

- (ii) It is necessary and desirable for the resident to remain in the facility.
 - (iii) It is feasible to meet the resident's health needs and, in an ICF, SNF AND ICF-MR, the resident's habilitative/rehabilitative needs, through alternative institutional or noninstitutional services.
- (c) Basis for inspection team's determinations

In making the determinations on adequacy of services for each resident, the team may consider such items as whether:

- (i) The medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care and, where required, the plan of habilitation/rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded;
- (ii) The attending physician reviews prescribed medications;
 - (a) At least every thirty days in SNFs; and
 - (b) At least every sixty days in ICFs and ICFs-MR.
- (iii) Tests or observations of each resident indicated by the medication regimen are made at appropriate times and properly recorded;
- (iv) Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the resident;
- (v) The resident receives adequate services, based on such observations as:
 - (a) Cleanliness;
 - (b) Absence of decubitus ulcers;
 - (c) Absence of signs of malnutrition or dehydration; and
 - (d) Apparent maintenance of maximum physical, mental, and psychosocial functions.

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- (vi) In an SNF, ICF, AND ICF/MR, the resident r e c e i v e s a d e q u a t e habilitative/rehabilitative services, as evidence by:
 - (a) A planned program of activities to prevent regression; and
 - (b) Progress toward meeting objectives of the plan of care.
- (vii) The resident needs any service that is ~~not~~ furnished by the facility or through arrangements with others; and
- (viii) The resident needs continued placement in the facility or there is an appropriate plan to transfer the resident to an alternate setting of care.

(d) Reports of inspections

The team submits a report for each individual resident and a facility summarization report promptly to ~~the central office of the department~~ on each inspection. ~~The individual~~ INDIVIDUAL recipient reports ~~are totalled to provide a facility profile which contains~~ CONTAIN the information identified below and ~~is~~ ARE distributed as identified below.

- (i) The report contains the observations, conclusions, and recommendations of the team by:
 - (a) Listing the services needed but not received by residents;
 - (b) Listing the number and type of nursing and habilitative hours needed but not received by residents;
 - (c) Identifying the observations, conclusions and recommendations relating to the provision of social service and activity programs in each facility in addition to specific findings regarding individual residents.

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(ii) The department sends a copy of ~~each overall facility profile~~ THE INFORMATION AS APPLICABLE to:

- (a) The facility inspected;
- (b) The Ohio department of health;
- (c) Other state agencies that use the information in the reports to perform their official function.

(D) Action on reports

The department will take corrective action based on the team's report and recommendations. Corrective action will include:

- (1) Imposition of a fiscal disallowance for services needed but not received by the resident (reference rule 5101:3-3-23 ("NONALLOWABLE COSTS") of the Administrative Code).
- (2) Follow-up visit by appropriate ~~team members~~ ODHS REPRESENTATIVE(S) if the resident's needs as documented by the LTCF do not correspond with the team's observation of the resident or when, despite entries in the records, it appears that a service recorded as delivered has not been delivered (reference paragraph (B)~~(4)~~ (5) of this rule).

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Certification: _____

_____ Date

Promulgated Under RC Chapter 119.
Statutory Authority RCS 5111.02(D), 5111.23(D), and 5111.29
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LEVEL OF CARE REVIEW PROCESS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED.

- (A) "LEVEL OF CARE REVIEW", AS USED IN THIS RULE, IS AN ASSESSMENT OF AN INDIVIDUAL'S PHYSICAL, MENTAL, HABILITATIVE AND SOCIAL/EMOTIONAL NEEDS TO DETERMINE WHETHER THE INDIVIDUAL REQUIRES INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED. INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED ARE THOSE SERVICES AVAILABLE IN FACILITIES CERTIFIED AS INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF-MR) BY THE OHIO DEPARTMENT OF HEALTH.

