DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities

2) Code Citation: 89 Ill. Adm. Code 147

3)

Section Numbers:	Proposed Action:
147.5	Repeal
147.125	Repeal
147.150	Repeal
147.175	Repeal
147.200	Repeal
147.310	New Section
147.315	New Section
147.320	New Section
147.325	New Section
147.330	New Section
147.335	New Section
147.340	New Section
147.350	Amendment
147.355	Repeal
147. TABLE A	Repeal
147. TABLE B	Repeal

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 96-1530

5) Complete Description of the Subjects and Issues Involved: The proposed amendments are necessary for compliance with Public Act 96-1530 that requires the Department to implement, effective July 1, 2012, an evidence-based payment methodology for the reimbursement of nursing facility services. Additionally, the methodology must take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Resident Assessment Instrument, adopted and in use by the federal government. Reimbursement for nursing component shall be calculated using RUGs.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

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8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

12) Time, Place, and Manner in which Interested Persons may Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/782-1233

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded long term care facilities

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: July 2011

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

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

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147.355 Reimbursement for Residents with Exceptional Needs (Repealed)

147.TABLE A	Staff Time (in Minutes) and Allocation by Need Level (Repealed)
147.TABLE B	MDS-MH Staff Time (in Minutes and Allocation by Need Level) (Repealed)
147.TABLE C	Comprehensive Resident Assessment (Repealed)
147.TABLE D	Functional Needs and Restorative Care (Repealed)
147.TABLE E	Service (Repealed)
147.TABLE F	Social Services (Repealed)
147.TABLE G	Therapy Services (Repealed)
147.TABLE H	Determinations (Repealed)
147.TABLE I	Activities (Repealed)
147.TABLE J	Signatures (Repealed)
147.TABLE K	Rehabilitation Services (Repealed)
147.TABLE L	Personal Information (Repealed)

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; amended at 36 Ill. Reg. _____, effective April 27, 2012; amended at 36 Ill. Reg. ____, effective_____.

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

(Source: Repealed at 36 Ill. Reg. _____, effective_____)

Section 147.125 Nursing Facility Resident Assessment Instrument (Repealed)

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(Source: Repealed at 36 Ill. Reg. _____, effective_____)

Section 147.150 Minimum Data Set (MDS) Based Reimbursement System (Repealed)

(Source: Repealed at 36 Ill. Reg. _____, effective _____)

Section 147.175 Minimum Data Set (MDS) Integrity (Repealed)

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(Source: Repealed at 36 Ill. Reg. _____, effective _____)

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

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(Source: Repealed at 36 Ill. Reg. _____, effective _____)

Section 147.310 Implementation of a Case Mix System

a) P.A. 96-1530 requires the Department to implement, effective July 1, 2012, an evidence-based payment methodology for the reimbursement of nursing facility services. The methodology shall take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Resident Assessment Instrument (RAI), adopted and in use by the federal government.

b) This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing facilities. Resident reimbursement classification shall be established according to the 48 group, Resource Utilization Groups IV (RUGs-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) except the CMS weights for groups PA1, PA2, BA1 and BA2 shall be reduced by 50 percent and in addition, an Illinois specific group will be established and identified as AA1 with an assigned weight equal to the weight assigned to group PA1.

c) Determination of a statewide base nursing component of the per diem rate. For each fiscal year, the Department shall:

1) Determine the total dollar amount available to be paid for nursing facility services under this Section. In making such determination, the Department shall (i) take into consideration available appropriations and (ii) identify an amount to be reserved to account for improved compliance and coding by the nursing facilities.

2) Estimate the number of resident-days to be paid under each of the 49 groups (the 48 RUGs-IV groups plus group AA1).

3) For each of the groups, multiply the number of resident-days in each group, as estimated in subsection (c)(2) of this Section, by the weight assigned to that group, as described in subsection (b) of this Section.

4) Compute the statewide base nursing component as the quotient that results from dividing the total dollar amount available, as in subsection (c)(1) of this Section, by the sum of the products computed in subsection (c)(3) of this Section.

d) Determination of resident-specific nursing component of the per diem rate. The nursing component of the rate shall be calculated quarterly. For each resident, the Department shall:

1) Determine the group to which resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUGs resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to group AA1. A resident for whom an assessment necessary to determine group classification is incomplete or has not been submitted within 14 calendar days of the time requirements in Section 147.315 shall be assigned to group AA1.

2) Compute the resident-specific nursing component as the product of the statewide base nursing component, as determined in subsection (c)(4) of this Section, and the weight associated with the group to which the resident has been assigned.

e) For services provided on or after:

1) July 1, 2012, the Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components, as determined in subsection (d)(2) of this Section, assigned to Medicaid-enrolled resident on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), as present in the facility on the last day of the second quarter preceding the rate period.

2) July 1, 2013, or a later date as determined by the Department, the nursing component of the rate, as determined in subsection (d)(2) of this Section, shall be paid on a resident-specific basis.

f) The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.315 Nursing Facility Resident Assessment Instrument

a) A facility shall conduct and electronically submit a Minimum Data Set (MDS) assessment that conforms with the assessment schedule and guidance defined by Code of Federal Regulations, Title 42, Section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), in the Long Term Care Assessment Instrument Users Manual, Version 3.0, and subsequent updates when issued by CMS. The Department may substitute successor manuals or questions and answer documents published by CMS, to replace or supplement the current version of the manual or document.

b) A facility shall complete the MDS Comprehensive Item Set form, that includes all items Section A-Z, for each resident quarterly, regardless of the resident's payment source. The Comprehensive Item Set refers to the MDS items that are active on a particular assessment type or tracking form. While a Comprehensive Item Set is required for all assessments including quarterlies, a comprehensive assessment is not required on a quarterly basis. A comprehensive assessment is defined as both the completion of a Comprehensive Item Set as well as completion of the Care Area Assessment (CAA) process and care planning. When completing the Comprehensive Item Set for the quarterly MDS, the CAA process is not required. The federal regulatory requirements at 42 CFR 483.20(d) requires nursing facilities to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record.

c) A facility shall electronically transmit to the database the following MDS assessments in the timeframes identified.

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1) The Omnibus Budget Reconciliation Act (OBRA) regulations require nursing facilities that are Medicare and/or Medicaid certified to conduct initial and periodic assessments for all their residents. The MDS 3.0 is part of that assessment process and is required by CMS. The assessment that will be used for the purpose of rate calculations shall be identified as an OBRA assessment on the MDS following the guidance in the RAI manual.2) Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive Assessments shall identify the MDS was transmitted to CMS database no later than 14 calendar days after the care plan completion date. The quarterly assessment shall indentify the MDS was transmitted to the CMS database no later than 14 calendar days after the MDS completion date.

3) An MDS admission assessment and CAAs shall be completed by the 14th calendar day from the resident's admission date. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. Care plan completion date is 7 calendar days after the MDS/CAA completion date. Transmission date is within 14 calendar days after the care plan completion date.

4) An annual assessment shall have an assessment reference date (ARD) within 366 calendar days of the ARD after the last comprehensive assessment. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. The MDS/CAA completion date is the ARD plus 14 calendar days. The care plan completion date is MDS/CAA completion date plus 7 calendar days. Transmission date is care plan completion date plus 14 calendar days.

5) A significant change assessment shall be completed within 14 calendar days after the identification of a significant change. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. The MDS/CAA completion date is 14 calendar days after the determination date plus 7 calendar days. Transmission date is care plan date plus 14 calendar days.

6) All quarterly assessments shall have an ARD within 92 calendar days of the previous ARD assessment. This assessment includes the completion of the MDS Comprehensive Item Set, but does not include the completion

of the CAA process and care planning. MDS completion date is ARD plus 14 calendar days. Transmission date is completion date plus 14 calendar days.

7) The significant correction to a prior comprehensive assessment or significant correction to a prior quarterly assessment shall be completed when the interdisciplinary team determines that a resident's prior assessment contains a significant error that has not been corrected by more recent assessments. Nursing facilities document the initial identification of a significant error in a prior assessment in the progress notes.

d) A facility shall comply with the following:

1) All staff completing any part of the MDS shall enter their signatures, titles, section or portion(s) of section(s) they completed and the date completed.

