4123-6-38.2 Payment of nursing home and residential care/assisted living services.

(A) Payment to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only when the need for such care is the direct result of the allowed conditions in the claim.

(B) Payment will be made only for care provided in nursing homes and residential care/assisted living facilities meeting the qualifications specified in paragraph (C) of rule 4123-6-02.2 of the Administrative Code.

(C) Nursing home or residential care/assisted living facility care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.

(1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the bureau, MCO, QHP, or self-insuring employer.

(2) Nursing home care shall be provided on a semiprivate bed basis, unless a situation exists when the use of a private room is medically necessary due to the allowed industrial condition. In these cases, the use of such a private room must be pre-authorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where the claimant's condition would be endangered by delay.

(3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy in compliance with the rules of this chapter of the Administrative Code.

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