CareSource

MEDICAL POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Nursing Facility Stay Level of Care Determinations-MyCare Ohio FIDE-MM-1853	01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) 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, then the plan contract 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 Stay Level of Care Determinations

B. Background

Long-term care facility (LTCF) services may be required when an individual's long-term services and supports (LTSS) needs exceed what can be provided in a community setting. This care may include services that address an individual's need for assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and/or skilled nursing or therapy services. Individuals seeking care in a LTCF must meet the criteria outlined in the Ohio Administrative Code (OAC) for nursing facility (NF) based level of care and medical necessity requirements.

This policy outlines the medical necessity criteria for evaluating members seeking long term care.

C. Definitions

- **Activities of Daily Living (ADLs)** – Activities that include personal or self-care to address basic care needs. This includes tasks like bathing, dressing, eating, toileting, grooming, and mobility (OAC 5160-3-05).
- **Adverse Level of Care Determination** – A determination that an individual does not meet the criteria for a specific level of care (OAC 5160-3-05).
- **Assistance** – The hands-on provision of help in the initiation and/or completion of a task. It is generally considered to be any aid in which the caregiver makes direct, physical contact with an individual to assist with tasks, rather than just supervision or cueing.
- **Coverage Determination Letter (CDL)** – Communication regarding an adverse determination. It includes information regarding a member's hearing rights
- **Instrumental Activities of Daily Living (IADLs)** – Activities that include meal preparation, housekeeping, managing finances, and community mobility (OAC 5160-3-05).
- **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. An individual 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 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 Disabilities (ICF/IID)** – A Medicaid certified residential setting that provides 24-hour care and support to individuals with intellectual and developmental disabilities with a focus on habilitation, development, and supportive health services. See Long Term Care Facility.

- **Level of Care (LOC)** – The level of services and supports required by an individual to manage medical conditions, activities of daily living (ADLs), and instrumental activities of daily living (IADL) needs.
- **Long Term Care** – Care provided to Medicaid eligible individuals in a nursing facility (OAC 5160:1-6-01.1).
- **Long Term Care Facility (LTCF)** – A nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or medical institution with respect to which payment is made based on a level of care provided in the facility (OAC 5160:1-6-01.1).
- **Long-Term Services and Supports (LTSS)** – An array of medical and personal care services for an individual who requires support or assistance with self-care due to aging, physical, cognitive, or mental conditions or disabilities. LTSS include, but are not limited to:
  - nursing facility care
  - adult day programs
  - personal care services
  - transportation
- **Nursing Facility (NF)** – A facility that provides nursing and medical care to individuals who do not require care in an acute setting, but do require nursing services, rehabilitation services, other health-related services, and/or personal care services that must be performed by or under the supervision of a skilled, licensed professional that cannot be provided in the community (See LTCF).
- **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.
- **Preadmission Screening/Resident Review (PASRR)** – A federal requirement to help ensure that individuals with indications of serious and persistent mental illness (SPMI) and/or development disabilities (DD) are not inappropriately placed in nursing homes for care.
- **Protective Level of Care** – Supervision provided to assist an individual in meeting three instrumental activities of daily living (IADLs) and one activity of daily living (ADL) or medication administration. An individual has a need for less than 24-hour supervision to prevent harm due to a cognitive impairment.
- **Respite Nursing Facility Stay** – The admission of an individual to a nursing facility for a maximum of 14 days in order to provide respite to in-home caregivers to whom the individual is expected to return following the respite stay.
- **Respite Services** – Services that provide short-term, temporary relief to the informal unpaid caregiver of a managed care member in order to support and preserve the primary care giving relationship.
- **Skilled Level of Care** – Care provided to an individual that exceeds the protective and intermediate levels of care. The individual requires at least 1 skilled nursing service at least 7 days per week or 1 skilled rehabilitation service at least 5 days per week, and the individual’s medical condition is not stable.

- **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 (OAC 5160-3-05).
- **Skilled Rehabilitation Services** – Specific tasks that must be provided directly by a licensed or other appropriately certified technical or professional health care personnel (OAC 5160-3-05).

