Ohio Medicaid Managed Care/MyCare Ohio
Nursing Facility Request Form

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Regulations

- PASRR Federal Statutes: 1919(e)(7) of the Social Security Act, 42 CFR 483.100-483.138
- PASRR State Regulations: OAC 5160-3-15, OAC 5160-3-15.1, OAC 5160-3-15.2, OAC 5123-14-01, OAC 5122-21-03
- Level of Care State Regulations: 5160-3-08 Criteria for nursing facility-based level of care, 5160-3-06 Criteria for the protective level of care, 5160-3-05 Level of care definitions

When should the NF Request Form be used?

The Managed Care Plans require request for prior authorization and level of care assessment for:

- MyCare and Medicaid skilled stays
- Medicaid long term care stays

The Managed Care Plans require a request for level of care assessment only for:

- MyCare long term care stays

To minimize confusion and create a standard process across all the managed care plans for nursing facilities to request PA/LOC, the Nursing Facility Request Form was developed in collaboration with the Ohio Department of Medicaid.

Where is the NF Request Form located?

The **Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form** can be found on the Ohio Department of Medicaid's website at this link:

https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Forms/2021_01-NF-Request-Form.pdf

NF Request Form
Instructions + additional supporting documentation

Ohio Medicaid Managed Care/MyCare Ohio
Nursing Facility Request Form

Aetna 855-734-9393 | **Paramount** 844-282-4908
Buckeye 866-529-0291 (Medicaid) | 877-861-6722 (MyCare)
CareSource 855-262-9791 (Medicaid) | 844-417-6157 (MyCare)
Molina 866-449-6843 (Medicaid) | 844-834-2152 (MyCare)
United 800-366-7304

Instructions for Submitting Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form

» Complete Sections I through VI of this form entirely and submit it to the appropriate plan. A medical necessity and level of care determination will not be able to be completed if supporting documentation is not submitted with the form. To ensure a determination is able to be made by the plan, the following documentation should be submitted with the form:
  - ☐ Clinical documentation including diagnoses, medications, current therapy notes, wound descriptions, IV medication, ventilator dependency (if applicable), current assistive device(s) used, and validation of protective level of care (including the need for assistance with any instrumental activities of daily living).
  - ☐ Documentation to support medical necessity using ODM criteria.
  - ☐ Documentation to support that PASRR requirements have been met; the PASRR determination letter should be attached to this submission if available.
  - ☐ Treatment plan or care plan; include a discharge plan if applicable and any noted barriers to discharge.
  - ☐ Any other pertinent information or noted barriers to reach goals.
» A signed order from a physician, nurse practitioner, or physician's assistant may be included in the clinical documentation in lieu of providing a signed certification on this form. If a signed order is not included in the clinical documentation, the certification signature on this form is required by one of the authorities listed above. When an order is used in lieu of the certification, the order should include the level of care under which the member is certified for admission to the NF.
» If applicable, include documentation showing previous level of care determination (include date of last level of care determination) or prior level of function.
» Requests for continued stays should be submitted in sufficient time prior to the end of the previous authorization.
» Routine requests will be determined within 10 calendar days; expedited/urgent requests will be determined within 48 hours.

NF Request Form PASRR Requirements

Prior to skilled nursing or long-term care admission, the nursing facility must complete the PASRR process as defined by the OAC rules. PASRR can be met through one of the following processes:

- **Hospital Exemption Notice (07000 Form), or**
- **Emergency Stay approval, or**
- **The PASRR Review Results letter. If 2nd level review is triggered, the 2nd level review results letter.**

The nursing facility must keep a copy of the results letter in the member's record as well as submit to the managed care plan with the Prior Authorization and/or Level of Care request. The PASRR process is required to be complete prior to the level of care determination.

Additional materials related to PASRR submission can be found here:

- https://medicaid.ohio.gov/Provider/ProviderTypes/NursingFacilities
- https://www.pasrrassist.org/

NF Request Form Section I

Section I – Member Information		
Date of Request (mm/dd/yyyy)	**Plan Type** ☐ Medicaid ☐ MyCare	**Request Type** ☐ Initial ☐ Concurrent
Member Name		
Date of Birth (mm/dd/yyyy)	**Member ID Number**	**Member Phone Number**
Service Is ☐ Routine ☐ Expedited/Urgent*	**Signature of Requesting Provider if Urgent/Expedited Request**	

*The Expedited/Urgent service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine.

