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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2012

<u>Issue #</u>	<u>Rules Due Date</u>	<u>Date of Issue</u>
1	December 27, 2011	January 6, 2012
2	January 3, 2012	January 13, 2012
3	January 9, 2012	January 20, 2012
4	January 17, 2012	January 27, 2012
5	January 23, 2012	February 3, 2012
6	January 30, 2012	February 10, 2012
7	February 6, 2012	February 17, 2012
8	February 14, 2012	February 24, 2012
9	February 21, 2012	March 2, 2012
10	February 27, 2012	March 9, 2012
11	March 5, 2012	March 16, 2012
12	March 12, 2012	March 23, 2012
13	March 19, 2012	March 30, 2012
14	March 26, 2012	April 6, 2012
15	April 2, 2012	April 13, 2012
16	April 9, 2012	April 20, 2012
17	April 16, 2012	April 27, 2012
18	April 23, 2012	May 4, 2012
19	April 30, 2012	May 11, 2012
20	May 7, 2012	May 18, 2012
21	May 14, 2012	May 25, 2012
22	May 21, 2012	June 1, 2012
23	May 29, 2012	June 8, 2012

24	June 4, 2012	June 15, 2012
25	June 11, 2012	June 22, 2012
26	June 18, 2012	June 29, 2012
27	June 25, 2012	July 6, 2012
28	July 2, 2012	July 13, 2012
29	July 9, 2012	July 20, 2012
30	July 16, 2012	July 27, 2012
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32	July 30, 2012	August 10, 2012
33	August 6, 2012	August 17, 2012
34	August 13, 2012	August 24, 2012
35	August 20, 2012	August 31, 2012
36	August 27, 2012	September 7, 2012
37	September 4, 2012	September 14, 2012
38	September 10, 2012	September 21, 2012
39	September 17, 2012	September 28, 2012
40	September 24, 2012	October 5, 2012
41	October 1, 2012	October 12, 2012
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47	November 13, 2012	November 26, 2012
48	November 19, 2012	November 30, 2012
49	November 26, 2012	December 7, 2012
50	December 3, 2012	December 14, 2012
51	December 10, 2012	December 21, 2012
52	December 17, 2012	December 28, 2012

Editor's Note: The Secretary of State Index Department is providing this opportunity to remind you that the next filing period for your Regulatory Agenda will occur from May 1st to July 2nd, 2012.

ATTORNEY GENERAL

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Married Families Domestic Violence Grants
- 2) Code Citation: 89 Ill. Adm. Code 1110
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
1110.10	Amendment
1110.15	New
1110.20	Amendment
1110.40	Amendment
1110.50	Amendment
1110.60	Amendment
- 4) Statutory Authority: Implementing and authorized by Section 6z-72 of the State Finance Act [30 ILCS 105/6z-72]
- 5) A Complete Description of the Subjects and Issues Involved: The amendments address changes required for consistency with Public Act 97-4, effective May 31, 2011. Specifically, the name of the fund and the source of moneys for the fund are updated to reflect the changes required by Public Act 97-4. A new Section is added to define and clarify terms used in rules.
- 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
- 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 or create or expand a State mandate under the State Mandates Act.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

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NOTICE OF PROPOSED AMENDMENTS

Lynn Patton
Rules Coordinator
Office of the Attorney General
500 South Second Street
Springfield, Illinois 62705

Cynthia Hora
Chief, Crime Victim Services Division
Office of the Attorney General
100 West Randolph Street, 13th Floor
Chicago, Illinois 60601

217/524-1504
217/782-1396 (fax)

312/814-1427
312/814-7105 (fax)

All written comments filed within 45 days after the date of publication of this Notice will be considered.

13) Initial Regulatory Flexibility Analysis:

- A) Types of small businesses, small municipalities and not for profit corporations affected: Municipal agencies and not for profit agencies that provide the targeted legal services may apply for grants awarded from the fund.
- B) Reporting, bookkeeping or other procedures required for compliance: Grantees shall submit financial and activity reports every three months to the Administrator detailing costs and expenditures, fiscal summary, names of funded staff persons, requested revisions, reallocations and adjustments, clients served, services provided, and revisions, if any, of time-tables and activities to reflect the current program status and future activity. Grantees must also submit the resume of any funded staff person no later than October 15 of the funded year. All accounting entries of a grantee must be supported by appropriate source documents, recorded in books of original entry, and posted to a general ledger on a monthly basis.
- C) Types of professional skills necessary for compliance: Grant funded staff persons must be (i) attorneys licensed to practice law in Illinois, (ii) supervised by an attorney licensed to practice law in Illinois, or (iii) advocates who have undergone a minimum of forty hours of training in domestic violence, advocacy, crisis intervention and related areas.

14) Regulatory Agenda on which this rulemaking was summarized: July 2011

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

ATTORNEY GENERAL

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER IX: ATTORNEY GENERAL

PART 1110

~~MARRIED FAMILIES~~ DOMESTIC VIOLENCE GRANTS

SUBPART A: GENERAL ADMINISTRATIVE PROVISIONS

Section

1110.10	Administration of the Married Families Domestic Violence Fund
<u>1110.15</u>	<u>Definitions of Terms</u>
1110.20	Eligible Agencies
1110.30	Conflict of Interest
1110.40	Grant Application Requirements
1110.45	First Year Application Deadline
1110.50	Funding Priorities
1110.60	General Programming and Staffing Requirements

SUBPART B: FISCAL AND MONITORING REQUIREMENTS

Section

1110.100	Accounting Requirements
1110.110	Allowable and Non-allowable Expenses
1110.120	Interest
1110.130	Audits
1110.140	Grant Agreement
1110.150	Payment
1110.160	Termination of Grant Agreement
1110.170	Lapsed Funds
1110.180	Quarterly and Staff Reporting
1110.190	On-site Visits and Inspection of Records

AUTHORITY: Authorized by and implementing Section 6z-72 of the State Finance Act [30 ILCS 105/6z-72].

SOURCE: Adopted at 33 Ill. Reg. 7838, effective May 26, 2009; amended at 36 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL ADMINISTRATIVE PROVISIONS

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NOTICE OF PROPOSED AMENDMENTS

Section 1110.10 Administration of the ~~Married Families~~-Domestic Violence Fund

The Illinois Attorney General (~~the "Administrator"~~) is charged with administering the disbursement of monies from the ~~Married Families~~-Domestic Violence Fund, including the selection of qualified applicants to receive funding to provide free domestic violence legal advocacy, legal assistance, or legal services to ~~married or formerly married~~-victims who have been subjected to~~of~~ domestic violence by a spouse or former spouse.

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

Section 1110.15 Definitions of Terms

As used in this Part, the term:

"Administrator" means the Illinois Attorney General.

"Domestic violence" means abuse as defined in Section 103 of the Illinois Domestic Violence Act of 1986 [750 ILCS 60].

"Domestic violence program" means any unit of local government, organization or association whose major purpose is to provide one or more of the following: information, crisis intervention, emergency shelter, referral, counseling, advocacy or emotional support to victims of domestic violence.

"Former spouse" means a person who was formerly married or formerly a party to a civil union.

"Grantee" or "grant recipient" means an agency that has been awarded a grant.

"Legal advocacy" and "legal assistance" refer to services provided by victim advocates who have undergone a minimum of 40 hours of training in domestic violence, advocacy, crisis intervention and related areas and who provide services through a domestic violence program.

"Legal services" refers to services, consultation or representation provided by an attorney licensed in Illinois or by legal support staff working under the supervision of a licensed attorney.

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"Spouse" means a person who is married or is a party to a civil union.

"Victim" means a person subjected to domestic violence by a spouse or former spouse.

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

Section 1110.20 Eligible Agencies

The following types of agencies may apply for funding from the ~~Married Families~~ Domestic Violence Fund:

- a) An agency of the United States, the State of Illinois, or a unit of local government that provides legal advocacy, legal assistance, or legal services to victims of domestic violence.
- b) A private, nonprofit entity that provides legal advocacy, legal assistance, or legal services to victims of domestic violence, if it:
 - 1) has a tax exempt ruling from the Internal Revenue Service under section 501(c)(3) of the Internal Revenue Code (26 USC 501(c)(3)); and
 - 2) is compliant with the Charitable Trust Act [760 ILCS 55] and the Solicitations for Charity Act [225 ILCS 460] or is exempt from these Acts.