D. Policy

I. For Medicaid covered nursing facility stays, CareSource will evaluate the MyCare Ohio FIDE member's need for the level of services provided by a nursing facility using the criteria for nursing facility-based level of care found in OAC rules 5160-3-06, 5160-3-08, 5160-3-14, and 5160-1-01.
   A. All requests will be evaluated for the intermediate and skilled levels of care concurrently when the review is completed.
   B. Evidence of non-adverse Preadmission Screening and Resident Review (PASRR) requirements being met must be provided to CareSource before a level of care determination can be issued

II. Documentation to Support Nursing Facility-Based Care Determinations
For a LOC determination to be made, a complete level of care request must be submitted to CareSource by the LTCF for review.
   A. LOC request submitted using:
      1. Ohio Department of Medicaid 03697 Form
      2. CareSource LOC Request form, or
      3. ODM Nursing Facility Request Form
   B. PASRR Documentation. Evidence of non-adverse preadmission screening results or the exemption notification must be submitted as part of the level of care request:
      1. Preadmission Assessment and Results:
         a. PASRR Level I screen and preadmission screen (PAS) or resident review (RR) results
         b. PASRR Level II evaluation and results, if the outcome of the level I assessment requires a level II assessment.
      2. Hospital Exemption from Preadmission Screening Notification (for NF stays expected to be less than 30 days). For stays in which the hospital exemption notification 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 and resident review results must be submitted to CareSource.
   B. Medical Records. Required documentation to complete the LOC review includes:
      1. demographic information (eg, member's Medicaid ID, CareSource ID, legal name, date of birth, current address)
      2. the original date of admission to the NF, if applicable
      3. requested date of the level of care
      4. NF name, address, estimated length of stay, provider ID
      5. diagnoses and dates of onset, if available

6. history and physical exam pertinent to the member's care
7. ordered medications and treatments
8. therapy evaluation and treatment notes, if applicable
9. assessment of current cognitive, physical and behavioral function compared to the prior level of function (PLOF)
10. the level of assistance required to complete ADLs and IADLs
11. updated clinical evaluation to support on-going concurrent review
12. Minimum Data Set (MDS) documentation of cognitive, mood, functional performance, DME use, and/or nutritional status
13. complete discharge planning assessment including member preferences and identification of formal and informal supports
14. certification in the form of a signature, e-signature, or signature received via fax or mail from a physician, nurse practitioner or physician assistant identifying member's need for nursing facility-based level of care
    a. Certification must be provided within thirty calendar days of submission of the level of care request (OAC 5160-3-14).
    b. Verbal certification from the physician, nurse practitioner, or physician assistant is acceptable in the instance of emergent NF admission due to an identified health, safety, or welfare concern. Written certification must be provided within thirty days of the verbal certification (OAC 5160-3-14).

III. Timeframes for Completion of a Level of Care Determination
   A. Level of care determinations are primarily completed through desk review within the required timeframes.
      1. Within 1 business day from the date of receipt of a complete level of care request in the following circumstances:
         a. Member is seeking admission or re-admission to a NF from a hospital or emergency room
         b. Member is receiving adult protectives services at the time of the level of care request
      2. Within 5 calendar days from the date of receipt of a complete level of care determination when:
         a. Member is changing from a non-Medicaid payor to Medicaid payment for the individual's continued NF stay
         b. Member is transferring from one NF to another NF
         c. Member is residing in the NF and becomes eligible for CareSource MyCare
   B. An in-person level of care determination may be required in certain circumstances and will be completed within the required timeframes.
      1. Within 10 calendar days from the date of the receipt of a complete level of care request when:
         a. A member or their authorized representative requests an in-person level of care determination.
         b. An adverse determination is made during a desk review level of care determination.

c. The information needed to make a level of care determination through a desk review is inconsistent.
d. Member resides in the community and does not have a current NF-based LOC (i.e., is not enrolled in HCBS waiver services).
e. Member has a pending disenrollment from a NF-cases HCBS waiver program due to no longer meeting a NF-based level of care criteria.

