CareSource

MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Nursing Facility Level of Care-OH MCD-MM-1218	11/01/2024-10/31/2025
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Nursing Facility Level of Care

B. Background
Nursing facilities (NFs) provide professional skilled and non-skilled services that facilitate member recovery and stability. Nursing facility care should be considered when a member no longer requires acute care services but continues to need healthcare services that can only be managed in the recovery facility environment. When primarily rehabilitation services are needed, health professionals working in acute care hospitals should recognize members' needs for rehabilitation care and facilitate transition to appropriate rehabilitation care settings.

C. Definitions
- **Assistance** – Assistance is defined by the Ohio Administrative Code (OAC) as "the hands-on provision of help in the initiation and/or completion of a task." Hands-on help is generally considered to be any aid in which the caregiver makes direct, physical contact with members to provide assistance with tasks, rather than just supervision or cueing.
- **Intermediate Level of Care (ILOC)** – A level of care for members whose needs are less than skilled level of care, but more than the protective level of care, and are stable. These members also do not meet the criteria for the ICF-IID-based level of care. The member has a need for a minimum of one of the following:
  - Assistance with a minimum of 2 activities of daily living
  - Assistance with a minimum of 1 ADL and medication administration
  - A minimum of 1skilled nursing service or skilled rehabilitation service
  - 24-hour support in order to prevent harm due to a cognitive impairment as diagnosed by a physician or other licensed health professional acting within their scope of practice.
- **Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID)** – A place where someone with a disability can choose to live and get the services that help them live their lives with staff and aides who work at the facility 24 hours a day**.**
- **Level of Care (LOC)** –The level of services and supports required by an individual to manage medical conditions and/or activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. The criteria for NF based level of care includes an "individual requiring assistance with" mobility, bathing, grooming, toileting, dressing, and eating. The two levels of care in Ohio that qualify an individual to receive nursing facility based care are Intermediate LOC and Skilled LOC
- **Long-Term Services and Supports (LTSS)** – Encompasses an array of medical and personal care services for people who struggle with self-care due to aging, physical, cognitive, or mental conditions or disabilities. People commonly receive LTSS services for months or even years, which is the reason LTSS are sometimes referred to as "long-term care." It includes cost-effective, person-centered home and case managed community-based alternatives to institutional care. LTSS include, but are not limited to:

  - nursing facility care
  - adult daycare programs
  - home health aide services
  - personal care services
  - transportation
  - assistance provided by a family caregiver
- **Nursing Facility (NF)** – Institutions that provide nursing and medical care to members who no longer require care in an acute setting, but do require licensed nursing services, rehabilitation services, or other health-related services that must be performed by a skilled, licensed professional on a daily basis that cannot be provided in the home. The nursing facility-based level of care includes both the intermediate and skilled levels of care.
- **Ohio Administrative Code (OAC)** – The rules adopted by the agencies of the state of Ohio. State agencies adopt rules to carry out the policies and intent of laws passed by the General Assembly. The rules are collected and published in the OAC.
- **Clinical Care Reviewer (CCR)** – A clinical professional who reviews clinical information, applies criteria, and evaluates the care needs of a member who needs inpatient or outpatient services that require a prior authorization.
- **Preadmission Screening/Resident Review (PASRR)** – A federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for care. PASRR requirements must be completed prior to an individual being admitted to a Medicaid certified nursing facility. Evidence of PASRR requirements being met must be provided to CareSource at the time of the request for authorization.
- **Protective Level of Care** – Care provided primarily to assist a member in meeting the instrumental activities of daily living but not requiring nursing facility based care**.** Protective care can reasonably and safely be provided by non-licensed caregivers in a community setting.
- **Skilled Level of Care** – Skilled level of care is when:
  - The member's LTSS needs exceed the criteria for the protective level of care, the intermediate level of care, or the ICF-MR-based level of care.
  - The member requires either 1 skilled nursing service no less than 7 days a week or one skilled rehabilitation service no less than 5 days a week, or
  - The member has an unstable medical condition.
- **Skilled Nursing Services** – Tasks that must be provided by a registered nurse directly or by a licensed practical nurse at the direction of a registered nurse.
- **Skilled Rehabilitation Services** – Specific tasks that must be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

D. Policy

I. CareSource will review all Ohio Medicaid Nursing Facility requests (for admission and continued stays) for skilled **and** intermediate level of care using OAC 5160-3-08, Criteria for nursing facility-based level of care for an adult **and** OAC 5160-1-01, Medical Necessity.

