

5160-3-05

**Level of care definitions.**

~~(A) This rule contains the definitions used in the process of making a determination of an individual's level of care. The definitions in this rule apply unless a term is otherwise defined in a specific rule.~~

~~(B)~~(A) Definitions. For purposes of determining an individual's nursing-facility (NF) based level of care, the following definitions apply unless a term is otherwise defined in a specific rule:

~~(1) "Active Treatment" means a continuous treatment program including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services for individuals with mental retardation and/or other developmental disabilities that are directed toward the following:~~

~~(a) The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and~~

~~(b) The prevention or deceleration of regression or loss of current optimal functional status.~~

~~(2)~~(1) -"Activity of daily living (ADL)" means a personal or self-care task that enables an individual to meet basic life needs. For purposes of this rule, the term "ADL" includes the following defined activities:

~~(a) -"Bathing" means the ability of an individual to cleanse one's body by showering, tub, or sponge bath, or any other generally accepted method.~~

~~(b) -"Dressing" means the ability of an individual to complete the activities necessary to dress oneself and includes the following two components:~~

~~(i) Putting on and taking off an item of clothing or prosthesis; and~~

~~(ii) Fastening and unfastening an item of clothing or prosthesis.~~

~~(c) -"Eating" means the ability of an individual to feed oneself. Eating includes the processes of getting food into one's mouth, chewing, and swallowing, and/or the ability to use and self-manage a feeding tube.~~

~~(d) -"Grooming" means the ability of an individual to care for one's appearance and includes the following three components:~~

~~(i) -Oral hygiene;~~

- (ii) -Hair care; and
  - (iii) -Nail care.
- (e) -"Mobility" means the ability of an individual to use fine and gross motor skills to reposition or move oneself from place to place and includes the following three components:
- (i) -"Bed mobility" means the ability of an individual to move to or from a lying position, turn from side to side, or otherwise position the body while in bed or alternative sleep furniture;
  - (ii) "Locomotion" means the ability of an individual to move between locations by ambulation or by other means; and
  - (iii) -"Transfer" means the ability of an individual to move between surfaces, including but not limited to, to and from a bed, chair, wheelchair, or standing position.
- (f) -"Toileting" means the ability of an individual to complete the activities necessary to eliminate and dispose of bodily waste and includes the following four components:
- (i) -Using a commode, bedpan, or urinal;
  - (ii) Changing incontinence supplies or feminine hygiene products;
  - (iii) -Cleansing self; and
  - (iv) -Managing an ostomy or catheter.
- ~~(3)~~(2) -"Adverse level of care determination" means a determination that an individual does not meet the criteria for a specific level of care.
- ~~(4)~~(3) -"Alternative form" means a form that is used in place of and contains all of the data elements of, the ~~JFS-03697~~ODM 03697, "Level of Care Assessment" (rev. 4/2003) to request a level of care determination from the ~~Ohio department of job and family services (ODJFS)~~Ohio department of medicaid (ODM) or its designee.
- ~~(5)~~(4) -"Assistance" means the hands-on provision of help in the initiation ~~and/or~~ completion of a task.

- ~~(6)~~(5) —"Authorized representative" has the same meaning as in rule ~~5101:1-37-01~~5160-1-33 of the Administrative Code.
- ~~(7)~~"CBDD" means a county board of developmental disabilities as established under ~~Chapter 5126. of the Revised Code.~~
- ~~(8)~~(6) -"Current diagnoses" means a written medical determination by the individual's attending physician, whose scope of practice includes diagnosis, listing those diagnosed conditions that currently impact the individual's health and functional abilities.
- ~~(9)~~(7) -"Delayed ~~face-to-face~~in-person visit" means an in-person visit that occurs within a specified period of time after a desk review has been conducted that includes the elements of a long-term care consultation, in accordance with Chapter 173-43 of the Administrative Code, for the purposes of exploring home and community-based services (HCBS) options and making referrals to the individual as appropriate.
- ~~(10)~~(8) -"Desk review" means a level of care determination process that is not conducted in person.
- (9) "Developmental disabilities level of care" means the level of care as described in rule 5123-8-01 of the Administrative Code.
- ~~(11) "Developmental delay" means that an individual age birth through five has not achieved developmental milestones as expected for the individual's chronological age as measured, documented, and determined by qualified professionals using generally accepted diagnostic instruments or procedures.~~
- ~~(12) "Face-to-face" means an in-person level of care assessment and determination process with the individual for the purposes of exploring nursing facility services or HCBS options and making referrals to the individual as appropriate; that is not conducted by a desk review only.~~
- ~~(13) "Habilitation" in accordance with 42 U.S.C. 1396n(e)(5) as in effect December 27, 2005, means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.~~
- ~~(14)~~(10) "ICF-MR""ICF-IID" means an intermediate care facility for persons with mental retardation individuals with intellectual disabilities as defined in section 5124.01 of the Revised Code.

