TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 147
REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17 Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective

July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended at 32 Ill. Reg. 8614, effective May 29, 2008; amended at 33 Ill. Reg. 9337, effective July 1, 2009; emergency amendment at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; emergency amendment modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 14, 2010.

Section 147.5 Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System

a) For Class I Institution for Mental Diseases (IMDs), until data can be collected and the payment methodology implemented using the Illinois Minimum Data Set-Mental Health (IL MDS-MH), appropriate for the care needs of the IMD resident population, as described in Table B of this Part, the nursing component shall be the rate in effect on July 1, 2006. The payment methodology using the IL MDS-MH shall be implemented on July 1, 2010.

b) To receive payment based on Table B, Class I IMDs shall obtain software that produces the Mental Health Assessment Protocols, outcome measures, and quality indicators, which are part of the MDS-MH system, and train staff to utilize this clinical information in resident treatment and care planning.

c) The nursing component of the rate shall be calculated annually and may be adjusted semi-annually. The determination of rates shall be based upon a composite of MDS-MH data collected from each eligible resident in accordance with Table B for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the six-month period preceding the rate period. Residents for whom MDS-MH resident identification information is missing or inaccurate, or for whom there is no current MDS-MH record for that period, shall be placed in the lowest MDS-MH acuity level for calculation purposes for that rate period. The nursing component of the rate may be adjusted on a semi-annual basis if any of the following conditions are met:

1) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds total variable nursing time calculated for the previous rate period by more than five percent.

2) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds:

A) total variable nursing time as calculated for the annual rate period by more than 10 percent;

B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

3) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No semi-

annual nursing component rate reduction shall exceed five percent from the annual rate determination.

d) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.

1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the MDS-MH is associated with an amount of time and staff level (Table B). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service, except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:

A) The mean wages for the applicable staff levels (licensed staff, RNs, LPNs, certified nursing assistants (CNAs), social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.

B) Fringe benefits shall be calculated in accordance with Section 147.150(c)(1)(B).

C) The base wage shall be calculated in accordance with Section 147.150(c)(1)(C).

D) Special minimum wage factor shall be calculated in accordance with Section 147.150(c)(1)(D).

E) Beginning July 1, 2010, Class I IMDs shall be paid a rate based upon the sum of the following:

i) The facility MDS-MH system based rate multiplied by a ratio the numerator of which is the quotient obtained by dividing the funds appropriated specifically to pay for rates based upon the MDS-MH methodology by the total number of Medicaid patient days utilized by facilities covered by the MDS-MH based system and the denominator of which

is the difference between the weighted mean rate obtained by the MDS-MH methodology and the weighted mean rate direct care rate for IMDs in effect on July 1, 2006.

ii) The facility rate in effect on July 1, 2006, multiplied by one minus the ratio computed in subsection (d)(1)(E)(i).

2) Vacation, sick leave and holiday time shall be calculated in accordance with Section 147.150(c)(2).

3) Special supplies, consultants and the Director of Nursing shall be calculated in accordance with Section 147.150(c)(3).

e) Determination of Facility Rates
An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection(d)(1) of this Section), adding the amounts for vacation, sick and holiday time (see Section 147.150(c)(2)), and supplies, consultants, and the Director of Nursing (see Section 147.150(c)(3)). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.

f) In order to code any item on the MDS-MH and receive subsequent reimbursement according to Table B, Class I IMDs shall follow all criteria and specific guidelines in the IL MDS-MH manual (Hirdes et al., RAI-MH Training Manual and Resource Guide 2.0, Toronto, Ontario Joint Policy and Planning Committee, 2003).

g) In order for services to qualify for reimbursement according to Table B, Class I IMDs shall maintain a minimum ratio for Psychiatric Rehabilitation Services Coordinator staff of one for every 20 residents.

h) The Department shall not pay for any new admissions to the Class I IMDs who are age 60 years or older or do not have a severe mental illness as determined by the State's mental health pre-admission screening program.

i) Service providers under Section L, Service Utilization/Treatments, of the MDS-MH shall be coded in column A when services are delivered by staff employed by the facility. Column B shall be coded for services delivered by outside individuals not employed by the facility. The Medicaid rate shall reflect only those services delivered by staff that is employed by the facility.

j) The Medicaid rate determined by Table B for Class I IMDs shall be the combination of a nursing component and socio-development component.

k) The Department of Healthcare and Family Services and the Department of Human Services-Division of Mental Health shall have the right of entry and inspection to all Class I IMD facilities in order to assess resident mix, monitor data quality, develop service quality indicators, and conduct studies, such as staff time samples, in order to test and refine the payment method.

(Source: Amended at 31 Ill. Reg. 8654, effective June 11, 2007)

Section 147.15 Comprehensive Resident Assessment (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.25 Functional Needs and Restorative Care (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.50 Service Needs (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.75 Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.100 Reconsiderations (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.105 Midnight Census Report

a) The census recorded must reflect the complete activities which took place in the 24 hour period from midnight to midnight.

b) The facility is required to compile a midnight census report daily. The information to be contained in the report includes:

1) Total licensed capacity.

2) Current number of residents in-house.

3) Names and disposition of residents not present in facility, i.e. therapeutic home visit, home visit, hospital (payable bedhold), hospital (non-payable bedhold), other.

(Source: Amended at 18 Ill. Reg. 4271, effective March 4, 1994)

Section 147.125 Nursing Facility Resident Assessment Instrument

a) Except as specified in subsection (b) of this Section, all Medicaid certified nursing facilities shall comply with the provisions of the current federal Long Term Care Resident Assessment Instrument User's Manual, version 2. (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2005), and the Resident Assessment Instrument-Mental Health Illinois version 2 (July 2003), adopted from Minimum Data Set-Mental Health version 2. This incorporation by reference includes no later amendments or editions.)

b) Nursing facilities shall, in addition, comply with the following requirements:

1) Complete a full Minimum Data Set (MDS) assessment, which includes required items A through R, in addition to any State required items, for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS assessment for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Section T. RAPs and Section T are only required with the comprehensive assessment described in the current federal Long Term Care Resident Assessment Instrument User's Manual, which includes assessments completed at admission, annually, for a significant change or for a significant correction of a prior MDS.

2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, the rate set will be based on the MDS received two quarters prior to the rate effective date and MDS not received within 31 days will be given a default rate.

c) While a new rate system referenced in Section 147.150 is under development, Medicaid-certified Class I IMDs shall electronically submit both the MDS pursuant to subsections (a) and (b) of this Section and the Illinois Minimum Data Set-Mental Health (IL MDS-MH) as specified by the Department at the following frequencies:

1) Complete a full IL MDS-MH within 14 days after admission for each resident, regardless of the resident's payment source.

2) Complete a full IL MDS-MH at 90 days after admission for each resident, regardless of the resident's payment source.

3) Complete a full IL MDS-MH at six months after admission for each resident, regardless of the resident's payment source, and every six months thereafter.

4) Transmit electronically to the Department's IL MDS-MH database, the IL MDS-MH for all required assessments within 31 days after the completion date of the assessment.

(Source: Amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006)

Section 147.150 Minimum Data Set (MDS) Based Reimbursement System

a) Public Act 94-0964 requires the Department to implement, effective January 1, 2007, a payment methodology for the nursing component of the rate paid to nursing facilities. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, reimbursement for the nursing component shall be calculated using the Minimum Data Set (MDS). Increased reimbursement under this payment methodology shall be paid only if specific appropriation for this purpose is enacted by the General Assembly.

b) Except as referenced in subsection (c)(1)(E)(iv) of this Section, the nursing component of the rate shall be calculated and adjusted quarterly. The determination of rates shall be based upon a composite of MDS data collected from each eligible resident in accordance with Section 147.Table A for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter.

c) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.

1) Variable Time Reimbursement.
Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Section 147.Table A). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:

A) The mean wages for the applicable staff levels (RNs, LPNs, certified nursing assistants (CNAs), activity staff, social workers),

as reported on the cost reports and determined by regional rate area, will be the mean wages.

B) Fringe benefits will be the average percentage of benefits to actual salaries of all nursing facilities based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the mean wage.

C) The base wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected base wage changes.

D) Special minimum wage factor. The process used in subsection (c)(1)(A) of this Section to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.

E) Beginning January 1, 2007, facilities shall be paid a rate based upon the sum of the following:

i) the facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006 funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology and the weighted mean rate in effect on December 31, 2006.

ii) the facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569(a)(1), multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). The exceptional care reimbursement per diem effective January 1, 2007 computed in 89 Ill. Adm. Code 140.569 shall be included in the nursing component of the June 30, 2006 rate unless the total variable nursing time for a rate quarter as calculated in

subsection (c)(1) of this Section is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive for the rate period zero percent of the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569.

iii) Until October 1, 2009, for facilities in which the number of ventilator care residents in any quarter has increased over the number used to compute the exceptional care per diem as specified in 89 Ill. Adm. Code 140.569(a)(1), the rate computed in subsections (c)(1)(E)(i) and (c)(1)(E)(ii) shall add the sum of total variable time reimbursement for the ventilator care add-on, vacation time, the average facility special patient need factors, and supply, consultant, and Director of Nursing factors for each resident receiving ventilator care in excess of the number used to compute the exceptional care per diem as specified in 89 Ill. Adm. Code 140.569(a)(1) divided by the total number of residents used to compute the MDS portion of the paid rate for that quarter. The resulting ventilator add-on shall be multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). This addition to the rate shall apply for each quarter regardless of the facility's eligibility for use of that quarter's MDS rate for computation of the paid facility rate as defined in subsection (b) of this Section.

iv) The calculations referenced in subsections (c)(1)(E)(i) and (ii) of this Section shall only change annually.

F) The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007 is $60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008 is $50 million. The annual amount of new funds for MDS reimbursement methodology beginning January 1, 2009 is $84 million.

2) Vacation, Sick Leave and Holiday Time.
The time to be added for vacation, sick leave, and holidays will be determined by multiplying the total of variable time by 5%.

3) Special Supplies, Consultants and the Director of Nursing.
Reimbursement will be made for health care and program supplies,

consultants required by the Department of Public Health (including the Medical Director), and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830.)

A) Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). Health care and program salaries shall be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.

B) The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for the Director of Nursing and consultant costs shall be the Statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.

C) These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).

d) Determination of Facility Rates.
An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection (c)(1) of this Section), adding the amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section), and supplies, consultants, and the Director of Nursing (see subsection (c)(3) of this Section). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.

e) A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect July 1, 2003 shall be provided for a period not exceeding December 31, 2006, as follows:

1) MDS-based rate adjustments under this Section shall not be effective until the attainment of a threshold. The threshold shall be attained at the earlier of either:

A) when all nursing facilities have established a rate (sum of all components) which is no less than the rate effective June 30, 2002, or

B) January 1, 2007.

2) For a facility that would receive a lower nursing component rate per resident day under the payment methodology effective July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be held at the level in effect on June 30, 2003 until a higher nursing component rate of reimbursement is achieved by that facility.

3) For a facility that would receive a higher nursing component rate per resident day under the payment methodology in effect on July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be adjusted based on the payment methodology in effect July 1, 2003.

4) Notwithstanding subsections (e)(2) and (3) of this Section, the nursing component rate per resident day for the facility shall be adjusted in accordance with subsection (c)(1)(E) of this Section.

(Source: Amended at 34 Ill. Reg. 3786, effective March 14, 2010)

Section 147.175 Minimum Data Set (MDS) Integrity

a) The Department shall conduct reviews to determine the accuracy of resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. Such reviews may, at the discretion of the Department, be conducted electronically or in the facility.

b) The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews. The Department may select facilities for on-site review based upon facility characteristics, past performance, or the Department's experience. This may include, but is not limited to, analysis of case mix profile of nursing facilities in regard to frequency in distribution of the residents in identified reimbursement categories. In addition, the Department may use findings of the licensing and certification survey conducted by IDPH indicating the facility is not accurately assessing residents. It may also include resident assessments submitted by the provider that do not meet submission deadlines, facilities with a high percentage of corrections and facilities with high submission error rates.

c) Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.

d) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals.

1) On-site reviews may be conducted with respect to residents or facilities that are identified pursuant to subsection (b) or (c) of this Section. Such review may include, but shall not be limited to, the following:

A) Review of resident records and supporting documentation, as identified in Section 147.200, observation and interview, to determine the accuracy of data relevant to the determination of reimbursement rates.

B) Review and collection of information necessary to assess the need for a specific service or care area.

C) Review and collection of information from the facility that will establish the direct care staffing level. The amount of staff available in the facility shall be sufficient to carry out the number and frequency of restorative programs identified for reimbursement.

