# Level of Care (LOC) Requests

**How does the NF request a LOC?**

Refer to the Level of Care Checklist and Submission Tips for submission requirements.

The NF faxes the request to (513) 810-3360 or e-mails the request to preadmissionreview@help4seniors.org.

**What is a LOC and who needs one?**

A LOC is "a determination of an individual`s physical, mental and social/emotional status" according to legal guidelines set forth in the Ohio Administrative Code. The LOC is not needed for DJFS to authorize payment, but that if the NF doesn't have a LOC in the post-payment audit process, ODM can recover any payments that were made to the NF.

In our area, Council on Aging of Southwestern Ohio has the contract to authorize LOCs.

- LOCs are needed for individuals residing in Nursing Facilities whose payer source is 100% traditional Medicaid and who are not enrolled in hospice.
- A LOC is not needed for individuals covered by Medicaid managed care.
- A LOC is not needed if an individual only used Medicaid as a co-payer.
- A LOC is not needed while an individual on Medicaid is enrolled with hospice, but a new LOC is needed when an individual on Medicaid dis-enrolls from hospice.
- A LOC is not needed for bed-hold days.

**How can a Pre-Admission Screening date or a Resident Review impact a LOC date?**
According to the Ohio Administrative Code, the effective date of a LOC cannot be prior to the effective date of the Pre-Admission Screening (PAS). "The LOC effective date cannot precede the date the PASRR requirements were met." This means that if an individual was required to go through PAS but failed to do so, their LOC cannot be dated prior to the date the PAS requirements were met. Also according to law, if the NF was not in compliance with the timelines or process of the Resident Review (RR) the dates of the LOC authorization can be impacted.

More information: Medicaid Level of Care Criteria

***Why is a LOC needed?***

- An intermediate (ILOC) or skilled (SLOC) LOC authorization by the PAA (such as Council on Aging) is needed for an individual to receive traditional Medicaid payment for a Nursing Facility (NF) stay.
- The LOC authorization is needed for individuals who are not enrolled in hospice and have days at the NF where traditional Medicaid is paying 100%. A LOC is not needed while Medicaid is only a co-payer or for bed-hold days.
- A LOC authorization is needed for the Department of Job and Family Services to start Medicaid "vendor payment" to the NF

***When is a LOC needed?***

- When the resident becomes financially eligible for Medicaid and needs Medicaid to start paying 100% of their NF stay
- When Medicare "cuts" an individual from coverage, they do not have enough money to pay out-of-pocket, and they qualify for Medicaid
- When an insurance policy no longer covers the individual`s NF stay, they do not have enough money to pay out-of-pocket, and they qualify for Medicaid
- When an individual with Medicaid payment transfers from one Ohio NF to another Ohio NF
- When an individual came from out-of-state, gets approved for Ohio Medicaid, and needs Ohio Medicaid to pay for their NF stay
- When an individual on NF Medicaid goes out to the hospital and has run out of "leave days" or "bed hold days" and wishes to return to the NF
- When the hospital did not obtain the LOC prior to the admission of the individual who was 100% Medicaid since their date of admission from the hospital
- When an individual has an actual gap in their Medicaid eligibility (not just a "glitch"). This often happens when an individual sells their house.
- When an individual under Medicaid at a NF is disenrolled from hospice. A LOC is not needed while an individual is enrolled in hospice.
- When an individual goes from managed care Medicaid to traditional Medicaid

***When is a LOC <u>not</u> needed?***

- When an individual is not 100% Medicaid
- When an individual is using Medicaid as a co payer or for bed-hold days only
- When an individual has a Medicaid managed care
- While an individual on Medicaid is enrolled in hospice