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

Section 1110.40 Grant Application Requirements

In order to be considered for an award of grant funds under this Part, applicants must, on or before the first Friday of March preceding the fiscal year for which funding is required, submit the following information on, or, whenwhere indicated, attached to, a properly completed grant application form provided by the Administrator:

- a) Identification of the applicant, including:
 - 1) Organization name and type, Federal Employer Identification Number, complete address, telephone number, and e-mail address;

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- 2) The agency's Illinois Charitable Trust registration number or a statement that the agency is exempt;
 - 3) The name and telephone number of the agency's chief executive officer or executive director;
 - 4) The name, telephone number and e-mail address of the agency's contact person for purposes of the grant.
- b) A description of the applicant and the services it provides, including:
- 1) A summary of the history and purpose of the applicant and the specific program for which funding is sought;
 - 2) A detailed description of the services program for which funding is sought;
 - 3) The number of clients served by applicant in the previous year;
 - 4) Applicant's past experience in providing legal advocacy, legal assistance, or legal services to victims of domestic violence;
 - 5) Applicant's current capacity to serve ~~married or formerly married~~ victims of domestic violence.
- c) A description of existing needs of the community to be served in relation to legal advocacy, legal assistance, or legal services for ~~married or formerly married~~ victims of domestic violence, including descriptions of:
- 1) Community support for and involvement with the applicant;
 - 2) Memberships in multidisciplinary organizations or coalitions;
 - 3) Agencies with which applicant has networking agreements.
- d) A proposal describing the legal advocacy, legal assistance, and legal services to be provided with grant funding. The proposal must include:

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- 1) Identification of the types of civil proceedings for which services will be provided;
 - 2) A description of direct services to be provided and of any programmatic service limitations or restrictions;
 - ~~32~~) A description of the client population to be served;
 - ~~43~~) A description of the geographic area to be served, including counties and legislative districts;
 - ~~54~~) A statement of goals, objectives, and activities of the program for which funding is sought;
 - ~~65~~) A description of any memoranda of intent in place for proposed networks of working relationships, including target dates for implementation.
- e) A request for a specific dollar amount, along with a detailed budget showing income and expenses, on the forms prescribed by the Administrator, which will include the following elements:
- 1) A budget summary detailing expenses for personnel, operations (contractual services, supplies, printing, other), travel, trainings attended, trainings hosted, and any other expenses for which funding has been provided or is sought in the current fiscal year and the fiscal year for which funding is requested;
 - 2) Itemized budgets for personnel, operations, and travel and training expenses to be funded by the grant, with a narrative description of each budget item requested;
 - 3) A statement of income for the program to be funded by the grant that includes income received in the applicant's current fiscal year and anticipated to be received in the fiscal year for which funding is requested, in the following categories:
 - Ai) State or federal government;
 - Bi) Township or county government;

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| Ciii) Administrator;

| Div) Private foundations and corporate contributions;

| Ev) Local support;

| Fvi) Other contributions;

| Gvii) Fundraisers;

| Hviii) United Way;

| Iix) Revenue sharing.

- f) A signed certification that, with respect to each of the following items, the applicant has either put in place and is implementing written policies or that the requirement does not apply:
- 1) A reasonable accommodation policy for persons with disabilities;
 - 2) Drug free workplace policies as required by law;
 - 3) Non-discrimination;
 - 4) Client intake;
 - 5) Client rights;
 - 6) Volunteer training;
 - 7) Personnel policies and procedures;
 - 8) Conflict of interest rules;
 - 9) Fee schedule with details of charges for specific services, other than those funded by the grant (copy to be attached to the application).

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- g) A description of staffing, including the total number of applicant staff members, the numbers of full- and part-time employees, the number of program staff and:
- 1) Identification of all full- or part-time compensated program staff by name and title, designating those for whom funding is requested;
 - 2) A copy of the current job description for the positions listed;
 - 3) A description of the training provided to staff for whom funding is requested;
 - 4) A listing of at least one goal for each funded staff person for the next year.
- h) A description of the applicant's use of volunteers, including the numbers of full- and part-time volunteers, the job functions they perform in the operation of the program for which funding is sought, and the training provided to those who work directly with clients.
- i) A copy of the most recent fiscal audit required by Section 1110.130 or a statement that the most recent audit has been filed with the Attorney General as part of another grant application identified in the statement.
- j) At least one letter of support from a local domestic violence services agency dated no more than six months before the date of the application.
- k) A list of the members of the applicant's governing board.
- l) A certification that applicant will keep proper, complete, and accurate accounting records of all grant funds, as required by Section 11 of the Grant Funds Recovery Act [30 ILCS 705/11].
- m) A certification, signed by the authorized official of the agency, that the statements in the application are true and correct and submitted in proper format.

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

Section 1110.50 Funding Priorities

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- a) The Administrator shall consider the following factors in determining whether and how much to fund a given applicant:
- 1) The stated goals of the applicant, as contained in the grant application;
 - 2) The applicant's commitment and ability to provide the services sought to be funded. Evidence of commitment and ability includes: legal expertise (i.e., experience of agency staff in providing legal services relating to domestic violence), level of resources available to the agency, and past services provided;
 - 3) The number of ~~married or formerly married domestic violence~~ victims of domestic violence served;
 - 4) The extent to which the grant would expand the provision of services described in Section 1110.60;
 - 5) The extent to which the grant would serve the needs of the community by bringing services to un- or under-served areas or populations;
 - 6) Evidence of support by local domestic violence services agencies;
 - 7) The extent to which different areas of the State are served; and
 - 8) Applicant's history of compliance with reporting, accounting and other requirements pertaining to grants awarded under this Part or under any other government program.
- b) Grants will be made for a term of one year corresponding to the State's fiscal year. The number of applicants selected for funding will depend upon the amount of appropriated funds available in the ~~Married Families~~ Domestic Violence Fund for that year. Rather than award small amounts to all eligible applicants, the Administrator shall make a limited number of awards of sufficient size that the funding will make a substantial impact in the areas to be served.

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

Section 1110.60 General Programming and Staffing Requirements

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- a) Requirements for provision of services by ~~grantees~~ Grantees.
- 1) The services provided by virtue of a grant awarded under this Part shall be provided to ~~married or formerly married~~ victims of domestic violence without charge.
 - 2) The services provided shall be legal advocacy, legal assistance, or legal services relating to one or more of the following proceedings:
 - A) Order of protection proceedings;
 - B) Dissolution of marriage or civil union proceedings;
 - C) Declaration of invalidity of marriage or civil union proceedings;
 - D) Legal separation proceedings;
 - E) Child custody proceedings;
 - F) Visitation proceedings; and
 - G) Proceedings for civil remedies for domestic violence, including, but not limited to:
 - i) Remedies under the Safe Homes Act [765 ILCS 750];
 - ii) Remedies under the Gender Violence Act [740 ILCS 82];
 - iii) Child support enforcement remedies;
 - iv) Remedies under any federal law for violence against women; and
 - v) Remedies under the Victims of Trafficking and Violence Protection Act of 2000 (22 USC 7101).
 - 3) Grant recipients must have in place written policies and procedures pertaining to client rights, including the release of information about a client. For purposes of this subsection (a)(3), the term "client rights" shall

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NOTICE OF PROPOSED AMENDMENTS

in all cases include, but not be limited to, the right to confidentiality and the right of personal privacy.

- 4) Grant recipients shall not deny services to clients on the basis of race, color, religion, sex, sexual orientation, national origin, ancestry, citizenship status, age, marital status, unfavorable military discharge, military status, or physical, mental, or perceived handicap.
- 5) Client intake policies and procedures shall be set forth in writing and be available for review by the Administrator to verify that the agency's services are being provided to the population described in the grant application.
- 6) Grant recipients shall comply with the mandatory reporting requirements of the Abused and Neglected Child Reporting Act [325 ILCS 5].

b) Personnel Requirements

- 1) Grant recipients shall not discriminate in the hiring or promotion of staff based on race, color, religion, sex, sexual orientation, national origin, ancestry, citizenship status, age, [order of protection status](#), marital status, unfavorable military discharge, military status, or physical, mental, or perceived [disabilityhandicap](#).
- 2) Personnel policies shall be set forth in writing and be available for review by the Administrator upon request. Those policies shall demonstrate compliance with equal employment opportunity and drug free workplace requirements.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
140.445	Amendment
140.523	Amendment
140.539	Amendment
140.570	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete Description of the Subjects and Issues Involved: This amendment for 140.445, regarding benchmark pricing for generic drugs, changes the methodology from Suggested Wholesale Price (SWP) – 25% to Wholesale Acquisition Cost (WAC) + 1%. This change is being made as a result of feedback from the federal Centers for Medicare and Medicaid Services (CMS) regarding the Department's State Plan Amendment that proposed a change from Average Wholesale Price (AWP) – 25% to Suggested Wholesale Price (SWP) – 25% for generic drugs.

In addition, pending adoption of the FY 2013 Budget the Department must meet federal public notice requirements regarding any modifications of Medicaid rate methodologies for institutional providers (nursing facilities and hospitals). Thus, the Department is proposing amendments that eliminate bed hold payments for adults in nursing facilities and ICF/DDs for an annual reduction of \$5.4 million, lowering from 11% to 4% for the rate of return on capital investments for nursing facilities for an annual reduction of \$71 million, removing the nurses aid training component from ICF/DDs but adding a standard amount to individual providers in order to reduce administrative costs.

- 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? Yes
- 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? Yes

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
140.462	Amendment	35 Ill. Reg. 11126; July 15, 2011
140.1001	Amendment	36 Ill. Reg. 11126; May 25, 2012

- 11) Statement of Statewide Policy Objective: This rulemaking does affect units of local government. It will have an impact on county government entities that own or operate nursing facilities enrolled in the Medical Assistance Program.
- 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 East, 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 pharmacies, hospital providers, nursing facilities, skilled nursing facilities, and intermediate nursing facilities.
 - B) Reporting, bookkeeping or other procedures required for compliance: Preparation, documentation, and submission of facility's cost report.
 - C) Types of Professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2012

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 140

MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section

- 140.1 Incorporation By Reference
- 140.2 Medical Assistance Programs
- 140.3 Covered Services Under Medical Assistance Programs
- 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
- 140.5 Covered Medical Services Under General Assistance
- 140.6 Medical Services Not Covered
- 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
- 140.8 Medical Assistance For Qualified Severely Impaired Individuals
- 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
- 140.10 Medical Assistance Provided to Persons Confined or Detained by the Criminal Justice System

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section

- 140.11 Enrollment Conditions for Medical Providers
- 140.12 Participation Requirements for Medical Providers
- 140.13 Definitions
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- 140.15 Recovery of Money
- 140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.18 Effect of Termination or Revocation on Persons Associated with Vendor

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
- 140.20 Submittal of Claims
- 140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
- 140.22 Magnetic Tape Billings (Repealed)
- 140.23 Payment of Claims
- 140.24 Payment Procedures
- 140.25 Overpayment or Underpayment of Claims
- 140.26 Payment to Factors Prohibited
- 140.27 Assignment of Vendor Payments
- 140.28 Record Requirements for Medical Providers
- 140.30 Audits
- 140.31 Emergency Services Audits
- 140.32 Prohibition on Participation, and Special Permission for Participation
- 140.33 Publication of List of Sanctioned Entities
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- 140.72 Drug Manual (Recodified)
- 140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