2) Staff completing the MDS is expected to read the attestation statement on the MDS carefully. The signature attests that the information entered by them, to the best of their knowledge, most accurately reflects the resident's status during the timeframes identified.

3) Federal regulations require the RN assessment coordinator to sign and thereby certify that the assessment is completed.

4) When the electronic MDS record submitted to the state does not match the facility's copy of the MDS, the items on the MDS submitted will be used for purposes of validation.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.320 Definitions

For purposes of this Part, the following terms shall be defined as follows:

"Active Disease Diagnosis" means an illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments.

"Assessment Reference Date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all

minimum data set items refer back in time from that point. This period of time is also called the observation or assessment period.

"Case Mix" means a method of classifying care that is based on the intensity of care and services provided to the resident.

"Case Mix Index" means the weighting factors assigned to RUG-IV classifications.

Case Mix Reimbursement System" means a payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident.

"Department" means the Illinois Department of Healthcare and Family Services (HFS).

"Fraud" means an intentional deception, omission, or misrepresentation made by a person with the knowledge that the deception, omission, or misrepresentation could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Because payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court.

"Index Maximization" classifies a resident who could be assigned to more than one category, to the category with the highest case mix index.
"Minimum Data Set" means the assessment instrument specified by the Centers for Medicare and Medicaid Services (CMS) and designated by HFS. A core set of screening, clinical, and functional status elements, including common definitions and coding categories, forms the foundation of a comprehensive assessment.

"Monitoring" means the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress towards a goal. Monitoring can detect any improvements, complications or adverse consequences of the condition or of the treatments, and support decisions about adding, modifying, continuing or discontinuing any interventions.

"Nursing Monitoring" means clinical monitoring (e.g. serial blood pressure evaluations, medication management, etc.) by a licensed nurse.

"Resource Utilization Group" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by a facility's minimum data set.

"Significant Error" means an error in an assessment where a resident's overall clinical status in not accurately represented, and the error has not been corrected via submission of a more recent assessment.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.325 Resident Reimbursement Classifications and Requirements

a) Resident reimbursement classification shall be based on the Minimum Data Set (MDS), Version 3.0 assessment instrument, or its successor version mandated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) that nursing facilities are required to complete for all residents. The Department shall establish resident classes according to the 48 grouper, Version IV or RUG-IV model. Resident classes shall be established based on the individual items indentified on the MDS and shall be completed according to the Case Mix Classification Manual issued by the Department. The Department may substitute successor manuals or question and answer documents to replace or supplement the current version of the manual.

b) Each resident shall be classified based on the information from the MDS according to the categories as identified in Section 147.330 and as defined in the case mix classification manual issued by the Department.

c) General Documentation Requirements

1) A facility shall maintain resident records on each resident in accordance with acceptable professional standards and practices.

2) Supportive documentation in the clinical record used to validate the MDS item response(s) shall be dated during the Assessment Reference Date (ARD) period or other timeframe as specified by the Department. Records shall be retained for at least three years from the date of discharge.

3) Supportive documentation entries shall be dated and their authors identified by signature or initials. Signatures are required to authenticate all documentation utilized to support MDS item response(s). At a

minimum, the signature shall include the first initial, last name, and title/credentials. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there shall also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e. on the MDS). When electronic signatures are used, the facility shall have policies in place to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures.

4) Each page or individual document in the clinical record shall contain the resident's identification information.

5) A multi-page supportive documentation form completed by one staff member may be signed and dated at the end of the form, provided that each page is identified with the resident's identification information and the date(s) are clearly indentified on the form.

6) Corrections/Obliterations/Errors/Mistaken entries. At a minimum, there shall be one line through the incorrect information, the staff's initial, the date of correction was made, and the corrected information. Information that is deemed illegible by Department reviews will not be considered for validation purposes.

7) An error correction in the electronic record applies the same principles as for the paper clinical record. Some indication that a previous version of the entry exists shall be evident to the caregiver or other person viewing the entry.

8) Late entries shall be clearly labeled as a late entry and contain the current date, time and authorized signature. Amendments are a form of late entry. Amendments shall be clearly labeled as an addendum or amendment and include the current date, time and authorized signature.

9) Facilities shall have a written policy and procedures that states who is authorized to make amendments, late entries, and correct errors in the electronic health records (EHRs) and clearly dictate how these changes to the EHR are made.

10) Resident records shall be complete, accurately documented, readily accessible to Department staff, and systematically organized. At a minimum, the record shall contain sufficient information to identify the resident, a record of the resident's assessments, care plan, record of services provided, and progress notes.

11) Documentation from all disciplines and all portions of the resident's clinical record may be used to validate an MDS item response. All supporting documentation shall be produced by a facility during an onsite visit.

12) Documentation shall support all conditions or treatments were present or occurred within the observation period which includes the full 24 hours of the ARD. Documentation shall apply to the appropriate observation period and reflect the resident's status on all shifts.

13) Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom or problem. Documentation shall reflect the resident's status on all shifts.

14) Problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan.

15) Insufficient or inaccurate documentation may result in a determination that the MDS item submitted was not validated.

16) Documentation shall support that the services delivered were medically necessary.

17) Documentation shall support an individualized care plan was developed based on the MDS and other assessments and addressed the resident's strengths and needs. In addition, documentation, observation and/or interview shall support services were delivered as required by the care plan.

18) When there is a significant change in status assessment done, documentation shall include the identification of the significant change in status in the clinical record.

d) Disease Diagnosis Requirements

1) The disease condition shall require a physician-documented diagnosis in the clinical record during the 60 days prior to ARD.

2) The diagnosis shall be determined to be active during the 7-day observation period. Conditions that have been resolved or no longer affect the resident's current functioning or care plan during the 7 day observation period shall not be included.

3) Documentation shall support that the active diagnoses have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the observation period.

4) There shall be specific documentation in the record by a physician stating the disease is active. Including a disease/diagnosis on the resident's clinical record problem list is not sufficient for determining active or inactive status. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease.

A) Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy during the 7 day observation period.

B) Symptoms and abnormal signs indicating ongoing or decompensating disease in the last 7-days observation period.

C) Ongoing therapy with medication or other interventions to mange a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the 7 day observation period. A medication indicates active disease if that medication is prescribed to mange an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.

D) When documentation of conditions that are generally short term in nature (i.e., fever, Septicemia, pneumonia, etc) are noted over a long period of time by the facility staff, the physician may be

interviewed to determine appropriateness of the diagnosis. In addition, when questions regarding the validity of the diagnosis are found during review of the documentation the physician may be interviewed.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements

a) Activities of Daily Living (ADL)

1) Documentation shall support the ADL coded level as defined in the Resident Assessment Instrument (RAI) manual.

2) Documentation of ADLs shall be 24 hours/7 days on all three shifts within the observation period while in the facility. There shall be signatures/initials for each shift and dates to authenticate the services provided. If using an ADL grid for supporting documentation, the key for self-performance and support provided shall be equivalent to definitions to the MDS key.

3) The ADL scores for residents lacking documentation shall be reset to zero.

b) Extensive Services. Documentation shall support that the following requirements were met during the observation period based on the MDS items identified.

1) Documentation shall support tracheostomy care was completed during the observation period while a resident in the facility.

2) Documentation shall support the use of a ventilator or respirator during the observation period while a resident in the facility. Documentation shall support the device was an electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration. This does not include BiPAP or CPAP devices or a ventilator or respirator that is used only as a substitute for BiPAP or CPAP.

3) Documentation supports the need for and use of isolation during the observation period while a resident is in the facility.

4) Documentation shall support the following conditions for "strict isolation" was met during the observation period:

A) The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission;

B) Precautions are over and above standard precautions. That is, transmission-based precautions (Contact, droplet, and/or airborne) must be in effect; and

C) The resident is in a room alone because of active infection and cannot have a roommate even if the roommate has a similar active infection that requires isolation. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining etc).

