

5101:3-3-05

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) Definitions.

(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) "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) "Adverse level of care determination" means a determination that an individual does not meet the criteria for a specific level of care.

(4) "Alternative form" means a form that is used in place of and contains all of the data elements of, the JFS 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) or its designee.

(5) "Assistance" means the hands-on provision of help in the initiation and/or completion of a task.

(6) "Authorized representative" has the same meaning as in rule 5101:1-37-01 of the Administrative Code.

(7) "CBDD" means a county board of developmental disabilities as established under Chapter 5126. of the Revised Code.

(8) "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) "Delayed face-to-face 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) "Desk review" means a level of care determination process that is not conducted in person.
- (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(c)(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) "ICF-MR" means an intermediate care facility for persons with mental retardation.
- (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.
- (16) "Individual" means a medicaid recipient or person with pending medicaid eligibility.
- (17) "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) "Less than twenty-four hour support" means that an individual requires the presence of another person, or the presence of a remote monitoring device that does not require the individual to initiate a response, during a portion of a twenty-four hour period of time.
- (19) "Level of care determination" means an assessment and evaluation by ODJFS 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 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 of the Administrative Code, and make a decision about whether an individual meets the criteria for a level of care.
- (20) "Level of care validation" means the verification process for ODJFS or its designee to review and enter an individual's current level of care in the electronic records of the individual that are maintained by ODJFS.
- (21) "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) "Medication administration" means the ability of an individual to prepare and self-administer all forms of over-the-counter and prescription medication.
- (25) "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) "Nursing facility (NF)" has the same meaning as in section 5111.20 of the Revised Code. A facility that has submitted an application packet for medicaid certification to ODJFS is considered to be in the process of obtaining its initial medicaid certification by the Ohio department of health

and shall be treated as a NF for the purposes of this rule.

- (27) "NF-based level of care" means the intermediate and skilled levels of care, as described in rule 5101:3-3-08 of the Administrative Code.
- (28) "NF-based level of care program" means a NF, a home and community-based services medicaid waiver that requires a NF-based level of care, or other medicaid program that requires a NF-based level of care.
- (29) "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 of the Administrative Code.
- (30) "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) "Skilled nursing services" means specific tasks that must, 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) "Skilled rehabilitation services" means specific tasks that must, 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) "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) "Twenty-four hour support" means that an individual requires the continuous presence of another person throughout the course of the entire day and night during a twenty-four hour period of time.

(40) "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) The individual's signs and symptoms require 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;

(c) Changes in the individual's medical condition are uncontrollable or unpredictable and may require 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.

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5101:3-3-06

Criteria for the protective level of care.

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

(B) 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) of rule 5101:3-3-08 of the Administrative Code.

(2) The individual's LTSS needs are less than the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 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 5101:3-3-05 of the Administrative Code and as described in paragraph (C) 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 5101:3-3-05 of the Administrative Code and as described in paragraph (D) of this rule.

(C) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an ADL when:

(1) The individual requires 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 of bathing.

(3) The individual requires 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 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 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 of eating.

(D) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an IADL when:

(1) The individual requires assistance with meal preparation.

(2) The individual requires 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 with personal laundry.

(4) The individual requires 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 with shopping.

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5101:3-3-08**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) 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) of rule 5101:3-3-06 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) of this rule.

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

(4) The individual has a need for 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 of the Administrative Code and as described in paragraph (C) of this rule;

(b) Assistance with the completion of a minimum of one ADL as described in paragraph (C) 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.

(C) For the purposes of meeting the criteria described in paragraph (B)(4) of this rule, an individual has a need in an ADL when:

(1) The individual requires 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 with bathing.

(3) The individual requires 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 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 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 with eating.

(D) 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) of rule 5101:3-3-06 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) of this rule.

(3) The individual's LTSS needs exceed the criteria for the ICF-MR-based level of

care.

(4) The individual requires 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.

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

(E) When an individual meets the criteria for a skilled level of care, as described in paragraph (D) of this rule, the individual may request placement in an intermediate care facility for persons with mental retardation (ICF-MR) 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, 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.