~~(15) "ICF-MR-based level of care" means the levels of care as described in rules 5101:3-3-07, 5101:3-3-15.3, and 5101:3-3-15.5 of the Administrative Code.~~

(11) "Immediate need" means an individual has a need that may result in substantial harm or decline in functioning if waiver services and supports are not received within thirty calendar days.

(12) "In-person" means a level of care assessment and determination process conducted in the physical presence of the individual for the purposes of exploring nursing facility services or HCBS options and making referrals to the individual as appropriate, that is not conducted by a desk review only.

~~(16)~~(13) "Individual" means a medicaid recipient or person with pending applying for medicaid eligibility.

~~(17)~~(14) "Instrumental activity of daily living (IADL)" means the ability of an individual to complete community living skills. For the purposes of this rule, the term "IADL" includes the following defined activities:

(a) -"Community access-" means the ability of an individual to use available community services and supports to meet one's needs and includes the following three components:

(i) -"Accessing transportation" means the ability to get and use transportation.

(ii) -"Handling finances" means the ability of an individual to manage one's money ~~and does not include transportation~~. Handling finances includes all of the following:

(a) -Knowing where money is;

(b) -Knowing how to get money;

(c) -Paying bills; and

(d) -Knowing how to get and use benefits and services, including but not limited to:

(i) -Health benefits and insurance;

(ii) -Social benefits; and

(iii) -Home utilities.

- (iii) -"Telephoning" means the ability to make and answer telephone calls or use technology to connect to community services and supports.
- (b) -"Environmental management" means the ability of an individual to maintain the living arrangement in a manner that ensures the health and safety of the individual and includes the following three components:
  - (i) -"Heavy chores" means the ability to move heavy furniture and appliances for cleaning, turn mattresses, and wash windows and walls; and
  - (ii) "House cleaning" means the ability to make beds, clean the bathroom, sweep and mop floors, dust, clean and store dishes, pick up clutter, and take out trash;
  - (iii) -"Yard work and/or maintenance" means the ability to care for the lawn, rake leaves, shovel snow, complete minor home repairs, and paint.
- (c) -"Meal preparation" means the ability of an individual to prepare or cook food for oneself.
- (d) "Personal laundry" means the ability of an individual to wash and dry one's clothing and household items by machine or by hand.
- (e) -"Shopping" means the ability to obtain or purchase one's necessary items. Necessary items include, but are not limited to, groceries, clothing, and household items. Shopping does not include handling finances or accessing transportation.
- ~~(18)~~(15) "Less than twenty-four hour support" means that an individual ~~requires~~needs the presence of another person, or the presence of a remote monitoring device that does not ~~require~~need the individual to initiate a response, during a portion of a twenty-four hour period of time.
- ~~(19)~~(16) -"Level of care determination" means an assessment and evaluation by ~~ODHS~~SODM or its designee of an individual's physical, mental, social, and emotional status, using the processes described in ~~rules 5101:3-3-15, 5101:3-3-15.3, and 5101:3-3-15.5~~rule 5160-3-14 of the Administrative Code, to compare the criteria for all of the possible levels of care as described in ~~rules 5101:3-3-06 to 5101:3-3-08~~5160-3-06 to 5160-3-08 of the Administrative Code, and make a decision about whether an individual meets the criteria for a level of care.