5) Treatment and/or procedures the resident received shall be care planned and reevaluated to ensure continued appropriateness.

6) Extensive Services are defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG GROUP
Extensive Services-At least one of the following:			
Tracheostomy Care while a resident	>=2	Tracheostomy care and Ventilator/Respirator	ES3
(O0100E2)	>=2	Tracheostomy care OR Ventilator/Respirator	ES2
Ventilator or Respirator while a resident			
(O0100F2)	>=2	Infection Isolation: • Without trach • Without Ventilator /Respirator	ES1
Infection Isolation while a resident			
O0100M2)			

c) Rehabilitation-Documentation shall support the following requirements were met during the observation period based on the MDS items identified.

1) All RAI requirements and definitions shall be met, including the qualifications for therapists.

2) Documentation shall support medically necessary therapies that occurred after admission/readmission to the facility that were:

   A) Ordered by a physician based on a qualified therapist's (i.e., one who meets Medicare requirements) and treatment plan;

   B) Documented in the clinical record; and

   C) Care planned and periodically evaluated to ensure the resident receives needed therapies and the current treatment plans are effective. Any service provided at the request of the resident or family that is not medically necessary shall not be included, even when performed by a therapist or a therapy assistant. It does not include the services performed when a facility elects to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aids performing these maintenance service that are considered restorative care.

3) Documentation shall support the therapies were provided once the individual was living and being cared for at the long-term care facility. It does not include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or recipient of home care or community based services.

4) Documentation supports the services were ordered or certified by a physician.

5) Documentation supports the services shall be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with a qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of these services in the facility.

6) Documentation supports the services shall be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge , and skills of a therapist.

7) Documentation supports the services shall be provided with expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.

8) Documentation shall support the services are considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition.

9) Documentation shall support the medically necessary for the treatment of the resident's condition. This includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel.

10) Documentation shall include the actual minutes of therapy. Minutes shall not be rounded to the nearest 5^{th} minute and conversion of units to minutes or minutes to units is not acceptable.

11) Documentation shall identify the different modes of therapy (i.e., individual, concurrent, group) and the documentation shall support the criteria for the mode identified is met.

12) Documentation shall support that the restorative program include nursing interventions that promote the residents ability to adapt and adjust to living as independently and safely as possible. The program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

13) Documentation shall support the following components for a restorative program is met:

    A) There are measurable objectives/interventions established for the performance of the activity;

    B) A registered nurse must evaluate and document the results of the evaluation related to the program on a quarterly basis.

C) Documentation includes the actual number of minutes the activity was performed and supports at least 15 minutes in a 24 hour period for a minimum of 6 days; and

D) Individuals who implement the program must be trained in the interventions and supervised by a nurse.

14) Documentation shall support the requirements identified for coding ADL was met:

15) Rehabilitation is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	IL Rug Group
5 days or more (15 min per day minimum) in any combination of Speech, Occupational or Physical Therapy in the last 7 days. (O0400A4, O0400B4, O0400C4) AND 150 minutes or greater of any combination of Speech, Occupational or Physical Therapy in the last 7 days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3)	15-16	None	RAE
	11-14	None	RAD
	6-10	None	RAC
	2-5	None	RAB
	0-1	None	RAA
OR 3 days or more (15 min per day minimum) in any combination of Speech, Occupational, or Physical Therapy in the last 7 days (O0400A4, O0400B4, O0400C4) AND 45 minutes or greater in any combination of Speech, Occupational or Physical Therapy in the last 7			

days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3) AND at least 2 nursing rehabilitation services.			

d) Special Care High-Documentation shall support the following requirements were met during the observation period based on the MDS items identified.

1) Documentation shall support the requirements/criteria for coding an active disease diagnosis was met.

2) Documentation shall support the ADL scores met the criteria/requirements for coding.

3) Documentation shall include the time/date, and the staff member completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date/time observed, a brief description of the symptoms, staff observing, and any interventions.

4) Documentation shall support a diagnosis of coma or persistent vegetative state.

5) Documentation shall support an active diagnosis of Septicemia. Interventions and/or treatments for the diagnosis shall be documented upon delivery.

6) Documentation shall support an active diagnosis of diabetes, and supports insulin injections were given the entire 7 days of the observation period and there were orders for insulin changes on 2 or more days during the observation period.

7) Documentation supports the active diagnosis of Quadriplegia.

8) Documentation supports the active diagnosis of Chronic Obstructive Pulmonary Disease and/or asthma with shortness of breath while lying flat. Interventions and/or treatments for the condition shall be documented upon delivery.

9) Documentation to support fever shall include a recorded temperature of at least 2.4 degrees higher than the baseline temperature and documentation of one of the following: pneumonia, vomiting, weight loss, and/or feeding tube with at least 51% of total calories or if 26-50% of the calories there is also fluid intake of 501cc or more per day. Interventions and/or treatments for the condition shall be documented upon delivery.

10) Documentation to support parenteral or IV feedings. Documentation shall support the intervention was administered for nutrition or hydration.

11) Documentation of respiratory therapy that includes the following:

A) Physician orders that include a statement of frequency, duration, and scope of treatment;

B) The actual minutes the therapy was provided while a resident in the facility;

C) Evidence that the services are provided by a qualified professional; and

D) That the services are directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel.

E) Special Care High is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG IV Group
Special Care High (ADL Score of >=2 or more and at least one of the following:	15-16	Depression	HE2
	15-16	No Depression	HE1
Comatose (B0100) and completely ADL dependent or ADL did not	11-14	Depression	HD2

occur (G0100A1, G0100B1, G0100H1, G0100I1 all = 4 or 8) Septicemia (I2100)	11-14	No Depression	HD1
Diabetes (I2900) with both of the following:	6-10	Depression	HC2
• Insulin injections for all 7 days (N0350A=7)	6-10	No Depression	HC1
• Insulin order changes on 2 or more days (N0350B>=2)	2-5	Depression	HB2
Quadriplegia (I5100) with ADL score >=5	2-5	No Depression	HB1
Asthma or COPD (I6200) AND shortness of breath while lying flat (J1100C)		(Note: See description of depression indicators)	
Fever (J1550A) and one of the following:			
• Pneumonia (I2000)			
• Vomiting (J1550B)			
• Weight Loss (K0300=1 or 2)			
• Feeding Tube (K0510B1 or K0510B2) with at least 51% of total calories (K0700A=3) OR 26% to 50% through parenteral/enteral intake (K0700A=2) and fluid intake is 501cc or more per day (K0700B=2)			
Parenteral/IV Feeding (K0510A1 or K0510A2)			
Respiratory Therapy for all 7 days (O0400D2=7)			
If a resident qualifies for Special Care High but the ADL score is a 1 or less, then the resident classifies as Clinically Complex			

e) Special Care Low – Documentation shall support the following requirements were met during the observation period based on the MDS items identified.

1) Documentation shall support the requirements/criteria for coding disease diagnosis was met. This includes an active diagnosis of Cerebral Palsy, Multiple Sclerosis, and/or Parkinson's.

2) Documentation shall support an active diagnosis of respiratory failure and the administration of oxygen therapy while a resident. Documentation shall include the date and method of delivery. Documentation shall support a need for the use of oxygen.

3) Documentation shall support the requirements/criteria for coding ADLs were met.

4) Documentation shall include the time, date, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date and time observed, a brief description of the symptom, any interventions and identification of staff observing.

5) Documentation shall support the presence of a feeding tube and the proportion of calories received through the tube feeding.

6) Documentation shall support the presence of 2 or more Stage 2 pressure ulcers or any Stage 3 or 4 pressure ulcer as defined in the RAI manual. Documentation shall include observation date, location, and measurement/description of the ulcer. Other factors related to the ulcer shall be noted including: condition of the tissue surrounding the area (color/temperature/etc.), exudates/drainage present, fever, presence of pain, absence/diminished pulses, and origin of the wound (such as pressure, injury or contributing factors) if known. Interventions/treatments for the ulcer shall be documented as delivered.