NF Request Form Section II, III, IV

Section II – Requesting Provider Information		
Requesting Provider Name	**Requesting Provider NPI/Provider Tax ID Number**	
Requesting Provider Contact Name	**Phone Number/Fax Number**	
Section III – Servicing Provider/Facility Information ☐ Same as Requesting Provider		
Servicing Provider/Facility Name	**Provider NPI/Provider Tax ID Number**	
Contact Name	**Phone Number/Fax Number**	**Provider Status** ☐ PAR ☐ Non-PAR
Section IV – Service Information		
Admission Date (mm/dd/yyyy)	**Discharge Date**** (mm/dd/yyyy)	**LOC Request Date** (mm/dd/yyyy)
PASRR Requirements Met For (select one): ☐ Hospital Exemption (30 days) ☐ Respite Stay (14 days) ☐ Emergency Stay (7 days) ☐ Unspecified Time Approval ☐ Specified Time Approval (_____ days)		

**If Discharge Date is unknown, length of stay will be based upon medical necessity.

Member Attestation – I understand my healthcare options and choose to receive nursing facility services.	
Member or Authorized Representative Signature	**Date** (mm/dd/yyyy)

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NF Request Form Section V

Member Name:	Date:

Section V – Level of Care Information				
A. ACTIVITIES OF DAILY LIVING (ADLs)				
	Independent	*Supervision*	*Assistance*	*Source**
1. Bathing	☐	☐	☐	
2. Dressing	☐	☐	☐	
3. Eating	☐	☐	☐	
4. Grooming a. Oral Hygiene b. Hair Care c. Nail Care	 ☐ ☐ ☐	 ☐ ☐ ☐	 ☐ ☐ ☐	
5. Toileting	☐	☐	☐	
6. Mobility a. Bed b. Transfer c. Locomotion	 ☐ ☐ ☐	 ☐ ☐ ☐	 ☐ ☐ ☐	
B. MEDICATION ADMINISTRATION				
☐ Independent ☐ Supervision ☐ Assistance		**Source of Information**		
C. COGNITIVE IMPAIRMENT				
List activities for which 24-hour supervision is required to prevent harm due to cognitive impairment and explain:				

*List all sources of information for each item as follows: P=Physician, MR=Medical Record, C=Client, CG=Caregiver, AR=Authorized Representative, AO= Assessor Observation

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NF Request Form Section V cont.

D. SYSTEMS REVIEW Check if condition is unstable, if no abnormalities are reported, or if medical complications are present.			
	Unstable	*No abnormalities*	*Medical Complication*
Eyes, Ears, Mouth, and Throat	☐	☐	☐
Neurological	☐	☐	☐
Pulmonary	☐	☐	☐
Cardiovascular and Circulatory	☐	☐	☐
Musculoskeletal	☐	☐	☐
Gastrointestinal	☐	☐	☐
Genitourinary	☐	☐	☐
Skin	☐	☐	☐
Source of Information			

*List all sources of information for each item as follows: P=Physician, MR=Medical Record, C=Client, CG=Caregiver, AR=Authorized Representative, AO= Assessor Observation

NF Request Form Section VI

Section VI – Level of Care (LOC) Assessment Summary and Recommendation	
Activities of Daily Living (list total by category) ☐ Independent: ☐ Supervision: ☐ Assistance:	**Unstable Medical Condition** ☐ Yes ☐ No
Medication Administration ☐ Independent ☐ Supervision ☐ Assistance	**Needs 24 hour Supervision due to Cognitive Impairment** ☐ Yes ☐ No
Skilled Nursing Service(s) - list type(s) and frequency	**Skilled Rehabilitation Service(s) -** list type(s) and frequency
LOC Recommendation – based on review of the authorization form, it is recommended that the level of care indicated is appropriate. ☐ Intermediate ☐ Skilled	

CERTIFICATION: I certify that I have reviewed the information contained herein, and that the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended above is required.

Signature	Date

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NF Request Form Response from MCP

Managed care plans will provide notification to the nursing facility with the level of care and/or prior authorization determination.

If the member does not meet nursing facility level of care the facility will be notified and the member will receive a notice of action letter which includes hearing rights.

If the member is residing at the nursing facility at the time of the adverse LOC determination or denial of prior authorization/concurrent stay and the member is enrolled in care management, the managed care plan care manager will actively engage with the member and facility on discharge planning.

Contacts

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Thank you!


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