2) The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded**.**

3) Upon the conclusion of any review, the Department shall conduct a meeting with facility management to discuss preliminary conclusions of the review. If facility management disagrees with those preliminary conclusions, facility management may, at that time, provide additional documentation to support their position.

e) Corrective action. Upon the conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate.

1) Data Accuracy

A) Final conclusions with respect to inaccurate data shall be referred to the Department of Public Health.

B) The Department, in collaboration with the Department of Public Health, shall make available additional training in the completion of resident assessments and the coding and transmission of MDS records.

2) Recalculation of Reimbursement Rate. The Department shall determine if reported MDS data or facility staffing data that were subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data. No change in reimbursement required as a result of a review shall take effect before July 1, 2004. Prior to the record review of residents receiving skills training, the following components of this Part will be reviewed to ensure compliance:

A) Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.

B) A private room shall be available with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.

C) Schedules shall be presented that identify residents and reflect the facility's ability to provide the sessions in increments of a minimum of 30 minutes for each skills training (not including time to assemble and settle). The sessions shall be scheduled at least three times per week.

D) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions.

3) In the event one or more of these components are not in place, the recalculated rate may be extrapolated to the entire population receiving this service.

4) When problems are noted in 30 percent of the population of residents receiving skills training during the record review, the recalculated rate may be extrapolated to the entire population receiving this service. When the recalculated rate has been extrapolated to the entire population, the facility shall obtain prior approval from the Department before future reimbursement for skills training is allowable. The Department shall have up to 90 days to determine this approval.

5) When problems are noted in 30 percent of coded responses to the sample population for other services areas, the review may be expanded to up to 100 percent for those service areas. The original sample population is defined as 20%, or no less than 10, of the eligible residents pursuant to Section 147.150(b).

6) In addition, the facilities with widespread problems in restorative and psychosocial adaptation may be subject to follow up reviews to ensure problems are corrected.

7) A facility's rate will be subject to change if the recalculation of the direct care component rate, as a result of using MDS data that are verifiable:

A) Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

B) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

C) Decreases the rate by more than ten percent in addition to the rate change specified in this subsection (e)(7). The direct care component of the rate shall be reduced, retroactive to the beginning of the rate period, by $1 for each whole percentage decrease in excess of two percent.

8) Any evidence or suspicion of deliberate falsification or misrepresentation of MDS data shall be referred to the Department's Inspector General and the Department of Public Health.

f) Appeals. Facilities disputing any rate change may submit an appeal request pursuant to 89 Ill. Adm. Code 140.830.

(Source: Amended at 32 Ill. Reg. 8614, effective May 29, 2008)

Section 147.200 Minimum Data Set (MDS) On-Site Review Documentation

a) Pursuant to Section 147.175, Department staff shall conduct on-site reviews of Minimum Data Set (MDS) data to determine the accuracy of resident information that is relevant to the determination of reimbursement rates.

1) Department staff shall request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDSs for the previous 15 months shall be provided to the review team within an hour after this request. Additional documentation regarding reimbursement areas for the identified Assessment Reference Date (ARD) timeframe shall be provided to the review team within four hours after the initial request.

2) When further documentation is needed by the review team to validate an area, the team will identify the area of reimbursement requiring additional documentation and provide the facility with the opportunity to produce that information. The facility shall provide the team with the additional documentation within 24 hours after the initial request. All documentation that is to be considered for validation must be provided to the team prior to exit.

3) Pursuant to 89 Ill. Adm. Code 140.12(f), the facility shall provide Department staff with access to residents, professional and non-licensed direct care staff, facility assessors, clinical records and completed resident assessment instruments, as well as other documentation regarding residents' care needs and treatments.

4) Failure to provide timely access to records may result in suspension or termination of a facility's provider agreement in accordance with 89 Ill. Adm. Code 140.16(a)(4).

5) Some states may have regulations that require supportive documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system (RAI Manual, page 1-24). These additional documentation requirements shall be met for reimbursement.

6) The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with medical peer review organizations to provide utilization review and quality assurance.

b) There shall be documentation in the resident's record to support an MDS coded response indicating that the condition or activity was present or occurred during the observation or look back period. Directions provided by the RAI User's Manual (as described in Section 147.125) are the basis for all coding of the MDS. Section S is reserved for additional State-defined items. All documentation requirements pertain to the MDS 2.0 and Section S items.

c) Each nursing facility shall ensure that MDS data for each resident accurately and completely describes the resident's condition, as documented in the resident's clinical records, maintained by the nursing facility, and the clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

d) Documentation guidance has been compiled from the RAI Manual, instructions that are present on the MDS 2.0 form itself, RAI-MH, and Illinois additional documentation requirements. If later guidance is released by CMS that contradicts or augments guidance provided in this Section, the more current information from CMS becomes the acceptable standard. If additional ICD-9 codes are published, they will be reviewed for appropriateness.

e) Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. All supporting documentation shall be found in the facility during an on-site visit.

f) All conditions or treatments shall have been present or occurred within the designated observation period. Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom/problem. Documentation shall apply to the appropriate observation period and reflect the resident's status on all shifts. In addition, the problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan. Insufficient or inaccurate documentation may result in a determination that the MDS item response submitted could not be validated.

g) Disease Diagnoses. Throughout Table A, when a diagnosis is required, the following must be met:

1) Code only those diseases or infections that have a relationship to the resident's current ADL (Activities of Daily Living) status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death as directed in the RAI Manual.

2) The disease conditions require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

3) Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

h) Activities of Daily Living (ADL).

1) Facilities shall maintain documentation that supports the coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period. The documentation shall show the MDS coded level of resident self-performance and support has been met.

2) Documentation shall be dated within the look-back period and must contain information from all three shifts that clearly supports the level of self-performance and support needed.

3) When there is a widespread lack of supporting documentation as described in subsections (h)(1) and (2), the ADL scores for the residents lacking documentation will be reset to zero.

4) When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.

i) Restorative services are programs under the direction and supervision of a licensed nurse and are provided by nursing staff. The programs are designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The focus is on achieving and/or maintaining optimal physical, mental, and psychosocial functioning. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Although therapists may participate in designing the initial program, members of nursing staff are still responsible for the overall coordination and supervision of restorative nursing programs. Staff completing the programs shall be communicating progress, maintenance, regression and other issues/concerns to the licensed nurse overseeing the programs. To qualify for reimbursement, the provision of restorative programs shall meet the following criteria for each program identified for reimbursement:

1) When programs are designed using verbal cueing as the only intervention, documentation and/or observation must support the following:

A) Without such cueing the resident would be unable to complete the required ADL task.

B) The verbal interventions are aimed at providing the resident with instructions for completing the task in such a way that promotes the resident's safety and awareness.

C) Verbal interventions that are simply reminders to complete the task may not be the sole content of the program.

2) Documentation shall clearly define the resident's need for the program and the defined program shall correspond to the identified need of the resident. Observation and/or interview shall also support the need for the program.

3) The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning. Staff completing the programs shall be aware of the program and the resident's need for the program.

4) Documentation must support that the program was reevaluated and goals and interventions were revised as necessary to assist the resident in reaching and/or maintaining his or her highest level of functioning.

5) Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized from one report to the next.

6) Goals shall be resident specific, realistic, and measurable. Goals shall be revised as necessary. Revisions shall be made based on the resident's response to the program.

7) The resident's ability to participate in the program shall be addressed.

8) Written evidence of measurable objectives and interventions shall be in the restorative plan of care and be individualized to the resident's problems and needs. There shall be evidence the objectives and interventions were reviewed quarterly and revised as necessary.

9) There shall be evidence of quarterly evaluation written by a licensed nurse in the clinical record. The evaluation must assess the resident's progress and participation in the program since the last evaluation. It shall contain specific information that includes the resident's response to the program

(i.e., amount of assistance required, devices used, the distance, the progress made, how well the resident tolerated the program). An evaluation shall be documented on each restorative program the resident is receiving.

10) There shall be written evidence that staff carrying out the programs have been trained in techniques that promote resident involvement in the activity.

11) If volunteers or other staff were assigned to work with specific residents, there shall be written evidence of specific training in restorative techniques that promote the resident's involvement in the restorative program.

12) There shall be documentation to support that the programs are ongoing and administered as planned outside the look-back period, unless there is written justification in the clinical record that supports the need to discontinue the program. Observation and/or interviews must also support that the programs are ongoing and administered as planned.

13) If a restorative program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, duration and frequency as part of the care planning process. The results of this reassessment shall be documented in the record.

14) The actual number of minutes per day spent in a restorative program shall be documented for each resident and for each restorative program during the look-back period.

15) The Department designated endurance assessment must be completed quarterly on each resident receiving two or more restorative programs. A licensed nurse must complete this assessment.

16) A resident coded as totally dependent in an ADL function will only be reimbursed for one quarter for the following corresponding restorative programs: bed mobility, transfer, walking, dressing/grooming, and/or eating/swallowing.

17) A resident scoring and/or receiving hospice services shall not be eligible for the following restorative programs: bed mobility, transfer, walking, dressing/grooming, eating and/or other restoratives.

18) When multiple restoratives are coded in a facility, the staff levels must support the ability to deliver these programs based on the number and frequency of programs coded.

19) All restorative programs shall meet the specifications of the RAI Manual for the individual restoratives.

j) Passive Range of Motion (PROM).

1) The restorative program shall meet the definition of PROM as identified in the RAI Manual.

2) The PROM program shall address the functional limitations identified in section G4 of the MDS.

3) There shall be evidence that the program is planned and scheduled. PROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.

k) Active Range of Motion (AROM).

1) The restorative program meets the definition of AROM as identified in the RAI Manual.

2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.

3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.

4) AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.

l) Splint/Brace Assistance. A splint or brace is defined as an appliance for the fixation, union, or protection of an injured part of the body.

m) Dressing or Grooming Restorative. Grooming programs, including programs to help the resident learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These programs shall have goals, objectives, and documentation of progress and be related to the identified deficit.

n) Scheduled Toileting.

1) The program shall have documentation to support that all the requirements identified in the RAI Manual are met.

2) The description of the plan shall be documented, including: frequency, reason, and response to the program.

3) The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.

4) This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, when there is no participation in the plan by the resident.

5) There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.

6) A resident scoring S1 = 1 (meets Subpart S criteria) shall have a corresponding diagnosis of cerebral vascular accident (CVA) or multiple sclerosis to qualify for reimbursement in scheduled toileting.

o) Continence Care.

1) Documentation shall support that catheter care was administered during the look-back period.

2) The type and frequency of the care shall be documented.

3) Documentation shall support that the RAI requirements for a bladder retraining program were administered during the look-back period.

4) The resident's level of incontinence shall be documented during the look-back period to support the bladder retraining program.

5) Bladder scanners cannot be the sole content of the bladder retraining program.

p) Pressure Ulcer Prevention.

1) Documentation shall support the history of resolved ulcer in the identified timeframe and/or the use of the coded interventions during the identified timeframe.

2) Interventions and treatments shall meet the RAI definitions for coding.

3) Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.

4) There shall be documentation that the resident was assessed related to his or her risk for developing ulcers. A resident assessed to be at high risk shall have interventions identified in the plan of care.

q) Moderate Skin Care/Intensive Skin Care.

1) Interventions and treatments shall meet the RAI definitions for coding.

2) Documentation of ulcers shall include staging as the ulcers appear during the look-back period.

3) Documentation of ulcers shall include a detailed description that includes, but is not limited to, the stage of the ulcer, the size, the location, any interventions and treatments used during the look-back period.

4) Documentation of burns shall include, but is not limited to, the location, degree, extent, interventions and treatments during the look-back period.

5) Documentation of open lesions shall include, but is not limited to, location, size, depth, any drainage, interventions and treatments during the look-back period.

6) Documentation of surgical wounds shall include, but is not limited to, type, location, size, depth, interventions and treatment during the look-back period.

7) All treatments involving M5e, M5f, M5g, and M5h shall have a physician's order with the intervention and frequency.

8) Documentation to support that the intervention was delivered during the look-back period shall be included.

9) Documentation of infection of the foot shall contain a description of the area and the location.

10) Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.

11) Documentation for items coded in M4 shall include documentation of an intervention, treatment, and/or monitoring of the problem or condition identified.

r) IV Therapy.

1) Documentation shall include the date delivered, type of medication and method of administration.

2) Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse as required in subsection (y) of this Section.

s) Injections. Documentation shall include the drug, route given and dates given.

t) Oxygen Therapy. Documentation shall include a physician's order and the method of administration and date given.

u) Chemotherapy. Documentation shall support the resident was monitored for response to the chemotherapy.

v) Dialysis. Documentation shall support the resident was monitored for response to the dialysis.

w) Blood Glucose Monitoring.

1) Documentation shall support that RAI criteria for coding a diagnosis was met, including a physician documented diagnosis.