- ~~(20)~~(17) "Level of care validation" means the verification process for ~~ODJFS~~ODJFSODM or its designee that includes verifying the preadmission screening and resident review criteria have been met for an individual as well as reviewing and entering to review and enter an individual's current level of care in the electronic records ~~of the individual~~ that are maintained by ~~ODJFS~~ODJFSODM.
- ~~(21)~~(18) "Long-term services and supports" means institutional or community-based medical, health, psycho-social, habilitative, rehabilitative, or personal care services that may be provided to medicaid-eligible individuals.
- ~~(22)~~ "Major life area" ~~has the same meaning as in rule 5101:3-3-07 of the Administrative Code.~~
- ~~(23)~~ "Manifested" ~~means a condition is diagnosed and interferes with the individual's ability to develop or maintain functioning in at least one major life area.~~
- ~~(24)~~(19) -"Medication administration" means the ability of an individual to prepare and self-administer all forms of over-the-counter (OTC) and prescription medication. Intravenous medication administration will be considered a skilled nursing service for the purposes of determining NF-based level of care. OTC and all other self-administered prescription medication will not be considered a skilled nursing service.
- ~~(25)~~(20) -"Need" means the inability of an individual to complete a necessary and applicable task independently, safely, and consistently. An individual does not have a need when:
- (a) -The individual is not willing to complete a task or does not have the choice to complete a task.
  - (b) -The task can be completed with the use of available assistive devices and accommodations.
- ~~(26)~~(21) -"Nursing facility (NF)" has the same meaning as in section ~~5111-20~~5165.01 of the Revised Code. A facility that has submitted an application packet for medicaid certification to ~~ODJFS~~the Ohio department of health is considered to be in the process of obtaining its initial medicaid certification ~~by the Ohio department of health and shall~~will be treated as a NF for the purposes of this rule.
- ~~(27)~~(22) -"NF-based level of care" means the intermediate and skilled levels of care, as described in rule ~~5101:3-3-08~~5160-3-08 of the Administrative Code.

- ~~(28)~~(23) -"NF-based level of care program" means a NF, a home and community-based services medicaid waiver that ~~requires~~uses a NF-based level of care, or other medicaid program that ~~requires~~uses a NF-based level of care.
- ~~(29)~~(24) -"PASRR" means the preadmission screening and resident review requirements mandated by section 1919(e)(7) of the Social Security Act and implemented in accordance with rules ~~5101:3-3-14, 5101:3-3-15.1, 5101:3-3-15.2 and 5122-21-03 and 5123:2-14-01~~5160-3-14, 5160-3-15.1, 5160-3-15.2, 5122-21-03, and 5123-14-01 of the Administrative Code.
- ~~(30)~~(25) -"Physician" means a person licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice medicine and surgery or osteopathic medicine and surgery.
- ~~(31)~~ "Psychiatrist" means a physician licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice psychiatry.
- ~~(32)~~ "Psychologist" means, a person licensed in Ohio as a psychologist or school psychologist, or licensed in another state as a psychologist as defined by applicable law.
- ~~(33)~~ The terms "psychologist," "the practice of psychology," "psychological procedures," "school psychologist," "practice of school psychology," "licensed psychologist," "licensed school psychologist," and "certificated school psychologist" have the same meanings as in section 4732.01 of the Revised Code.
- ~~(34)~~(26) -"Skilled nursing services" means specific tasks that ~~must~~are, in accordance with Chapter 4723. of the Revised Code, ~~be~~ provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.
- ~~(35)~~(27) -"Skilled rehabilitation services" means specific tasks that ~~must~~are, in accordance with Title 47 of the Revised Code, ~~be~~ provided directly by a licensed or other appropriately certified technical or professional health care personnel.
- ~~(36)~~ "Sponsor" means an adult relative, friend, or guardian of an individual who has an interest in or responsibility for the individual's welfare.
- ~~(37)~~ "Substantial functional limitation" means the inability of an individual to independently, adequately, safely, and consistently perform age-appropriate tasks as associated with the major life areas and as referenced in paragraph (B) ~~(4)~~ of this rule, without undue effort and within a reasonable period of time.

~~An individual who has access to and is able to perform the tasks independently, adequately, safely, and consistently with the use of adaptive equipment or assistive devices is not considered to have a substantial functional limitation.~~

~~(38)~~(28) - "Supervision" means either of the following:

- (a) -Reminding an individual to perform or complete an activity; or
- (b) -Observing while an individual performs an activity to ensure the individual's health and safety.

~~(39)~~(29) -"Twenty-four hour support" means that an individual ~~requires~~needs the continuous presence of another person throughout the course of the entire day and night during a twenty-four hour period of time.