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- 140.80 Hospital Provider Fund
- 140.82 Developmentally Disabled Care Provider Fund
- 140.84 Long Term Care Provider Fund
- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
- 140.95 Hospital Services Trust Fund
- 140.96 General Requirements (Recodified)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 140.97 Special Requirements (Recodified)
- 140.98 Covered Hospital Services (Recodified)
- 140.99 Hospital Services Not Covered (Recodified)
- 140.100 Limitation On Hospital Services (Recodified)
- 140.101 Transplants (Recodified)
- 140.102 Heart Transplants (Recodified)
- 140.103 Liver Transplants (Recodified)
- 140.104 Bone Marrow Transplants (Recodified)
- 140.110 Disproportionate Share Hospital Adjustments (Recodified)
- 140.116 Payment for Inpatient Services for GA (Recodified)
- 140.117 Hospital Outpatient and Clinic Services (Recodified)
- 140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
- 140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
- 140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
- 140.203 Limits on Length of Stay by Diagnosis (Recodified)
- 140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
- 140.350 Copayments (Recodified)
- 140.360 Payment Methodology (Recodified)
- 140.361 Non-Participating Hospitals (Recodified)
- 140.362 Pre July 1, 1989 Services (Recodified)
- 140.363 Post June 30, 1989 Services (Recodified)
- 140.364 Prepayment Review (Recodified)
- 140.365 Base Year Costs (Recodified)
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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: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; preemptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; preemptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; preemptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; preemptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June

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Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October

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1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999;

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amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004;

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emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency

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expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011; amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill. Reg. 7545, effective May 7, 2012; amended at 36 Ill. Reg. _____, effective _____.

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.445 Legend Prescription Items (Not Compounded)

Effective ~~June~~February 1, 2012, for legend (prescription) drugs, the Department shall pay the lower of:

- a) the pharmacy's usual and customary charge to the general public; or
- b) the Department's maximum price plus the established dispensing fee of \$6.35 for generic drugs and \$3.40 for brand name drugs. If the generic dispensing rate during the quarter ending June 30, 2014 is not 2% higher than the generic dispensing rate during the quarter ending December 31, 2011, then effective January 1, 2015, the dispensing fee shall be \$4.60 for generic drugs and \$3.40 for brand name drugs.
 - 1) For generic drugs, the Department's maximum price is calculated as the lowest of:
 - A) Wholesale Acquisition Cost (WAC) + 1%~~Suggested Wholesale Price (SWP) minus 25%~~; or

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- B) the Federal upper limit as established under section 1927(e)(4) of the Social Security Act (42 USC 1396r-8(e)(4)); or
 - C) the State upper limit.
- 2) For brand name drugs, the Department's maximum price is calculated as the lowest of:
- A) WAC plus 1%; or
 - B) the State upper limit.

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

SUBPART E: GROUP CARE

Section 140.523 Bed Reserves

- a) Effective for dates of service on or after July 1, 2012, no payments for bed reserves will be made to nursing facilities.~~Nursing Facilities~~
 - 1) ~~All payable bed reserves must:~~
 - A) ~~be authorized by a physician;~~
 - B) ~~have post payment approval from Bureau of Long Term Care staff based on satisfying the requirements of this Section;~~
 - C) ~~be limited to residents who desire to return to the same facility; and~~
 - D) ~~be limited to facilities having a 93 percent or higher occupancy level and, of that occupancy level, 90 percent or higher shall be Medicaid eligible. The occupancy level shall be calculated including both payable and non-payable (non-payable defined as those residents that have transitioned from the maximum days allowed for payable bed reserve to non-payable bed reserve status) bed reserve days as occupied beds.~~
 - 2) ~~The Department shall make payment for resident absences due to~~

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~~hospitalization. In such instances, bed reserve is limited to ten days per hospital stay. In accordance with the Nursing Home Care Act [210 ILCS 45/3-401.1], a recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following a hospital admission. The day the resident is transferred to the hospital is the first day of the reserve bed period.~~

- ~~3) Payment may be approved for home visits which have been indicated by a physician as therapeutically beneficial. In such instances, bed reserve is limited to seven consecutive days in a billing month or ten non-consecutive days in a billing month. The day after the resident leaves the facility for a therapeutic home visit is the first day of the payable or nonpayable reserve bed period. Home visits may be extended with the approval of the Department.~~
- ~~4) Bureau of Long Term Care staff will approve ongoing therapeutic home visits based on the physician's standing orders for the individual. Standing orders for therapeutic home visits limited to ten days per month are valid for a period not exceeding six months.~~
- ~~5) Payment for approved bed reserves is a daily rate at 75 percent of an individual's current Medicaid per diem.~~
- ~~6) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.~~

b) ICF/MR Facilities (including ICF/DD and SNF/Ped licenses)

- 1) All bed reserves must:
 - A) be authorized by the interdisciplinary team (IDT); ~~and~~
 - B) be limited to residents who desire to return to the same facility; ~~and-~~
 - C) be for persons who are under 21 years of age.

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- 2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments.
- 3) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.
- 4) Payment may be approved for hospitalization for a period not to exceed 45 consecutive days. The day the resident is transferred to the hospital is the first day of the reserve bed period. Payment for approved bed reserves for hospitalization is a daily rate at:
 - A) 100 percent of a facility's current Medicaid per diem for the first ten days of an admission to a hospital;
 - B) 75 percent of a facility's current Medicaid per diem for days 11 through 30 of the admission;
 - C) 50 percent of a facility's current Medicaid per diem for days 31 to 45 of the admission.
- 5) Payment may be approved for therapeutic visits which have been indicated by the IDT as therapeutically beneficial. There is no limitation on the bed reserve days for such approved therapeutic visits. The day after the resident leaves the facility is the first day of the bed reserve period. Payment for approved bed reserves for therapeutic visits is a daily rate at:
 - A) 100 percent of a facility's current Medicaid per diem for a period not to exceed ten days per State fiscal year;
 - B) 75 percent of a facility's current Medicaid per diem for a period which exceeds ten days per State fiscal year.

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

Section 140.539 Reimbursement for Basic Nursing Assistant, ~~Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide~~ Training and Nursing Assistant Competency Evaluation

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a) Training Reimbursement

- 1) Nursing~~Long term care~~ facilities shall be reimbursed for the reasonable costs of assistant and aide training. Upon the individual's successful completion of a course which has been approved by the Department of Public Health (77 Ill. Adm. Code 395.110), the facility may claim reimbursement for the following costs, provided that they are actually incurred:
 - A) tuition, up to the prevailing community college rate in the health service area for a six credit hour course;
 - B) instructional materials, up to \$25.00; and
 - C) salary and fringe benefits (fringe benefits are payroll taxes, unemployment insurance, worker's compensation, health insurance and meals if provided) up to the prevailing entry level for the health service area.
- 2) The Department will reimburse for actual approved hours up to 130 hours.
- 3) Facilities shall also receive an additional factor of five percent of the total claim to recognize costs for those who do not successfully complete the course.
- 4) The Department shall reimburse on a pro rata basis according to the percentage of Medicaid residents in the facility at the time the request for reimbursement is submitted to the Department.
- 5) Successful completion of a course by each individual for whom reimbursement is being requested shall be verified through the Department of Public Health Nurse Aide Registry. In the event that an individual's name does not appear on the Registry within three months after the Department's receipt of the reimbursement request, the Department reserves the right to request documentation that shows proof of:
 - A) submittal of the individual's name for entry on the Nurse Aide Registry (for example, a copy of the notification to the Department

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of Public Health), if applicable, and

- B) successful completion of the course by the individual (for example, an instructor signed attendance form or other instructor certification).
- 6) No individual who is employed by, or who has received an offer of employment from, a facility on the date on which the individual begins a Basic Nursing Assistant, ~~Developmental Disabilities Aide, Basic Child Care Aide or Habilitation Aide~~ training program may be charged for any portion of the program (including any fees for textbooks or other required course materials). This provision applies whether or not the facility requests Medicaid reimbursement for the training, the individual fails the competency exam or the individual subsequently leaves employment.
- b) Basic Nursing Assistant Competency Evaluation
- 1) Nursing facilities shall be reimbursed for the reasonable costs for basic nursing assistant competency evaluations. Only evaluations approved by the Department of Public Health are reimbursable. The facility may claim reimbursement for the cost of each approved competency evaluation successfully completed with a passing grade.
 - 2) Payment will not be made under this Section for costs incurred in administering tests not approved by the Department of Public Health, or for any additional tests administered by the facility during or subsequent to basic nursing assistant training.
 - 3) Payment will be made for all competency evaluations successfully completed with a passing grade after October 1, 1989.
 - 4) The maximum reimbursable cost per competency evaluation successfully completed with a passing grade is the current fee charged by the Department of Public Health approved evaluation service. The Department will reimburse on a pro rata basis according to the percentage of Medicaid residents in the facility at the time the request for reimbursement is submitted to the Department. The Department will not pay any other costs associated with the evaluation process.

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- 5) No payment will be made for any competency evaluation in which a failing grade is received for any part of the evaluation. An individual must pass both the demonstration of manual skills and written components of the evaluation before reimbursement may be claimed.
- 6) Passage of the competency evaluation for each individual for whom reimbursement is being requested shall be verified through the Department of Public Health Nurse Aide Registry. In the event that an individual's name does not appear on the Registry, the Department reserves the right to request documentation of such passage before authorizing payment.
~~Competency evaluations do not apply to Basic Child Care Aides, Habilitation Aides or Developmental Disabilities Aides.~~
- 7) Facilities shall receive an additional factor of five percent of the total claim to recognize costs for those who do not successfully pass the evaluation.
- 8) No individual who is employed by, or who has received an offer of employment from, a facility on the date on which the individual begins a basic nursing assistant program may be charged for any costs associated with competency evaluation. This provision applies whether or not the facility requests Medicaid reimbursement for the competency evaluation, the individual fails the competency evaluation or the individual subsequently leaves employment.