II. **Preadmission Screening and Resident Review Requirements**
CareSource requires evidence that Preadmission Screening and Resident Review requirements have been met prior to the member's admission to a NF as part of the prior authorization and level of care review processes in accordance with OAC 5160-3-14 process and timeframes for a level of care determination for nursing facility-based level of care programs, OAC 5160-3-15.1 Preadmission screening requirements for individuals seeking admission to nursing facilities, and OAC 5160-3-15.2 Resident Review requirements for individuals residing in nursing facilities.

III. **Skilled Level of Care Criteria**
CareSource considers skilled care in a nursing facility medically necessary when the following factors have been met:

A. Member must have an unstable medical condition as defined in OAC 5160-3-05(B)(40) in that clinical signs and symptoms are present in an individual and a physician has determined that:
   1. The individual's signs and symptoms are outside of the normal range for that individual.
   2. 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.
   3. Changes in the individual's medical condition are uncontrollable or unpredictable and may require immediate interventions.
   4. 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.

B. The member requires skilled nursing services **or** skilled rehabilitation services, ie, services that must be performed by or under the supervision of professional or technical personnel, that are ordered by a physician.

C. The daily skilled services can be provided only on an inpatient basis in a NF.

D. The services delivered are reasonable and necessary for the treatment of a member's illness or injury, ie, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.

E. The member requires a minimum of one of the following:
   1. 1 skilled nursing service daily (or more frequently) 7 days per week
   2. 1 skilled rehabilitation service within the day at least 5 days per week

F. The request meets the requirements of OAC 5160-1-01 Conditions of Medical Necessity.

G. There is a therapeutic plan to provide ALL of the following:
   1. Case management and evaluation to meet member needs, achieve treatment goals, and ensure medical safety
   2. Observation and assessment of member's changing condition to evaluate the need for treatment modification or for additional procedures until condition is stabilized

3. Member education to teach member self-maintenance or to teach caregiver member care.

H. When they are not safe to perform at a lower level of care, examples of direct **skilled** nursing services or **skilled** rehabilitation services include, but are not limited to:
Daily nursing treatments are needed for one or more of the following:
1. *Intravenous (IV) infusion, IV injection, or intramuscular injection*
2. *Insulin regimen establishment in presence of unstable blood sugar reading*
3. *Tube feeding for example, gastrostomy tubes, jejunostomy tubes percutaneous endoscopic gastrostomy (PEG) tubes, nasogastric tubes) required because member needs feeding to supply at least 26% of daily calories and at least 501 mL of daily fluids*
4. *Nasopharyngeal or tracheostomy suctioning and suprapubic catheter irrigation*
5. *Pain management for infusion of pain medications*
6. *Wound care that requires dressing changes with prescription medication or clean technique and treatment for:*
   01. Burns
   02. Foot infections or wounds
   03. Open lesions
   04. Surgical wound complications
   05. Treatment with any stage III or IV pressure injury
   06. Treatment with 2 or more wounds, including venous ulcers, arterial ulcers, or stage II pressure injuries
   07. Widespread skin disorder treatments
7. *Heat treatments that require nurse observation to evaluate response*
8. *Oxygen administration, starting or managing changes, including ventilator*
9. *Member care training and assistance for 1 or more of the following:*
   01. Exercise program (eg, range of motion, pulmonary, cardiac)
   02. Preventing complications and the start or revision of the member's maintenance therapy plan
   03. Safe performance of ADL (eg, dressing, communicating, eating)
   04. Splint, brace, cast, prosthesis, or orthosis management
   05. Urinary or bowel toileting program
10. *Pain management for infusion of pain medications*

I. *Rehabilitation therapy treatments (PT, OT, or SLP) are needed for 1 or more of the following:*
1. *Ongoing assessment of rehabilitation needs and potential (eg, range of motion, strength, balance)*
2. *Supervision of therapeutic exercises or activities to ensure member safety and treatment effectiveness*
3. *Gait evaluation and training*
4. *Preventing complications and the start or revision of the member's maintenance therapy plan*
5. *Therapy modalities that require PT or OT observation to evaluate response*

6. *Restoration of speech or swallowing with services of speech-language pathologist*
7. *Prosthetic evaluation and training.*