~~(40)~~(30) -"Unstable medical condition" means clinical signs and symptoms are present in an individual and a physician has determined that:

~~(a) The individual's signs and symptoms are outside of the normal range for that individual;~~

~~(b)~~(a) -The individual's signs and symptoms ~~require~~need extensive monitoring and ongoing evaluation of the individual's status and care and there are supporting diagnostic or ancillary testing reports that justify the need for frequent monitoring or adjustment of the treatment regimen; and

~~(c)~~(b) -Changes in the individual's medical condition are uncontrollable or unpredictable and may ~~require~~need immediate interventions; ~~and~~

~~(d) A licensed health professional must provide ongoing assessments and evaluations of the individual that will result in adjustments to the treatment regimen as medically necessary. The adjustments to the treatment regimen must happen at least monthly, and the designated licensed health professional must document that the medical interventions are medically necessary.~~



Effective: 7/1/2025

Five Year Review (FYR) Dates: 1/14/2025 and 07/01/2030

CERTIFIED ELECTRONICALLY

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Certification

06/18/2025

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Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.04

Prior Effective Dates: 04/07/1977, 10/14/1977, 07/01/1980, 11/10/1983,  
08/01/1984, 01/17/1992 (Emer.), 04/16/1992,  
09/24/1993 (Emer.), 10/01/1993 (Emer.), 12/24/1993,  
12/31/1993, 11/05/2001 (Emer.), 01/20/2002,  
07/01/2008, 03/19/2012

5160-3-06

**Criteria for the protective level of care.**

~~(A)~~ This rule describes the criteria for an individual to meet the protective level of care.

~~(B)~~(A) The criteria for the protective level of care is met when:

(1) ~~The individual's needs for long-term services and supports (LTSS), as defined in rule 5101:3-3-05 of the Administrative Code, are less than the criteria for the intermediate or skilled levels of care, as described in paragraphs (B)(4), (C), and (D)(4)~~(A)(4), (B), and (C) of rule 5101:3-3-085160-3-08 of the Administrative Code.

(2) ~~The individual's LTSS needs are less than the criteria for the ICF-MR-based developmental disabilities level of care, as defined in rule 5101:3-3-055123-8-01 of the Administrative Code.~~

(3) The individual has a need for:

(a) ~~Less than twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law; or~~

(b) ~~Supervision, as defined in rule 5101:3-3-05 of the Administrative Code, of one activity of daily living (ADL), as defined in rule 5101:3-3-055160-3-05 of the Administrative Code and as described in paragraph (C)(B) of this rule, or supervision of medication administration, as defined in rule 5101:3-3-05 of the Administrative Code; and~~

(c) ~~Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with three instrumental activities of daily living (IADL), as defined in rule 5101:3-3-055160-3-05 of the Administrative Code and as described in paragraph (D)(C) of this rule.~~

(d) If the individual is age seventeen years or younger, the age-appropriate need for supervision or assistance with items described in paragraphs (A)(3)(b) and (A)(4)(c) of this rule will be assessed in accordance with the ODM-approved assessment guide.

~~(C)~~(B) For the purposes of meeting the criteria described in paragraph ~~(B)(3)~~(A)(3) of this rule, an individual age eighteen years or older has a need in who needs supervision of an ADL when needs:

- (1) ~~The individual requires supervision~~ Supervision of mobility in at least one of the following three components:
    - (a) Bed mobility;
    - (b) Locomotion; or
    - (c) Transfer.
  - (2) ~~The individual requires supervision~~ Supervision of bathing.
  - (3) ~~The individual requires supervision~~ Supervision of grooming in all of the following three components:
    - (a) Oral hygiene;
    - (b) Hair care; and
    - (c) Nail care.
  - (4) ~~The individual requires supervision~~ Supervision of toileting in at least one of the following four components:
    - (a) Using a commode, bedpan, or urinal;
    - (b) Changing incontinence supplies or feminine hygiene products;
    - (c) Cleansing self; or
    - (d) Managing an ostomy or catheter.
  - (5) ~~The individual requires supervision~~ Supervision of dressing in at least one of the following two components:
    - (a) Putting on and taking off an item of clothing or prosthesis; or
    - (b) Fastening and unfastening an item of clothing or prosthesis.
  - (6) ~~The individual requires supervision~~ Supervision of eating.
- ~~(D)(C)~~ For the purposes of meeting the criteria described in paragraph ~~(B)(3)~~ (A)(3) of this rule, an individual age eighteen years or older ~~has a need in~~ who needs assistance with an IADL when needs:
- (1) ~~The individual requires assistance~~ Assistance with meal preparation.

