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: July 1, 2025

(A) Level of care determination process, generally:

(1) A level of care determination may occur in-person, by a desk review, or by telephone and is one component of medicaid eligibility to receive medicaid payment for services provided in a nursing facility (NF) or through a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program.:

(2) An individual who is seeking admission to a NF 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 will 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 consider payment for services provided to an individual in a NF who is eligible for medicaid, the individual will have received a non-adverse PASRR determination and subsequent NF-based level of care determination.

(i) NF services that predate the PASRR determination are not eligible for medicaid payment.

(ii) The level of care effective date cannot precede the date that the PASRR criteria were met.

(iii) A level of care cannot be requested or determined retroactively with an effective date prior to or within an active post-payment claim review period.

(iv) Not-withstanding paragraphs (A)(2)(b)(i), (A)(2)(b)(ii), and (A)(2)(b)(iii) of this rule if an individual is admitted to a NF for a stay of thirty calendar days or less under a hospital exemption that has been submitted in accordance with rule 5160-3-15.1 of the Administrative Code, the level of

care criteria will be deemed met for the first thirty days after admission. If the individual remains in the NF after the thirtieth calendar day, a level of care determination will be requested in accordance with paragraphs (B) through (H) of this rule.

(v) If an individual receives a non-adverse level II PASRR determination indicating the need for NF services and the individual meets the criteria for the intermediate level of care described in paragraphs (A)(4) and (B) of rule 5160-3-08 of the Administrative code, or the skilled level of care described in paragraph (C) of rule 5160-3-08 of the Administrative Code, a level of care determination may be issued effective on or after the date that the PASRR criteria were met.

(vi) Not-withstanding paragraph (A)(2)(b)(iv) of this rule, if a NF receives medicaid payment from ODM or its designee for an individual who does not have a NF-based level of care determination, the NF is subject to the claim adjustment for overpayments process described in rule 5160-1-19 of the Administrative Code.

(vii) If an individual receives an adverse level II PASRR determination, the individual appearing to meet the criteria described in paragraphs (A)(4) and (B), or paragraph (C) of rule 5160-3-08 or receipt of a non-adverse NF-based level of care determination will not be used to overturn the adverse level II determination.

(3) Services will not be eligible for medicaid payment for any individual applying for a NF-based HCBS waiver or other NF-based level of care program until the specific program eligibility criteria are met.

(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 will receive a complete level of care request from a NF or a complete application for a NF-based HCBS waiver or program. 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" or alternative form and any necessary supporting documentation is submitted with the ODM 03697 or alternative form, as described in paragraphs (B)(2) to (B)(5) of this rule.

(2) A complete level of care request, alternative form, or submitted documentation will not be considered a substitute for a level of care determination.

(3) Necessary data elements:

(a) Individual's legal name;

(b) Individual's medicaid case number, if applicable;

(c) Date of original admission to the facility, if applicable;

(d) Individual's current address, including county of residence;

(e) Individual's current diagnoses or diagnoses as of the requested retroactive effective date, if applicable;

(f) Date of onset for each diagnosis, if available;

(g) Individual's current medications, treatments, and required medical services or as of the requested retroactive effective date, if applicable;

(h) A description of the individual's current activities of daily living and instrumental activities of daily living or description as of the requested retroactive effective date, if applicable;

(i) A description of the individual's current mental and behavioral status or status as of the requested retroactive effective date, if applicable; and

(j) Type of service setting requested.

(4) Certification on the ODM 03697 or alternative form.

(a) A certification means a signature from a physician, 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. ODM will allow an electronic signature or signature received via fax or mail for the certification.

(b) A certification will 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 will obtain a certification within thirty days of the verbal certification.

(5) 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" and ODM 07000, "Hospital Exemption from Preadmission Screening Notification" , 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) When a complete level of care request is received:

(1) ODM will issue a level of care determination and notify the individual and authorized representative, as applicable, of the level of care determination. If the determination is adverse, information regarding the individual's hearing rights will be included with the determination 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) When an incomplete level of care request is received:

(1) ODM will notify the submitter and specify the necessary information to be provided on or with the ODM 03697 or alternative form and allow fourteen calendar days to provide the information. If the submitter provides a complete level of care within fourteen calendar days, the steps described in paragraph (C) of this rule will be performed.

(a) If a complete level of care request is not received within fourteen calendar days of the notification of an incomplete request, the request may be denied and documented in the 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 will occur 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 an ODM 03697 or alternative form at the time of the level of care request.

(2) A desk review level of care determination will occur 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) In-person level of care determination.

(1) An in-person level of care determination will occur 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 an in-person level of care determination.

(b) ODM makes an adverse level of care determination during a desk review level of care determination.

(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) An in-person level of care determination will occur 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 an ODM 03697 or alternative form at the time of the level of care request.

(3) Except as provided in paragraph (F)(1) or (F)(2) of this rule, ODM will allow a telephonic or video conference level of care determination at the request of the individual.

(G) Delayed in-person visit.

(1) A delayed in-person visit will occur within ninety calendar days after ODM conducts a desk review level of care determination for an individual as described in paragraph (E)(1)(a), (E)(1)(b), or (E)(2)(a) of this rule.

(2) Not-withstanding paragraph (G)(1) of this rule a delayed in-person visit does not have to occur for the following:

(a) An individual as described in paragraph (E)(2)(b) or (E)(2)(c) of this rule.

(b) An individual who declines a delayed in-person 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 rule 5160-3-15.2 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) Level of care validation.

ODM may conduct a level of care validation in lieu of an in-person level of care determination within one business day from the date of a level of care request for:

(1) An individual who is currently enrolled on a NF-based HCBS waiver and is seeking admission to a NF.

(2) An individual who is currently a NF resident and is seeking readmission to the same NF after a

hospitalization.