III. **Intermediate Level of Care Criteria**

For members needing assistance that cannot safely be performed at a lower level of care or the resources to provide the needed care and services in a home or community-based setting are not available, the **Intermediate Level of Care** (ILOC) is a lower cost alternative that effectively addresses and treats the medical problem, as described in OAC 5160-1-01, Medicaid medical necessity: definitions and principles. Criteria include, but are not limited to:

A. The individual's needs for long-term services and supports (LTSS) exceed the criteria for the protective level of care.
B. The individual's LTSS needs are less than the criteria for the skilled level of care.
C. Individual requires assistance (not necessarily a licensed professional) with the completion of a minimum of two activities of daily living (ADL) as outlined below:
    1. Assistance with mobility in at least one of the following three components:
        a. Bed mobility
        b. Locomotion
        c. Transfer
    2. Assistance with bathing
    3. Assistance with grooming in all of the following three components:
        a. Oral hygiene
        b. Hair care
        c. Nail care
    4. 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
        d. Managing an ostomy or catheter
    5. Assistance with dressing in at least one of the following two components:
        a. Putting on and taking off items of clothing or prosthesis
        b. Fastening and unfastening an item of clothing or prosthesis
    6. Assistance with eating
D. Assistance with the completion of a minimum of 1 ADL and assistance with medication administration (ADLs listed in III C 1-6), which is required due to
    1. Medication administration is required due to member's inability to safely self-manage medications. Reasons may include but are not limited to:
        a. Does not know current medications
        b. Lacks insight into reasons medications are prescribed
        c. Lacks ability to take medications as ordered due to cognitive impairment
E. Need for 24 hour support in order to prevent harm due to a cognitive impairment. Examples may include:
    1. Member resides in a locked dementia unit
    2. Negative results of mini mental status exam

F. Direct skilled rehabilitation services less than five days per week
G. Wound care that cannot be done in the community (wounds less than stage III).

NOTE: Members already enrolled in NF services, in particular those requiring intermediate care, should be individually assessed for medical necessity. CareSource supports lower cost alternatives that effectively address the problem. For example home health or family caregivers, are viable and medically appropriate options.

IV. Documentation to Support Nursing Facility-Based Care Determinations
A. The Caresource prior authorization form or the ODM Nursing Facility Request Form will be accepted for submission of requests.
B. PASRR Documentation. One of the following is required at the time of the initial request for nursing facility services:
1. PASRR Level I screen and preadmission screen (PAS) or resident review (RR) results
2. PASRR Level II evaluation and results, if indicated
3. Hospital Exemption Notice (for stays expected to be less than 30 days). Note: For stays in which the hospital exemption notice was submitted at the time of the initial request and the stay is expected to or exceeds 30 days, the PASRR Level I or II, determined by indications of serious mental illness and/or developmental disabilities or related conditions for the member, and resident review results are required to be submitted to CareSource.
C. The member's medical record must document all of the following:
1. The history and physical exam pertinent to the member's care including the response or changes in behavior to previously administered skilled services
2. The skilled services provided
3. The plan for future care based on the rationale of prior results
4. A detailed rationale that explains the need for the skilled service in light of the member's overall medical condition and experiences
5. The complexity of the service to be performed
6. A decline in physical function compared to the prior level of function (PLOF)
7. Inability to safely ambulate household distance (50 feet)
8. The member requires minimum assist to perform mobility-related activities of daily living (MRADLs)
9. The need for active assistance (hands-on vs. supervision)
10. The documentation in the member's medical record must be accurate and avoid vague or subjective descriptions of the member's care that would not be sufficient to indicate the need for skilled care
11. Updated clinical evaluation to support on-going concurrent review
12. The services promote the documented therapeutic goals
13. Minimum Data Set (MDS) documentation of cognitive, mood, functional performance, DME use, and/or nutritional status
14. Complete discharge planning assessment and ongoing changes to the plan

NOTE: The treatment goal cannot be modified retrospectively.

V. Bed-Hold Days
   A. In accordance with OAC 5160-3-16.4, CareSource will provide payment to a NF provider to reserve a bed for not more than 30 days in any calendar year when:
      1. A member is authorized by CareSource for the nursing facility stay at either the skilled or intermediate level of care.
      2. A member is not discharged from the NF.
      3. A member, who is a resident of the NF, is temporarily absent from the NF due to a hospitalization, therapeutic leave, or visitation with friends or relatives and has the intent and ability to return to the same NF.
   B. Bed-hold days do not require prior authorization.