- (2) ~~The individual requires assistance~~ Assistance with environmental management in all of the following three components:
- (a) Heavy chores;
  - (b) House cleaning; and
  - (c) Yard work ~~and/or~~ maintenance.
- (3) ~~The individual requires assistance~~ Assistance with personal laundry.
- (4) ~~The individual requires assistance~~ Assistance with community access in at least one of the following three components:
- (a) Accessing transportation;
  - (b) -Handling finances; or
  - (c) -Telephoning.
- (5) ~~The individual requires assistance~~ Assistance with shopping.

Effective: 7/1/2025

Five Year Review (FYR) Dates: 1/14/2025 and 07/01/2030

CERTIFIED ELECTRONICALLY

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Certification

06/18/2025

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Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.04

Prior Effective Dates: 09/24/1993 (Emer.), 12/24/1993, 07/01/2008,  
03/19/2012

5160-3-08

**Criteria for nursing facility-based level of care.**

~~(A) This rule describes the criteria for an individual to meet the nursing facility (NF)-based level of care. The NF-based level of care includes the intermediate and skilled levels of care. An individual is determined to meet the NF-based level of care when the individual meets the criteria as described in paragraphs (B) to (D) of this rule.~~

~~(B)~~(A) -The criteria for the intermediate level of care is met when:

(1) The individual's needs for long-term services and supports (LTSS), ~~as defined in rule 5101:3-3-05 of the Administrative Code~~, exceed the criteria for the protective level of care, as described in paragraph ~~(B)(3)~~(A)(3) of rule ~~5101:3-3-06~~5160-3-06 of the Administrative Code.;

(2) The individual's LTSS needs are less than the criteria for the skilled level of care, as described in paragraph ~~(D)(4)~~(C) of this rule.;

(3) The individual's LTSS needs do not meet the criteria for the ~~ICF-MR-based~~developmental disabilities level of care, ~~as defined in rule 5101:3-3-05 of the Administrative Code~~, or meets one of the following:

(a) The individual has been evaluated through an Ohio department of medicaid (ODM)-approved assessment tool and determined to have medical condition(s) or related need(s) necessitating an immediate need for support as determined by (ODM), or

(b) The individual receives a non-adverse level II pre-admission screening and resident review (PASRR) determination indicating the need for NF services; and

(4) -The individual ~~has a need for~~needs a minimum of one of the following:

(a) Assistance, ~~as defined in rule 5101:3-3-05 of the Administrative Code~~, with the completion of a minimum of two activities of daily living (ADL), as defined in rule ~~5101:3-3-05~~5160-3-05 of the Administrative Code and as described in paragraph ~~(C)~~(B) of this rule;

(b) -Assistance with the completion of a minimum of one ADL as described in paragraph ~~(C)~~(B) of this rule, and assistance with medication administration, ~~as defined in rule 5101:3-3-05 of the Administrative Code~~;

(c) A minimum of one skilled nursing service or skilled rehabilitation service; ~~as defined in rule 5101:3-3-05 of the Administrative Code~~; or

(d) Twenty-four hour support, ~~as defined in rule 5101:3-3-05 of the Administrative Code~~, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law.

(e) If the individual is age seventeen years or younger, the age-appropriate need for assistance with items described in paragraphs (A)(4)(a) and (A)(4)(b) of this rule will be assessed in accordance with the ODM-approved assessment guide.

~~(C)(B)~~ For the purposes of meeting the criteria described in paragraph ~~(B)(4)~~(A)(4) of this rule, an individual age eighteen years or older ~~has a need in~~ who needs assistance with an ADL when ~~needs~~:

(1) ~~The individual requires assistance~~ Assistance with mobility in at least one of the following three components:

- (a) Bed mobility;
- (b) Locomotion; or
- (c) Transfer.

(2) ~~The individual requires assistance~~ Assistance with bathing.

(3) ~~The individual requires assistance~~ Assistance with grooming in all of the following three components:

- (a) Oral hygiene;
- (b) Hair care; and
- (c) Nail care.

(4) ~~The individual requires assistance~~ Assistance with toileting in at least one of the following four components:

- (a) Using a commode, bedpan, or urinal;
- (b) Changing incontinence supplies or feminine hygiene products;
- (c) Cleansing self; or
- (d) Managing an ostomy or catheter.

(5) ~~The individual requires assistance~~ Assistance with dressing in at least one of the following two components:

(a) Putting on and taking off an item of clothing or prosthesis; or

(b) Fastening and unfastening an item of clothing or prosthesis.

(6) ~~The individual requires assistance~~ Assistance with eating.