7) Documentation shall support the presence of two or more venous/arterial ulcers as defined in the RAI manual. Documentation shall include observation date, location, and measurement/description of the ulcer. Interventions/treatment for the ulcer shall be documented as delivered.

8) Documentation shall support the presence of a Stage 2 pressure ulcer and a venous/arterial ulcer. Documentation shall include observation date, location, and measurement/description of the ulcer. Interventions/treatments for the ulcer shall be documented as delivered.

9) Documentation shall support two or more of the following interventions when ulcers are noted: pressure relieving devices, turning/repositioning, nutrition/hydration, ulcer care, application of dressing and/or application of ointments. Documentation shall support the interventions identified were implemented during the observation period.

10) Documentation and/or observation shall support the use of pressure relieving devices for the resident. This does not include egg crate cushions, doughnuts or rings.

11) Documentation for a turning/repositioning program shall include specific approaches for changing the resident's position and realigning the body and the frequency it is to be implemented. Documentation shall support the program was implemented and is monitored and reassessed to determine the effectiveness of the intervention.

12) Documentation shall support the nutrition/hydration interventions were delivered. These shall be based on an individual assessment of the resident's nutritional deficiencies and needs. Vitamins and mineral supplements shall only be coded when noted through a thorough nutritional assessment.

13) Documentation for ulcer care shall support the care was delivered. Documentation shall include the date/time; type of care delivered, and identifies the person delivering the care.

14) Documentation shall support the application of non-surgical dressing and shall include date and time applied and identification of the staff delivering the care. This does not include application of a band-aid.

15) Documentation shall support the application of ointments or medications were actually applied to somewhere other than the feet. This includes only ointments or medications used to treat and/or prevent skin conditions. Documentation shall include name and description of the ointment used, date and time applied, and identification of the staff delivering the care.

16) Documentation of infections of the foot and/or presence of diabetic foot ulcers or open lesions to the foot shall include a description of the area.

17) Interventions/treatments for the problem shall be noted. Documentation shall define the intervention and treatment, the date and time delivered and the identification of the staff delivering the care.

18) Documentation shall support the application of dressing to the feet was actually delivered. Documentation shall include the date and time applied and identification of the staff delivering the care.

19) Documentation shall support the reason for and the administration of radiation while a resident. Documentation shall include the date and time of administration and identification of the staff delivering the care.

20) Documentation shall support dialysis was administered while a resident. Documentation shall include type of dialysis, date and time, and identification of the staff delivering the care.

21) Special Care Low is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	ILL RUG IV Group
Special Care Low-ADL score of 2 or more and at least one of the following:	15-16	Depression	LE2
	15-16	No Depression	LE1
Cerebral Palsy (I4400) with ADL score >=5	11-14	Depression	LD2
Multiple Sclerosis (I5200) with ADL score >=5	11-14	No Depression	LD1
Parkinson's disease (I5300) with ADL score >=5	6-10	Depression	LC2
Respiratory Failure (I6300) and oxygen therapy while a resident (O0100C2)	6-10	No Depression	LC1
Feeding Tube (K0510B1 or K0510B2) with at least 51% of total calories (K0700A=3) OR 26% to	2-5	Depression	LB2
	2-5	No Depression	LB1

50% through parenteral/enteral intake (K0700A=2) and fluid intake is 501cc or more per day (K0700B=2) Two or more Stage 2 pressure ulcers (M0300B1) with two or more skin treatments • Pressure relieving device for chair (M1200A) and/or bed (M1200B) • Turning/Repositioning (M1200C) • Nutrition or hydration intervention (M1200D) • Ulcer care (M1200E) • Application of dressing (M1200G) • Application of ointments (M1200H) Any Stage 3 or 4 pressure ulcer (M0300C1, D1, F1) with two or more skin treatments-See above list Two or more venous/arterial ulcers (M1030) with two or more skin treatments-See above list One Stage 2 pressure ulcer (M0300B1) and one venous/arterial ulcer (M1030) with two or more skin treatments-See above list Foot infection (M1040A), Diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressing to feet (M1200I) Radiation treatment while a resident (O0100B2) Dialysis treatment while a resident (O0100J2)		Note: See description of depression indicators	

If a resident qualifies for Special Care Low but the ADL score is 1 or less-then the resident classifies as Clinically Complex			

f) Clinically Complex – Documentation shall support the following requirements were met during the observation period based on the MDS items identified.

1) Documentation shall support the requirements/criteria for coding disease diagnosis was met. This shall include documentation of an active diagnosis of pneumonia that includes current symptoms and any interventions.

2) Documentation shall also support an active diagnosis of hemiplegia/hemiparesis.

3) Documentation shall support the requirements/criteria for coding ADLs was met.

4) Documentation shall include the time, date, and staff completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date and time observed, brief description of the symptom, any interventions, and identification of staff observing.

5) Documentation shall support the presence of open lesions other than ulcers. The documentation shall include, but is not limited to, an entry noting the observation date, location, measurement/description of the lesion and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of nonsurgical dressing to an area other than the feet and/or application of ointments to an area other than the feet, and documentation that it was implemented.

6) Documentation shall support the presence of a surgical wound. The documentation shall include an entry noting the observation date, origin of the wound, location, measurement/description, and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of nonsurgical dressing to an area other

than the feet and/or application of ointments to an area other than the feet. Documentation shall include the type of intervention, date and time delivered and the staff delivering the care.

7) Documentation shall support the presence of a burn. Documentation shall include an entry noting the observation date, location, measurement/description, and any interventions.

8) Documentation shall support the administration of a chemotherapy agent while a resident in the facility. Documentation shall include the name of the agent, date and time delivered and the staff delivering the care.

9) Documentation shall support the administration of oxygen while a resident in the facility. This shall include the date and method of delivery. Additionally, documentation shall support a need for the use of oxygen.

10) Documentation shall support the administration of an IV medication while a resident in the facility. The documentation shall include the name of the medication, date delivered, method of delivery and identification of staff delivering the care.

11) Documentation shall support the resident received a transfusion while a the resident was at the facility. Documentation shall include the date and time, reason for use and identification of staff delivering the care.

12) Clinically Complex is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	ILL RUG IV Group
Clinically Complex-At least one of the following:	15-16	Depression	CE2
Pneumonia (I2000)	15-16	No Depression	CE1
Hemiplegia/hemiparesis (I4900) with ADL score >=5	11-14	Depression	CD2
Surgical wounds (M1040E) or open lesion (M1040D) with any selected skin treatment below	11-14	No Depression	CD1
• Surgical wound care (M1200F)	6-10	Depression	CC2

• Application of nonsurgical dressing (M1200G) not to feet	6-10	No Depression	CC1
	2-5	Depression	CB2
• Application of ointment (M1200H) not to feet	2-5	No Depression	CB1
Burns (M1040F)			
Chemotherapy while a resident (O0100A2)	0-1	Depression	CA2
Oxygen therapy while a resident (O0100C2)	0-1	No Depression	CA1
IV Medication while a resident (O0100H2)			
Transfusions while a resident (O0100I2)			
If a resident qualifies for Special Care High or Special Care Low, but the ADL score of 1 or 0, then the resident classifies in Clinically Complex CA1 or CA2			

g) Behavioral Symptoms and Cognitive Performance – Documentation shall support the following requirements were met during the observation period based on the MDS items identified.

1) Documentation shall include the time, date, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date and time observed, brief description of the symptom, any interventions and identification of staff observing.

2) Documentation shall include the time, date and staff completing the Brief Interview for Mental Status (BIMS).

3) Documentation shall support the occurrence of a hallucination and/or delusion that include the time, date, description, and name of staff observing.

4) Documentation shall include the date/time, staff observing, frequency, and description of resident's specific physical/verbal or other behavioral

symptom. Documentation shall include any interventions and the resident's response.

5) Documentation shall include the date/time, staff observing, frequency and description of the behavior of rejection of care. Rejection of care shall meet all of the coding requirements. Residents, who have made an informed choice about not wanting a particular treatment, procedure, etc., shall not be identified as "rejecting care". Documentation shall include any interventions and the resident's response.