VI. Non-covered services in a NF
   Clinical documentation that does not support the medical necessity requirements outlined in OAC 5160-1-01 that meets, at a minimum, the ILOC criteria for the following services:
   A. Repetitious exercises to improve gait, or to maintain strength and endurance and assistive walking can be appropriately provided by supportive personnel.
   B. When the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the member or with the assistance of non-therapists, including unskilled caregivers.
   C. General exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation or the supervision of taught exercises.
   D. Lack of a competent person to provide a nonskilled service regardless of the importance of the service to the member, does not make it a skilled service when a nurse provides the service.
   E. Protective LOC services.
   F. Services not expected to produce the desired outcome.

VII. Transitioning from a Nursing Facility
   A. Evaluation
      1. As part of the discharge planning process and in conjunction with the nursing facility staff, CareSource Case Management (CM) may evaluate a member receiving nursing facility care and services for potential for referral to home and community based services and/or other state and local resources to assist members in receiving needed services in the least restrictive environment.
      2. In compliance with OAC 5160-1-01, members will be reassessed. When the member no longer meets the medical necessity criteria for **skilled** or **intermediate** nursing facility care, CareSource will evaluate for discharge to the community (ie, home with needed services and supports).
      3. In compliance with OAC 5160-1-01, if the member no longer meets the skilled level of care, or intermediate level of care, CareSource will evaluate for

discharge to an appropriate community setting that will meet the member's care needs.

4. After an initial evaluation period, the UM clinical care reviewer must evaluate the member's progress. This initial evaluation may be followed by case management. These reports will include clinical review from the member's care team including documentation from facility discharge planning staff.
5. CareSource may perform a re-evaluation of members to identify any changes that require modification of the treatment plan and incorporate these into discharge planning.

B. Discharge Planning
   1. CareSource expects discharge planning for all members admitted to a nursing facility to begin immediately upon admission. Discharge planning should not be delayed until the member is stable for discharge as this frequently leads to unnecessary delays in a discharge and unnecessary lengthening of the member's facility stay. Discharge planning includes:
      a. Treatment plan development involving providers engaged in member's care
      b. Evaluation of member's premorbid functioning compared to current state
      c. Member and caregiver preferences and abilities
      d. Evaluation for services at next level of care as appropriate for member's continued needs
      e. Housing
      f. Evaluation of psychosocial status and needs
      g. Coordination of follow up appointments, planned or scheduled
      h. Transportation
      i. Coordination of prescription medications and treatments to be available to member upon discharge
      j. Home care services, if applicable
      k. Referrals made for assistance and support including to state and local programs and/or community based organizations
      l. Medical equipment and supplies coordinated
      m. Transition plan communicated to all members of member's care team
   2. CareSource Utilization Management (UM) and Case Management (CM) will work, either In-person or via telephonic outreach, with the Nursing Facility to ensure a safe and timely discharge for our members. This collaboration should start within 3 days of the member's admission to the NF.
   3. The NF must develop and share with CareSource UM during each review a post-discharge plan of care to address the anticipated needs of a member for discharge to a private residence, to another NF, or to another type of residential facility such as a group home, medical respite facility, sober living home, or an intermediate care facility for individuals with intellectual disabilities.
   4. Upon request, the discharge plan must be shared with CareSource CM.

C. Discharge Criteria

Once skilled nursing services (ie, wound care, IV or IV antibiotics treatment) and/or rehabilitation have been completed for safe transfer to lower level of care OR the member is no longer demonstrating significant functional gains and does not meet criteria for intermediate or skilled level of care, the following criteria must be completed prior to discharge:

a. Medication regimen established and reconciliation completed
b. Medical status stable for member's condition and manageable at lower level of care
c. Any inserted or implanted device discontinued, or functioning normally and manageable at lower level of care
d. Medical equipment and supplies are available at next level of care and safe use has been demonstrated
e. Wound(s) or dressing changes are manageable at a lower level of care
f. Skilled services (as needed) and logistical requirements can be met at a lower level of care
g. Transition plans and education are understood by the member and/or the caregiver

