CareSource

MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Nursing Facility Level of Care-OH MCD-MM-1218	11/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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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** – Per the Ohio Administrative Code (OAC) is "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 developmental disabilities 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 (activities of daily living) 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. These facilities are also referred to as long-term care facilities or skilled nursing facilities.
- **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.
- **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, and the developmental disabilities level of care.
  - The member requires at minimum either one 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 requests for nursing facility admission and continued stay using OAC rule 5160-3-06, Criteria for the Protective Level of Care, OAC rule 5160-3-08, Criteria for nursing facility-based level of care for an adult **and** OAC rule 5160-

1-01, Medicaid Medical Necessity. At minimum, a member must meet criteria for the intermediate level of care and medical necessity criteria as determined by CareSource in addition to meeting preadmission screening requirements to be eligible for an approved nursing facility stay.

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 the skilled level of care in a nursing facility medically necessary when current clinical documentation demonstrates the following factors have been met:

A. The member's needs exceed the criteria for the protective and intermediate levels of care and do not meet the developmental disabilities levels of care
B. Member has an unstable medical condition as defined in OAC 5160-3-05(A)(30) in that clinical signs and symptoms are present in an individual and a physician has determined that:
    1. 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.
    2. Changes in the individual's medical condition are uncontrollable or unpredictable and may require immediate interventions.
C. 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.
D. The daily skilled services can be provided only on an inpatient basis in a NF.
E. 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.
F. The member requires a minimum of one of the following:
    1. One skilled nursing service daily (or more frequently) no less than 7 days per week
    2. One skilled rehabilitation service daily, at least 5 days per week
G. The request meets the requirements of OAC 5160-1-01 Medicaid Medical Necessity.
H. There is a documented therapeutic plan to provide **ALL** of the following:

Commented [RB1]: Instability?

Commented [JA1R2]: Unstable condition remains defined in the rule.

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.

I. 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 (eg, 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*

J. *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. CareSource considers the criteria for the intermediate level of care to be met when:

A. The member's needs for long-term services and supports (LTSS) exceed the criteria for the protective level of care.
B. The member's LTSS needs are less than the criteria for the skilled level of care.
C. The member does not meet the criteria for the developmental disabilities level of care or meets one of the following:
    1. The member is determined after evaluation completed via an Ohio Department of Medicaid approved assessment tool to have a medical condition(s) or related need(s) requiring immediate need for support or
    2. The member receives a non-adverse Level II PASRR determination indicating the need for NF services
D. The member needs a minimum of one of the following:
    1. Requires assistance (not necessarily a licensed professional) with the completion of a minimum of two activities of daily living (ADL) as outlined below:
        a. Assistance with mobility in **at least** 1of the following components:
            (1). bed mobility
            (2). locomotion
            (3). transfer
        b. Assistance with bathing
        c. Assistance with grooming in **ALL** of the following components:
            (1). oral hygiene
            (2). hair care
            (3). nail care
        d. Assistance with toileting in **at least 1** of the following components:
            (1). Using a commode, bedpan, or urinal
            (2). Changing incontinence supplies or feminine hygiene products
            (3). Cleansing self

(4). Managing an ostomy or catheter

e. Assistance with dressing in **at least 1** of the following components:

(1) Putting on and taking off items of clothing or prosthesis

(2) Fastening and unfastening an item of clothing or prosthesis

f. Assistance with eating

2. Assistance with the completion of a minimum of 1 ADL and assistance with medication administration (ADLs listed in III D 1a-f), which are required due to member's inability to safely self-manage medications. Reasons may include but are not limited to:

01. Does not know current medications

02. Lacks insight into reasons medications are prescribed

03. Lacks ability to take medications as ordered due to cognitive impairment

3. Need for 24-hour support in order to prevent harm due to a cognitive impairment. Examples may include:

a. Member resides in a locked dementia unit

b. Negative results of mini mental status exam

4. A minimum of 1 skilled nursing service or skilled rehabilitation service

E. Direct skilled rehabilitation services less than 5 days per week

F. 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 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 non-adverse results, if indicated
3. Hospital Exemption Notice (for stays expected to be less than 30 days)
   NOTE: If a hospital exemption notice was submitted with the initial request and after admission it is determined that the member requires greater than a 30 day stay in the NF, the NF must provide valid, non-adverse PASRR results to CareSource by the 30th day of the stay.