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5101:3-3-15

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 5101:3-3-05 of the Administrative Code, for a nursing facility (NF)-based level of care program, as defined in rule 5101:3-3-05 of the Administrative Code.

(1) The processes described in this rule shall not be used for a determination for an ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(2) A level of care determination may occur face-to-face or by a desk review, as defined in rule 5101:3-3-05 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 5101:3-3-14, 5101:3-3-15.1, 5101:3-3-15.2, 5122-21-03, and 5123:2-14-01 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 job and family services (ODJFS) 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) ODJFS 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 ODJFS 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 5101:3-1-19 of the Administrative Code.

(B) Level of care request.

(1) In order for ODJFS or its designee (hereafter referred to as ODJFS) to make a

level of care determination, ODJFS 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 JFS 03697, "Level of Care Assessment" (rev. 4/2003) or alternative form, as defined in rule 5101:3-3-05 of the Administrative Code, and any necessary supporting documentation is submitted with the JFS 03697 or alternative form, as described in paragraphs (B)(2) to (B)(4) of this rule.

(2) Necessary data elements on the JFS 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) Physician certification on the JFS 03697 or alternative form.

- (a) A physician certification means a signature from a physician, as defined in rule 5101:3-3-05 of the Administrative Code, and date on the JFS 03697 or alternative form.
- (b) A physician certification must be obtained within thirty calendar days of submission of the JFS 03697 or alternative form.
- (c) Exceptions to the physician certification:
 - (i) When an individual resides in the community and ODJFS determines that the individual's health and welfare is at risk and that it is not possible for the submitter of the JFS 03697 or alternative form to obtain a physician signature and date at the time of the submission of the JFS 03697 or alternative form, a

verbal physician certification is acceptable.

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

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

(a) A copy of the JFS 03622, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 11/2010) and JFS 07000, "Hospital Exemption from Preadmission Screening Notification" (rev. 11/2010), as applicable, in accordance with rules 5101:3-3-15.1 and 5101:3-3-15.2 of the Administrative Code; and

(b) Any preadmission screening results and assessment forms.

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

(1) When ODJFS determines that a level of care request is complete, ODJFS shall:

(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 5101:3-3-05 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 5101:1-38-01 and 5101:1-39-23 of the Administrative Code, the county department of job and family services (CDJFS) shall determine medicaid eligibility and issue proper notice and hearing rights to the individual.

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

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

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

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

 - (i) When the submitter provides a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS shall perform the steps described in paragraph (C) of this rule.
 - (ii) When the submitter does not provide a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS may deny the level of care request and document the denial in the individual's electronic record maintained by ODJFS.
- (2) In accordance with rules 5101:1-38-01 and 5101:1-39-23 of the Administrative Code, the CDJFS shall 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) ODJFS 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 JFS 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) ODJFS 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) ODJFS 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) ODJFS determines that an individual is transferring from one NF to another NF.

(F) Face-to-face level of care determination.

- (1) A face-to-face 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) ODJFS makes an adverse level of care determination, as defined in rule 5101:3-3-05 of the Administrative Code, during a desk review level of care determination.
 - (c) ODJFS 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 ODJFS verifies that the individual does not have a current NF-based level of care.
 - (e) ODJFS 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 face-to-face 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 JFS 03697 or alternative form at the time of the level of care request.

(G) Delayed face-to-face visit.

- (1) A delayed face-to-face visit, as defined in rule 5101:3-3-05 of the Administrative Code, is required within ninety calendar days after ODJFS conducts a desk review level of care determination for an individual as described in paragraphs (E)(1)(a), (E)(1)(b), and (E)(2)(a) of this rule.
- (2) The following are exceptions to the delayed face-to-face visit:
- (a) An individual as described in paragraphs (E)(2)(b) and (E)(2)(c) of this rule.
 - (b) An individual who declines a delayed face-to-face 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 Chapter 5101:3-3 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.

ODJFS may conduct a level of care validation, as defined in rule 5101:3-3-05 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.

Replaces: 5101:3-3-15

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Certification

Date

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