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

Section 140.570 Capital Rate Component Determination

- a) Capital rates for all long term care facilities – except State Institutions, Specialized Living Centers and campus facilities, shall be reimbursed in the manner described in Sections 140.570 through 140.573. Capital rates for Specialized Living Centers are set forth in 140.579. Campus facilities are reimbursed in accordance with 140.583.
- b) The terms used in Sections 140.570 through 140.574 are defined as follows.
 - 1) "Arm's-length transaction" means a transaction between a buyer and a seller both free to act, each seeking his own best economic interest. A

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transaction between related parties as defined in Section 140.537 is not considered to be an arm's-length transaction.

- 2) "Base Year" refers to the weighted average year of investment in the actual construction of the building. The Base Year is determined using the components of the building cost, which are included in the Original Building Base Cost, and the corresponding years of acquisition or construction. The year of each component of the total investment is multiplied by the cost of each year's investment. The sum of these products is then divided by the total Original Building Base Cost to yield an average year of construction. Any fractional portion of the Base Year derived from this calculation will be truncated. The Base Year will not change due to sale or lease of the building subsequent to January 1, 1978.
- 3) "Capital Days" are used to convert all capital items to per diem amounts unless otherwise specified. If a facility's occupancy rate is above 93 percent, then capital days shall be equal to the actual patient days. If occupancy is below 93 percent, then 93 percent of available bed days (the number of licensed beds multiplied by the number of calendar days in a period) shall be the capital days.
- 4) Building Basis:
 - A) "Original Building Base Cost" means either the cost of construction or the cost of the latest purchase of the building in an arm's-length transaction prior to January 1, 1978. The allowable cost of subsequent improvements to the building will be included in the original building base cost. The original building base cost will not change due to sales or leases of the facility after January 1, 1978. In the case of a nursing home building constructed after January 1, 1978, the allowable construction cost plus the cost of subsequent improvements will be the original building base cost.
 - B) If a portion of the building is vacant or is used for functions other than a nursing home, then a portion of the building's original building base cost will not be used in the rate calculation. This cost allocation will be based upon the proportion of the total square feet in the building being used for nursing home functions.

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- 5) "Rate of Return" will be ~~4.011-0~~ percent regardless of base year for dates of service on or after July 1, 2012, for base years which are 1979 and later and 9.13 percent for base years which are 1978 and earlier.
- 6) "Means Construction Index" means the index of changes in construction costs from year-to-year developed from the annual publication Means Building Construction Cost data as published by R.S. Means Company, Inc.
- 7) "Means New Construction Cost Per Square Foot" is defined as the costs published by the R.S. Means Company, Inc. Data will come from the most recent edition of the Means Square Foot Costs publication. The cost used per square foot for new construction is based upon nursing home construction projections using 40,000 square foot category with face brick with concrete block back-up and steel joists. The Means New Construction Cost Per Square Foot will be adjusted where necessary to ensure an increase of at least a three percent from the previous year but no more than a seven percent increase.
- 8) "Square Feet Per Bed" is defined as 316 square feet per bed. This was the average for existing long term care facilities in Illinois.
- 9) "Location". The long term care facilities will be separated into one of the following areas:

Northeast area – HSAs 6, 7, 8, 9
Downstate area – HSAs 1, 2, 3, 4, 5, 10, 11
- 10) "Uniform Building Value" is calculated using the following steps:
 - A) The Means New Construction Cost Per Square Foot is multiplied by 316 square feet per bed to obtain a preliminary cost per bed. For example, \$68.65 cost per square foot times 316 equals a \$21,693 preliminary cost per bed.
 - B) The preliminary cost per bed is multiplied by an adjustment factor to obtain the revised cost per bed for new construction. The adjustment factor is 1.30 for the northeast area and 1.19 for the downstate area. For example, a \$21,693 preliminary cost per bed

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times the 1.30 factor equals a \$28,200 revised cost per bed for the northeast area.

- C) The revised cost per bed for new construction will be the uniform building value for any facility for which the base year is the same as the current year. The current year is the calendar year in which the rate year starts. The uniform building value for facilities with a base year which is older than the current year will have the revised cost per bed for new construction discounted by a three percent obsolescence factor for each year between the base year and the current year. The uniform building value will be no lower than ten percent of the revised cost per bed for new construction. For example:

Base Year	Factor	Uniform Building Value
1991	100%	\$28,200
1990	97%	\$27,354
1989	94%	\$26,508
1988	91%	\$25,662
1987	88%	\$24,816
1986	85%	\$23,970
—		
1975	52%	\$14,664
—		
1960	10%	\$ 2,820

- 11) "Building Specific Historical Cost Per Bed" is the inflated original building base cost divided by the number of licensed beds on the cost report used to calculate rates for the rate year. If licensed beds changed during the cost report period, the licensed beds on the last day of the cost report period will be used as the divisor. The original building base cost is inflated based upon the Means Construction Index and the base year.
- 12) The "ERVWC" factor relates to equipment, rent, vehicle and working capital cost. The ERVWC factor will be the greater of \$1.75 per diem or the amount from the following calculation based upon a sample of 50 percent or more of all long term care facilities:
- A) Working Capital: Allowable support costs, nursing or program

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costs and administrative costs will be updated for inflation and be divided by Capital days and multiplied by 60 days to yield two months of Working Capital investment on a per diem basis.

- B) The per diem investment in equipment and vehicle will be added to the working capital investment on a per diem basis (the vehicle investment is limited to fifty cents per diem). This total investment is multiplied by 9.13 percent.
 - C) The result of Step B is added to the per diem equipment rent cost to obtain an ERVWC base factor.
- c) Any items of fixed equipment which are no longer in use or are not providing significant value for inpatient long term care purposes must not be reported on the cost report fixed asset schedules for land, buildings, equipment and vehicle. For example, portions of a building not being used for nursing home operations must not be reported. Any assets which were removed from the cost report depreciation schedules prior to the 1986 cost report due to the asset being fully depreciated may not now be included in the building or equipment basis. Also, if a vehicle is used partially for personal purposes or purposes other than operation of the nursing home then this portion of the cost must not be included in the vehicle cost section of the cost report.
- d) No asset may be included in the building or equipment basis unless complete documentation for the cost and year of purchase or construction is maintained. This data must be maintained to facilitate efficient audit reviews by representatives of the Department.

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

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- 1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities
- 2) Code Citation: 89 Ill. Adm. Code 147
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
147.5	Repeal
147.125	Repeal
147.150	Repeal
147.175	Repeal
147.200	Repeal
147.310	Amend
147.315	Amend
147.320	Amend
147.325	Amend
147.330	Amend
147.335	Amend
147.340	Amend
147.350	Amend
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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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

147.5	Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System <u>(Repealed)</u>
147.15	Comprehensive Resident Assessment (Repealed)
147.25	Functional Needs and Restorative Care (Repealed)
147.50	Service Needs (Repealed)
147.75	Definitions (Repealed)
147.100	Reconsiderations (Repealed)
147.105	Midnight Census Report
147.125	Nursing Facility Resident Assessment Instrument <u>(Repealed)</u>
147.150	Minimum Data Set (MDS) Based Reimbursement System <u>(Repealed)</u>
147.175	Minimum Data Set (MDS) Integrity <u>(Repealed)</u>
147.200	Minimum Data Set (MDS) On-Site Review Documentation <u>(Repealed)</u>
147.205	Reimbursement for Ventilator Dependent Residents
147.250	Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)
147.300	Payment to Nursing Facilities Serving Persons with Mental Illness
147.301	Sanctions for Noncompliance
147.305	Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)
147.310	<u>Implementation of a Case Mix System</u> Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)
147.315	<u>Nursing Facility Resident Assessment Instrument</u> Comprehensive Functional Assessments and Reassessments (Repealed)
147.320	<u>Definitions</u> Interdisciplinary Team (IDT) (Repealed)
147.325	<u>Resident Reimbursement Classifications and Requirements</u> Comprehensive Program Plan (CPP) (Repealed)
147.330	<u>Resource Utilization Groups (RUGs) Case Mix Requirements</u> Specialized Care—Administration of Psychopharmacologic Drugs (Repealed)
147.335	<u>Enhanced Care Rates</u> Specialized Care—Behavioral Emergencies (Repealed)
147.340	<u>Minimum Date Set On-Site Reviews</u> Discharge Planning (Repealed)

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- 147.345 Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)
- 147.350 Reimbursement for Additional Program Costs Associated with Providing Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities
- 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,

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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 35 Ill. Reg. 19514, effective December 1, 2011; amended at 36 Ill. Reg. 7077, effective April 27, 2012; amended at 36 Ill. Reg. _____, effective _____.