2. Within 2 business days from the date of a level of care request for a member receiving adult protective services when the required medical records are not provided to complete the desk review.

IV. Level of Care Validation
A. A level of care validation will be completed in lieu of an in-person level of care determination within one business day from the date of a level of care request when:
1. A member who is currently enrolled on a NF-based HCBS waiver seeks admission to a NF.
2. An individual who resides in a NF is seeking readmission to the same NF after a hospitalization.
B. The level of care validation includes:
1. Verification that preadmission screening and resident review criteria are met
2. Member's current level of care is accurately reflected in the care coordination record. Elements used may include:
a. comprehensive assessment records
b. person-centered care plan
c. person-centered service plan
d. care coordination notes

V. Requirements for Level of Care Determinations
A. The preadmission screening process must be completed before a LOC determination or level of care validation can be issued. A level of care determination cannot predate a non-adverse PASRR result.
B. The levels of care that qualify for payment of a Medicaid covered NF stay are intermediate and skilled.
1. For CareSource to consider payment for services provided to a MyCare member in a NF, the member must have both a non-adverse PASRR determination and a non-adverse level of care determination.
2. NF services that predate the PASRR determination are not eligible for Medicaid payment.
C. A level of care cannot be requested or determined retroactively with an effective date prior to or within an active post-payment claims review period
D. A level of care that is requested retroactively must include medical records and PASRR documentation that demonstrate level of care criteria was met from the date the level of care is requested.

VI. Notification of Level of Care Determinations

A. Members, their authorized representative(s) when applicable, and the Nursing Facility will be notified in writing of the level of care determination.
B. If the level of care determination is adverse, CareSource will provide the CDL which will include details regarding the determination and information regarding the individual's hearing rights.

VII. 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 has a valid level of care issued 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.
B. Bed-hold days do not require prior authorization.

VIII. Respite Services
C. In accordance with OAC 5160-3-15, CareSource will provide waiver members up to 14 days in a nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the respite stay.
D. Members will maintain their waiver designation as long as there is no more than a 90-day gap in receiving waiver services.
E. When a waiver member reaches the 100-day mark, the member is evaluated for redetermination of eligibility for Medicaid benefits based on a significant change of condition.

E. Conditions of Coverage
NA

F. Related Policies/Rules
Nursing Facility Level of Care

G. Review/Revision History

	DATE	ACTION
Date Issued	11/19/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References
1. CG-GRFAC (RFC) General Recovery Facility Comparison Tool. MCG Guidelines. 29th ed. 2025. Accessed November 12, 2025. www.careweb.careguidelines.com
2. Criteria for nursing facility-based level of care. OHIO ADMIN. CODE 5160-3-08 (2025)
3. Criteria for protective level of care. OHIO ADMIN. CODE 5160-3-06 (2025)

4. Level of Care Definitions. OHIO ADMIN. CODE 5160-3-05 (2025)
5. Medicaid: definitions relating to eligibility for long-term care services. OHIO ADMIN. CODE 5160:1-6-01.1 (2024)
6. Medicaid medical necessity: definitions and principles. OHIO ADMIN. CODE 5160-1-01 (2022).
7. Nursing facilities (NFs): covered days and bed-hold days. OHIO ADMIN. CODE 5160-3-16.4 (2017)
8. Nursing facility-based level of care home and community-based services programs: out-of-home respite services. OHIO ADMIN. CODE 5160-44-17 (2024).
9. ODM 03697 Form. Ohio Department of Medicaid (2025) Accessed October 9, 2025. www.ohio.gov. ODM03697fillx.pdf
10. Preadmission screening and resident review (PASRR) definitions. OHIO ADMIN. CODE 5160-3-15 (2019)
11. Process and timeframes for a level of care determination for nursing facility-based level of care programs. OHIO ADMIN. CODE 5160-3-14 (2025)

Approved by ODM 11/25/2025