

Here is information from the Ohio Department of Medicaid that we would like to share with you. This is information regarding the LOC process vs the 9401 process/LTC Detail Screen in Ohio Benefits information. If you are told by your DJFS representative that a "LOC/Level of Care" is needed, please use this information as a reference to resolve the issue.

Level of care versus the LTC Detail screen in the Ohio Benefits system

- "Level of care" requirements are separate from the LTC Detail Screen in the Ohio Benefits Medicaid system. The two follow completely different processes. Facilities can bill Medicaid and they will get paid if there is no level of care. They **SHOULDN'T** though and in the claims review process – if there is no level of care, the claims that were paid will be charged as an overpayment and will be collected back from the facility through an established process. The level of care is not housed in OB or in MITS. The level of care is in PIMS and reviewers check PIMS (the data base used by the Area Agencies on Aging) to ensure the level of care has been met in the claims review process.
- An LTC Detail screen does **NOT** equal a level of care. An LTC Detail screen equals an admission or discharge date in the case of a NF or ICF-IID, or equals an enrollment or disenrollment date in the case of a waiver.
- You need to have the admission entered, or the discharge in some instances, so DJFS can run the case. The admissions and discharges are entered in the LTC Detail Screen in Ohio Benefits, but the level of care doesn't affect the Medicaid eligibility determination process at all.
- The level of care is requested either through the managed care plan if on an MCP, or through the AAA (Preadmission Review at Council on Aging) by sending an ODM 03697 or appropriate medical documentation. The 9401 (or electronic equivalent) is **NOT** a level of care request and never has been.
- Ohio Benefits no longer has the level of care date on the LTC Detail Screen since Ohio Benefits is a Medicaid financial eligibility system. Remember, by being institutionalized for over 30 days the individual may be able to be on Medicaid if otherwise financially eligible. Without the approved LTC detail record, DJFS will not be able to approve Medicaid and other providers, such as hospitals, will not be able to have claims paid. PASRR and LOC should not stop the eligibility process from happening at the county DJFS level, but would come into play when the facility is trying to get paid.
- DJFS workers have access to Provider Gateway. If they are telling you that a "level of care" is needed, either have them check Provider Gateway for information about your 9401 or have them check the journal notes in Ohio Benefits, as there is often information entered by the Medicaid specialists who enter the LTC Detail Screen. If there is an issue with the 9401 submission, they should be able to find documentation about it. Or you can check Provider Gateway for information on the status of the 9401 that you submitted.
- Remember that you do not need an approved level of care in order to submit the 9401 in Provider Gateway. If your county DJFS worker tells you that a "level of care" is needed, you can remind them that they should not be using the term "level of care," but that DJFS just needs to see the NF admissions/discharges in the LTC Detail Screen in order to authorize benefits.