5123:2-7-06 **Intermediate care facilities - level of care review process.**

(A) For the purposes of this rule, the following definitions shall apply:

(1) "Form 03697" means the Ohio office of medical assistance form 03697, "Level of Care Assessment" (revised April 2003).

(2) "Individual" means a medicaid recipient or person with pending medicaid eligibility who is making application to an intermediate care facility, or who resides in an intermediate care facility, or is applying for home and community-based services waiver enrollment.

(3) "Level of care review," as used in this rule, is an assessment of an individual's physical, mental, habilitative, and social/emotional needs to determine whether the individual requires services available in an intermediate care facility. Level of care review is conducted pursuant to paragraph 1902 (a)(30)(A) of the Social Security Act, 42 U.S.C. 1396a (1999), and are those activities necessary to safeguard against unnecessary utilization. The evaluation of an individual's level of care needs determines the appropriately certified facility type for which medicaid vendor payment can be made. Except as provided in paragraph (C) of this rule, vendor payment can be initiated to an intermediate care facility only when the applicant is determined by the department to need the level of care according to the criteria specified in rule 5101:3-3-07 of the Administrative Code.

(4) "Physician" means a doctor of medicine or osteopathy who is licensed to practice medicine in the state of Ohio.

(5) "Psychologist" means a degreed psychologist who has been licensed by the Ohio board of psychology to practice psychology in the state of Ohio.

(B) Level of care review is required for individuals in the following situations:

(1) Hospitalized individuals who are not currently residents of an intermediate care facility who are applying for intermediate care facility placement.

(2) Hospitalized individuals who are current residents of an intermediate care facility who are seeking admission to a different intermediate care facility.

(3) Individuals seeking readmission to an intermediate care facility after exhausting available paid hospital leave days.

(4) Individuals who are current residents of an intermediate care facility who are seeking admission to a different intermediate care facility.

(5) Individuals who are not currently residents of an intermediate care facility who are seeking admission to an intermediate care facility from community living arrangements.

(6) Individuals who were on paid leave days, are not in a hospital setting, and who have exhausted their paid leave days, who are seeking readmission to an intermediate care facility.

(7) Current residents of an intermediate care facility who are requesting medicaid reimbursement of their stay at the intermediate care facility.

(8) Individuals applying for home and community-based services waiver services.

(C) Under the circumstances in paragraphs (C)(1), (C)(2), and (C)(3) of this rule, vendor payment shall be continued or reinstated when a change in institutional setting is sought.

(1) Current residents of an intermediate care facility receiving medicaid vendor payment who wish to transfer to another intermediate care facility must submit a completed form 03697, not later than the day of transfer to the new intermediate care facility, as specified in paragraphs (D)(1) and (D)(2) of this rule to initiate reimbursement in the new intermediate care facility effective from the date of admission.

(a) Vendor payment to the new intermediate care facility will be authorized back to the date of the individual's admission to the facility. The department shall enter the level of care determination and date into the client registry information system-enhanced to allow for vendor payment. If the department determines that the individual is no longer in need of the level of care, the department shall notify the recipient and the intermediate care facility of the adverse determination and the department's intent to terminate vendor payment. The notice shall set forth the recipient's hearing rights and the time frames within which they must be exercised.

(b) If a hearing request is received in response to the notice specified in paragraph (C)(1)(a) of this rule within time frames specified in division 5101:6 of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.

(c) If the individual does not submit a hearing request within the time frame specified in paragraph (C)(1)(b) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of the department's intent to terminate vendor payment.

(2) Hospitalized individuals who are current residents of an intermediate care facility and are seeking admission to a different intermediate care facility, must meet the requirements in paragraphs (C)(1)(a), (C)(1)(b), and (C)(1)(c) of this rule in order to have vendor payment authorized from the date of

admission. These requirements must be met regardless of whether they have exhausted paid leave days.

(3) Hospitalized individuals who are seeking readmission to the same intermediate care facility after exhaustion of paid leave days may be readmitted to that intermediate care facility regardless of the results of the level of care determination if, not later than the date of readmission, the recipient submits a completed form 03697 to initiate reimbursement effective from the date of readmission. If the level of care determination does not match the certification of the facility as specified in paragraph (A)(3) of this rule, the following procedures will apply:

(a) Vendor payment to the intermediate care facility will be authorized back to the date of the individual's admission to the facility. The department shall enter the level of care determination and date into the client registry information system-enhanced to allow for vendor payment. If the department determines that the individual is no longer in need of the level of care, the department shall notify the recipient and the intermediate care facility of the adverse determination and the department's intent to terminate vendor payment. The notice shall set forth the recipient's hearing rights and the time frames within which they must be exercised.