THE EVALUATION OF AN INDIVIDUAL'S LOC NEEDS DETERMINES THE APPROPRIATELY CERTIFIED FACILITY TYPE FOR WHICH MEDICAID VENDOR PAYMENT CAN BE MADE. EXCEPT AS PROVIDED IN PARAGRAPH (D) OF THIS RULE, VENDOR PAYMENT CAN BE INITIATED TO AN ICF-MR ONLY WHEN THE APPLICANT IS DETERMINED TO NEED AN ICF-MR LOC ACCORDING TO THE CRITERIA SPECIFIED IN RULE 5101:3-3-07 OF THE ADMINISTRATIVE CODE.

(B) DEFINITIONS:

- (1) "CDHS" MEANS COUNTY DEPARTMENT OF HUMAN SERVICES.
- (2) "ICF-MR" MEANS INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED. AN ICF-MR IS A LONG TERM CARE FACILITY CERTIFIED TO PROVIDE SERVICES TO INDIVIDUALS WITH MENTAL RETARDATION OR A RELATED CONDITION WHO REQUIRE ACTIVE TREATMENT AS DEFINED AT 42 CFR 483 SUBPART D. IN ORDER TO BE ELIGIBLE FOR VENDOR PAYMENT IN AN ICF-MR, A MEDICAID RECIPIENT MUST BE ASSESSED AND DETERMINED BY CDHS TO BE IN NEED OF AN ICF-MR LEVEL OF CARE AS OUTLINED IN RULE 5101: 3-3-07 OF THE ADMINISTRATIVE CODE.
- (3) "INDIVIDUAL" MEANS A MEDICAID RECIPIENT OR PERSON WITH PENDING MEDICAID ELIGIBILITY WHO IS MAKING APPLICATION TO A NURSING FACILITY (NF) OR ICF-MR; OR WHO RESIDES IN A NF OR AN ICF-MR; OR IS APPLYING FOR HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER ENROLLMENT.
- (4) "PHYSICIAN" MEANS A DOCTOR OF MEDICINE OR OSTEOPATHY LEGALLY AUTHORIZED TO PRACTICE MEDICINE IN THE STATE OF OHIO.
- (5) "PSYCHOLOGIST" MEANS AN INDIVIDUAL LICENSED BY THE OHIO BOARD OF PSYCHOLOGY.

(C) LEVEL OF CARE REVIEW IS REQUIRED FOR INDIVIDUALS IN THE FOLLOWING SITUATIONS:

- (1) HOSPITALIZED INDIVIDUALS WHO ARE NOT CURRENTLY ICF-MR RESIDENTS WHO ARE APPLYING FOR ICF-MR PLACEMENT.
- (2) HOSPITALIZED INDIVIDUALS WHO ARE CURRENT ICF-MR RESIDENTS WHO ARE SEEKING ADMISSION TO A DIFFERENT ICF-MR.
- (3) INDIVIDUALS SEEKING READMISSION TO THE ICF-MR AFTER EXHAUSTING AVAILABLE PAID HOSPITAL LEAVE DAYS (SEE RULE 5101:3-3-03 OF THE ADMINISTRATIVE CODE FOR A DISCUSSION OF AVAILABLE LEAVE DAYS).