2) Documentation shall support coding of a therapeutic diet being ordered and given to the resident.

3) Documentation shall support coding of a dietary supplement being ordered and given to the resident during the look-back period. There shall be evidence to support it was not part of a unit's daily routine for all residents.

4) Documentation shall support the coding that injections were given the entire seven days of the look-back period.

x) Infectious Disease.

1) Documentation shall support that the criteria defined in the RAI Manual for coding this subsection were met.

2) Documentation shall support the active diagnosis by the physician and shall include signs and symptoms of the illness.

3) Interventions and treatments shall be documented.

4) Documentation shall support that all RAI requirements for coding a Urinary Tract Infection (UTI) are met.

5) Administration of maintenance medication to prevent further acute episodes of UTI is not sufficient to code I2j.

y) Acute Medical Conditions.

1) Documentation shall support that the RAI requirements for coding these areas are met.

2) Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse.

3) There shall be evidence that the physician has evaluated and identified the medically unstable or acute condition for which clinical monitoring is needed.

4) There shall be evidence of significant increase in licensed nursing monitoring.

5) There shall be evidence that the episode meets the definition of acute, which is usually of sudden onset and time-limited course.

z) Pain Management.

1) There shall be documentation to support the resident's pain experience during the look-back period and that interventions for pain were offered and/or given.

2) Residents shall be assessed in a consistent, uniform and standardized process to measure and assess pain.

aa) Discharge Planning.

1) Social services shall document monthly the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made.

2) Social service documentation shall demonstrate realistic evaluation, planning, and follow-through.

3) Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.

bb) Nutrition.

1) Documentation shall support coding of tube feeding during the look-back period.

2) Intake and output records and caloric count shall be documented to support the coding of K6.

3) Documentation of a planned weight change shall include a diet order and a documented purpose or goal that is to facilitate weight gain or loss.

4) Documentation of a dietary supplement shall include evidence that resident received the supplement and that it was ordered and given between meals.

cc) Hydration.

1) Documentation shall support that the resident passes two or fewer bowel movements per week, or strains more than one of four times when having a bowel movement during the look-back period to support the coding of H2b.

2) Documentation shall support that the resident received a diuretic medication during the look-back period to support the coding of O4e.

3) Documentation shall include frequency of episodes and accompanying symptoms to support the coding of vomiting.

4) Documentation shall include signs and symptoms, interventions and treatments used to support the coding of volume depletion, dehydration or hypovolemia.

5) There shall be documentation of temperature to support the coding of fever.

6) There shall be documentation to support the coding of internal bleeding that shall include the source, characteristics and description of the bleeding.

7) There shall be documentation that interventions were implemented related to the problem identified.

dd) Psychosocial Adaptation. Psychosocial adaptation is intended for residents who require a behavior symptom evaluation program or group therapy to assist them in dealing with a variety of mood or behavioral issues. The criteria for reimbursement in this area requires both an intervention program and the identification of mood or behavioral issues. Residents shall be assessed for mood and behavioral issues and interventions shall be implemented to assist the resident in dealing with the identified issues. To qualify for reimbursement in this area, the facility must meet the following criteria:

1) Criteria for a special behavior symptom evaluation program.

A) There must be documentation to support that the program is an ongoing and comprehensive evaluation of behavior symptoms.

B) Documentation must support the resident's need for the program.

C) The documentation must show that the purpose of the program is to attempt to understand the "meaning" behind the resident's identified mood or behavioral issues.

D) Interventions related to the identified issues must be documented in the care plan.

E) The care plan shall have interventions aimed at reducing the distressing symptoms.

2) Criteria for group therapy.

A) There is documentation the resident regularly attends sessions at least weekly.

B) Documentation supports that the therapy is aimed at helping reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve.

C) This area does not include group recreational or leisure activities.

D) The therapy and interventions are addressed in the care plan.

E) This must be a separate session and cannot be conducted as part of skills training.

3) Criteria for indicators of depression.

A) There must be documentation to support that identified indicators occurred during the look-back period.

B) The documentation shall support the frequency of the indicators as coded during the look-back period.

C) There shall be documentation to support that interventions were implemented to assist the resident in dealing with these issues.

4) Criteria for sense of initiative/involvement.

A) There is documentation to support the resident was not involved or did not appear at ease with others or activities during the look-back period.

B) There shall be evidence that interventions were implemented to assist the resident in dealing with these issues.

5) Criteria for unsettled relationships/past roles.

A) There is documentation to support the issues coded in this area during the look-back period.

B) There shall be evidence that interventions were implemented to assist the resident in dealing with the issues identified.

6) Criteria for behavioral symptoms.

A) There is documentation to support that the behaviors occurred during the look-back period and the interventions used.

B) Documentation should reflect the resident's status and response to interventions.

C) Documentation should include a description of the behavior exhibited and the dates it occurred, as well as staff response to the behaviors.

D) Documentation supporting that the behaviors coded meet the RAI definitions for the identified behavior.

E) The care plan identifies the behaviors and the interventions to the behaviors.

7) Criteria for delusions/hallucinations.

A) There is documentation to support that the delusions or hallucinations occurred during the look-back period.

B) Documentation contains a description of the delusion or hallucinations the resident was experiencing.

C) There is documentation to support the interventions used.

ee) Psychotropic Medication Monitoring.
Documentation shall support the facility followed the documentation guidelines as directed by 42 CFR 483.25(l), Unnecessary drugs (State Operations Manual F-tag F329).

ff) Psychiatric Services (Section S).

1) There shall be evidence the resident met IDPH Subpart S criteria during the look-back period.

2) There shall be evidence a pre-admission screening completed by a Department of Human Services-Division of Mental Health screening entity was completed on the resident that identifies the resident as having a serious mental illness (SMI).

3) Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.

4) Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan (ITP).

5) Facilities must ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.

6) Adjustments in the rate for utilization of ancillary providers shall be calculated based upon Department claims data for ancillary provider billing.

gg) Skills Training. Skills training is specific methods for assisting residents who need and can benefit from this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria:

1) Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.

2) Addresses identified skill deficits related to goals noted in the treatment plan.

3) Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.

4) Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.

5) Training shall be provided in groups no larger than ten, with reduced group size for residents requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.

6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the severe mentally ill (SMI) and Mental Illness/Substance Abuse (MISA) populations are available for use and as models.)

7) The curriculum shall address discrete sets of skill competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.

8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.

9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.

10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.

11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary. However, on-going 1:1 training shall not qualify under this area.

hh) Close or Constant Observations.

1) Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item shall not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from hospital, or as a part of periodic resident headcounts.

2) There shall be documentation for the reason for use, confirmation that the procedure was performed as coded with staff initials at appropriate intervals, brief explanation of the resident's condition and reason for terminating the observation.

ii) Cognitive Impairment/Memory Assistance Services.

1) Documentation shall include a description of the resident's short-term memory problems.

2) A method of assessing and determining the short-term memory problem shall be documented.

3) Documentation shall include a description of the resident's ability to make everyday decisions about tasks or activities of daily living.

4) Documentation shall include a description of the resident's ability to make himself or herself understood.

jj) Dementia Care Unit.

1) Unit was Illinois Department of Public Health certified during look-back period.

2) Resident resided in the unit during the look-back period.

3) Activity programming is planned and provided seven days a week for an average of eight hours per day.

4) Required assessments were completed on the resident.

5) If the resident has a Cognitive Performance Scale (CPS) score of five, care planning shall address the resident's participation in the unit's activities.

6) If a particular resident does not participate in at least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.

7) Documentation shall support staff's efforts to involve the resident.

kk) Exceptional Care Services.

1) Respiratory Services.

A) A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.

B) Documentation of respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.

C) Documentation of a physician's orders for the treatments.

D) Respiratory therapy requires documentation in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.

E) Documentation of suctioning includes type, frequency and results of suctioning.

F) Documentation of trach care includes type, frequency and description of the care provided.

2) Weaning From Ventilator.
Documentation shall be in place to support weaning from the ventilator.

3) Morbid Obesity.

A) A dietician's evaluation shall be completed with evidence of on-going consultation.

B) On-going monitoring of weight shall be evident.

C) The psychosocial needs related to weight issues shall be identified and addressed.

4) Complex Wounds.
Facilities are to follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual F-tag F314). All documentation requirements listed in F314 shall be met.

5) Traumatic Brain Injury (TBI).

A) Documentation shall support that psychological therapy is being delivered by licensed mental health professionals, as described in the RAI Manual.

B) Documentation shall support a special symptom evaluation program as an ongoing, comprehensive, interdisciplinary

evaluation of behavioral symptoms as described in the RAI Manual.

C) Documentation shall support evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder, or other mental health problems by a qualified clinical professional as described in the RAI Manual.

D) The care plan shall address the behaviors of the resident and the interventions used.

ll) Accident/Fall Prevention.

1) Documentation shall support that the resident has the risk factor identified on the MDS.

2) Documentation shall support that the resident has been assessed for fall risks.

3) If the resident is identified as high risk for falls, documentation shall support that interventions have been identified and implemented.

mm) Restraint Free.

1) There shall be documentation to support the previous use of a restraint and the resident response to the restraint.

2) There shall be evidence that the restraint was discontinued.

nn) Clarification and additional documentation requirements are as follows:

1) Defined actions such as further assessment or documentation, described in the RAI Manual as "good clinical practice", are required by the Department as supporting documentation. Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths, that monitors his or her condition on an on-going basis, and that records treatments and response to treatment is a matter of good clinical practice and is an expectation of trained and licensed health care professionals (RAI page 1−23).

2) The facility shall have in place policies and procedures to address specific care needs of the residents, written evidence of ongoing in-services for

staff related to residents' specific care needs and all necessary durable medical equipment to sustain life and carry out the plan of care as designed by the physician. In the absence of these items, a referral will be made to the Illinois Department of Public Health.

3) No specific types of documentation or specific forms are mandated, but documentation shall be sufficient to support the codes recorded on the MDS. Treatments and services ordered and coded shall be documented as delivered in the clinical record.

4) When completing a significant change assessment, the guidelines provided in the RAI Manual shall be followed. This includes documenting "the initial identification of a significant change in terms of the resident's clinical status in the progress notes" as described in RAI page 2−7.

5) Documentation used to support coding must be signed or initialed and dated. Changes to documentation shall be done in accordance with professional standards of practice, which includes lining through the error, initialing and dating the changes made.

(Source: Amended at 34 Ill. Reg. 3786, effective March 14, 2010)

Section 147.205 Reimbursement for Ventilator Dependent Residents

a) Pursuant to Public Act 96-473, effective October 1, 2009, Department of Healthcare and Family Services (HFS) shall begin paying nursing facilities for ventilator dependent residents through a system separate from the Minimum Data Set (MDS) based reimbursement methodology. For purposes of this Section, ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

b) Payment shall be made for each individual resident receiving ventilator services through the Medicaid Management Information System (MMIS). The rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $150 supply cost.

c) Other services coded by a facility on the MDS for a ventilator dependent resident shall continue to be applied toward the nursing component of the nursing facility rate.

d) Staffing

1) A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health (DPH) in 77 Ill. Adm. Code 300.1240 or 250.910(e) and 250.910(f)(1), as appropriate). Additional RN staff may be determined necessary by HFS, based on HFS' review of the ventilator services.

2) A minimum of the required number of LPN staff (as required by DPH in 77 Ill. Adm. Code 300.1230, 300.1240 or 250.910(e) and 250.910(f)(1), as appropriate), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.

3) A certified respiratory therapy technician or registered respiratory therapist shall be available at the facility or on call 24 hours a day.

4) A certified respiratory therapist shall evaluate and document the respiratory status of the ventilator resident on a weekly basis.

5) At least one of the full-time licensed nursing staff members must have successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist

or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons.

6) All staff caring for ventilator dependent residents must have documented in-service training in ventilator care prior to providing that care. In-service training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent persons. In-service training documentation shall include name and qualification of the in-service director, duration of presentation, content of presentation and signature and position description of all participants.

e) Physical Plant
The Provider shall have and maintain physical plant adaptations to accommodate the necessary equipment, such as, an emergency electrical backup system.

f) Notification to HFS
A provider shall notify HFS, in writing, when a ventilator dependent resident is admitted and discharged from the facility. Notification in either instance shall occur within five days after the admission or discharge. Discharge is defined as the resident leaving the facility with no intention of returning. It does not mean an admission to a hospital.

g) Accessibility
The provider must make accessible to HFS and/or DPH all provider, resident and other records necessary to determine that the needs of the resident are being met and to determine the appropriateness of ventilator services.