(b) If a hearing request is received in response to the notice specified in paragraph (C)(3)(a) of this rule within the time frames specified in division 5101:6 of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.

(c) If the individual does not submit a hearing request within the time frame specified in paragraph (C)(3)(b) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of the department's intent to terminate vendor payment.

(D) In order to obtain a level of care determination, a form 03697 or an alternative form specified by the department, which has been appropriately completed, accurately reflects the individual's current mental and physical condition, and is certified by a physician must be submitted to the department for review.

(1) The form 03697 or alternative form must include the following components and/or attachments:

(a) Individual's name; medicaid number; date of original admission to the facility, if applicable; current address; name and address of residence if current residence is a licensed or certified residential setting or hospital; and county where the individual's medicaid case is active.

(b) A comprehensive medical, social, and psychological evaluation of the individual. The psychological evaluation must be made before admission, but not more than three months before admission. Each evaluation must include:

(i) Diagnosis, including medical, psychiatric, and developmental diagnoses, including dates of onset, if the date of onset is significant in determining whether the individual has a developmental disability;

(ii) Summary of medical, social, and developmental findings;

(iii) Medical and social family history;

(iv) Mental and physical functional capacity;

(v) Prognoses;

(vi) Kinds of services needed including medical treatments, medications, and other professional medical services;

(vii) Evaluation of the resources available in the home, family, and community; and

(viii) A physician's certification of the individual's need for intermediate care facility services made at the time of admission, or if the individual applies for medicaid while a resident of an intermediate care facility, prior to the initiation of vendor payment.

(2) The entity (i.e., county department of job and family services, hospital, or intermediate care facility) submitting the level of care request must ensure that all required components are included before submission.

(a) Following receipt of the form 03697, the department shall make a determination of whether the form 03697 is sufficiently complete to perform the level of care review. If the form 03697 is not complete, the department shall notify, in writing, the recipient, the contact person indicated on the form 03697, and the intermediate care facility or any other entity responsible for the submission of the form 03697, that additional documentation is necessary in order to complete the level of care review. This notice shall specify the additional documentation that is needed and shall indicate that the individual or another entity has twenty days from the date the department mails the notice to submit additional documentation or the form 03697 will be denied for incompleteness with no level of care authorized. In the event an

individual or other entity is not able to complete form 03697 in the time specified, the department shall, upon good cause, grant one extension of no more than five days when an extension is requested by the recipient or other entity.

(b) If the form 03697 is complete upon receipt by the department, or, if within the periods specified in paragraph (D)(2)(a) of this rule, the recipient submits the required documentation, the department shall issue a level of care determination within sixty days. A level of care determination will be issued pursuant to rules 5101:3-3-05 and 5101:3-3-07 of the Administrative Code.

(3) A request for level of care will not be denied by the department for the reason that the individual does not need intermediate care facility services until a registered nurse or a qualified intellectual disability professional conducts a face-to-face assessment of the individual, reviews the medical records that accurately reflect the individual's condition for the time period in which payment is being requested, makes a reasonable effort to contact the individual's physician, and investigates and documents alternative community resources including resources available in the home and family which may be available to meet the needs of the individual.

(E) Level of care review process

(1) The department shall review the application submitted for the individual and enter the level of care determination into the client registry information system-enhanced.

(2) Authorization of payment to an intermediate care facility shall correspond with the effective date of the level of care determination specified in the client registry information system-enhanced. This date shall be:

(a) The date of admission to the intermediate care facility if it is within thirty days of the physician's signature; or

(b) A date other than that specified in paragraph (E)(2)(a) of this rule. This alternative date may be authorized only upon receipt of a letter which contains a credible explanation for the delay from the originator of the level of care request. If the request is to backdate the level of care more than thirty days from the physician's signature, the physician must verify the continuing accuracy of the information and need for inpatient care by either adding a statement to that effect on the form 03697 or by attaching a separate letter of explanation.

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Certification

12/31/2012

Date

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