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

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

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~~indicators, which are part of the MDS-MH system, and train staff to utilize this clinical information in resident treatment and care planning.~~

- e) ~~The nursing component of the rate shall be calculated annually and may be adjusted semi-annually. The determination of rates shall be based upon a composite of MDS-MH data collected from each eligible resident in accordance with Table B for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the six-month period preceding the rate period. Residents for whom MDS-MH resident identification information is missing or inaccurate, or for whom there is no current MDS-MH record for that period, shall be placed in the lowest MDS-MH acuity level for calculation purposes for that rate period. The nursing component of the rate may be adjusted on a semi-annual basis if any of the following conditions are met:~~
- 1) ~~Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds total variable nursing time calculated for the previous rate period by more than five percent.~~
 - 2) ~~Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds:~~
 - A) ~~total variable nursing time as calculated for the annual rate period by more than 10 percent;~~
 - B) ~~total variable nursing time as recalculated and adjusted for the annual period by more than five percent.~~
 - 3) ~~Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No semi-annual nursing component rate reduction shall exceed five percent from the annual rate determination.~~
- d) ~~Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.~~

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- 1) ~~Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the MDS-MH is associated with an amount of time and staff level (Table B). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service, except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:~~
- A) ~~The mean wages for the applicable staff levels (licensed staff, RNs, LPNs, certified nursing assistants (CNAs), social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.~~
 - B) ~~Fringe benefits shall be calculated in accordance with Section 147.150(c)(1)(B).~~
 - C) ~~The base wage shall be calculated in accordance with Section 147.150(c)(1)(C).~~
 - D) ~~Special minimum wage factor shall be calculated in accordance with Section 147.150(c)(1)(D).~~
 - E) ~~Beginning July 1, 2010, Class I IMDs shall be paid a rate based upon the sum of the following:~~
 - i) ~~The facility MDS-MH system based rate multiplied by a ratio the numerator of which is the quotient obtained by dividing the funds appropriated specifically to pay for rates based upon the MDS-MH methodology by the total number of Medicaid patient days utilized by facilities covered by the MDS-MH based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-MH methodology and the weighted mean rate direct care rate for IMDs in effect on July 1, 2006.~~

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- ~~j) The Medicaid rate determined by Table B for Class I IMDs shall be the combination of a nursing component and socio-development component.~~
- ~~k) The Department of Healthcare and Family Services and the Department of Human Services Division of Mental Health shall have the right of entry and inspection to all Class I IMD facilities in order to assess resident mix, monitor data quality, develop service quality indicators, and conduct studies, such as staff time samples, in order to test and refine the payment method.~~

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

Section 147.125 Nursing Facility Resident Assessment Instrument (Repealed)

- ~~a) Except as specified in subsection (b) of this Section, all Medicaid-certified nursing facilities shall comply with the provisions of the current federal Long Term Care Resident Assessment Instrument User's Manual, version 2. (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2005), and the Resident Assessment Instrument-Mental Health Illinois version 2 (July 2003), adopted from Minimum Data Set-Mental Health version 2. This incorporation by reference includes no later amendments or editions.)~~
- ~~b) Nursing facilities shall, in addition, comply with the following requirements:
 - ~~1) Complete a full Minimum Data Set (MDS) assessment, which includes required items A through R, in addition to any State required items, for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS assessment for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Section T. RAPs and Section T are only required with the comprehensive assessment described in the current federal Long Term Care Resident Assessment Instrument User's Manual, which includes assessments completed at admission, annually, for a significant change or for a significant correction of a prior MDS.~~
 - ~~2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment.~~~~

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~~Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, the rate set will be based on the MDS received two quarters prior to the rate effective date and MDS not received within 31 days will be given a default rate.~~

- e) ~~While a new rate system referenced in Section 147.150 is under development, Medicaid-certified Class I IMDs shall electronically submit both the MDS pursuant to subsections (a) and (b) of this Section and the Illinois Minimum Data Set-Mental Health (IL MDS-MH) as specified by the Department at the following frequencies:~~
- ~~1) Complete a full IL MDS-MH within 14 days after admission for each resident, regardless of the resident's payment source.~~
 - ~~2) Complete a full IL MDS-MH at 90 days after admission for each resident, regardless of the resident's payment source.~~
 - ~~3) Complete a full IL MDS-MH at six months after admission for each resident, regardless of the resident's payment source, and every six months thereafter.~~
 - ~~4) Transmit electronically to the Department's IL MDS-MH database, the IL MDS-MH for all required assessments within 31 days after the completion date of the assessment.~~

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

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

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

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- b) ~~Except as referenced in subsection (c)(1)(E)(iv) of this Section, the nursing component of the rate shall be calculated and adjusted quarterly. The determination of rates shall be based upon a composite of MDS data collected from each eligible resident in accordance with Section 147. Table A for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter.~~
- e) ~~Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.~~
- 1) ~~Variable Time Reimbursement.~~
~~Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Section 147. Table A). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:~~
- A) ~~The mean wages for the applicable staff levels (RNs, LPNs, certified nursing assistants (CNAs), activity staff, social workers); as reported on the cost reports and determined by regional rate area, will be the mean wages.~~
- B) ~~Fringe benefits will be the average percentage of benefits to actual salaries of all nursing facilities based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the mean wage.~~

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- ~~C) The base wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected base wage changes.~~
- ~~D) Special minimum wage factor. The process used in subsection (c)(1)(A) of this Section to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.~~
- ~~E) Beginning January 1, 2007, facilities shall be paid a rate based upon the sum of the following:~~
- ~~i) the facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006 funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology and the weighted mean rate in effect on December 31, 2006.~~
 - ~~ii) the facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569(a)(1), multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). The exceptional care reimbursement per diem effective January 1, 2007 computed in 89 Ill. Adm. Code 140.569 shall be included in the nursing component of the June 30, 2006 rate unless the total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive~~

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~~for the rate period zero percent of the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569.~~

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

- F) ~~The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007 is \$60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008 is \$50 million. The annual amount of new funds for MDS reimbursement methodology beginning January 1, 2009 is \$84 million. Subject to approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the annual amount of new funds for MDS reimbursement methodology, beginning May 1, 2011, is \$222.5 million.~~

- 2) ~~Vacation, Sick Leave and Holiday Time.~~

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~~The time to be added for vacation, sick leave, and holidays will be determined by multiplying the total of variable time by 5%.~~

- 3) ~~Special Supplies, Consultants and the Director of Nursing. Reimbursement will be made for health care and program supplies, consultants required by the Department of Public Health (including the Medical Director), and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830.)~~
- A) ~~Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). Health care and program salaries shall be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.~~
- B) ~~The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for the Director of Nursing and consultant costs shall be the Statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.~~
- C) ~~These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).~~
- d) ~~Determination of Facility Rates. An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection (c)(1) of this Section), adding the amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section), and supplies, consultants, and the Director of Nursing (see subsection (c)(3) of this Section). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.~~

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- e) ~~A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect July 1, 2003 shall be provided for a period not exceeding December 31, 2006, as follows:~~
- 1) ~~MDS-based rate adjustments under this Section shall not be effective until the attainment of a threshold. The threshold shall be attained at the earlier of either:~~
 - A) ~~when all nursing facilities have established a rate (sum of all components) which is no less than the rate effective June 30, 2002,~~
~~or~~
 - B) ~~January 1, 2007.~~
 - 2) ~~For a facility that would receive a lower nursing component rate per resident day under the payment methodology effective July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be held at the level in effect on June 30, 2003 until a higher nursing component rate of reimbursement is achieved by that facility.~~
 - 3) ~~For a facility that would receive a higher nursing component rate per resident day under the payment methodology in effect on July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be adjusted based on the payment methodology in effect July 1, 2003.~~
 - 4) ~~Notwithstanding subsections (e)(2) and (3) of this Section, the nursing component rate per resident day for the facility shall be adjusted in accordance with subsection (e)(1)(E) of this Section.~~

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

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

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

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- b) ~~The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews. The Department may select facilities for on-site review based upon facility characteristics, past performance, or the Department's experience. This may include, but is not limited to, analysis of case mix profile of nursing facilities in regard to frequency in distribution of the residents in identified reimbursement categories. In addition, the Department may use findings of the licensing and certification survey conducted by IDPH indicating the facility is not accurately assessing residents. It may also include resident assessments submitted by the provider that do not meet submission deadlines, facilities with a high percentage of corrections and facilities with high submission error rates.~~
- e) ~~Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.~~
- d) ~~On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals.~~
- 1) ~~On-site reviews may be conducted with respect to residents or facilities that are identified pursuant to subsection (b) or (c) of this Section. Such review may include, but shall not be limited to, the following:~~
- A) ~~Review of resident records and supporting documentation, as identified in Section 147.200, observation and interview, to determine the accuracy of data relevant to the determination of reimbursement rates.~~
- B) ~~Review and collection of information necessary to assess the need for a specific service or care area.~~
- C) ~~Review and collection of information from the facility that will establish the direct care staffing level. The amount of staff available in the facility shall be sufficient to carry out the number and frequency of restorative programs identified for reimbursement.~~

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- ~~2) The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded.~~
- ~~3) Upon the conclusion of any review, the Department shall conduct a meeting with facility management to discuss preliminary conclusions of the review. If facility management disagrees with those preliminary conclusions, facility management may, at that time, provide additional documentation to support their position.~~
- e) ~~Corrective action. Upon the conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate.~~
 - 1) ~~Data Accuracy~~
 - A) ~~Final conclusions with respect to inaccurate data shall be referred to the Department of Public Health.~~
 - B) ~~The Department, in collaboration with the Department of Public Health, shall make available additional training in the completion of resident assessments and the coding and transmission of MDS records.~~
 - 2) ~~Recalculation of Reimbursement Rate. The Department shall determine if reported MDS data or facility staffing data that were subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data. No change in reimbursement required as a result of a review shall take effect before July 1, 2004. Prior to the record review of residents receiving skills training, the following components of this Part will be reviewed to ensure compliance:~~
 - A) ~~Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.~~