C. The member's medical record must document 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 type, frequency, and duration of skilled nursing or rehabilitation services provided and the member's response to the intervention(s)

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 level of assistance the member needs from another person with ADLs, including whether the support is hands-on or limited to supervision for dressing, bathing, grooming, toileting, mobility and/or eating.
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.
2. Discharge planning includes:
1. Treatment plan development involving providers engaged in member's care
2. Evaluation of member's premorbid functioning compared to current state
3. Member and caregiver preferences and abilities
4. Evaluation for services at next level of care as appropriate for member's continued needs
5. Housing
6. Evaluation of psychosocial status and needs
7. Coordination of follow up appointments, planned or scheduled

8. Transportation
9. Coordination of prescription medications and treatments to be available to member upon discharge
10. Home care services, if applicable
11. Referrals made for assistance and support including to state and local programs and/or community-based organizations
12. Medical equipment and supplies coordinated
13. Transition plan communicated to all members of member's care team

3. 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.
4. The NF must develop and share with CareSource UM during each review a discharge plan of care to address the anticipated needs of a member to remain in the current NF or 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. 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 by the NF provider to facilitate discharge from the facility:
1. Medication regimen has been established and reconciliation completed.
2. Medical status is stable for member's condition and manageable at lower level of care.
3. Any inserted or implanted device discontinued, or functioning normally and manageable at lower level of care.
4. Medical equipment and supplies are available at next level of care and safe use has been demonstrated.
5. Wound(s) or dressing changes are manageable at a lower level of care.
6. Skilled services (as needed) and logistical requirements can be met at a lower level of care.
7. 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 are submitted to the Ohio Department of Medicaid by CareSource for eligible members. 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 criteria:

a. Be enrolled in a Medicaid category identified by the Ohio Department of Medicaid as eligible for disenrollment.
b. Be authorized by CareSource for the NF stay 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).
e. In addition, when a member meets criteria outlined in D.2 a, c, and d, the following scenarios are considered:
   i. If a member is admitted to a nursing facility while enrolled with another MCO and changes to CareSource, CareSource will align the disenrollment request to the disenrollment table dates.
   ii. If the admission date to the nursing facility is greater than three months prior to enrollment with CareSource, CareSource will submit the disenrollment request during the initial enrollment month to disenroll the member the last calendar date of the month prior to the initial enrollment.
   iii. If a member is admitted to a nursing facility prior to being enrolled with CareSource and was admitted under fee-for-service Medicaid, CareSource will submit a disenrollment request during the initial enrollment month to disenroll the member the last calendar date of the month prior to initial enrollment. If the disenrollment request is not submitted in the initial month, the member will be disenrolled as of the last calendar date of the submission month.

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

3. Requests for disenrollment will be submitted in the format specified by ODM. The disenrollment table lists the earliest disenrollment date if all criteria are 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)

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	E-voted adding new section V. on Bed-Hold days
	05/10/2023	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.
	07/16/2024	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.
	07/30/2025	Changed MCP to MCO to align language to the current provider agreement; Added disenrollment language from the new contract.
	07/29/2026	Updated language in definitions to match current language in OAC 5160-3-08. Updated references. Approved at Committee
Date Effective	11/01/2026	
Date Archived		

H. References

1. ASPE. An Overview of Long-Term Services and Supports and Medicaid: Final report. May 8, 2018. Accessed July 7, 2026. www.hhs.gov
2. CareSource Procedure. Utilization Management - Level of Care. 2023. Accessed June 8, 2026. www.CareSource.com
3. CG-GRFAC (RFC) General Recovery Facility Comparison Tool. MCG Guidelines. 28th ed. 2024. Accessed July 7, 2026. www.careweb.careguidelines.com
4. CMS. Long-Term Services and Supports Rebalancing Toolkit. 2020. Accessed June 8, 2026. www.Medicaid.gov

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

5. Criteria for Nursing Facility-Based Level of Care, OHIO ADMIN. CODE 5160-3-08 (2025).
6. Criteria for the protective level of care. OHIO ADMIN. CODE 5160-3-06 (2025).
7. Jopson AD, Fabius CD, Wolff JL. Managed Long-Term Services and Supports and Caregiving Among Dually Enrolled Older Adults. *JAMA Netw Open*. 2025;8(8):e2528006. Published 2025 Aug 1.
8. Level of Care Definitions, OHIO ADMIN. CODE 5160-3-05 (2025).
9. Managed Care: Termination of Enrollment, OHIO ADMIN. CODE 5160-26-02.1 (2025).
10. Medicaid Medical Necessity: Definitions and Principles, OHIO ADMIN. CODE 5160-1-01 (2022).
11. Nursing Facilities (NFs): Covered Days and Bed-Hold Days, OHIO ADMIN. CODE 5160-3-16.4 (2022).
12. Nursing Home and Residential Care Facility Definitions, OHIO REV. CODE § 3721.01 (2025).
13. ODM. Nursing Facility Request Form. Accessed June 8, 2026. www.medicaid.ohio.gov
14. Process and timeframes for a level of care determination for nursing facility-based level of care programs. OHIO ADMIN. CODE 5160-3-14 (2025).
15. Skilled Nursing, OHIO REV. CODE § 3721.011 (2023).

ODM approved 09/25/2026