6) Documentation shall include the date/time, staff observing, frequency and description of any wandering behavior. Documentation shall support a determination for the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety and the resident's response to any interventions. Care plans shall address the impact of wandering on resident safety and disruption to others and shall focus on minimizing these issues.

7) Documentation shall identify how the coded behavior affected the resident, staff and/or others. Care plan interventions shall address the safety of the resident and others and be aimed at reducing distressing symptoms.

8) Documentation supports presence of a restorative program. This shall include, but is not limited to, the following: Documentation of the actual number of minutes the program was provided that equals 15 minutes, a restorative care plan that contains measurable objectives, and goals that are specific, realistic and measurable. In addition, documentation shall support the programs are supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse, and staff are trained in skilled techniques to promote the resident's involvement in the activity.

9) Behavioral Symptoms and Cognitive Performance is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	ILL RUG IV GROUP
Behavioral Symptoms and	2-5	2 or more Restorative Nursing	BB2

Cognitive Performance BIMS score of 9 or less AND an ADL score of 5 or less OR Defined as Impaired Cognition by Cognitive Performance Scale AND an ADL score of 5 or less Hallucinations (E0100A) Delusions (E0100B) Physical Behavioral symptom directed toward others (E0200A=2 or 3) Verbal behavioral symptom directed towards others (E0200B=2 or 3) Other behavioral symptom not directed towards others (E0200C=2 or3) Rejection of care (E08002 or 3) Wandering (E0900=2 or 3)	 2-5 0-1 0-1	Programs 0-1 Restorative Nursing Programs 2 or more Restorative Nursing Programs 0-1 Restorative Nursing Programs	 BB1 BA2 BA1

h) Reduced Physical Function

1) Documentation shall support the ADL coded level.

2) Documentation support presence of a restorative program. This shall include, but is not limited to, documentation of the actual number of minutes the program was provided that equals 15 minutes a day for 6 or more days a week, a restorative care plan that contains measureable objectives, and goals that are specific, realistic and measurable, documentation that supports the programs are supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse and staff are trained in skilled techniques to promote the resident's involvement in the activity.

3) Reduced Physical Function is defined as indicated in the chart below.

Category (Description)	ADL Score	End Splits or Special Requirements	ILL RUG IV Group
Reduced Physical Function	15-16	2 or more Restorative	PE2

No Clinical Conditions	15-16	0-1 Restorative	PE1
	11-14	2 or more Restorative	PD2
	11-14	0-1 Restorative	PD1
	6-10	2 or more Restorative	PC2
	6-10	0-1 Restorative	PC1
	2-5	2 or more Restorative	PB2
	2-5	0-1 Restorative	PB1
	0-1	2or more Restorative	PA2
	0-1	0-1 Restorative	PA1

Illinois Specific Classification

An assessment that is missing and/or submitted more than 14 days late from the due date	N/A		AA1

Additional Scoring Indicators

ADL	Self-Performance	Support	ADL Score
Bed Mobility (G0100A) Transfer (G0110B) Toilet Use (G0110I)	Coded -, 0, 1, 7, or 8	Any Number	0
	Coded 2	Any Number	1
	Coded 3	-,0,1, or 2	2
	Coded 4	-,0,1,or 2	3
	Coded 3 or 4	3	4
Eating (G0110H)	Coded -,0,1,2,7 or 8	-,0,1 or 8	0

	Coded -,0,1,2,7 or 8	2 or 3	2
	Coded 3 or 4	-,0 or 1	2
	Coded 3	2 or 3	3
	Coded 4	2 or 3	4

Depression Indicator

The depression end split is determined by either the total severity score from the resident interview in Section D0200 (PHQ-9) or from the total severity score from the caregiver assessment of Mood D0500 (PHQ9-OV)

Residents that were interviewed D0300 (Total Severity Score) >=10 and D0300<=27
Staff Assessment-Interview not conducted D0600 (Total Severity Score >=10 and D0600 <=30.

Restorative Nursing – Activities that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's clinical record. These are nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The program must be performed for a total of at least 15 minutes during a 24-period. Measurable objective and interventions must be documented in the care plan. There must be evidence of periodic evaluation by the licensed nurse. A registered nurse or licensed practical nurse must supervise the activities. This does not include groups with more than four residents per supervising staff.

Restorative Nursing Programs-2 or more required to be provided 6 or more days a week

Passive Range of Motion (O0500A) and/or Active Range of Motion (O0500B)*
These are exercises performed by the resident or staff that are individualized to the resident's needs, planned, monitored, and evaluated. Movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative program. Staff must be trained in the procedures.

Splint or Brace Assistance (O0500C)-This includes verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or there is a scheduled program of applying and removing a splint or brace. The resident's skin and circulation under the device should be assessed and the limb repositioned in correct alignment.

The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

Bed Mobility Training (O0500D) and/or walking training (O0500F)*- Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and position self in bed. Walking-Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.

Transfer Training (O0500E)-Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

Dressing and/or grooming training (O0500G)-Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Eating and/or swallowing training (O0500H)-Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Amputation/Prosthesis (O0500I)-Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Communication training (O0500J)-Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

No count days required for current toileting program or trail (H0200C) and/or Bowel training program (H0500)*-This is a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current stands of practice. The program is based on an assessment of the resident's unique voiding pattern. The individualized program requires notations of the resident's response to the program and subsequent evaluations as needed. It does not include simple tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene.

*Count as one service even if both are provided.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Cognitive Impairment

Cognitive impairment is determined by either the summary score from the resident interview in Section C0200-C0400 (BIMS) or from the calculation of Cognitive Performance Scale if the BIMS is not conducted.

Brief Interview for Mental Status (BIMS)
BIMS summary score (C0500 <=9)

Cognitive Performance Scale

Determine whether the resident is cognitively impaired based on the staff assessment rather than on resident interview. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.
The resident is cognitively impaired if one of the three following conditions exists.
B0100 Coma (B0100=1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all =4 or 8)

C0100 Severely impaired cognitive skills (C1000=3)

B0700, C0700, C1000 Two or more of the following impairment indicators are present:
B0700>0 Problem being understood
C0700=1 Short term memory problem
C1000>0 Cognitive skills problem
And
One or more of the following severe impairment indicators are present:
B0700>=2 Severe problem being understood

C1000>=2 Severe cognitive skills problem

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.335 Enhanced Care Rates

An additional enhance rate is applied for certain categories of residents that are in need of more resources. A facility must complete and submit the Department required form for each area to be eligible for an enhanced rate. In addition, a Section S item response may be used for each category.

a) Ventilator Services

1) Ventilators are defined as any type of electrical or pneumatical 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.

2) nursing facility shall notify the department using a department designated form that includes a physician order sheet that identifies the need and delivery of ventilator services. A facility shall also use the designated form to notify the department when a resident is no longer receiving ventilator services. The following criteria shall be met in order for a facility to qualify for ventilator care reimbursement.

A) A facility shall establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.

B) Facilities shall be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.

C) Clinical assessment of oxygenation and ventilation-arterial blood gases or other methods of monitoring carbon dioxide and oxygenation shall be available on-site for the management of residents.

D) Emergency and life support equipment, including mechanical ventilators, shall be connected to electrical outlets with back-up generator power in the event of a power failure.

E) Ventilators shall be equipped with internal batteries to provide a short back-up system in case of a total loss of power.

F) An audible, redundant ventilator alarm system shall be required to alert staff of a ventilator malfunction, failure or resident disconnect. A back-up ventilator shall be available at all times.

G) For facilities licensed under the Nursing Home Care Act, a minimum of one RN on duty for eight consecutive hours, seven days per week, as required by77 Ill. Adm. Code 300.1240. For facilities licensed under the Hospital Licensing Act, an RN shall be on duty at all times, as required by 77 Ill. Adm. Code 250.910. Additional RN staff may be determined necessary by HFS, based on the HFS' review of the ventilator services.

H) Licensed nursing staff shall be on duty in sufficient numbers to meet the needs of residents as required by 77 Ill. Adm. Code 300.1230. For facilities licensed under the Nursing Home Care Act, HFS requires that an RN shall be on call, if not on duty, at all times.