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- ~~B) A private room shall be available with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.~~
- ~~C) Schedules shall be presented that identify residents and reflect the facility's ability to provide the sessions in increments of a minimum of 30 minutes for each skills training (not including time to assemble and settle). The sessions shall be scheduled at least three times per week.~~
- ~~D) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions.~~
- 3) ~~In the event one or more of these components are not in place, the recalculated rate may be extrapolated to the entire population receiving this service.~~
- 4) ~~When problems are noted in 30 percent of the population of residents receiving skills training during the record review, the recalculated rate may be extrapolated to the entire population receiving this service. When the recalculated rate has been extrapolated to the entire population, the facility shall obtain prior approval from the Department before future reimbursement for skills training is allowable. The Department shall have up to 90 days to determine this approval.~~
- 5) ~~When problems are noted in 30 percent of coded responses to the sample population for other services areas, the review may be expanded to up to 100 percent for those service areas. The original sample population is defined as 20%, or no less than 10, of the eligible residents pursuant to Section 147.150(b).~~
- 6) ~~In addition, the facilities with widespread problems in restorative and psychosocial adaptation may be subject to follow up reviews to ensure problems are corrected.~~
- 7) ~~A facility's rate will be subject to change if the recalculation of the direct care component rate, as a result of using MDS data that are verifiable:~~

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- A) ~~Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.~~
- B) ~~Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.~~
- C) ~~Decreases the rate by more than ten percent in addition to the rate change specified in this subsection (e)(7). The direct care component of the rate shall be reduced, retroactive to the beginning of the rate period, by \$1 for each whole percentage decrease in excess of two percent.~~
- 8) ~~Any evidence or suspicion of deliberate falsification or misrepresentation of MDS data shall be referred to the Department's Inspector General and the Department of Public Health.~~
- f) ~~Appeals. Facilities disputing any rate change may submit an appeal request pursuant to 89 Ill. Adm. Code 140.830.~~

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

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

- a) ~~Pursuant to Section 147.175, Department staff shall conduct on-site reviews of Minimum Data Set (MDS) data to determine the accuracy of resident information that is relevant to the determination of reimbursement rates.~~
 - 1) ~~Department staff shall request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDSs for the previous 15 months shall be provided to the review team within an hour after this request. Additional documentation regarding reimbursement areas for the identified Assessment Reference Date (ARD) timeframe shall be provided to the review team within four hours after the initial request.~~

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- 2) ~~When further documentation is needed by the review team to validate an area, the team will identify the area of reimbursement requiring additional documentation and provide the facility with the opportunity to produce that information. The facility shall provide the team with the additional documentation within 24 hours after the initial request. All documentation that is to be considered for validation must be provided to the team prior to exit.~~
- 3) ~~Pursuant to 89 Ill. Adm. Code 140.12(f), the facility shall provide Department staff with access to residents, professional and non-licensed direct care staff, facility assessors, clinical records and completed resident assessment instruments, as well as other documentation regarding residents' care needs and treatments.~~
- 4) ~~Failure to provide timely access to records may result in suspension or termination of a facility's provider agreement in accordance with 89 Ill. Adm. Code 140.16(a)(4).~~
- 5) ~~Some states may have regulations that require supportive documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system (RAI Manual, page 1-24). These additional documentation requirements shall be met for reimbursement.~~
- 6) ~~The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with medical peer review organizations to provide utilization review and quality assurance.~~
- b) ~~There shall be documentation in the resident's record to support an MDS coded response indicating that the condition or activity was present or occurred during the observation or look back period. Directions provided by the RAI User's Manual (as described in Section 147.125) are the basis for all coding of the MDS. Section S is reserved for additional State-defined items. All documentation requirements pertain to the MDS 2.0 and Section S items.~~
- e) ~~Each nursing facility shall ensure that MDS data for each resident accurately and completely describes the resident's condition, as documented in the resident's~~

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~~clinical records, maintained by the nursing facility, and the clinical records shall be current, accurate and in sufficient detail to support the reported resident data.~~

- ~~d) Documentation guidance has been compiled from the RAI Manual, instructions that are present on the MDS 2.0 form itself, RAI MH, and Illinois additional documentation requirements. If later guidance is released by CMS that contradicts or augments guidance provided in this Section, the more current information from CMS becomes the acceptable standard. If additional ICD-9 codes are published, they will be reviewed for appropriateness.~~
- ~~e) Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. All supporting documentation shall be found in the facility during an on-site visit.~~
- ~~f) All conditions or treatments shall have been present or occurred within the designated observation period. Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom/problem. Documentation shall apply to the appropriate observation period and reflect the resident's status on all shifts. In addition, the problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan. Insufficient or inaccurate documentation may result in a determination that the MDS item response submitted could not be validated.~~
- ~~g) Disease Diagnoses. Throughout Table A, when a diagnosis is required, the following must be met:
 - ~~1) Code only those diseases or infections that have a relationship to the resident's current ADL (Activities of Daily Living) status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death as directed in the RAI Manual.~~
 - ~~2) The disease conditions require a physician documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.~~
 - ~~3) Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.~~~~

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- h) ~~Activities of Daily Living (ADL)-~~
- 1) ~~Facilities shall maintain documentation that supports the coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period. The documentation shall show the MDS coded level of resident self-performance and support has been met.~~
 - 2) ~~Documentation shall be dated within the look-back period and must contain information from all three shifts that clearly supports the level of self-performance and support needed.~~
 - 3) ~~When there is a widespread lack of supporting documentation as described in subsections (h)(1) and (2), the ADL scores for the residents lacking documentation will be reset to zero.~~
 - 4) ~~When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.~~
- i) ~~Restorative services are programs under the direction and supervision of a licensed nurse and are provided by nursing staff. The programs are designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The focus is on achieving and/or maintaining optimal physical, mental, and psychosocial functioning. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Although therapists may participate in designing the initial program, members of nursing staff are still responsible for the overall coordination and supervision of restorative nursing programs. Staff completing the programs shall be communicating progress, maintenance, regression and other issues/concerns to the licensed nurse overseeing the programs. To qualify for reimbursement, the provision of restorative programs shall meet the following criteria for each program identified for reimbursement:~~
- 1) ~~When programs are designed using verbal cueing as the only intervention, documentation and/or observation must support the following:~~

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- A) ~~Without such cueing the resident would be unable to complete the required ADL task.~~
 - B) ~~The verbal interventions are aimed at providing the resident with instructions for completing the task in such a way that promotes the resident's safety and awareness.~~
 - C) ~~Verbal interventions that are simply reminders to complete the task may not be the sole content of the program.~~
- 2) ~~Documentation shall clearly define the resident's need for the program and the defined program shall correspond to the identified need of the resident. Observation and/or interview shall also support the need for the program.~~
 - 3) ~~The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning. Staff completing the programs shall be aware of the program and the resident's need for the program.~~
 - 4) ~~Documentation must support that the program was reevaluated and goals and interventions were revised as necessary to assist the resident in reaching and/or maintaining his or her highest level of functioning.~~
 - 5) ~~Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized from one report to the next.~~
 - 6) ~~Goals shall be resident specific, realistic, and measurable. Goals shall be revised as necessary. Revisions shall be made based on the resident's response to the program.~~
 - 7) ~~The resident's ability to participate in the program shall be addressed.~~
 - 8) ~~Written evidence of measurable objectives and interventions shall be in the restorative plan of care and be individualized to the resident's problems and needs. There shall be evidence the objectives and interventions were reviewed quarterly and revised as necessary.~~

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- 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~~

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~~programs: bed mobility, transfer, walking, dressing/grooming, and/or eating/swallowing.~~

- ~~17) A resident scoring and/or receiving hospice services shall not be eligible for the following restorative programs: bed mobility, transfer, walking, dressing/grooming, eating and/or other restoratives.~~
 - ~~18) When multiple restoratives are coded in a facility, the staff levels must support the ability to deliver these programs based on the number and frequency of programs coded.~~
 - ~~19) All restorative programs shall meet the specifications of the RAI Manual for the individual restoratives.~~
- j) ~~Passive Range of Motion (PROM):~~
- ~~1) The restorative program shall meet the definition of PROM as identified in the RAI Manual.~~
 - ~~2) The PROM program shall address the functional limitations identified in section G4 of the MDS.~~
 - ~~3) There shall be evidence that the program is planned and scheduled. PROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~
- k) ~~Active Range of Motion (AROM):~~
- ~~1) The restorative program meets the definition of AROM as identified in the RAI Manual.~~
 - ~~2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.~~
 - ~~3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~

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- 4) ~~AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.~~
- l) ~~Splint/Brace Assistance. A splint or brace is defined as an appliance for the fixation, union, or protection of an injured part of the body.~~
- m) ~~Dressing or Grooming Restorative. Grooming programs, including programs to help the resident learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These programs shall have goals, objectives, and documentation of progress and be related to the identified deficit.~~
- n) ~~Scheduled Toileting.~~
- 1) ~~The program shall have documentation to support that all the requirements identified in the RAI Manual are met.~~
- 2) ~~The description of the plan shall be documented, including: frequency, reason, and response to the program.~~
- 3) ~~The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.~~
- 4) ~~This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, when there is no participation in the plan by the resident.~~
- 5) ~~There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.~~
- 6) ~~A resident scoring S1 = 1 (meets Subpart S criteria) shall have a corresponding diagnosis of cerebral vascular accident (CVA) or multiple sclerosis to qualify for reimbursement in scheduled toileting.~~
- o) ~~Continence Care.~~
- 1) ~~Documentation shall support that catheter care was administered during the look-back period.~~