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- (4) INDIVIDUALS WHO ARE CURRENT ICF-MR RESIDENTS WHO ARE SEEKING ADMISSION TO A DIFFERENT ICF-MR.
 - (5) INDIVIDUALS WHO ARE NOT CURRENTLY ICF-MR RESIDENTS WHO ARE SEEKING ADMISSION TO AN ICF-MR FROM COMMUNITY LIVING ARRANGEMENTS.
 - (6) INDIVIDUALS WHO WERE ON PAID LEAVE DAYS AND ARE NOT IN A HOSPITAL SETTING AND WHO HAVE EXHAUSTED THEIR PAID LEAVE DAYS, WHO ARE SEEKING READMISSION TO A ICF-MR.
 - (7) CURRENT ICF-MR RESIDENTS WHO ARE REQUESTING MEDICAID REIMBURSEMENT OF THEIR ICF-MR STAY.
 - (8) INDIVIDUALS APPLYING FOR HCBS WAIVER SERVICES.
- (D) UNDER THE CIRCUMSTANCES IN PARAGRAPHS (D) (1), (D) (2) AND (D) (3) OF THIS RULE, VENDOR PAYMENT SHALL BE CONTINUED OR REINSTATED WHEN A CHANGE IN INSTITUTIONAL SETTING IS SOUGHT.
- (1) CURRENT ICF-MR RESIDENTS RECEIVING MEDICAID VENDOR PAYMENT WHO WISH TO TRANSFER TO ANOTHER ICF-MR MUST SUBMIT A COMPLETED DHS 3697 FORM, NOT LATER THAN THE DAY OF TRANSFER TO THE NEW ICF-MR, AS SPECIFIED IN PARAGRAPHS (E) (1) AND (E) (2) OF THIS RULE TO INITIATE REIMBURSEMENT IN THE NEW ICF-MR EFFECTIVE FROM THE DATE OF ADMISSION.
 - (a) UNDER THIS CIRCUMSTANCE, VENDOR PAYMENT TO THE NEW ICF-MR WILL BE AUTHORIZED BACK TO THE DATE OF THE INDIVIDUAL'S ADMISSION TO THE FACILITY. ODHS SHALL NOTIFY THE APPROPRIATE CDHS TO BEGIN VENDOR PAYMENT. IF ODHS DETERMINES THAT THE INDIVIDUAL IS NO LONGER IN NEED OF A ICF-MR LOC, ODHS WILL NOTIFY THE RECIPIENT AND THE ICF-MR AS TO THE ADVERSE ODHS DETERMINATION AND ODHS'S INTENT TO TERMINATE VENDOR PAYMENT. THE NOTICE SHALL SET FORTH THE RECIPIENT'S HEARING RIGHTS AND THE TIMES IN WHICH THEY MAY BE EXERCISED. ODHS MAY INSTRUCT THE APPROPRIATE CDHS, AS ITS DESIGNEE TO ISSUE THIS NOTICE.
 - (b) IF A HEARING REQUEST IS RECEIVED IN RESPONSE TO THE NOTICE SPECIFIED IN PARAGRAPH (D) (1) (a) OF THIS RULE WITHIN TIME FRAMES SPECIFIED IN OHIO ADMINISTRATIVE CODE (OAC) 5101:1 CHAPTER 35 THAT REQUIRES THE CONTINUATION OF BENEFITS, AUTHORIZATION FOR PAYMENT WILL BE CONTINUED PENDING THE ISSUANCE OF A STATE HEARING DECISION.