(Source: Added by emergency rulemaking at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; Section modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; added at 34 Ill. Reg. 3786, effective March 14, 2010)

Section 147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L.100-203) (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.300 Payment to Nursing Facilities Serving Persons with Mental Illness

a) Reimbursement rates for nursing facilities (ICF and SNF) for program costs associated with the delivery of psychiatric rehabilitation services to residents with mental illness will remain at the level in effect on January 1, 2001, except as may otherwise be provided by 305 ILCS 5/5-5.4 and 89 Ill. Adm. Code 153.

b) Payment for services provided by nursing facilities for residents who have a primary diagnosis of mental illness will be dependent upon the facility meeting all criteria specified in 77 Ill. Adm. Code 300.4000 through 300.4090.

(Source: Amended at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.301 Sanctions for Noncompliance

Based on a finding of noncompliance by the Department of Public Health on the part of a nursing facility with any requirement for providing services to persons with mental illness pursuant to 77 Ill. Adm. Code 300.4000 through 300.4090, the Department may take action to terminate or suspend the facility pursuant to 89 Ill. Adm. Code 140.16 and 140.19 or recommend to the Department of Public Health imposition of any of the remedies or penalties available under the Nursing Home Care Act [220 ILCS 45/3-101].

(Source: Added at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.305 Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.310 Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 25, 2002)

Section 147.315 Comprehensive Functional Assessments and Reassessments (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093 effective February 15, 2002)

Section 147.320 Interdisciplinary Team (IDT) (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.325 Comprehensive Program Plan (CPP) (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.330 Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.335 Specialized Care – Behavioral Emergencies (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.340 Discharge Planning (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.345 Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.350 Reimbursement for Additional Program Costs Associated With Providing Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities

a) Nursing facilities (ICF and SNF) providing specialized services to individuals with developmental disabilities, excluding state operated facilities for the developmentally disabled, will be reimbursed for providing a specialized services program for each client with developmental disabilities as specified in 89 Ill. Adm. Code 144.50 through 144.250.

b) Beginning February 1, 1990, facility reimbursement for providing specialized services to individuals with developmental disabilities will be made upon conclusion of resident reviews that are conducted by the state's mental health authority or their contracted agent. Facility reimbursement for providing specialized services as a result of resident reviews concluded prior to February 1, 1990, will begin with the facility's February billing cycle.

c) The additional reimbursement for costs associated with specialized services programs is based upon the presence of three (3) determinants. The three determinants are:

1) Minimum Staffing

A) Direct Services – Facilities must be in compliance with the Health Care Financing Administration's (HCFA) (42 CFR 442.201 or 42 CFR 442.302 (1989)) and the Illinois Department of Public Health's (IDPH) (77 Ill. Adm. Code 300.1230) minimum staffing standards relative to facility type.

B) The number of additional direct services staff necessary for delivering adequate specialized services programs for individuals with developmental disabilities is based upon a full time equivalent (FTE) staff to client ratio of 1:7.5.

2) Qualified Mental Retardation Professional Services

A) Each individual's specialized services program must be integrated, coordinated and monitored by a Qualified Mental Retardation Professional (QMRP). Any facility required to provide specialized services programs to individuals with developmental disabilities must provide QMRP services. Delivery of these services is based upon a full-time equivalent ratio of one (1) QMRP to thirty (30) individuals being served.

B) A Qualified Mental Retardation Professional (QMRP) is a person who has at least one year of experience working directly with persons with mental retardation and is one of the following:

i) A doctor of medicine or osteopathy;

ii) A registered nurse;

iii) An individual who holds at least a bachelor's degree in one of the following professional categories: Occupational Therapist; Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Psychologist, Master's Degree; Social Worker; Speech-Language Pathologist or Audioligist; Recreation Specialist; Registered Dietitian; and Human Services, including but not limited to Sociology, Special Education, Rehabilitation Counseling, and Psychology (42 CFR 483.430(1989)).

3) Assessment and Other Program Services

A) A comprehensive functional assessment that identifies an individual's needs must be performed as needed to supplement any preliminary evaluations conducted prior to admission to a nursing facility.

B) A Comprehensive Assessment must include:

i) physical development and health;

ii) dental examination that includes an assessment of oral hygiene practices;

iii) nutritional status;

iv) sensorimotor development/auditory functioning;

v) social development;

vi) speech and language development;

vii) adaptive behaviors or independent living skills necessary for the individual to be able to function in the community (Scales of Independent Behavior (SIB) or the Inventory for

Client and Agency Planning (ICAP) are the assessment instruments that must be used for this assessment);

viii) vocational or educational skills (if applicable);

ix) cognitive development;

x) medication and immunization history;

xi) psychological evaluation (within 5 years) that includes an assessment of the individual's emotional and intellectual status;

xii) capabilities and preferences relative to recreation/leisure activities;

xiii) other assessments indicated by the individual's needs, such as physical and occupational therapy assessments;

xiv) seizure disorder history (if applicable) with information regarding frequency of occurrence and classification; and

xv) screenings (the facility performs or obtains) in the areas of nutrition, vision, auditory and speech/language.

d) Costs associated with specialized services programs reimbursement includes other program costs such as consultants, inservice training, and other items necessary for the delivery of specialized services to clients in accordance with their individual program plans.

e) Total program reimbursement for the additional costs associated with the delivery of specialized services to individuals with developmental disabilities residing in nursing facilities will be ten dollars ($10) per day, per individual being served. Facility eligibility for specialized services program reimbursement is dependent upon the facility meeting all criteria specified in Sections 147.5 through 147.205, 147.350 and 144.25 through 144.250.

(Source: Amended at 16 Ill. Reg. 17332, effective November 6, 1992)

Section 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level

a) Effective July 1, 2003, each Medicare and Medicaid certified nursing facility shall complete, and transmit quarterly to the Department, a full Minimum Data Set (MDS) for each resident who resides in a certified bed, regardless of payment source. A description of the MDS items referenced in the tables found following subsection (e) of this Table A are contained in the Long Term Care Resident Assessment Instrument User's Manual available from the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002).

b) Table A identifies MDS items that shall be used to calculate a profile on each Medicaid-eligible resident within each facility.

c) The profile for each Medicaid-eligible resident shall then be blended to determine the nursing component of the nursing facility's Medicaid rate.

d) Each MDS item in Table A includes a description of the item and the variable time referred to in Section 147.150(c)(1). The variable time assigned to each level represents the type of staff that should be delivering the service (unlicensed, licensed, social worker and activity) and the number of minutes allotted to that service item.

e) Following is a listing of the reimbursable MDS items found in Table A.

1) Base Social Work and Activity

2) Activities of Daily Living (ADL)

3) Restorative Programs

PROM/AROM

Splint/Brace

Bed Mobility

Mobility/Transfer

Walking

Dressing/Grooming

Eating

Prosthetic Care

Communication

Other Restorative

Scheduled Toileting

4) Medical Services

Continence Care

Catheter Care

Bladder Retraining

Pressure Ulcer Prevention

Moderate Skin Care Services

Intensive Skin Care Services

Ostomy Care

IV Therapy

Injections

Oxygen Therapy

Chemotherapy

Dialysis

Blood Glucose Monitoring

End Stage Care

Infectious Disease

Acute Medical Conditions

Pain Management

Discharge Planning

Nutrition

Hydration

5) Mental Health (MH) Services

Psychosocial Adaptation

Psychotropic Medication Monitoring

Psychiatric Services (Section S)

Skills Training

Close or Constant Observation

6) Dementia Services

Cognitive Impairment/Memory Assistance

Dementia Care Unit

7) Exceptional Care Services

Extensive Respiratory Services

Total Weaning From Ventilator

Morbid Obesity

Complex Wound Care

Traumatic Brain Injury (TBI)

8) Special Patient Need Factors:

Communication: add 1% of staff time accrued for ADLs through Exceptional Care Services

Vision Problems: add 2% of staff time accrued for ADLs through Exceptional Care Services

Accident/Fall Prevention: add 3% of staff time accrued for ADLs through Exceptional Care Services

Restraint Free Care: add 2% of staff time accrued for ADLs through Exceptional Care Services

Activities: add 2% of staff time accrued for ADLs through Exceptional Care Services

MDS ITEMS AND ASSOCIATED STAFF TIMES

Throughout Table A, where multiple levels are identified, only the highest level shall be scored.

1) Base Social Work and Activity

Level		Unlicensed	Licensed	Social Worker	Activity
I	All Clients	0	0	5	10

2) Activities of Daily Living

Documentation shall support the following for scoring Activities of Daily Living.

1) Coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period.

2) MDS coded level of resident self-performance and support has been met.

3) When there is a widespread lack of supporting documentation as described in subsections (1) and (2) of this item **(2)**, the ADL scores for the residents lacking documentation will be reset to zero.

4) When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.

Level	Composite Scores	Unlicensed	Licensed	Social Worker	Activity
I	Composite 7-8	50	7.5 RN		

			7.5 LPN		
II	Composite 9-11	62	9.5 RN 9.5 LPN		
III	Composite 12-14	69	10.5 RN 10.5 LPN		
IV	Composite 15-29	85	12.5 RN 12.5 LPN		

ADL Scoring Chart for the above Composite Levels

MDS values equal to "-" denote missing data.

ADL	MDS items	Description	Score
Bed Mobility	G1aA = - or G1aA = 0 or G1aA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1aA = 2.	Self-Performance = limited assistance	3
	G1aA = 3 or G1aA = 4 or G1aA = 8 AND G1aB = - or G1aB = 0 or G1aB = 1 or G1aB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1aB = 3 or G1aB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Transfer	G1bA = - or G1bA = 0 or G1bA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1bA = 2.	Self-Performance = limited assistance	3
	G1bA = 3 or G1bA = 4 or G1bA = 8 AND G1bB = - or G1bB = 0 or G1bB = 1 or G1bB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4

	G1bB = 3 or G1bB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Locomotion	G1eA = - or G1eA = 0 or G1eA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1eA = 2.	Self-Performance = limited assistance	3
	G1eA = 3 or G1eA = 4 or G1eA = 8 AND G1eB = - or G1eB = 0 or G1eB = 1 or G1eB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1eB = 3 or G1eB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Toilet	G1iA = - or G1iA = 0 or G1iA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1iA = 2.	Self-Performance = limited assistance	3
	G1iA = 3 or G1iA = 4 or G1iA = 8 AND G1iB = - or G1iB = 0 or G1iB = 1 or G1iB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1iB = 3 or G1iB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Dressing	G1gA = - or G1gA = 0 or G1gA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1

	G1gA = 2.	Self-Performance = limited assistance	2
	G1gA = 3 or G1gA = 4 or G1gA = 8.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur	3

Hygiene	G1jA = - or G1jA = 0 or G1jA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1jA = 2.	Self-Performance = limited assistance	2
	G1jA = 3 or G1jA = 4 or G1jA = 8.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur	3

Eating	G1hA = - or G1hA = 0 or G1hA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1hA = 2.	Self-Performance = limited assistance	2
	G1hA = 3 or G1hA = 4 or G1hA = 8	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur	3
	Or		
	K5a = 1 or K5b = 1 and Intake = 1	Parenteral/IV in last 7 days Tube feeding in last 7 days See below	
	Where		
	Intake = 1 if		
	K6a = 3 or	Parenteral/enteral intake 51-75% of total calories	
	K6a = 4	Parenteral/enteral intake 76-100% of total calories	
	Or Intake = 1 if		
	K6a = 2 and	Parenteral/enteral intake 26-50% of total calories	

	K6b = 2 or K6b = 3 or K6b = 4 or K6b = 5.	Average fluid intake by IV or tube is 501-1000 cc/day Average fluid intake by IV or tube is 1001-1500 cc/day Average fluid intake by IV or tube is 1501-2000 cc/day Average fluid intake by IV or tube is 2001 or more cc/day	

3) Restorative Programs

With the exception of amputation/prosthesis care and splint or brace assistance restoratives, the total number of restorative programs eligible for reimbursement shall be limited to four, with no more than three being a Level II restorative. Scheduled toileting shall be included in this limit. Splint or brace assistance and amputation/prosthesis care shall be reimbursed independently. A resident coded in I1t (CVA/stroke), I1v (hemiplegia/hemiparesis), I1w (Multiple Sclerosis), I1x (paraplegia) or I1cc (Traumatic Brain Injury) on the MDS and also coded as B4≤2 (cognitive skills for decision making) shall be limited to a total of six restoratives with no more than four being a Level II restorative. A Department designed assessment shall be required quarterly to assess the resident's endurance and the resident's ability to benefit from two or more restorative programs.

For the following restorative programs: bed mobility, mobility/transfer, walking, dressing/grooming, and eating, when the corresponding ADL is coded a "1" under self-performance on the current MDS, the previous MDS must have a code of greater than "1" to qualify for reimbursement.

If PROM is scored, AROM is reset to zero unless the resident has a diagnosis of CVA, hemiplegia/hemiparesis, multiple sclerosis, paraplegia or traumatic brain injury.