~~(D)(C)~~ -The criteria for the skilled level of care is met when:

(1) The individual's LTSS needs exceed the criteria for the protective level of care, as described in paragraph ~~(B)(3)(A)(3)~~ of rule ~~5101:3-3-06~~ 5160-3-06 of the Administrative Code;

(2) The individual's LTSS needs exceed the criteria for the intermediate level of care as described in paragraph ~~(B)(4)(A)(4)~~ of this rule;

(3) The individual's LTSS needs exceed the criteria for the ~~ICF-MR-based~~ developmental disabilities level of care;

(4) The individual ~~requires~~ needs a minimum of one of the following:

(a) ~~One skilled nursing service within the day on no less than seven days per week; or~~

(b) One skilled rehabilitation service within the day on no less than five days per week;and

(5) The individual has an unstable medical condition,~~as defined in rule 5101:3-3-05 of the Administrative Code.~~

(D) When an individual has been previously determined to meet the criteria for the intermediate or skilled level of care and has been enrolled in a NF-based home and community-based services (HCBS) waiver and has maintained enrollment, failure to meet the criteria in paragraph (A)(3) of this rule will not be a sufficient reason alone to deny level of care at the annual reassessment.

(E) ~~When an individual meets the criteria for a skilled level of care, as described in paragraph (D)(C) of this rule, the individual may request placement in an intermediate care facility for persons with mental retardation (ICF-MR) individuals with intellectual disabilities (ICF-IID) that provides services to individuals who have a skilled level of care. When an individual with a skilled level of care~~



requests placement in an ~~ICF-MR~~ ICF-IID they will need to meet the criteria for the developmental disabilities level of care; ~~the following requirements apply:~~

- ~~(1) The individual may be determined to meet the criteria for the ICF-MR-based level of care; and~~
- ~~(2) The ICF-MR must provide written certification that the services provided in the facility are appropriate to meet the needs of an individual who meets the criteria for a skilled level of care.~~

Effective: 7/1/2025

Five Year Review (FYR) Dates: 1/14/2025 and 07/01/2030

CERTIFIED ELECTRONICALLY

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Certification

06/18/2025

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Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.04

Prior Effective Dates: 07/01/1980, 11/10/1983, 10/01/1993 (Emer.),  
12/31/1993, 07/01/2008, 03/19/2012

5160-3-14

**Process and timeframes for a level of care determination for nursing facility-based level of care programs.**

(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.~~ Level of care determination process, generally:

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

~~(2)~~ (1) A level of care determination may occur face-to-face in-person, 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 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.:

~~(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)~~ (2) -An individual who is seeking a NF 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 must~~ 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 authorize payment to consider payment for services provided to an individual in a NF who is eligible for medicaid, the individual must~~ will 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~~ 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 requirements~~ 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) Notwithstanding 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.
  - ~~(iii)~~ (vi) Notwithstanding 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 must 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" ~~(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)~~ (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.
- ~~(2)(3)~~ (3) -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 if applicable;~~ 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.
- ~~(3)(4)~~ (4) 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 or signature received via fax or mail for the certification. ~~or standard certification via mail.~~~~
- (b) ~~-A certification must 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 ~~must~~ will obtain a certification within thirty days of the verbal certification.
- ~~(4)~~ (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" ~~(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. When a complete level of care request is received:~~
  - (1) ~~When ODM determines that a level of care request is complete, 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.:~~

- ~~(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.~~ When an incomplete level of care request is received:
- (1) ~~When ODM determines that a level of care request is not complete, 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. 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~~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~~an ODM 03697 or alternative form at the time of the level of care request.

(2) ~~A~~ desk review level of care determination ~~is required~~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) ~~Face-to-face~~In-person 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~~An in-person level of care determination ~~is required~~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 ~~a face-to-face~~ an in-person 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~~ An in-person level of care determination ~~is required~~ 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) Notwithstanding 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.

~~(G)~~(H) 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~~ 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.

Effective: 7/1/2025

Five Year Review (FYR) Dates: 1/14/2025 and 07/01/2030

CERTIFIED ELECTRONICALLY

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Certification

06/18/2025

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Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.04

Prior Effective Dates: 04/07/1977, 10/14/1977, 07/01/1980, 08/01/1984,  
01/17/1992 (Emer.), 04/16/1992, 10/01/1993 (Emer.),  
12/31/1993, 07/01/2008, 03/19/2012, 06/12/2020  
(Emer.), 04/02/2021