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- (c) IF THE INDIVIDUAL DOES NOT MAKE A HEARING REQUEST WITHIN THE TIME FRAME SPECIFIED IN (D) (1) (b) OF THIS RULE, VENDOR PAYMENT WILL AUTOMATICALLY TERMINATE ON THE DATE SPECIFIED IN THE NOTICE ADVISING THE RECIPIENT OF ODHS' INTENT TO TERMINATE VENDOR PAYMENT.
- (2) HOSPITALIZED INDIVIDUALS WHO ARE CURRENT ICF-MR RESIDENTS AND ARE SEEKING ADMISSION TO A DIFFERENT ICF-MR, MUST MEET THE REQUIREMENTS IN PARAGRAPHS (D) (1) (a), (b) AND (c) OF THIS RULE IN ORDER TO HAVE VENDOR PAYMENT AUTHORIZED FROM THE DATE OF ADMISSION. THESE REQUIREMENTS MUST BE MET REGARDLESS OF WHETHER THEY HAVE EXHAUSTED PAID LEAVE DAYS.
- (3) HOSPITALIZED INDIVIDUALS WHO ARE SEEKING READMISSION TO THE SAME ICF-MR AFTER EXHAUSTION OF PAID LEAVE DAYS MAY BE READMITTED TO THAT ICF-MR REGARDLESS OF THE RESULTS OF THE LOC DETERMINATION, IF NOT LATER THAN THE DATE OF READMISSION THE RECIPIENT SUBMITS A COMPLETED DHS 3697 FORM TO INITIATE REIMBURSEMENT EFFECTIVE FROM THE DATE OF READMISSION. IF THE LOC DETERMINATION DOES NOT MATCH THE CERTIFICATION OF THE FACILITY AS SPECIFIED IN PARAGRAPH (A) OF THIS RULE, THE FOLLOWING PROCEDURES WILL APPLY:
- (a) VENDOR PAYMENT TO THE ICF-MR WILL BE AUTHORIZED BACK TO THE DATE OF THE INDIVIDUAL'S ADMISSION TO THE FACILITY. ODHS SHALL NOTIFY THE APPROPRIATE ODHS TO BEGIN VENDOR PAYMENT. IF ODHS DETERMINES THAT THE INDIVIDUAL IS NO LONGER IN NEED OF A ICF-MR LOC, ODHS WILL NOTIFY THE RECIPIENT AND THE ICF-MR AS TO THE ADVERSE ODHS DETERMINATION AND ODHS'S INTENT TO TERMINATE VENDOR PAYMENT. THE NOTICE SHALL SET FORTH THE RECIPIENT'S HEARING RIGHTS AND THE TIMES IN WHICH THEY MAY BE EXERCISED. ODHS MAY INSTRUCT THE APPROPRIATE ODHS, AS ITS DESIGNEE TO ISSUE THIS NOTICE.
- (b) IF A HEARING REQUEST IS RECEIVED IN RESPONSE TO THE NOTICE SPECIFIED IN (D) (3) (a) OF THIS RULE WITHIN TIME FRAMES SPECIFIED IN OAC 5101:1 CHAPTER 35 THAT REQUIRES THE CONTINUATION OF BENEFITS, AUTHORIZATION FOR PAYMENT WILL BE CONTINUED PENDING THE ISSUANCE OF A STATE HEARING DECISION.
- (c) IF THE INDIVIDUAL DOES NOT SUBMIT A HEARING REQUEST WITHIN THE TIME FRAME SPECIFIED IN (D) (3) (b) OF THIS RULE, VENDOR PAYMENT WILL AUTOMATICALLY TERMINATE ON THE DATE SPECIFIED IN THE NOTICE ADVISING THE RECIPIENT OF ODHS' INTENT TO TERMINATE VENDOR PAYMENT.
- (E) IN ORDER TO OBTAIN A LOC DETERMINATION, A DHS 3697, OR AN ALTERNATIVE FORM SPECIFIED BY ODHS, WHICH HAS BEEN APPROPRIATELY COMPLETED, ACCURATELY REFLECTS THE INDIVIDUAL'S CURRENT STATUS, AND IS CERTIFIED BY A PHYSICIAN MUST BE SUBMITTED FOR REVIEW BY ODHS.
- (1) THE DHS 3697, OR OTHER ODHS-AUTHORIZED ALTERNATIVE FORM MUST INCLUDE THE FOLLOWING COMPONENTS AND/OR ATTACHMENTS:

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- (a) INDIVIDUAL'S NAME; MEDICAID NUMBER; DATE OF ORIGINAL ADMISSION TO THE FACILITY, IF APPLICABLE; CURRENT ADDRESS; NAME AND ADDRESS OF RESIDENCE IF CURRENT RESIDENCE IS A LICENSED OR CERTIFIED RESIDENTIAL SETTING OR HOSPITAL; AND COUNTY WHERE THE INDIVIDUAL'S MEDICAID CASE IS ACTIVE.
 - (b) ALL OF THE INDIVIDUALS CURRENT DIAGNOSES, INCLUDING MEDICAL, PSYCHIATRIC AND DEVELOPMENTAL DIAGNOSES.
 - (c) THE INDIVIDUAL'S MEDICAL AND SOCIAL FAMILY HISTORY.
 - (d) ALL OF THE INDIVIDUAL'S CURRENT MEDICATIONS, TREATMENTS, AND ANCILLARY SERVICES REQUIRED.
 - (e) THE INDIVIDUAL'S CURRENT PHYSICAL FUNCTIONAL CAPACITY AND PROGNOSSES.
 - (f) AN INDICATION OF THE INDIVIDUAL'S FUNCTIONAL STATUS, INCLUDING AN ASSESSMENT OF CURRENT STATUS IN SELF CARE, MOBILITY, CAPACITY FOR INDEPENDENT LIVING, LEARNING, SELF DIRECTION AND COMMUNICATION SKILLS.
 - (g) KINDS OF SERVICES NEEDED BY THE INDIVIDUAL.
 - (h) AN EVALUATION OF THE RESOURCES AVAILABLE TO THE INDIVIDUAL IN THE HOME, FAMILY AND COMMUNITY.
 - (i) AN ASSESSMENT OF THE INDIVIDUAL'S CURRENT MENTAL/BEHAVIORAL STATUS.
 - (j) THE TYPE OF SERVICE SETTING FOR WHICH THE LOC DETERMINATION IS SOUGHT (ICF-MR HCBS).
 - (k) A SIGNED AND DATED STATEMENT BY A PHYSICIAN CERTIFYING THAT ALL INFORMATION PROVIDED ABOUT THE INDIVIDUAL IS A TRUE AND ACCURATE REFLECTION OF THE INDIVIDUAL'S CONDITION AND THAT THE INDIVIDUAL REQUIRES INPATIENT CARE AT THE ICF-MR LEVEL.
- (2) THE DHS 3697 MUST BE COMPLETE WHEN IT IS SUBMITTED TO ODHS IN ORDER FOR A LOC DETERMINATION TO BE MADE. ANY ENTITY (A ODHS, HOSPITAL OR ICF-MR) WHO SUBMITS A LOC REQUEST MUST ENSURE THAT ALL REQUIRED COMPONENTS ARE INCLUDED BEFORE SUBMISSION.
- (a) FOLLOWING RECEIPT BY ODHS OF THE DHS 3697, ODHS SHALL MAKE A DETERMINATION OF WHETHER THE DHS 3697 IS SUFFICIENTLY COMPLETE FOR ITS PERSONNEL TO PERFORM THE LOC REVIEW. IF THE DHS 3697 IS NOT COMPLETE, ODHS SHALL NOTIFY THE RECIPIENT IN WRITING, THE CONTACT PERSON INDICATED ON THE DHS 3697, AND THE ICF-MR OR ANY OTHER ENTITY RESPONSIBLE FOR THE SUBMISSION OF THE DHS 3697, THAT ADDITIONAL DOCUMENTATION IS NECESSARY IN ORDER TO COMPLETE THE LOC REVIEW. THIS NOTICE SHALL SPECIFY THE ADDITIONAL DOCUMENTATION THAT IS NEEDED AND SHALL INDICATE THAT THE INDIVIDUAL OR ANOTHER ENTITY HAS TEN DAYS FROM THE DATE ODHS MAILS THE NOTICE TO SUBMIT ADDITIONAL DOCUMENTATION OR THE DHS

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3697 WILL BE DENIED FOR INCOMPLETENESS WITH NO LOC AUTHORIZED. IN THE EVENT AN INDIVIDUAL OR OTHER ENTITY IS NOT ABLE TO COMPLETE A DHS 3697 IN THE TIME SPECIFIED, ODHS SHALL, UPON GOOD CAUSE, GRANT ONE EXTENSION OF NO MORE THAN FIVE DAYS WHEN AN EXTENSION IS REQUESTED BY THE RECIPIENT OR OTHER ENTITY.