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- 2) ~~The type and frequency of the care shall be documented.~~
 - 3) ~~Documentation shall support that the RAI requirements for a bladder retraining program were administered during the look-back period.~~
 - 4) ~~The resident's level of incontinence shall be documented during the look-back period to support the bladder retraining program.~~
 - 5) ~~Bladder scanners cannot be the sole content of the bladder retraining program.~~
- p) ~~Pressure Ulcer Prevention:~~
- 1) ~~Documentation shall support the history of resolved ulcer in the identified timeframe and/or the use of the coded interventions during the identified timeframe.~~
 - 2) ~~Interventions and treatments shall meet the RAI definitions for coding.~~
 - 3) ~~Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~
 - 4) ~~There shall be documentation that the resident was assessed related to his or her risk for developing ulcers. A resident assessed to be at high risk shall have interventions identified in the plan of care.~~
- q) ~~Moderate Skin Care/Intensive Skin Care:~~
- 1) ~~Interventions and treatments shall meet the RAI definitions for coding.~~
 - 2) ~~Documentation of ulcers shall include staging as the ulcers appear during the look-back period.~~
 - 3) ~~Documentation of ulcers shall include a detailed description that includes, but is not limited to, the stage of the ulcer, the size, the location, any interventions and treatments used during the look-back period.~~
 - 4) ~~Documentation of burns shall include, but is not limited to, the location,~~

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- ~~degree, extent, interventions and treatments during the look-back period.~~
- 5) ~~Documentation of open lesions shall include, but is not limited to, location, size, depth, any drainage, interventions and treatments during the look-back period.~~
- 6) ~~Documentation of surgical wounds shall include, but is not limited to, type, location, size, depth, interventions and treatment during the look-back period.~~
- 7) ~~All treatments involving M5e, M5f, M5g, and M5h shall have a physician's order with the intervention and frequency.~~
- 8) ~~Documentation to support that the intervention was delivered during the look-back period shall be included.~~
- 9) ~~Documentation of infection of the foot shall contain a description of the area and the location.~~
- 10) ~~Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~
- 11) ~~Documentation for items coded in M4 shall include documentation of an intervention, treatment, and/or monitoring of the problem or condition identified.~~
- r) ~~IV Therapy:~~
- 1) ~~Documentation shall include the date delivered, type of medication and method of administration.~~
- 2) ~~Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse as required in subsection (y) of this Section.~~
- s) ~~Injections. Documentation shall include the drug, route given and dates given.~~

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- t) ~~Oxygen Therapy. Documentation shall include a physician's order and the method of administration and date given.~~
- u) ~~Chemotherapy. Documentation shall support the resident was monitored for response to the chemotherapy.~~
- v) ~~Dialysis. Documentation shall support the resident was monitored for response to the dialysis.~~
- w) ~~Blood Glucose Monitoring.~~
 - 1) ~~Documentation shall support that RAI criteria for coding a diagnosis was met, including a physician documented diagnosis.~~
 - 2) ~~Documentation shall support coding of a therapeutic diet being ordered and given to the resident.~~
 - 3) ~~Documentation shall support coding of a dietary supplement being ordered and given to the resident during the look-back period. There shall be evidence to support it was not part of a unit's daily routine for all residents.~~
 - 4) ~~Documentation shall support the coding that injections were given the entire seven days of the look-back period.~~
- x) ~~Infectious Disease.~~
 - 1) ~~Documentation shall support that the criteria defined in the RAI Manual for coding this subsection were met.~~
 - 2) ~~Documentation shall support the active diagnosis by the physician and shall include signs and symptoms of the illness.~~
 - 3) ~~Interventions and treatments shall be documented.~~
 - 4) ~~Documentation shall support that all RAI requirements for coding a Urinary Tract Infection (UTI) are met.~~
 - 5) ~~Administration of maintenance medication to prevent further acute episodes of UTI is not sufficient to code I2j.~~

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- y) ~~Acute Medical Conditions.~~
- 1) ~~Documentation shall support that the RAI requirements for coding these areas are met.~~
 - 2) ~~Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse.~~
 - 3) ~~There shall be evidence that the physician has evaluated and identified the medically unstable or acute condition for which clinical monitoring is needed.~~
 - 4) ~~There shall be evidence of significant increase in licensed nursing monitoring.~~
 - 5) ~~There shall be evidence that the episode meets the definition of acute, which is usually of sudden onset and time-limited course.~~
- z) ~~Pain Management.~~
- 1) ~~There shall be documentation to support the resident's pain experience during the look-back period and that interventions for pain were offered and/or given.~~
 - 2) ~~Residents shall be assessed in a consistent, uniform and standardized process to measure and assess pain.~~
- aa) ~~Discharge Planning.~~
- 1) ~~Social services shall document monthly the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made.~~
 - 2) ~~Social service documentation shall demonstrate realistic evaluation, planning, and follow through.~~

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- 3) ~~Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.~~
- bb) ~~Nutrition:~~
- 1) ~~Documentation shall support coding of tube feeding during the look-back period.~~
 - 2) ~~Intake and output records and caloric count shall be documented to support the coding of K6.~~
 - 3) ~~Documentation of a planned weight change shall include a diet order and a documented purpose or goal that is to facilitate weight gain or loss.~~
 - 4) ~~Documentation of a dietary supplement shall include evidence that resident received the supplement and that it was ordered and given between meals.~~
- cc) ~~Hydration:~~
- 1) ~~Documentation shall support that the resident passes two or fewer bowel movements per week, or strains more than one of four times when having a bowel movement during the look-back period to support the coding of H2b.~~
 - 2) ~~Documentation shall support that the resident received a diuretic medication during the look-back period to support the coding of O4e.~~
 - 3) ~~Documentation shall include frequency of episodes and accompanying symptoms to support the coding of vomiting.~~
 - 4) ~~Documentation shall include signs and symptoms, interventions and treatments used to support the coding of volume depletion, dehydration or hypovolemia.~~
 - 5) ~~There shall be documentation of temperature to support the coding of fever.~~

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- ~~6) There shall be documentation to support the coding of internal bleeding that shall include the source, characteristics and description of the bleeding.~~
- ~~7) There shall be documentation that interventions were implemented related to the problem identified.~~
- ~~dd) Psychosocial Adaptation. Psychosocial adaptation is intended for residents who require a behavior symptom evaluation program or group therapy to assist them in dealing with a variety of mood or behavioral issues. The criteria for reimbursement in this area requires both an intervention program and the identification of mood or behavioral issues. Residents shall be assessed for mood and behavioral issues and interventions shall be implemented to assist the resident in dealing with the identified issues. To qualify for reimbursement in this area, the facility must meet the following criteria:
 - ~~1) Criteria for a special behavior symptom evaluation program:
 - ~~A) There must be documentation to support that the program is an ongoing and comprehensive evaluation of behavior symptoms.~~
 - ~~B) Documentation must support the resident's need for the program.~~
 - ~~C) The documentation must show that the purpose of the program is to attempt to understand the "meaning" behind the resident's identified mood or behavioral issues.~~
 - ~~D) Interventions related to the identified issues must be documented in the care plan.~~
 - ~~E) The care plan shall have interventions aimed at reducing the distressing symptoms.~~~~
 - ~~2) Criteria for group therapy:
 - ~~A) There is documentation the resident regularly attends sessions at least weekly.~~~~~~

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- B) ~~Documentation supports that the therapy is aimed at helping reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve.~~
 - C) ~~This area does not include group recreational or leisure activities.~~
 - D) ~~The therapy and interventions are addressed in the care plan.~~
 - E) ~~This must be a separate session and cannot be conducted as part of skills training.~~
- 3) ~~Criteria for indicators of depression.~~
- A) ~~There must be documentation to support that identified indicators occurred during the look-back period.~~
 - B) ~~The documentation shall support the frequency of the indicators as coded during the look-back period.~~
 - C) ~~There shall be documentation to support that interventions were implemented to assist the resident in dealing with these issues.~~
- 4) ~~Criteria for sense of initiative/involvement.~~
- A) ~~There is documentation to support the resident was not involved or did not appear at ease with others or activities during the look-back period.~~
 - B) ~~There shall be evidence that interventions were implemented to assist the resident in dealing with these issues.~~
- 5) ~~Criteria for unsettled relationships/past roles.~~
- A) ~~There is documentation to support the issues coded in this area during the look-back period.~~
 - B) ~~There shall be evidence that interventions were implemented to assist the resident in dealing with the issues identified.~~

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- 6) ~~Criteria for behavioral symptoms.~~
 - A) ~~There is documentation to support that the behaviors occurred during the look-back period and the interventions used.~~
 - B) ~~Documentation should reflect the resident's status and response to interventions.~~
 - C) ~~Documentation should include a description of the behavior exhibited and the dates it occurred, as well as staff response to the behaviors.~~
 - D) ~~Documentation supporting that the behaviors coded meet the RAI definitions for the identified behavior.~~
 - E) ~~The care plan identifies the behaviors and the interventions to the behaviors.~~
- 7) ~~Criteria for delusions/hallucinations.~~
 - A) ~~There is documentation to support that the delusions or hallucinations occurred during the look-back period.~~
 - B) ~~Documentation contains a description of the delusion or hallucinations the resident was experiencing.~~
 - C) ~~There is documentation to support the interventions used.~~
- ee) ~~Psychotropic Medication Monitoring.~~
~~Documentation shall support the facility followed the documentation guidelines as directed by 42 CFR 483.25(l), Unnecessary drugs (State Operations Manual F-tag F329).~~
- ff) ~~Psychiatric Services (Section S).~~
 - 1) ~~There shall be evidence the resident met IDPH Subpart S criteria during the look-back period.~~

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- 2) ~~There shall be evidence a pre-admission screening completed by a Department of Human Services Division of Mental Health screening entity was completed on the resident that identifies the resident as having a serious mental illness (SMI).~~
 - 3) ~~Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.~~
 - 4) ~~Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan (ITP).~~
 - 5) ~~Facilities must ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.~~
 - 6) ~~Adjustments in the rate for utilization of ancillary providers shall be calculated based upon Department claims data for ancillary provider billing.~~
- gg) ~~Skills Training. Skills training is specific methods for assisting residents who need and can benefit from this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria:~~
- 1) ~~Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.~~
 - 2) ~~Addresses identified skill deficits related to goals noted in the treatment plan.~~
 - 3) ~~Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.~~