D. MCO Initiated Nursing Facility Disenrollment Process
   1. Requests for member disenrollment from managed care to fee for service Medicaid due to a need for extended nursing facility care must be submitted to the Ohio Department of Medicaid by CareSource. Approval of disenrollment requests are made at the discretion of ODM.
   2. To be eligible for a request for disenrollment from managed care to be submitted to ODM, the member must meet **all** of the following:
      a. Be enrolled in a Medicaid category identified by the Ohio Department of Medicaid as eligible for disenrollment.
      b. Be authorized by CareSource for and have a continuous stay in the nursing facility for no less than the month of admission and two complete consecutive months thereafter.
      c. The member’s discharge plan documents that nursing facility discharge is not expected in the foreseeable future and the member has a need for long-term nursing facility care.
      d. The member has not used hospice services during the period outlined in (D)(2)(b).

   3. When the member is identified as eligible for potential disenrollment, the following occurs:
      a. The clinical care reviewer (CCR) reviews the continued stay request from the nursing facility and determines if the criteria for the disenrollment request is met.
      b. CCR will add specific criteria to Disenrollment Log.
      c. CCR will complete review and approve the request 60 days.
      d. CCR will provide update to the NF with authorization status and notification to ODM for potential member disenrollment back to FFS.

e. CCR will track requests for disenrollment submitted to ODM and ensure follow up to validate status of the request if 60 days lapse without a decision.

g. The prior authorization specialist (PAS) receives ODM disenrollment outcomes and updates cases accordingly, updates NF/provider, and emails CCR team.

NOTE: Modified Adjusted Gross Income (MAGI) Medicaid members in the Adult Extension (MAGI Group 8) category may not be disenrolled.

4. Requests for disenrollment will be submitted in the format specified y ODM. The disenrollment table lists the earliest disenrollment date if all criteria is met. See disenrollment table below:

Month of Nursing Facility Admission	Next Two Consecutive Months	Earliest Disenrollment Date
January	February & March	March 31
February	March & April	April 30
March	April & May	May 31
April	May & June	June 30
May	June & July	July 31
June	July & August	August 31
July	August & September	September 30
August	September & October	October 31
September	October & November	November 30
October	November & December	December 31
November	Dec. & Jan. (next CY)	January 31 (next CY)
December	January & February (next CY)	Last Day of February (next CY)

NOTE: If a member is admitted to a NF while enrolled with the MCP and the MCP disenrollment request is submitted after the Earliest Disenrollment Date, the member will be disenrolled as of the last calendar day of the submission month.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/01/2021	New Policy
Date Revised	05/11/2022	Updated references; no changes

	08/09/2022 05/10/2023 07/16/2024	E-voted adding new section V. on Bed-Hold days Changed Member Care Coordinator (PCC) to Clinical Care Reviewer (CCR). Added Preadmission Screening and Resident Review requirements to align with Provider Agreement. Added sections IV. A and B to align with Provider Agreement and reporting requirements. Updated references. Approved at Committee. Updated section IV.B.3 documentation for the Hospital Exemption Notice. Added to section V. Bed-hold Days criteria. Checked with Legal on current contract. Updated references. Approved at Committee.
Date Effective	11/01/2024	
Date Archived	10/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. ASPE. An Overview of Long-Term Services and Supports and Medicaid: Final report. May 8, 2018. Accessed June 21, 2024. www.hhs.gov
2. CareSource Desk Reference. Nursing Facility Disenrollment Process. July 1, 2019. Accessed June 21, 2024. www.CareSource.com.
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4. CG-GRFAC (RFC) General Recovery Facility Comparison Tool. MCG Guidelines. 28th ed. 2024. Accessed April 10, 2024. www.careweb.careguidelines.com
5. CMS. *Medicare Benefit Policy Manual*. Chapter 8. Coverage of Extended Care (SNF) Services Under Hospital Insurance. October 4, 2019. Accessed June 21, 2024. www.cms.gov
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9. Managed Care: Termination of Enrollment, OHIO ADMIN. CODE 5160-26-02.1 (2023).
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11. Nursing Facilities (NFs): Covered Days and Bed-Hold Days, OHIO ADMIN. CODE 5160-3-16.4 (2017). Accessed June 21, 2024. www.medicaid.ohio.gov
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13. ODM. Nursing Facility Request Form. Accessed June 21, 2024. www.medicaid.ohio.gov
14. Skilled Nursing, OHIO REV. CODE § 3721.011 (2023). Accessed June 21, 2024. www.codes.ohio.gov

ODM approved 07/25/2024.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.