When the number of restoratives coded on the MDS exceeds the allowable limits for reimbursement, the following order shall be used.

A) Eating Restorative

B) Scheduled Toileting

C) Walking Restorative

D) Transfer Restorative

E) PROM/AROM

F) Bed Mobility Restorative

G) Communication Restorative

H) Dressing/Grooming Restorative

I) Other Restorative

Restorative Services are programs under the direction and supervision of a licensed nurse and are provided by nursing staff. The programs are designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The focus is on achieving and/or maintaining optimal physical, mental, and psychosocial functioning. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Although therapists may participate in designing the initial program, members of nursing staff are still responsible for the overall coordination and supervision of restorative nursing programs. Staff completing the programs should be communicating progress, maintenance, regression and other issues/concerns to the licensed nurse overseeing the programs. To qualify for reimbursement, the provision of restorative programs shall meet the following criteria for each program identified for reimbursement:

1) When programs are designed using verbal cueing as the only intervention, documentation and/or observation must support the following:

   A) Without such cueing, the resident would be unable to complete the required ADL task.

   B) The verbal interventions are aimed at providing the resident with instructions for completing the task in such a way that promotes the resident's safety and awareness.

   C) Verbal interventions that are simply reminders to complete the task may not be the sole content of the program.

2) Documentation shall clearly define the resident's need for the program and the program defined shall correspond to the identified need of the resident. Observation and/or interview shall also support the need for the program.

3) The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of

functioning. Staff completing the programs shall be aware of the program and the resident's need for the program.

4) Documentation must support that the program was reevaluated and goals and interventions were revised as necessary to assist the resident in reaching and/or maintaining his or her highest level of functioning.

5) Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized from one report to the next.

6) Goals shall be resident specific, realistic, and measurable. Goals shall be revised as necessary. Revisions shall be made based on the resident's response to the program.

7) The resident's ability to participate in the program shall be addressed.

8) Written evidence of measurable objectives and interventions shall be in the restorative plan of care and be individualized to the resident's problems and needs. There shall be evidence the objectives and interventions were reviewed quarterly and revised as necessary.

9) There shall be evidence of quarterly evaluation written by a licensed nurse in the clinical record. The evaluation must assess the resident's progress and participation in the program since the last evaluation. It shall contain specific information that includes the resident's response to the program (i.e., amount of assistance required, devices used, the distance, the progress made, how well the resident tolerated the program). An evaluation shall be documented on each restorative program the resident is receiving.

10) There shall be written evidence that staff carrying out the programs have been trained in techniques that promote resident involvement in the activity.

11) If volunteers or other staff were assigned to work with specific residents, there shall be written evidence of specific training in restorative techniques that promote the resident's involvement in the restorative program.

12) There shall be documentation to support that the programs are ongoing and administered as planned outside the look-back period, unless there is written justification in the clinical record that supports the need to

discontinue the program. Observation and/or interviews must also support that the programs are ongoing and administered as planned.

13) If a restorative program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, duration and frequency as part of the care planning process. The results of this reassessment shall be documented in the record.

14) The actual number of minutes per day spent in a restorative program shall be documented for each resident and for each restorative program during the look-back period.

15) The Department designated endurance assessment must be completed quarterly on each resident receiving two or more restorative programs. A licensed nurse must complete this assessment.

16) A resident coded as totally dependent in an ADL function will only be reimbursed for one quarter for the following corresponding restorative programs: bed mobility, transfer, walking, dressing/grooming, and/or eating/swallowing.

17) A resident scoring and/or receiving hospice services shall not be eligible for the following restorative programs: bed mobility, transfer, walking, dressing/grooming, eating and/or other restoratives.

18) When multiple restoratives are coded in a facility, the staff levels must support the ability to deliver these programs based on the number and frequency of programs coded.

19) All restorative programs shall meet the specifications in the RAI Manual for the individual restoratives.

Passive Range of Motion (PROM)

The following documentation shall support the following for scoring PROM.

1) The restorative program shall meet the definition of PROM as identified in the RAI Manual.

2) The PROM program shall address the functional limitations identified in section G4 of the MDS.

3) There shall be evidence that the program is planned and scheduled. PROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.

Lev	MDS items	Description	Unl	Lic	SW	Act
	G4aA > 0 or	Any function limits in ROM of neck				
	G4bA > 0 or	Any function limits in ROM of arm				
	G4cA > 0 or	Any function limits in ROM of hand				
	G4dA > 0 or	Any function limits in ROM of leg				
	G4eA > 0 or	Any function limits in ROM of foot				
	G4fA > 0 or	Any function limits in ROM of other limitation or loss				
	G4aB > 0 or	Any function limits in voluntary movement of neck				
	G4bB > 0 or	Any function limits in voluntary movement of arm				
	G4cB > 0 or	Any function limits in voluntary movement of hand				
	G4dB > 0 or	Any function limits in voluntary movement of leg				
	G4eB > 0 or	Any function limits in voluntary movement of foot				
	G4fB > 0	Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3a ≤ 5	3 to 5 days of PROM rehab	10	3 RN 3 LPN		
II	6 ≤ P3a ≤ 7	6 to 7 days of PROM rehab	15	3 RN 3		

				LPN		

Active Range of Motion (AROM)

The following documentation shall support the following for scoring AROM.

1) The restorative program meets the definition of AROM as identified in the RAI Manual.

2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.

3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.

4) AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.

Lev	MDS items	Description	Unl	Lic	SW	Act
	G4aA > 0 or	Any function limits in ROM of neck				
	G4bA > 0 or	Any function limits in ROM of arm				
	G4cA > 0 or	Any function limits in ROM of hand				
	G4dA > 0 or	Any function limits in ROM of leg				
	G4eA > 0 or	Any function limits in ROM of foot				
	G4fA > 0 or	Any function limits in ROM of other limitation or loss				
	G4aB > 0 or	Any function limits in voluntary movement of neck				
	G4bB > 0 or	Any function limits in voluntary movement of arm				

	G4cB > 0 or G4dB > 0 or G4eB > 0 or G4fB > 0	Any function limits in voluntary movement of hand Any function limits in voluntary movement of leg Any function limits in voluntary movement of foot Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3b ≤ 5	3 to 5 days of AROM rehab	8	2 RN 2 LPN		
II	6 ≤ P3b ≤ 7	6 to 7 days of AROM rehab	12	2 RN 2 LPN		

Splint/Brace Assistance

The program shall meet the specifications of this restorative as defined in the RAI Manual.

A splint or brace is defined as an appliance for the fixation, union, or protection of an injured part of the body.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	3 ≤ P3c ≤ 5	3 to 5 days of assistance	8	2 RN 2 LPN		
II	6 ≤ P3c ≤ 7	6 to 7 days of assistance	12	2 RN 2 LPN		

Bed Mobility Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1aA < 8 AND G7 = 1	Need assistance in bed mobility Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3d ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3d ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Mobility (Transfer) Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1bA < 8 AND G7 = 1	Need assistance in transfer Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3e ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3e ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Walking Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	S W	Act
	0 < G1cA < 8 or 0 < G1dA < 8 or 0 < G1eA < 8 or 0 < G1fA < 8 AND G7 = 1	Need assistance in walking in room Need assistance in walking in corridor Need assistance in locomotion on unit Need assistance in locomotion off unit Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3f ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3f ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Dressing or Grooming Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Grooming programs, including programs to help the resident learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff.

These programs shall have goals, objectives, and documentation of progress and be related to the identified deficit.

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1gA < 8 or	Need assistance in dressing				

	0<G1jA<8 AND G7 = 1 AND	Need assistance in personal hygiene Some or all ADL tasks broken into subtasks				
	B4 ≤ 2	Cognitive skills for decision making				
	AND					
	S1 = 0 AND	Does not meet Illinois Department of Public Health (IDPH) Subpart S Criteria				
I	3 ≤ P3g ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3g ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Eating Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1hA < 8 or K1b = 1 AND G7 = 1	Need assistance in eating Has swallowing problem Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3h ≤ 5	3 to 5 days of rehab or restorative techniques	15	3 RN 3 LPN		

II	6 ≤ P3h ≤ 7	6 to 7 days of rehab or restorative techniques	20	3 RN 3 LPN		

Amputation/Prosthetic Care

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	3 ≤ P3i ≤ 5	3 to 5 days of assistance	10	3 RN 3 LPN		
II	6 ≤ P3i ≤ 7	6 to 7 days of assistance	15	3 RN 3 LPN		

Communication Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Lev	MDS items	Description	Unl	Lic	SW	Act
	C4 > 0	Deficit in making self understood				
	AND					
I	3 ≤ P3j ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3j ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Other Restorative

The program shall meet the specifications of this restorative as defined in the RAI Manual.

Other Restorative shall only be reimbursed for a total of two quarters regardless of the level.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P3k=3 or greater AND Q2 < 2 AND B2a = 0 AND B4 = 0 or 1 AND C6 = 0 or 1 AND S1 = 0	Other Restorative Improved or no change in care needs Short term memory okay Cognitive skills for decision making Ability to understand others Does not meet IDPH Subpart S criteria	6	5 RN 5 LPN		
II	P3k = 3 or greater AND Q1c = 1 or 2 AND Q2 < 2 AND P1ar = 1 AND B2a = 0 AND B4 = 0 or 1 AND	Other restorative Stay projected to be of a short duration – discharge expected to be within 90 days Improved or no change in care needs Provide training to return to the community Short-term memory Cognitive skills for decision making	6	7.5 RN 7.5 LPN		

	C6 = 0 or 1 AND S1 = 0	Ability to understand others Does not meet IDPH Subpart S criteria				

Scheduled Toileting

Documentation shall support the following for scoring scheduled toileting.

1) The program shall have documentation to support that all the requirements identified in the RAI Manual are met.

2) The description of the plan, including: frequency, reason, and response to the program.

3) The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.

4) This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, where there is no participation in the plan by the resident.

5) There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.

6) A resident scoring S1 = 1 (meets Subpart S criteria) shall have corresponding diagnosis of CVA or multiple sclerosis to qualify for reimbursement in scheduled toileting.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	H3a = 1 AND S1= 0 H3b = 0 AND H3d = 0 AND	Any scheduled toileting plan Does not meet criteria for Subpart S No bladder retraining program No indwelling catheter	22	1.5 RN 1.5 LPN		

	H1b > 1 or GliA> 1 and <8	Incontinent at least 2 or more times a week Self-performance = limited to total assistance				

4) Medical Services

Continence Care

Documentation shall support the following for scoring continence care.

1) That catheter care was administered during the look-back period.

2) The type and frequency of the care.

3) RAI requirements for bladder retraining program were administered during the look-back period.

4) The resident's level of incontinence shall be documented during the look-back period to support the bladder retraining program.

5) Bladder scanners cannot be the sole content of the bladder retraining program.

Continence Care − Level II (Bladder Retraining) shall only be reimbursed for two quarters.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	Catheter Care H3d = 1 AND H3a = 0	 Indwelling catheter present No scheduled toileting plan	12	.5 RN .5 LPN		
II	Bladder Retraining					

	H3b = 1 AND H3a = 0 AND H1b > 1 AND B4 = 0 or 1 OR H3b = 1 AND H3a = 0 AND H1b ≤ 1 AND H4 = 1 AND B4 = 0 or 1	Bladder retraining program No scheduled toileting plan Incontinent at least 2 or more times a week Cognitive skills for decision making Bladder retraining program No scheduled toileting plan Bladder continence Change in continence Cognitive skills in decision making	32	5 RN 5 LPN		

Pressure Ulcer Prevention

Documentation shall support the following for scoring pressure ulcer prevention.

1) History of resolved ulcer in the identified timeframe and/or the use of the identified interventions during the identified timeframe.

2) Interventions and treatments shall meet the RAI definitions for coding.

3) A specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.

4) Resident was assessed related to his or her risk for developing ulcers. A resident assessed to be at high risk shall have interventions identified in the plan of care.

Lev	MDS items	Description	Unl	Lic	SW	Act

I	M3 = 1 or	History of resolved ulcers in last 90 days	15	4 RN 4 LPN		
	Any two of:					
	M5a	Pressure relieving devices for chair				
	M5b	Pressure relieving devices for bed				
	M5c	Turning or repositioning program				
	M5d	Nutrition or hydration intervention for skin				
	M5i	Other prevention for skin (other than feet)				

Moderate Skin Care/Intensive Skin Care

Documentation shall support the following for scoring moderate skin care/intensive skin care.

1) Interventions and treatments shall meet the RAI definitions for coding.

2) Documentation of ulcers shall include staging as the ulcers appear during the look-back period.

3) Documentation of ulcers shall include a detailed description that includes, but is not limited to, the stage of the ulcer, the size, the location, any interventions and treatments used during the look-back period.

