of the Revised Code.

To the maximum extent possible, the assessment shall be based on information from the resident assessment instrument specified in rules authorized by section 5165.191 of the Revised Code. The assessment shall also be based on criteria and procedures established in rules authorized by division (F) of this section and information provided by the person being assessed or the person's representative.

The department of medicaid, or if the assessment is performed by an agency under contract with the department pursuant to division (G) of this section, the agency, shall, not later than the time the level of care determination based on the assessment is required to be provided under division (C) of this section, give written notice of its conclusions and the basis for them to the person assessed and, if the department or agency under contract with the department has been informed that the person has a representative, to the representative.

(C) The department or agency under contract with the department, whichever performs the assessment, shall provide a level of care determination based on the assessment as follows:

(1) In the case of a person applying or intending to apply for admission to a nursing facility while hospitalized, not later than one of the following:

(a) One working day after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules authorized by division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(2) In the case of a person applying or intending to apply for admission to a nursing facility who is not hospitalized, not later than one of the following:

(a) Five calendar days after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules authorized by division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(3) In the case of a person who resides in a nursing facility, not later than one of the following:

(a) Five calendar days after the person or the person's representative submits an application for medicaid and submits all information required for providing the level of care determination, as specified in rules authorized by division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(4) In the case of an emergency, as specified in rules authorized by division (F)(4) of this section, within the number of days specified in the rules.

(D) A person assessed under this section or the person's representative may appeal the conclusions reached by the department or agency under contract with the department on the basis of the assessment. The appeal shall be made pursuant to section 5160.31 of the Revised Code. The department or agency under contract with the department shall provide to the person or the person's

representative and the nursing facility written notice of the person's right to request a state hearing. The notice shall include an explanation of the procedure for requesting a state hearing. If a state hearing is requested, the state shall be represented in the hearing by the department or the agency under contract with the department, whichever performed the assessment.

(E) A nursing facility that admits or retains a person determined pursuant to an assessment required under this section not to need the level of care provided by the nursing facility shall not be paid under the medicaid program for the person's care.

(F) The medicaid director shall adopt rules under section 5165.02 of the Revised Code to implement and administer this section. The rules shall include all of the following:

(1) Criteria and procedures to be used in determining whether admission to a nursing facility or continued stay in a nursing facility is appropriate for the person being assessed;

(2) Information the person being assessed or the person's representative must provide to the department or agency under contract with the department for purposes of the assessment and providing a level of care determination based on the assessment;

(3) Circumstances under which a person is not required to be assessed;

(4) Circumstances that constitute an emergency for purposes of division (C)(4) of this section and the number of days within which a level of care determination must be provided in the case of an emergency.

(G) Pursuant to section 5162.35 of the Revised Code, the department of medicaid may enter into contracts in the form of interagency agreements with one or more other state agencies to perform the assessments required under this section. The interagency agreements shall specify the responsibilities of each agency in the performance of the assessments.