I) No less than one licensed respiratory care practitioner licensed in Illinois shall be available at the facility or on call 24 hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility. The practitioner shall evaluate and document the respiratory status of a ventilator resident on no less than a weekly basis.

J) A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a biweekly basis.

K) At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator dependent individuals and the use of the ventilators, conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals.

L) All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing such care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and qualification of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

b) Facilities shall be required to have established written protocols on the following areas:

1) Pressure Ulcers. A facility shall have established policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers. Staff shall receive in-service training on those areas.

A) Documentation shall support the resident has been assessed quarterly for their risk for developing pressure ulcers.

B) Interventions for pressure ulcer prevention shall be in place that include, but are not limited to, a turning and repositioning schedule, use of pressuring reducing devices, hydration and nutritional interventions and daily skin checks.

2) Pain. A facility shall have established policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.

A) Documentation shall support the resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.

B) Documentation shall support an effective pain management regime is in place for the resident.

3) Immobility. A facility shall have established policies and procedures to assess the possible effects of immobility and risk for developing infections. These shall include, but not be limited to, range of motion techniques, contracture risk, proper hand washing techniques, aseptic technique in delivering care to a resident and proper care of the equipment and supplies. Staff shall receive in-service on those areas.

A) Documentation shall support the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.

B) Documentation shall support the resident was given oral care every shift to reduce the risk of infection.

4) Social Isolation. A facility shall have a method of assessing a resident's risk for social isolation. Interventions shall be in place to involve a resident in activities when possible.

5) Ventilator Weaning. A facility shall have a method of routinely assessing a resident's weaning potential and interventions implemented as needed.

c) HFS staff shall conduct on-site visits on a random or targeted basis to ensure both facility and resident compliance with requirements identified in this subsection (c). All records shall be accessible to determine that the needs of a resident are being met and to determine the appropriateness of ventilator services. In addition to the requirements of this subsection, HFS review shall include, but not be limited to, the following:

1) Ventilator Associated Pneumonia;

2 Ventilator Weaning;

3) Length of Stay and Hospital Discharge;

4) Length of Stay and Discharge Destination; and

5) Length of Stay and Death.

d) An enhanced payment shall be added to the rate determined by the methodology currently in place:

1) Payment shall be made for each individual resident receiving ventilator services;

2) Reimbursement shall be made at two levels based on the number of hours a resident is on a ventilator; and

Criteria	Level
Resident has met the criteria identified, and required the use of a ventilator for a minimum of ten hours in a 24-hour period	I
Resident has met the criteria identified, and required the use of a ventilator for a minimum of 16 hours in a 24-hour period.	II

3) Level I rate shall include the facility specific support, capital and nursing components plus $102. Level II rate shall include the facility specific support, capital and nursing components plus $204.

TBI

1) Any facility meeting the criteria set forth in this subsection for TBI care to a resident shall receive the enhanced TBI reimbursement rate identified.

2) TBI is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

3) The following criteria shall be met in order for a facility to qualify for TBI reimbursement.

A) The facility shall have written policies and procedures for care of the residents with TBI and behaviors that include, but are not limited to, monitoring for behaviors, identification and reduction of agitation, safe and effective interventions for behaviors, and assessment of risk factors for behaviors related to safety of residents, staff and others.

B) The facility shall have staff to complete the required physical (PT), occupational (OT) or speech therapy (SP), as needed. Additionally,

a facility shall have staffing sufficient to meet the behavior, physical and psychosocial needs of the resident.

C) Staff caring for a TBI resident shall receive in-service for the care of a TBI resident and dealing with behavior issues identifying and reducing agitation, and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and qualifications of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

D) The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, lack of privacy, seclusion and social isolation.

E) Care plans on all residents shall address the physical, behavioral and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs, and shall be revised as necessary.

F) The facility shall use the "Rancho Los Amigos Cognitive Scale" to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse. Based on the level of functioning, and the services and interventions implemented, a resident will be placed in one of three tiers of payments. Tier 3 is the highest reimbursement. By completing a department designated form, facilities will be responsible for notifying the department of the applicable tier in which a resident falls is placed.

G) Documentation found elsewhere in the resident records shall support the scoring on the Rancho assessment as well as the delivery of coded interventions.

4) Admission Criteria

A) Documentation by a neurologist that the resident has a TBI diagnosis on the MDS 3.0 (I5500=1) that meets the RAI requirements for

coding. In addition, documentation from the neurologist shall identify the resident has the ability to benefit from rehabilitation and a potential for independent living.

B) Documentation the resident was assessed using the Rancho Los Amigos Cognitive Assessment and scored a Level IV-X. Residents scoring a Level I, II or III on the Rancho assessment shall not be eligible for TBI reimbursement.

C) Documentation the resident is medically stable and has been assessed for potential behaviors and safety risk to self, staff and others.

5) Tier I requirements are as follows.

A) Tier I shall not exceed six months.

B) The resident must have previously scored in Tier II or Tier III.

C) The resident has received intensive rehabilitation and is preparing for discharge to the community. The resident shall receive instructions focusing on independent living skills, prevocational training and employment support.

D) Resident scores a Level VIII-X on the Rancho Amigos Cognitive Scale (Purposeful, Appropriate, and stand-by assistance to Modified Independence).

E) No behaviors or Behaviors present, but less than 4 days (E0200A-C<2 AND E0500A-C=0 AND E0800,2 and E1000A+B=0 on the MDS 3.0).

F) Cognitive- Brief Interview for Mental Status (BIMS) is 13-15 (Cognitively intact, C0500 on the MDS 3.0).

G) Activities of daily living (ADL) functioning. All ADL tasks shall be coded less than 3 (Section G on the MDS 3.0).

H) An assessment shall be completed to identify the resident's needs and risk factors related to independent living. This assessment shall include,

but is not limited to, physical development and mobility, communication skills, cognition level, food preparation and eating behaviors, personal hygiene/grooming, health/safety issues, social/behavioral issues, ADL potential with household chores, transportation, vocational skills and money management.

I) Discharge Potential. There is an active discharge plan in place (Q0400A=1 on the MDS 3.0) or referral has been made to the local contact agency (Q0600=1 on the MDS 3.0). There shall be weekly documentation by a licensed social worker related to discharge potential and progress.

6) Tier II requirements are as follows.

A) Tier II shall not exceed twelve months.

B) Resident has reached a plateau in rehabilitation ability, but still requires services related to the TBI. Resident must have previously scored in Tier III.

C) Resident scores a Level IV-VII on the Rancho Amigos Cognitive Scale (Confusion, may or may not be appropriate).

D) Cognition. BIMS is less than 13 (C0500 on MDS 3.0) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3 on MDS 3.0).

E) Resident has behaviors (E0300=1 or E1000=1 on MDS 3.0) and these behaviors impact resident (E0500A-C=1) or impact others (E0600A-C=1). Behaviors shall be tracked daily and interventions implemented as needed. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and implementation of revisions as necessary.

F) ADL function (Section G on MDS 3.0) 3 or more ADL require limited or extensive assistance.

G) Resident is on 2 or more of the following restorative: Bed Mobility (O0500D=1 on MDS 3.0), Transfer (O0500E=1 on MDS 3.0), Walking (O0500F=1 on MDS 3.0), Dressing/Grooming (O0500G=1 on MDS 3.0), Eating (O0500H=1 on MDS 3.0) or Communication (O0500J=1 on MDS 3.0).

H) Resident receives either Psychological (O0400E2>1 on MDS 3.0) or Recreational Therapy (O0400F2>1 on MDS 3.0) at least two or more days a week.

I) Documentation shall support one to one meeting with a licensed social worker at least twice a week to discuss potential needs, goals and any behavior issues.

J) At least quarterly oversight of care plan by a neurologist.

K) Documentation the resident has received instruction and training that includes, but is not limited to, behavior modification, anger management, time management goal setting, life skills and social skills.

7) Tier III requirements are as follows.

A) Tier III shall not exceed nine months.

B) The injury resulting in a TBI diagnosis must have occurred within the prior six months to score in Tier III.