4) Documentation of burns shall include, but is not limited to, the location, degree, extent, interventions and treatments during the look-back period.

5) Documentation of open lesions shall include, but is not limited to, location, size, depth, any drainage, interventions and treatments during the look-back period.

6) Documentation of surgical wounds shall include, but is not limited to, type, location, size, depth, interventions and treatment during the look-back period.

7) All treatments involving M5e, M5f, M5g and M5h shall have a physician's order, with the intervention and frequency.

8) Documentation to support that the intervention was delivered during the look-back period shall be included.

9) Documentation of infection of the foot shall contain a description of the area and the location.

10) Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.

11) Documentation for items coded in M4 shall include documentation of an intervention, treatment and/or monitoring of the problem or condition identified.

Lev	MDS items	Description	Unl	Lic	SW	Act
I		Moderate Skin Care Services	5	5 RN		
	M1a > 0 or	Stage 1 ulcers		5 LPN		
	M1b > 0 or	Stage 2 ulcers				
	Any of:	Other Skin Problems (below):				
	M4b = 1	Burns				
	M4c = 1	Open lesions other than ulcers				
	M4d = 1	Rashes				
	M4e = 1	Skin desensitized to pain or pressure				
	M4f = 1	Skin tears or cuts (other than surgery)				
	M4g = 1 AND	Surgical wounds				
	4 of the following:	Skin Treatments (below):				
	M5a = 1	Pressure relieving devices for chair				
	M5b = 1	Pressure relieving devices for bed				

	M5c = 1	Turning or repositioning program				
	M5d = 1	Nutrition or hydration intervention for skin				
	M5e = 1	Ulcer care				
	M5f = 1	Surgical wound care				
	M5g = 1	Application of dressings (other than feet)				
	M5h = 1	Application of ointments (other than feet)				
	M5i = 1 OR	Other prevention for skin (other than feet)				
	(M6b = 1 or	Infection of the foot				
	M6c = 1) AND	Open lesion of the foot				
	M6f = 1	And application of a dressing				
II		Intensive Skin Care Services				
	M1c > 0 or	Stage 3 ulcers	5	15 RN 15 LPN		
	M1d > 0 AND	Stage 4 ulcers				
	4 of the following:	Skin Treatments (below):				
	M5a = 1	Pressure relieving devices for chair				
	M5b = 1	Pressure relieving devices for bed				
	M5c = 1	Turning or repositioning program				
	M5d = 1	Nutrition or hydration intervention for skin				
	M5e = 1	Ulcer care				
	M5f = 1	Surgical wound care				

	M5g = 1 M5h = 1 M5i = 1	Application of dressings (other than feet) Application of ointments (other than feet) Other prevention for skin (other than feet)				

Ostomy Services

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1af = 1	Ostomy care performed	5	2.5 RN 2.5 LPN		

IV Therapy

Documentation shall support the following for scoring IV Therapy.

1) Date delivered, type of medication and method of administration.

2) Monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse as required under acute medical conditions.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	Plac = 1 or K5a = 1 AND P1ae = 1	IV medication Parenteral/IV nutrition Monitoring acute medical condition	1	15 RN 15 LPN		

Injections

Documentation shall include the drug, route given and dates given.

Lev	MDS items	Description	Unl	Lic	SW	Act

I	O3 = 7	Number of injections in last 7 days		3 RN 3 LPN		

Oxygen Therapy

Documentation shall include a physician's order and the method of administration and date given.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ag = 1	Oxygen therapy administered in last 14 days	9	7.5 RN 7.5 LPN		

Chemotherapy

Documentation shall support that the resident was monitored for response to the chemotherapy.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1aa = 1	Chemotherapy given	1	5 RN 5 LPN		

Dialysis

Documentation shall support that the resident was monitored for response to the dialysis.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ab = 1	Dialysis given	1	5 RN 5 LPN	2	

Blood Glucose Monitoring

Documentation shall support the following for scoring blood glucose monitoring.

1) RAI criteria for coding that a diagnosis was met, including a physician documented diagnosis.

2) Coding of a therapeutic diet being ordered and given to the resident.

3) Coding of a dietary supplement being ordered and given to the resident during the look-back period. There shall be evidence to support it was not part of a unit's daily routine for all residents.

4) Coding that injections were given the entire seven days of the look-back period.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I1a = 1 AND K5e = 1 or K5f = 1 or O3 = 7	Diabetes mellitus Therapeutic diet Dietary supplement Injections daily		1 RN 1 LPN		

End Stage Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J5c = 1	End stage disease, 6 or fewer months to live Restoratives including scheduled toileting and bladder retraining sets to level '0' except AROM, PROM, splint/brace. Limit of 4 quarters	10	6 RN 6 LPN	8	

If End Stage Care has been scored, Discharge Planning shall be set to zero.

Infectious Disease

Documentation shall support the following for scoring infectious disease.

1) Criteria defined in the RAI Manual for coding this section was met.

2) Active diagnosis by the physician, including signs and symptoms of the illness.

3) Interventions and treatments shall be documented.

4) All RAI requirements for coding a urinary tract infection (UTI) are met.

5) Administration of maintenance medication to prevent further acute episodes of UTI is not sufficient to code I2j.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I2a = 1 or	Antibiotic resistant infection	18	8.5 RN 8.5 LPN	1	
	I2b = 1 or	Clostridium Difficile				
	12e = 1 or	Pneumonia				
	12g = 1 or	Septicemia				
	I2i = 1 or	TB				
	12 j = 1 or	Urinary Tract infection present				
	I2k = 1 or	Viral hepatitis				
	12l = 1 or	Wound infection				
	I3 = ICD9 code 041.01,133.0	Streptococcus Group A, scabies				

Acute Medical Conditions

Documentation shall support the following for scoring acute medical conditions.

1) RAI requirements for coding these areas are met.

2) Monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse.

3) Evidence that the physician has evaluated and identified the medically unstable or acute condition for which clinical monitoring is needed.

4) Evidence of significant increase in licensed nursing monitoring.

5) Evidence that the episode meets the definition of acute, which is usually of sudden onset and time-limited course.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J5b = 1 AND	Acute episode or flare-up of chronic condition	1	11.5 RN 11.5 LPN	1	
	P1ae = 1 AND	Monitoring acute medical condition				
	P1ao = 0 OR	Not hospice care				
	(J5a = 1 AND	Condition makes resident's cognitive, ADL, mood or behavior patterns unstable				
	P1ao = 0 AND	Not hospice care				
	P1ae = 1) OR	Monitoring acute medical condition				
	(B5a = 2 or	Easily distracted over last 7 days				
	B5b = 2 or	Periods of altered perceptions or awareness of surroundings over last 7 days				
	B5c = 2 or	Episodes of disorganized speech over last 7 days				
	B5d = 2 or	Periods of restlessness over last 7 days				
	B5e = 2 or	Periods of lethargy over last 7 days				
	B5f = 2) AND	Mental function varies over course of day in last 7 days				
	P1ae = 1 AND	Monitoring acute medical condition				
	P1ao = 0	Not hospice care				

Pain Management

There shall be documentation to support the resident's pain experience during the look-back period and that interventions for pain were offered and/or given.

Residents shall be assessed in a consistent, uniform and standardized process to measure and assess pain.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J2a > 0 AND J2b > 0	Demonstrate or complain of pain Mild to excruciating intensity	4	4 RN 4 LPN	1	1

Discharge Planning

Discharge planning shall only be reimbursed for two quarters.

If end stage care has been scored, discharge planning shall be set to zero.

Documentation shall support the following for scoring discharge planning.

1) Social services shall document monthly the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made.

2) Social service documentation shall demonstrate realistic evaluation, planning, and follow-through.

3) Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	Q1c = 1 or 2 AND	Stay projected to be of short duration – discharge expected to be within 90 days		8 RN 8 LPN	16	

	Q2 < 2 AND P1ar = 1 AND Sl=0	Improved or no change in care needs Provide training to return to community Does not meet IDPH Subpart S criteria				

Nutrition

Documentation shall support the following for scoring nutrition.

1) Coding of tube feeding during the look-back period.

2) Intake and output records and caloric count shall be documented to support the coding of K6.

3) Planned weight change, including a diet order and a documented purpose or goal, that is to facilitate weight gain or loss.

4) Dietary supplement, including evidence the resident received the supplement and that it was ordered and given between meals.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	K5h = 1 OR K5f = 1	On a planned weight change program Dietary supplement given between meals	2	.5 RN .5 LPN		
II	K5b =1 and Intake = 1 Intake = 1 if K6a = 3 or	Tube feeding in last 7 days See below Parenteral/ enteral intake 51-75% of total calories	2	12 RN 12 LPN	2	

	K6a = 4	Parenteral/enteral intake 76-100% of total calories				
	Or Intake = 1 if					
	K6a = 2 and	Parenteral/enteral intake 26-50% of total calories				
	K6b = 2 or	Average fluid intake by IV or tube is 501-1000 cc/day				
	K6b = 3 or	Average fluid intake by IV or tube is 1001-1500 cc/day				
	K6b = 4 or	Average fluid intake by IV or tube is 1501-2000 cc/day				
	K6b = 5	Average fluid intake by IV or tube is 2001 or more cc/day				

Hydration

Documentation shall support the following for scoring hydration.

1) The resident passes two or fewer bowel movements per week, or strains more than one of four times when having a bowel movement during the look-back period to support the coding of H2b.

2) Resident received a diuretic medication during the look-back period to support the coding of O4e.

3) Frequency of episodes and accompanying symptoms to support the coding of vomiting.

4) Signs and symptoms, interventions and treatments used to support the coding of volume depletion, dehydration or hypovolemia.

5) Documentation of temperature shall be present to support the coding of fever.

6) Coding of internal bleeding shall include the source, characteristics and description of the bleeding.

7) Interventions were implemented related to the problem identified.

Lev	MDS items	Description	Unl	Lic	SW	Act

I	H2b = 1 AND K5a = 0 AND K5b = 0 OR Any two of the following separate conditions: 1 ≤ O4e ≤ 7 or J1o = 1 or I3 a,b,c,d,e = 276.5 or 276.52 or J1c = 1 or J1d = 1 or J1h = 1 or J1j = 1 AND K5a = 0 AND K5b = 0	Constipation No parenteral/IV No feeding tube Received a diuretic medication in last 7 days Vomiting Volume depletion Hypovolemia Dehydrated Did not consume most fluids provided (3 days) Fever Internal bleeding Not have parenteral/IV No feeding tube	10	2 RN 2 LPN		1

5) Mental Health Services

Psychosocial Adaptation

Psychosocial adaptation is intended for residents who require a behavioral symptom evaluation program or group therapy to assist them in dealing with a variety of mood or behavioral issues. The criteria for reimbursement in this area require both an intervention program and the identification of mood or behavioral issues. Residents shall be assessed for mood and behavioral issues and interventions shall be implemented to assist the resident in dealing with the identified issues. To qualify for reimbursement in this area, the facility must meet the following criteria:

1) Criteria for special behavioral symptom evaluation program.

A) There must be documentation to support that the program is an ongoing and comprehensive evaluation of behavioral symptoms.

B) Documentation must support the resident's need for the program.

C) The documentation must show that the purpose of the program is to attempt to understand the "meaning" behind the resident's identified mood or behavioral issues.

D) Interventions related to the identified issues must be documented in the care plan.

E) The care plan shall have interventions aimed at reducing the distressing symptoms.

2) Criteria for group therapy.

A) There is documentation that the resident regularly attends sessions at least weekly.

B) Documentation supports that the therapy is aimed at helping reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve.

C) This area does not include group recreational or leisure activities.

D) The therapy and interventions are addressed in the care plan.

E) This must be a separate session and can not be conducted as part of skills training.

3) Criteria for indicators of depression.

A) There must be documentation to support identified indicators occurred during the look-back period.

B) The documentation shall support the frequency of the indicators as coded during the look-back period.

C) There shall be documentation to support that interventions were implemented to assist the resident in dealing with these issues.

4) Criteria for sense of initiative/involvement.

A) There is documentation to support that the resident was not involved or did not appear at ease with others or activities during the look-back period.

B) There shall be evidence that interventions were implemented to assist the resident in dealing with these issues.

5) Criteria for unsettled relationships/past roles.

A) There is documentation to support the issues coded in this area during the look-back period.

B) There shall be evidence that interventions were implemented to assist the resident in dealing with the issues identified.

6) Criteria for behavioral symptoms.

A) There is documentation to support that the behaviors occurred during the look-back period and the interventions used.

B) Documentation should reflect the resident's status and response to interventions.

C) Documentation should include a description of the behavior exhibited and the dates it occurred, as well as staff response to the behaviors.

D) Documentation supports that the behaviors coded meet the RAI definitions for the identified behavior.