- (b) IF THE DHS 3697 IS COMPLETE UPON RECEIPT BY ODHS, OR, IF WITHIN THE PERIODS SPECIFIED IN PARAGRAPH (E) (2) (a) OF THIS RULE, THE RECIPIENT SUBMITS THE REQUIRED DOCUMENTATION, ODHS SHALL ISSUE A LOC DETERMINATION WITHIN SIXTY DAYS OF THE ORIGINAL RECEIPT OF THE DHS 3697 BY ODHS. A LOC DETERMINATION WILL BE ISSUED PURSUANT TO THE CRITERIA SPECIFIED IN RULES 5101:3-3-05, 5101:3-3-06 AND 5101:3-3-07 OF THE ADMINISTRATIVE CODE.
- (3) A REQUEST FOR AN ICF-MR LOC WILL NOT BE DENIED BY ODHS FOR THE REASON THAT THE INDIVIDUAL DOES NOT NEED ICF-MR SERVICES UNTIL A QUALIFIED PROFESSIONAL WHOSE QUALIFICATIONS INCLUDE BEING A REGISTERED NURSE OR A QUALIFIED MENTAL RETARDATION PROFESSIONAL (AS SPECIFIED AT 42 CFR 483.430 CONDUCTS A FACE-TO-FACE ASSESSMENT OF THE INDIVIDUAL, REVIEWS THE MEDICAL RECORDS THAT ACCURATELY REFLECT THE INDIVIDUAL'S CONDITION FOR THE TIME PERIOD FOR WHICH PAYMENT IS BEING REQUESTED; MAKES A REASONABLE EFFORT TO CONTACT THE INDIVIDUAL'S PHYSICIAN; AND INVESTIGATES AND DOCUMENTS ALTERNATIVE COMMUNITY RESOURCES INCLUDING RESOURCES AVAILABLE IN THE HOME AND FAMILY WHICH MAY BE AVAILABLE TO MEET THE NEEDS OF THE INDIVIDUAL. AUTHORIZED PERSONNEL OTHER THAN THE PERSON WHO CONDUCTED THE ASSESSMENT WILL REVIEW THE ASSESSMENT AND MAKE THE FINAL LOC DECISION.

(F) THE LOC REVIEW PROCESS:

- (1) ODHS REVIEWS THE APPLICATION MATERIAL SUBMITTED FOR THE INDIVIDUAL AND COMPLETES THE PAYMENT AUTHORIZATION (DHS 3670) AND SENDS IT, ALONG WITH THE DHS 3697, TO THE CDHS DESIGNATED ON THE DHS 3697. THE CDHS SHALL SEND A COPY OF THE DHS 3697 TO THE ICF-MR.
- (2) AUTHORIZATION OF PAYMENT TO A ICF-MR WILL CORRESPOND WITH THE EFFECTIVE DATE OF THE LOC DETERMINATION SPECIFIED ON THE DHS 3670. THIS DATE WILL BE:
- (a) THE DATE OF ADMISSION TO THE ICF-MR IF IT IS WITHIN THIRTY DAYS OF THE PHYSICIAN'S SIGNATURE; OR
- (b) A DATE OTHER THAN THAT SPECIFIED IN PARAGRAPHS (F) (2) (a) OF THIS RULE. THIS ALTERNATIVE DATE MAY BE AUTHORIZED ONLY UPON RECEIPT OF A LETTER WHICH CONTAINS A CREDIBLE EXPLANATION FOR THE DELAY FROM THE ORIGINATOR OF THE LOC REQUEST. IF THE REQUEST IS TO BACKDATE THE LOC MORE THAN THIRTY DAYS FROM THE PHYSICIAN'S SIGNATURE, THE PHYSICIAN MUST VERIFY THE CONTINUING ACCURACY OF THE INFORMATION AND NEED FOR INPATIENT CARE BY EITHER ADDING A STATEMENT TO THAT EFFECT ON THE DHS 3697 OR BY ATTACHING A SEPARATE LETTER OF EXPLANATION.