C) Includes the acutely diagnosed resident with high rehabilitation needs.

D) Resident scores an IV-VII on the Rancho Amigos Cognitive Scale.

E) Cognition- BIMS is less than 13 (C0500 on the MDS 3.0) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3 on the MDS 3.0).

F) Documentation shall support the facility is monitoring behaviors and has implemented interventions to identify the risk factors for behaviors and to reduce the occurrence of behaviors.

G) Resident receives Rehabilitation therapy (PT, OT or ST) at least 500 minutes per week and at least 1 rehabilitation discipline 5 days/week (O400 on the MDS 3.0). The therapy shall meet the RAI guidelines for coding.

H) The facility shall have trained rehabilitation staff on-site working with the resident on a daily basis. This shall include a trained rehabilitation nurse and rehabilitation aides.

I) Documentation shall support there are weekly meetings of the interdisciplinary team to discuss the residents' rehabilitation progress and potential.

J) Resident receives Psychological Therapy (O0400E2>1 on MDS 3.0) at least 2 days per week.

K) There shall be documentation to support monthly oversight by a neurologist.

8) Rates of payment for each Tier are as follows:

A) The payment amount for Tier I is $265.17 per day

B) The payment amount for Tier II is $486.49 per day.

C) The payment amount for Tier III is $767.46 per day.

(Source: Added at 36 Ill. Reg. _____, effective _____)

Section 147.340 Minimum Data Set On-site Reviews

a) The Department shall conduct reviews to determine the accuracy of the resident assessment information <u>transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. The MDS data used by the Department to set the reimbursement rate will be used to conduct the validation reviews. Such reviews may, at the discretion of the Department, be conducted</u> electronically or onsite in the facility.

b) The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews.

c) The Department shall also select facilities for on-site review based upon facility characteristics, atypical patterns of scoring MDS items, non-submission/late submission of assessments, high percentage of significant corrections, previous history of review changes, or the Department's experience. The Department may also use the findings of the licensing and certification survey conducted by the Department of Public Health (DPH) indicating the facility is not accurately assessing residents.

d) In addition, the Department may conduct reviews if the Department determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstance include, but are not limited to, the following:

1) Frequent changes in administration or management of the facility;

2) An unusually high percentage of residents in a specific case mix classification or high percentage of change in the number of residents in a specific case mix classification;

3) Frequent adjustments of case mix classification as result of reconsiderations, reviews, or significant corrections submitted;

4) A criminal indictment alleging fraud; and

5) Other similar factors that relate to a facility's ability to conduct accurate assessments.

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

f) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals. The Department is authorized to conduct unannounced on-site reviews. On-site reviews may include, but shall not be limited to, the following:

1) Review of the resident records and supporting documentation, as identified in Section 147.330 and according to the facility manual for case mix classification issued by the Department.

2) Observation and interviews of residents, families and/or staff, to determine the accuracy of data relevant to the determination of reimbursement rates.

3) Review and collection of information necessary to assess the resident's need for a specific service or care area.

4) 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 meet the needs of the services identified for reimbursement.

g) The Department shall select at least 20 percent, with a minimum of ten assessments, of the assessments submitted. 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.

h) If more than 25 percent of the RUG-IV classifications are changed as a result of the initial review, the review shall be expanded to a second 25 percent, with a minimum of ten assessments. If the total changes between the first and second sample exceed 40 percent, the Department may expand the review to all the remaining assessments.

i) If the facilities qualify for an expanded review, the Department may review the facility again within six months. If a facility has two expanded reviews within a 24-month period, that facility may be subject to reviews every 6 months for the next 18 months and a penalty may be applied as defined in subsection (s).

j) 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 the residents' care needs and treatments. 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.l16(a)(4).

k) 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 review team within an hour after the 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.

l) When further documentation is needed by the review team to validate an area, the team will identify the MDS item, requiring additional documentation and provide the facility with the opportunity to produce that information. The facility shall provide the team with additional documentation within 24 hours after the initial request.

m) Facilities shall ensure that clinical records, regardless of form, are easily and readily accessible to Department staff.

n) Throughout the review, the Department shall identify to the facility any preliminary conclusions regarding the MDS item(s)/area(s) that could not be validated. If the facility disagrees with those preliminary conclusions they shall present the Department with any and all documentation to support their position. It is up to the facility to determine what documentation is needed to support both the Resident Assessment Instrument (RAI) and rule requirements regarding the MDS item(s) identified.

o) All documentation that is to be considered for validation must be provided to the team prior to exit. All RAI requirements and requirements identified in this subsection must be presented to validate the identified area.

p) Corrective Action. Upon conclusion of the review 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. The Department shall reclassify a resident if the Department determines that the resident was incorrectly classified.

q) Data Accuracy. Final conclusions with respect to inaccurate data may be referred to the appropriate agencies, including, but not limited to, the Department's Office of Inspector General, Illinois State Police or DPH.

r) Recalculation of Reimbursement Rate. The Department shall determine if the 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.

s) A facility's rate shall be subject to change if the recalculation of the direct care component rate, as a result of using RUGs-IV data that are verifiable:

1) 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.

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

t) Based on the areas identified as reclassified, the nursing facility may request that the Department reconsider the assigned classification. The request for reconsideration shall be submitted in writing to the Department within 30 days after the date of the Department's notice to the facility. The request for reconsideration shall include the name and address of the facility, the name of each resident in which reconsideration is requested, the reason(s) for the reconsideration for each resident, and the requested classification changes for each resident based on the MDS items coded. In addition, a facility may offer explanations as to how they feel the documentation presented during the review supports their request for reconsideration. However, all documentation used to validate an area must be submitted to the Department prior to exit. Documentation presented after exit will not be considered when determining a recalculation request. If the facility fails to provide the required information with the reconsideration request, or the request is not timely, the request shall be denied.

u) Reconsideration by the Department shall be made by individuals not directly involved in that facility review. The reconsideration shall be based upon the initial assessment documentation and the reconsideration information sent to the Department by the facility. The Department shall have 120 days after the date of the request for reconsideration to make

(Source: Added at 36 Ill. Reg. _____, effective _____)

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.

(Source: Amended at 36 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 147.355 Reimbursement for Residents with Exceptional Needs (Repealed)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

(Source: Repealed at 36 Ill. Reg. _____, effective _____)

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

~~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	Self-Performance = missing	
	G1aA = 0 or	Self-Performance = independent	1
	G1aA = 1.	Self-Performance = supervision	
	G1aA = 2.	Self-Performance = limited assistance	3
	G1aA = 3 or	Self-Performance = extensive assistance	
	G1aA = 4 or	Self-Performance = total dependence	
	G1aA = 8 AND	Self-Performance = activity did not occur	
	G1aB = - or	Support = missing	4
	G1aB = 0 or	Support = no set up or physical help	
	G1aB = 1 or	Support = set up help only	
	G1aB = 2.	Support = 1 person assist	

	~~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~~	~~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~~	

~~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~~ ~~G4bA > 0 or~~ ~~G4cA > 0 or~~ ~~G4dA > 0 or~~ ~~G4eA > 0 or~~ ~~G4fA > 0 or~~ ~~G4aB > 0 or~~ ~~G4bB > 0 or~~ ~~G4cB > 0 or~~ ~~G4dB > 0 or~~ ~~G4eB > 0 or~~ ~~G4fB > 0~~	~~Any function limits in ROM of neck~~ ~~Any function limits in ROM of arm~~ ~~Any function limits in ROM of hand~~ ~~Any function limits in ROM of leg~~ ~~Any function limits in ROM of foot~~ ~~Any function limits in ROM of other limitation or loss~~ ~~Any function limits in voluntary movement of neck~~ ~~Any function limits in voluntary movement of arm~~ ~~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 ≤ 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~~ ~~G4bB > 0 or~~ ~~G4cB > 0 or~~ ~~G4dB > 0 or~~ ~~G4eB > 0 or~~ ~~G4fB > 0~~	~~Any function limits in voluntary movement of neck~~ ~~Any function limits in voluntary movement of arm~~ ~~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 0<G1jA<8 AND G7 = 1 AND	Need assistance in dressing 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~~	~~Other Restorative~~	~~**6**~~	~~5 RN 5 LPN~~		
	~~Q2 < 2~~ ~~AND~~	~~Improved or no change in care needs~~				
	~~B2a = 0~~ ~~AND~~	~~Short term memory okay~~				
	~~B4 = 0 or 1~~ ~~AND~~	~~Cognitive skills for decision making~~				
	~~C6 = 0 or 1~~ ~~AND~~	~~Ability to understand others~~				