E) The care plan identifies the behaviors and the interventions to the behaviors.

7) Criteria for delusions/hallucinations.

A) There is documentation to support that the delusions or hallucinations occurred during the look back period.

B) Documentation contains a description of the delusions or hallucinations the resident was experiencing.

C) There is documentation to support the interventions used.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	(P2a = 1 or	Behavior symptom evaluation	12	3 RN 3 LPN	8	2
	P2c = 1) AND	Group therapy				
	Any E1a-p > 0 or	Indicators of depression				
	F1g = 1 or	No indicators of psychosocial well-being				
	Any F2a-g = 1 or	Any unsettled relationships				
	Any F3a-c = 1 or	Issues with past roles				
	E4aA > 0 or	Wandering in last 7 days				
	E4bA > 0 or	Verbally abusive in last 7 days				
	E4cA > 0 or	Physically abusive in last 7 days				
	E4dA > 0 or	Inappropriate or disruptive behavior in last 7 days				
	E4eA > 0 or	Resisted care in last 7 days				
	J1e= 1 or	Delusions				
	J1i = 1	Hallucinations				

Psychotropic Medication Monitoring

Documentation shall support that the facility followed the documentation guidelines as directed by 42 CFR 483.25(l), Unnecessary drugs (State Operations Manual F-tag F329).

Lev	MDS items	Description	Unl	Lic	SW	Act
I	O4a = 7 or O4b = 7 or O4c = 7 or	Antipsychotic meds Antianxiety meds Antidepressant meds	5	2.5 RN 2.5 LPN		

Psychiatric Services (Section S)

Documentation shall support the following for scoring psychiatric services (Section S).

1) There shall be evidence the resident met IDPH Subpart S criteria during the look-back period.

2) There shall be evidence a pre-admission screening completed by a Department of Human Services-Division of Mental Health screening entity was completed on the resident that identifies the resident as having a serious mental illness (SMI).

The following shall be used in coding ancillary provider services.

1) Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.

2) Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan.

3) Facilities shall ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.

4) Adjustments in the rate for utilization of ancillary providers shall be calculated based upon Department claims data for ancillary provider billing.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	S1 = 1 AND ADL Index = 4 AND One or more of the following are coded M1c or Mld >0 or K5b = 1 or K5a = 1 or Plab = 1 or J5c = 1 or Plaa = 1 or Plaj = 1 or Plal = 1 AND Psychiatric Services Level II, Level III, Level IV skills training, close and constant observation, dressing/grooming and other restorative, cognitive performance, dementia care unit and discharge	Meets IDPH Subpart S criteria Activities of Daily Living Composite Score = 15-29 Stage 3 or stage 4 ulcers Feeding tube Parenteral/IV Dialysis End Stage Disease Chemotherapy Tracheostomy Care provided Ventilator	6	1.5 RN 1.5 LPN	10	

	planning reset to zero					
II	Sl = 1 AND	Meets IDPH Subpart S criteria	13	2.5 RN 2.5 LPN	20	
	S8 = 1 AND Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero	Ancillary provider services delivered by non-facility providers				
III	Sl = 1 AND ADL Index=3 or 4 AND (AA3-A3a)/365.25 ≥ 65 AND	Meets IDPH Subpart S criteria ADL composite score between 12-29 Resident is 65 years of age or older at time of the assessment reference date	13	4.5 RN 4.5 LPN	20	
	Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero					
IV	Sl = 1 AND S8 = 0 AND Dressing/grooming and other	Meets IDPH Subpart S criteria Ancillary provider services delivered by facility providers	16	5 RN 5 LPN	25	

	restorative, cognitive performance, and dementia care unit and discharge planning reset to zero					

Skills Training – Section S

Skills training is specific methods for assisting residents who need, and can benefit from, this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria.

1) Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.

2) Addresses identified skill deficits related to goals noted in the treatment plan.

3) Skills training shall be provided by staff who are paid by the facility and have been trained in leading skills group by a Department approved trainer.

4) Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise and other distractions.

5) Training shall be provided in groups no larger than ten, with reduced group size for a resident requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.

6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the SMI and Mental Illness/Substance Abuse (MISA) populations are available for use and as models.)

7) The curriculum shall address discrete sets of skills competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.

8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.

9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.

10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.

11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary. However, on-going 1:1 training shall not qualify under this area.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	S7 = 1 AND S1 = 1	Skills training provided Meets IDPH Subpart S criteria	6	6 RN 6 LPN	8	6

Close or Constant Observation − Section S

The following criteria shall be met for coding close or constant observation.

1) Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item shall not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from the hospital, or as a part of periodic resident headcounts.

2) There shall be documentation for the reason for use, confirmation that the procedure was performed as coded, with staff initials at appropriate intervals, brief explanation of the resident's condition and reason for terminating the observation.

Lev	MDS items	Description	Unl	Lic	SW	Act

I	S5a-e ≥ 1 AND S1 = 1	Close or constant observation Meets IDPH Subpart S criteria	6	2 RN 2 LPN	5	

If close or constant observation is scored, acute medical conditions is reset to zero.

6) Dementia Services

Cognitive Impairment/Memory Assistance Services

Documentation shall support the following for scoring cognitive impairment/memory assistance services.

1) Description of the resident's short-term memory problems.

2) Method of assessing and determining the short-term memory problem shall be documented.

3) Description of the resident's ability to make everyday decisions about tasks or activities of daily living.

4) Description of the resident's ability to make himself or herself understood.

Lev	CPS items	Description	Unl	Lic	SW	Act
I	CPS = 2 AND S1 = 0	Cognitive performance scale of 2 Does not meet IDPH Subpart S criteria	6			4
II	CPS = 3 or 4 AND S1 = 0	Cognitive performance scale is 3 or 4 Does not meet IDPH Subpart S criteria	16	3 RN 3 LPN	11	10
III	CPS = 5 or 6 AND	Cognitive performance scale is 5 or 6	21	5.5 RN 5.5 LPN	16	15

	S1 = 0	Does not meet IDPH Subpart S criteria				

Cognitive Performance Scale Codes

Scale	Description
0	Intact
1	Borderline Intact
2	Mild Impairment
3	Moderate Impairment
4	Moderate Severe Impairment
5	Severe Impairment
6	Very Severe Impairment

Impairment Count for the Cognitive Performance Scale

I code	MDS items	Description
		Note: None of B2a, B4, or C4 can be missing
IC 1	B2a = 1	Memory problem
IC 2	B4 = 1 or 2	Some dependence in cognitive skills
IC 3	$1 \leq$ C4 $\leq$ 3	Usually understood to rarely or never understood

Severe Impairment Count for the Cognitive Performance Scale

I code	MDS items	Description
		Note: None of B2a, B4, or C4 can be missing
SIC 0	Below not met	
SIC 1	B4 = 2	Moderately impaired in cognitive skills
SIC 2	C4 = 2 or 3	Sometimes understood to rarely or never understood

Cognitive Performance Scale

Scale	MDS items	Description
Coma	N1a = 0 and N1b = 0 and	Awake all or most of the time in the morning Awake all or most of the time in the afternoon

	N1c = 0 and	Awake all or most of the time in the evening
	B1 = 1 and	Is comatose
	G1aA = 4 or 8 And	Bed-Mobility Self-Performance = total dependence or did not occur
	G1bA = 4 or 8 And	Transfer Self-Performance = total dependence or did not occur
	G1hA = 4 or 8 And	Eating Self-Performance = total dependence or did not occur
	G1iA = 4 or 8 And	Toilet Use Self-Performance = total dependence or did not occur
6	Not (B4 = 0,1, 2)	Not have cognitive skills independent to moderately impaired
6	B4 = 3 And	Cognitive skills severely impaired
	G1hA = 4 or 8	Eating Self-Performance = total dependence or did not occur
5	B4 = 3 And	Cognitive skills severely impaired
	G1hA = - or $\leq$ 3	Eating Self-Performance = missing to extensive assistance
4	If IC code = 2 or 3	Some dependence in cognitive skills
		Usually understood to rarely or never understood
	And SIC code = 2	Sometimes understood to rarely or never understood
3	If IC code = 2 or 3	Some dependence in cognitive skills
		Usually understood to rarely or never understood
	And SIC code = 1	Moderately impaired in cognitive skills
	If IC code = 2 or 3	Some dependence in cognitive skills
		Usually understood to rarely or never understood
2	And SIC code = 0	Better than moderate cognition skills and usually can be understood
1	If IC code = 1	Memory problem

Dementia Care Unit

Documentation shall support the following for scoring dementia care unit.

1) Unit was IDPH certified during the look-back period.

2) Resident resided in the unit during the look-back period.

3) Activity programming is planned and provided seven days a week for an average of eight hours per day.

4) If the resident has a CPS score of five, care planning shall address the resident's participation in the unit's activities.

5) If a particular resident does not participate in a least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.

6) Staff's efforts to involve the resident.

7) Required assessments were completed on the resident.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1an = 1 AND	Alzheimer's/Dementia special care unit	15	4 RN 4 LPN	10	10
	I1q = 1 or	Alzheimer's Disease				
	I1u = 1 AND	Dementia other than Alzheimer's				
	S1 = 0 AND	Does not meet IDPH Subpart S criteria				
	CPS 2,3,4,5 AND	CPS score				
	Dementia care unit is IDPH certified					

7) Exceptional Care Services

Respiratory Services

Documentation shall support the following for scoring respiratory services.

1) A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.

2) Respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.

3) Physician's order for the treatments.

4) Respiratory therapy in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.

5) Suctioning, including type, frequency and results of suctioning.

6) Trach care, including type, frequency and description of the care provided.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ai = 1 or P1aj = 1 or P1bdA = 7	Perform suctioning Administered trach care Respiratory therapy	5	15 RN 15 LPN		
II	P1ai = 1 AND P1aj = 1 AND P1bdA > 0	Performed suctioning Administered trach care Respiratory therapy	10	24 RN 24 LPN		

A $50.00 add-on cost will be applied to all residents receiving trach care.

Weaning From Ventilator

Documentation shall be in place to support weaning from ventilator.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1a1 = 0 on current MDS AND P1a1 = 1 on previous MDS	Resident no longer on ventilator Resident previously on ventilator	5	15 RN 15 LPN		

Morbid Obesity

Documentation shall support the following for scoring morbid obesity.

1) A dietician's evaluation was completed with evidence of on-going consultation.

2) On-going monitoring of weight shall be evident.

3) The psychosocial needs related to weight issues shall be identified and addressed.

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I3 = 278.01 AND	ICD9 for morbid obesity is marked	10	5 RN 5 LPN	5	
	K5e = 1 AND	On a therapeutic diet				
	K5h = 1 AND	On planned weight change program				
	G1aA = 3 and	Extensive assist				
	G1aB=3 or	Requires 2+ assist with bed mobility				
	G1bA=3 and	Extensive assist				
	G1bB=3 or	Requires 2+ assist with transfers				
	G1cA=3 and	Extensive assist				
	G1cB=3 AND	Requires 2+ assist with walk in room				
	P3d=7 or	On bed mobility restorative				
	P3e=7 or	On transfer restorative				
	P3f = 7	On walking restorative				

A $40.00 add-on shall be applied to all residents meeting the Morbid Obesity category.

Complex Wounds

Facilities shall follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual F-tag F314). All documentation requirements listed in F314 shall be met.
There are no minutes assigned to this area. It is strictly a $15.00 add-on applied to residents meeting the following criteria.

MDS item	Description
M1c or M1d > 0 AND	Presence of stage 3 or 4 PU
M2a > 0 or	Type of ulcer, pressure
M2b > 0 AND	Type of ulcer, stasis
B1 = 1 or	Comatose
G1Aa = 3 or 4 or	Bed mobility (extensive)
G1Ab = 3 or 4	Transfer (extensive)
AND any 3 of the follow:	
ICD 9 codes of (260, 261, 262, 263.0, 263.1, 263.2, 263.8, 263.9)	ICD 9-Malnutrition
ICD 9 585	ESRD
I1a = 1	Diabetes Mellitus
I1qq = 1	Renal Failure
I1j = 1	Peripheral vascular disease
I1x = 1	Paraplegia
I1z = 1	Quadriplegia
I1w = 1	Multiple Sclerosis
J5c = 1	End stage disease
H1a = 4	Incontinence of bowel
H1b = 4	Incontinence of bladder
J1c = 1	Dehydration
G6a = 1	Bedfast
J2a = 2	Pain daily
M3 = 1	History of resolved ulcers
AND all of the following:	
M5a = 1 and/or	Pressure relieving device/chair

M5b = 1 AND	Pressure relieving device/bed
M5c = 1 AND	Turn and position
M5d = 1 AND	Nutrition or hydration
M5e = 1	Ulcer care

Traumatic Brain Injury

Documentation shall support the following for scoring traumatic brain injury.