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Certification

Date

Promulgated Under: Revised Code Chapter 119.03

Rule Amplifies: Revised Code Sections 5111.02
and 5111.041

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5101:3-3-17 Methods for establishing payment and settlement rates.

As used in this rule, "total per diem rate" means the total of the per patient per diem rates determined under section 5111.222 or sections 5111.23, 5111.24, and 5111.25 of the Revised Code, including efficiency incentives.

(A) Pursuant to Section 23 of Amended Substitute House Bill 298, the department shall determine prospective per diem rates in accordance with paragraphs (A)(1) and (A)(2) of this rule.

(1) For services rendered during the period beginning July 1, 1991, and ending June 30, 1992:

(a) Determine from the calendar year 1990 cost report the 1990 interim settlement total per diem rate for each nursing facility and intermediate care facility for the mentally retarded. For purposes of paragraph (A)(1) of this rule, the nursing and habilitation ceiling shall be suspended.

(b) Determine from the calendar year 1990 cost reports the 1990 statewide average interim settlement total per diem rate for all nursing facilities and the 1990 statewide average interim settlement total per diem rate for all intermediate care facilities for the mentally retarded.

(c) Calculation of the quotient is determined as follows:

(i) Divide \$79.69 by the statewide average total per diem rate determined for nursing facilities under paragraph (A)(1)(b) of this rule.

(ii) Divide \$79.29 by the statewide average total per diem rate determined for nursing facilities under paragraph (A)(1)(b) of this rule.

(iii) Divide \$133.76 by the statewide average total per diem rate determined for intermediate care facilities for the mentally retarded under paragraph (A)(1)(b) of this rule.

(iv) Divide \$133.36 by the statewide average total per diem rate determined for intermediate care facilities for the mentally retarded under paragraph (A)(1)(b) of this rule.

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(d) Prospective per diem rate is calculated as follows:

- (i) For each nursing facility, multiply the facility's 1990 interim settlement total per diem rate determined under paragraph (A)(1)(a) of this rule, by the quotient determined under paragraph (A)(1)(c)(i) of this rule. The resulting product is the facility's prospective per diem rate for services rendered during the period beginning July 1, 1991, and ending July 31, 1991. No adjustments shall be made in this per diem rate except in accordance with paragraphs (A)(1)(g), (C), (D), and (H) of this rule.
- (ii) For each nursing facility, multiply the facility's 1990 interim settlement total per diem rate determined under paragraph (A)(1)(a) of this rule by the quotient determined under paragraph (A)(1)(c)(ii) of this rule. The resulting product is the facility's prospective per diem rate for services rendered during the period beginning August 1, 1991, and ending June 30, 1992. No adjustments shall be made in this rate except in accordance with paragraphs (A)(1)(g), (C), (D), and (H) of this rule.
- (iii) For each intermediate care facility for the mentally retarded, multiply the facility's 1990 interim settlement total per diem rate determined under paragraph (A)(1)(a) of this rule, by the quotient determined under paragraph (A)(1)(c)(iii) of this rule. The resulting product is the facility's prospective per diem rate for services rendered during the period beginning July 1, 1991, and ending July 31, 1991. No adjustments shall be made in this per diem rate except in accordance with paragraphs (A)(1)(g), (C), (D), and (H) of this rule.
- (iv) For each intermediate care facility for the mentally retarded, multiply the facility's 1990 interim settlement total per diem rate determined under paragraph (A)(1)(a) of this rule by the quotient determined under paragraph (A)(1)(c)(iv) of this rule.

The resulting product is the facility's prospective per diem rate for services rendered during the period beginning August 1, 1991, and ending June 30, 1992. No adjustments shall be made in this rate except in accordance with paragraphs (A)(1)(g), (C), (D), and (H) of this rule.