	S1 = 0	Does not meet IDPH Subpart S criteria				
H	P3k = 3 or greater AND Q1c = 1 or 2 AND Q2 < 2 AND P1ar = 1 AND B2a = 0 AND B4 = 0 or 1 AND C6 = 0 or 1 AND S1 = 0	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 Ability to understand others Does not meet IDPH Subpart S criteria	6	7.5 RN 7.5 LPN		

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~~	~~Any scheduled toileting plan~~ ~~Does not meet criteria for Subpart S~~	~~22~~	~~1.5~~ ~~RN~~ ~~1.5~~ ~~LPN~~		
	~~H3b = 0~~ ~~AND~~	~~No bladder retraining program~~				
	~~H3d = 0~~ ~~AND~~	~~No indwelling catheter~~				
	~~H1b > 1 or~~	~~Incontinent at least 2 or more times a week~~				
	~~GliA> 1 and <8~~	~~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		12	.5 RN .5 LPN		
	H3d = 1 AND	Indwelling catheter present				
	H3a = 0	No scheduled toileting plan				
II	Bladder Retraining					
	H3b = 1 AND	Bladder retraining program	32	5 RN 5 LPN		
	H3a = 0 AND	No scheduled toileting plan				
	H1b > 1 AND	Incontinent at least 2 or more times a week				
	B4 = 0 or 1 OR	Cognitive skills for decision making				
	H3b = 1 AND	Bladder retraining program				
	H3a = 0 AND	No scheduled toileting plan				
	H1b ≤ 1 AND	Bladder continence				

	H4 = 1 AND B4 = 0 or 1	Change in continence Cognitive skills in decision making				

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~~	~~Application of dressings (other than feet)~~				
	~~M5h = 1~~	~~Application of ointments (other than feet)~~				
	~~M5i = 1~~	~~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~~	~~Demonstrate or complain of pain~~	~~4~~	~~4~~ ~~RN~~ ~~4~~ ~~LPN~~	~~1~~	~~1~~
	~~J2b > 0~~	~~Mild to excruciating intensity~~				

~~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	Improved or no change in care needs				
	P1ar = 1 AND Sl=0	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 K6a = 4 Or Intake = 1 if K6a = 2 and K6b = 2 or K6b = 3 or K6b = 4 or K6b = 5	Tube feeding in last 7 days See below Parenteral/ enteral intake 51-75% of total calories Parenteral/enteral intake 76-100% of total calories Parenteral/enteral intake 26-50% of total calories 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	2	12 RN 12 LPN	2	

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~~	~~Constipation~~	~~10~~	~~2 RN 2 LPN~~		~~1~~
	~~AND~~					
	~~K5a = 0~~ ~~AND~~	~~No parenteral/IV~~				
	~~K5b = 0~~ ~~OR~~	~~No feeding tube~~				
	~~Any two of the following separate conditions:~~ ~~1 ≤ O4e ≤ 7 or~~	~~Received a diuretic medication in last 7 days~~				

	J1o = 1 or	Vomiting				
	I3 a,b,c,d,e = 276.5 or	Volume depletion				
	276.52 or	Hypovolemia				
	J1c = 1 or	Dehydrated				
	J1d = 1 or	Did not consume most fluids provided (3 days)				
	J1h = 1 or	Fever				
	J1j = 1 AND	Internal bleeding				
	K5a = 0 AND	Not have parenteral/IV				
	K5b = 0	No feeding tube				

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 F1g = 1 or~~	~~Indicators of depression 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	Antipsychotic meds	5	2.5 RN 2.5 LPN		
	O4b = 7 or	Antianxiety meds				
	O4c = 7 or	Antidepressant meds				

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,	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	

	dementia care unit and discharge planning reset to zero					
II	SI = 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	SI = 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	SI = 1	Meets IDPH Subpart S criteria	16	5 RN	25	

	~~AND~~ ~~S8 = 0~~ ~~AND~~ ~~Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero~~	~~Ancillary provider services delivered by facility providers~~		~~5~~ ~~LPN~~		

~~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 S1 = 0	Cognitive performance scale is 5 or 6 Does not meet IDPH Subpart S criteria	21	5.5 RN 5.5 LPN	16	15

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 ≤ C4 ≤ 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	Awake all or most of the time in the morning
	N1b = 0 and	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 ≤ 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~~ ~~And SIC code = 1~~ ~~If IC code = 2 or 3~~	~~Some dependence in cognitive skills~~ ~~Usually understood to rarely or never understood~~ ~~Moderately impaired in cognitive skills~~ ~~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 p~~eriod.

(Source: Repealed at 36 Ill. Reg. _____, effective _____)

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

~~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~~ ~~G1=3~~	~~Hygiene 1~~ ~~Hygiene 2~~	~~8~~ ~~12~~	~~1~~ ~~1~~		~~1~~ ~~1~~	~~3~~ ~~3~~
~~G1b=3 or G1c=3~~ ~~G1b=4 or G1b=5 or~~ ~~G1c=4 or G1c=5~~	~~Mobility 1~~ ~~Mobility 2~~	~~12~~ ~~17~~		~~1~~ ~~1~~	~~1~~ ~~1~~	~~1~~ ~~1~~
~~G1d=2~~ ~~G1d=3~~	~~Toilet 1~~ ~~Toilet 2~~	~~10~~ ~~14~~	~~1~~ ~~1~~	~~1~~	~~1.5~~ ~~1~~	~~1~~ ~~1~~
~~G1e=2~~ ~~Gle=3~~	~~Eating 1~~ ~~Eating 2~~	~~10~~ ~~16~~	~~1~~ ~~1~~	~~1~~	~~1~~	~~2~~ ~~1~~
~~G1f=2~~ ~~G1f=3~~	~~Bathing 1~~ ~~Bathing 2~~	~~10~~ ~~14~~	~~2~~ ~~1~~	~~1~~	~~1~~	~~3~~ ~~2~~
~~H1=2 or H1=3~~	~~Hearing 1~~	~~3~~			~~1~~	~~3~~
~~H2=2~~ ~~H2=3 or H2=4~~	~~Vision 1~~ ~~Vision 2~~	~~3~~ ~~3~~	~~1~~		~~1~~ ~~1~~	~~3~~ ~~3~~
~~H3=2 or H3=3~~ ~~H3=4~~	~~Expression 1~~ ~~Expression 2~~	~~6~~ ~~8~~	~~2~~ ~~2~~			~~4~~ ~~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~~	~~Cognitive Problems 1~~	~~4~~	~~2~~			~~5~~
~~CPS=5 or 6~~	~~Cognitive Problems 2~~	~~6~~	~~3~~			~~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~~	~~Self Injury 1~~	~~2~~				~~2~~
~~D1a=2~~	~~Self Injury 2~~	~~3~~	~~2~~			~~5~~
~~D1a=3 or D1a=4~~	~~Self Injury 3~~	~~10~~	~~5~~	~~1~~	~~2~~	~~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 A5b=3 or 4	Hx Crim Justice Viol 1 Hx Crim Justice Viol 2 Hx Crim Justice Nonviol 1 Hx Crim Justice Nonviol 2		2 4 1 2			3 5 2 4
M2a>0 or M2b>0 M2c>0 or M2d>0 or	Close or Constant Observation 1 Close or Constant	15 30	5 10			5 10

~~M2e>0~~	~~Observation 2~~					
~~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 and L4hA=2 and E1b~~	~~Behavior Management~~	~~2~~	~~3~~			~~13~~

~~or E1d or E1e>0~~						
~~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: Repealed at 36 Ill. Reg. _____, effective _____)