1) Psychological therapy shall be delivered by licensed mental health professionals as described in the RAI Manual.

2) A special symptom evaluation program shall be an on-going, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI Manual.

3) Evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder or other mental health problems by a qualified clinical professional as described in the RAI Manual.

4) Care plan shall address the behaviors of the resident and the interventions used.

There are no minutes assigned to this area. It is strictly a $50.00 add-on applied to residents meeting the following criteria.

MDS item	Description
I1cc = 1 AND	Traumatic brain injury
B1 = 0 AND	Not comatose
S1 = 0 AND	Does not meet Subpart S criteria
E4aA = 3 and E4 a B = 1 or	Wandering daily and alterability
E4bA = 3 and E4bB = 1 or	Verbally abusive behavioral symptoms daily and alterability

E4cA = 3 and E4cB = 1 or	Physically abusive behavioral symptoms daily and alterability
E4dA = 3 and E4dB = 1 or	Socially inappropriate/disruptive behavioral symptoms daily and alterability
E4eA = 3 and E4eB = 1 AND	Resists care daily and alterability
P1beA ≥ 1 AND	Psychological therapy
P2a = 1 AND	Special behavior symptom evaluation
P2b = 1	Evaluation by a mental health specialist in last 90 days

8) Special Patient Need Factors

There shall be documentation to support the deficits identified on the MDS in communication and vision problems.

Communication

Count	MDS items	Description	Staff Minutes
I	C4 > 0 or	Deficit in making self understood	1% of all staff time accrued in all categories from ADLs through Exceptional Care
	C6 > 0	Deficit in understanding others	

Vision Problems

Count	MDS items	Description	Staff Minutes
I	D1 > 0 or	Vision impaired to Severely impaired	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	D2a = 1 or	Decreased peripheral vision	

	D2b = 1	Experience halos around lights, light flashes	

Accident/Fall Prevention

Documentation shall support the following for scoring accident/fall prevention.

1) The resident has the risk factor identified on the MDS.

2) The resident has been assessed for fall risks.

3) If the resident is identified as high risk for falls, interventions have been identified and implemented.

Count	MDS items	Description	Staff Minutes
I	I1aa = 1 or O4a-d = 7 or H1b > 0 or J1f = 1 or J4a = 1 or J4b = 1 or J1n = 1 or E4aA > 0	Seizure disorder Medications Incontinent urine Dizziness Fell in past 30 days Fell in past 31-180 days Has unsteady gait Wandered in last 7 days	3% of all staff time accrued in all categories from ADLs through Exceptional Care

Restraint Free

There shall be documentation to support the previous use of a restraint and the resident response to the restraint. There shall be evidence that the restraint was discontinued.

Count	MDS items	Description	Staff Minutes
I	P4c > 1 or	In last assessment: Used trunk restraint daily in last 7 days	2% of all staff time accrued in all categories from ADLs through Exceptional Care

	P4d > 1 or	Used limb restraint daily in last 7 days	
	P4e > 1	Used chair that prevents rising daily in last 7 days	
	And	And in current assessment:	
	P4c = 0 and	Not used trunk restraint in last 7 days	
	P4d = 0 and	Not used limb restraint in last 7 days	
	P4e = 0	Not used chair that prevents rising in last 7 days	

Activities

There shall be documentation to support the average time involved in activities.

Count	MDS items	Description	Staff Minutes
I	N2 = 0 or 1 AND Any of the following checked:	Average time involved in activities	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	G6a = 1 or	Bedfast all or most of the time	
	C4 > 1 or	Sometimes too rarely understood	
	C6 > 1 or	Sometimes too rarely understands others	
	E1o > 0 or	Withdrawal from activity	

AA3 ≤ 50 or	Age is 50 or younger at assessment reference date	
E1p > 0 or	Reduced social interactions	
E4a-eA > 0 or	Any behavioral symptoms	
G4b-dB > 0 OR	Any limited ROM	
N2 = 0 or 1 AND	Average time involved in activities	
E2 > 0 AND	Mood persistence	
E1a > 0 or	Negative statements	
E1n > 0 or	Repetitive physical movements	
E4eA > 0 or	Resists care	
E1o > 0 or	Withdraws from activity	
E1p > 0 or	Reduced social interaction	
E1j > 0 or	Unpleasant mood in morning	
N1d =1 or	Not awake all or most of the time	

	E1g > 0 or	Statements that something terrible will happen	
	K3a = 1 or	Weight loss	
	(N1a,b,c ≤ 1 AND	Not awake all or most of the time	
	B1 =0)	Not comatose	

(Source: Amended at 34 Ill. Reg. 3786, effective March 14, 2010)

Section 147.TABLE B MDS-MH Staff Time (in Minutes) and Allocation by Need Level

As part of the transition to a new reimbursement system for Class I IMDs, Table B sets forth the initial criteria that may likely be used to incentivize provision of clinically appropriate services to individual residents of these facilities. The Department intends to secure data and begin analyzing this data, including a sample time study, prior to implementation of this payment model.

Each MDS-MH item in Table B includes a description of the item from the MDS-MH, and the variable time assigned to each level represents the type of staff that should be delivering the service (aide, licensed, RN, LPN and social services) and the number of minutes allotted to that service item.

MDS Item	Description of Medical Services	Aide	Licensed	RN	LPN	Social Service
	Program Base	25	11	1	1	25
G1a=2	Hygiene 1	8	1		1	3
G1=3	Hygiene 2	12	1		1	3
G1b=3 or G1c=3	Mobility 1	12		1	1	1
G1b=4 or G1b=5 or G1c=4 or G1c=5	Mobility 2	17		1	1	1
G1d=2	Toilet 1	10	1		1.5	1
G1d=3	Toilet 2	14	1	1	1	1
G1e=2	Eating 1	10	1			2
Gle=3	Eating 2	16	1	1	1	1
G1f=2	Bathing 1	10	2			3
G1f=3	Bathing 2	14	1	1	1	2
H1=2 or H1=3	Hearing 1	3			1	3
H2=2	Vision 1	3			1	3
H2=3 or H2=4	Vision 2	3	1		1	3
H3=2 or H3=3	Expression 1	6	2			4
H3=4	Expression 2	8	2			7

H4=2 or H4=3 H4=4	Understanding 1 Understanding 2	6 8	2 2			4 7
ICD-9=250 to 250.9	Diabetes 1	8		2	4	2
N2a=1 or N2b=1 or N2c=1 or N2d=1 or Hyperlipidemia (ICD-9=272.0 to 272.9)	Nutrition 1	5	1	1	2	2
N3a=1 or N3b=1 or N3c=1 or N4=1	Eating Disorders 1	5	3	1	2	3
L2a=1 or L2b=1 or L2c=1	Nursing Interventions 1	2		0.5	0.5	
L2a=2 or L2b=2 or L2c=2	Nursing Interventions 2	2.5	1	0.5	0.5	1
L2a=3 or L2b=3 or L2c=3	Nursing Interventions 3	3.5	1	1.5	1.5	1
L2a=4 or L2b=4 or L2c=4	Nursing Interventions 4	4.5	1	1.5	1.5	2
L2a=5 or L2b=5 or L2c=5	Nursing Interventions 5	5.5	1	2	2	2
L2a=6 or L2b=6 or L2c=6	Nursing Interventions 6	6	2	2	2	2
L2a=7 or L2b=7 or L2c=7	Nursing Interventions 7	7	2	3	2	2
CPS=3 or 4 CPS=5 or 6	Cognitive Problems 1 Cognitive Problems 2	4 6	2 3			5 7
Number of E1a to E1g scoring >1=1 or 2	Behavior Disturbance 1	5	2			5
Number of E1a to E1g scoring >1=3 or 4	Behavior Disturbance 2	10	2			8
Number of E1a to E1g scoring >1=5 or more	Behavior Disturbance 3	15	3			10

D1a=1 D1a=2 D1a=3 or D1a=4	Self Injury 1 Self Injury 2 Self Injury 3	2 3 10	 2 5	 1	 2	2 5 10
D1b=1	Intent to Kill Self 1	4	2			5
D1a=0 and D1c=1	Considered Self Injurious Act 1	5	2			1
D1a=0 and D1d=1	At Risk for Self Injury 1	2	2			5
D2a=1 D2a=2 D2a=3 or D2a=4	Violence 1 Violence 2 Violence 3	2 3 10	 2 5	 1	 2	2 5 10
D2b=1 D2b=2 D2b=3 or D2b=4	Intimidation Threats to Others 1 Intimidation Threats to Others 2 Intimidation Threats to Others 3	2 3 10	 2 5			2 5 10
D2c=2 D2c=3 or D2c=4	Violent Ideation 1 Violent Ideation 2	2 4	 2			1 7
K2b=1	Medication Support 1	6	1	1	1	5
K5>0	Acute Control Medications 1	2	1	2	2	5
M3a>0	Required Staff Accompaniment	5				2
A5a=1 or 2 A5a=3 or 4 A5b=1 or 2	Hx Crim Justice Viol 1 Hx Crim Justice Viol 2 Hx Crim Justice Nonviol 1		2 4 1			3 5 2

A5b=3 or 4	Hx Crim Justice Nonviol 2		2			4
M2a>0 or M2b>0 M2c>0 or M2d>0 or M2e>0	Close or Constant Observation 1 Close or Constant Observation 2	15 30	5 10			5 10
P3≤ 5 and L4a>1	Discharge Planning 1		10			25
L1i≥ 3	PRS Director or Coordinator Counseling					5
L3a or L3b=2 or 3 and L4aA=2 or 3 and P3<5	Community Reintegration	3	3			5
L3b=2 or 3 and L4bA=2 or 3	Social/Family Functioning	3	3			12
L3b or L3d + 2 or 3 and L4cA=2 or 3	Psych Rehab/ Recover Readiness and Support	3	4			15
L3b=2 or 3 and L4dA=2 or 3	Skills Training and Generalization	5	5			20
L3a, L3b or L3d=2 or 3 and L4eA=2 or 3 and C1>1 or C2=2	Substance Use/Abuse Management	6	5			15
L3a or L3b=2 or 3 and L4fA=2 or 3	Vocational/ Academic Development	2	3			12
L3a or L3b + 2 or 3 and L4gA=2 or 3 and D2a=2 or D2b=3 or D2c=3 or Elc>1	Aggression/Anger Management		5			15
L3a or L3b=2 or 3	Behavior	2	3			13

and L4hA=2 and E1b or E1d or E1e>0	Management					
L3b=2 and L4iA=2	Enhanced Activity Program	5	3			12
L3a or L3b=2 and L4jA=2	Work Program (Department of Labor Compliant)		5			25
L3b=2 or 3 and L4kA=2 or 3	Illness Self-Management (SAMHSA Toolkit)	5	5			20
L3a and L3b=2 or 3 and L41A=2 or 3	Specialized Therapies (DBT)		5			25
L5=1	Adherence with Programs 1	10	4			10
L6≥1	Required staff accompaniment to medical appointment mandated by the outside medical provider	10				
Psychotropic Medications as Listed in Section R	Psychotropic Medication Monitoring	7		8	8	

Compute Cognition Category Using Cognitive Performance Scale (CPS)	
Compute Intermediate Cognition Variables	

Count of Non-Independence Items for CPS (Cog1)	If (F1a=1) add 1 to Cog 1
	If (F2=1 or 2 or 3) add 1 to Cog 1
	If (H3=1 or 2 or 3 or 4) add 1 to Cog 1

Count of Moderate to Severe Impairments for CPS (Cog 2)	If (F2=2 or 3) add 1 to Cog 2 If (H3=3 or 4) add 1 to Cog 2
Compute CPS	
Compute CPS Level 1	If (Cog 1=1) CPS=1
Compute CPS Level 2	If (Cog 1=2 or 3 and Cog 2=0) CPS=2
Compute CPS Level 3	If (Cog 1=2 or 3 and Cog 2=1) CPS=3
Compute CPS Level 4	If (Cog 1=2 or 3 and Cog 2=2) CPS=4
Compute CPS Level 5	If (F2=4 or 5 and G1e <6) CPS=5
Compute CPS Level 6	If (F2=4 or 5 and G1e=6 or 8) CPS=6
Convert CPS to Cognition Reimbursement Categories	

(Source: Amended at 31 Ill. Reg. _____, effective June 11, 2007)

Section 147.TABLE C Comprehensive Resident Assessment (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE D Functional Needs and Restorative Care (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE E Service (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE F Social Services (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE G Therapy Services (Repealed)

(Source: Repealed at 17 Ill. Reg. 13498, effective August 6, 1993)

Section 147.TABLE H Determinations (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE I Activities (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE J Signatures (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE K Rehabilitation Services (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE L Personal Information (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)