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- ~~4) Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.~~
- ~~5) Training shall be provided in groups no larger than ten, with reduced group size for residents requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.~~
- ~~6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the severe mentally ill (SMI) and Mental Illness/Substance Abuse (MISA) populations are available for use and as models.)~~
- ~~7) The curriculum shall address discrete sets of skill competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.~~
- ~~8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.~~
- ~~9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.~~
- ~~10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.~~
- ~~11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary. However, on-going 1:1 training shall not qualify under this area.~~

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~~hh) Close or Constant Observations.~~

- ~~1) Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item shall not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from hospital, or as a part of periodic resident headcounts.~~
- ~~2) There shall be documentation for the reason for use, confirmation that the procedure was performed as coded with staff initials at appropriate intervals, brief explanation of the resident's condition and reason for terminating the observation.~~

~~ii) Cognitive Impairment/Memory Assistance Services.~~

- ~~1) Documentation shall include a description of the resident's short-term memory problems.~~
- ~~2) A method of assessing and determining the short-term memory problem shall be documented.~~
- ~~3) Documentation shall include a description of the resident's ability to make everyday decisions about tasks or activities of daily living.~~
- ~~4) Documentation shall include a description of the resident's ability to make himself or herself understood.~~

~~jj) Dementia Care Unit.~~

- ~~1) Unit was Illinois Department of Public Health certified during look-back period.~~
- ~~2) Resident resided in the unit during the look-back period.~~
- ~~3) Activity programming is planned and provided seven days a week for an average of eight hours per day.~~
- ~~4) Required assessments were completed on the resident.~~

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- 5) ~~If the resident has a Cognitive Performance Scale (CPS) score of five, care planning shall address the resident's participation in the unit's activities.~~
- 6) ~~If a particular resident does not participate in at least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.~~
- 7) ~~Documentation shall support staff's efforts to involve the resident.~~
- kk) ~~Exceptional Care Services.~~
 - 1) ~~Respiratory Services.~~
 - A) ~~A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.~~
 - B) ~~Documentation of respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.~~
 - C) ~~Documentation of a physician's orders for the treatments.~~
 - D) ~~Respiratory therapy requires documentation in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.~~
 - E) ~~Documentation of suctioning includes type, frequency and results of suctioning.~~
 - F) ~~Documentation of trach care includes type, frequency and description of the care provided.~~
 - 2) ~~Weaning From Ventilator.~~
~~Documentation shall be in place to support weaning from the ventilator.~~
 - 3) ~~Morbid Obesity.~~

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- ~~A) A dietician's evaluation shall be completed with evidence of on-going consultation.~~
 - ~~B) On-going monitoring of weight shall be evident.~~
 - ~~C) The psychosocial needs related to weight issues shall be identified and addressed.~~
- ~~4) Complex Wounds.
Facilities are to follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual F tag F314). All documentation requirements listed in F314 shall be met.~~
- ~~5) Traumatic Brain Injury (TBI).
 - ~~A) Documentation shall support that psychological therapy is being delivered by licensed mental health professionals, as described in the RAI Manual.~~
 - ~~B) Documentation shall support a special symptom evaluation program as an ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI Manual.~~
 - ~~C) Documentation shall support evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder, or other mental health problems by a qualified clinical professional as described in the RAI Manual.~~
 - ~~D) The care plan shall address the behaviors of the resident and the interventions used.~~~~
- ~~II) Accident/Fall Prevention.
 - ~~1) Documentation shall support that the resident has the risk factor identified on the MDS.~~~~

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- 2) ~~Documentation shall support that the resident has been assessed for fall risks.~~
- 3) ~~If the resident is identified as high risk for falls, documentation shall support that interventions have been identified and implemented.~~
- mm) ~~Restraint Free.~~
 - 1) ~~There shall be documentation to support the previous use of a restraint and the resident response to the restraint.~~
 - 2) ~~There shall be evidence that the restraint was discontinued.~~
- nn) ~~Clarification and additional documentation requirements are as follows:~~
 - 1) ~~Defined actions such as further assessment or documentation, described in the RAI Manual as "good clinical practice", are required by the Department as supporting documentation. Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths, that monitors his or her condition on an on-going basis, and that records treatments and response to treatment is a matter of good clinical practice and is an expectation of trained and licensed health care professionals (RAI page 1-23).~~
 - 2) ~~The facility shall have in place policies and procedures to address specific care needs of the residents, written evidence of ongoing in-services for staff related to residents' specific care needs and all necessary durable medical equipment to sustain life and carry out the plan of care as designed by the physician. In the absence of these items, a referral will be made to the Illinois Department of Public Health.~~
 - 3) ~~No specific types of documentation or specific forms are mandated, but documentation shall be sufficient to support the codes recorded on the MDS. Treatments and services ordered and coded shall be documented as delivered in the clinical record.~~
 - 4) ~~When completing a significant change assessment, the guidelines provided in the RAI Manual shall be followed. This includes documenting "the~~

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~~initial identification of a significant change in terms of the resident's clinical status in the progress notes" as described in RAI page 2=7.~~

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

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

**Section 147.310 ~~Implementation of a Case Mix System~~~~Inspection of Care (IOC) Review~~
~~Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities~~
~~for Individuals with Mental Illness (Repealed)~~**

- 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 (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMMS) except the CMMS 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 that determination, the Department shall take into consideration available appropriations and identify an

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- 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 RUG-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) by the weight assigned to that group, as described in subsection (b).
 - 4) Compute the statewide base nursing component as the quotient that results from dividing the total dollar amount available, as in subsection (c)(1) by the sum of the products computed in subsection (c)(3).
- d) Determination of the 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 the resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUG 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 after 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) 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), assigned to the Medicaid-enrolled resident on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid

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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), 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: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

Section 147.315 Nursing Facility Resident Assessment Instrument Comprehensive Functional Assessments and Reassessments (Repealed)

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

b) A facility shall complete the MDS Comprehensive Item Set form, which 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 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) require nursing facilities to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record.

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- c) A facility shall electronically transmit to the database the following MDS assessments in the timeframes identified.
- 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 CMMS. 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 the CMMS database no later than 14 calendar days after the care plan completion date. The quarterly assessment shall identify the MDS was transmitted to the CMMS 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. The care plan completion date is 7 calendar days after the MDS/CAA completion date. The 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 after the ARD following 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 the MDS/CAA completion date plus 7 calendar days. The transmission date is the 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

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completion date is 14 calendar days after the determination date plus 7 calendar days. The transmission date is the care plan date plus 14 calendar days.

- 6) All quarterly assessments shall have an ARD within 92 calendar days after 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. The MDS completion date is ARD plus 14 calendar days. The transmission date is the 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 and the sections or portions of sections 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 the staffer, to the best of his or her 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: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

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Section 147.320 Definitions~~Interdisciplinary Team (IDT) (Repealed)~~

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.

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"Minimum Data Set" means the assessment instrument specified by the Centers for Medicare and Medicaid Services (CMMS) 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 supports 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 in which a resident's overall clinical status is not accurately represented, and the error has not been corrected via submission of a more recent assessment.

(Source: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

**Section 147.325 Resident Reimbursement Classifications and Requirements
Comprehensive Program Plan (CPP) (Repealed)**

- 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 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMMS), 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

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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 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 responses shall be dated during the Assessment Reference Date (ARD) period or other timeframes 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 responses. 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 when 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 dates are clearly identified on the form.

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- 6) Corrections/obliterations/errors/mistaken entries. At a minimum, there shall be one line through the incorrect information, the staff's initials, the date the 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 and 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 that 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.

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- 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 that 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 that 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.

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- 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 day observation period.
- C) Ongoing therapy with medication or other interventions to manage 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 manage 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: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

Section 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements ~~Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)~~

- a) Activities of Daily Living (ADLs)

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- 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 was in the facility.
 - 2) Documentation shall support the use of a ventilator or respirator during the observation period while a resident was in the facility. Documentation shall support that 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 that the following conditions for "strict isolation" were 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;

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- 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 following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG Group</u>
<u>Extensive Services – At least one of the following:</u>			
<u>• Tracheostomy Care while a resident (O0100E2)</u>	<u>≥2</u>	<u>• Tracheostomy Care and Ventilator/Respirator</u>	<u>ES3</u>
<u>• Ventilator or Respirator while a resident (O0100F2)</u>	<u>≤2</u>	<u>• Tracheostomy Care OR Ventilator/Respirator</u>	<u>ES2</u>
<u>• Infection Isolation while a resident (O0100M2)</u>	<u>≥2</u>	<u>• Infection Isolation:</u> <u>• Without Trach</u> <u>• Without Ventilator/Respirator</u>	<u>ES1</u>

c) Rehabilitation. Documentation shall support that 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:

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- A) Ordered by a physician based on a qualified therapist's (i.e., one who meets Medicare requirements) 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 aides performing these maintenance services that are considered restorative care.
- 3) Documentation shall support that 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 was a recipient of home care or community based services.
 - 4) Documentation supports that the services were ordered or certified by a physician.
 - 5) Documentation supports that the services will 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 that the services will 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 that the services will 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

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- services must be necessary for the establishment of a safe and effective maintenance program.
- 8) Documentation supports that the services are considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition.
- 9) Documentation supports that the services are 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 must be furnished by qualified personnel.
- 10) Documentation shall include the actual minutes of therapy. Minutes shall not be rounded to the nearest 5th 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 that the criteria for the mode identified is met.
- 12) Documentation shall support that the restorative program includes nursing interventions that promote the resident's 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 that the following components for a restorative program are 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

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- D) Individuals who implement the program must be trained in the interventions and supervised by a nurse.
- 14) Documentation shall support that the requirements identified for coding ADL were met.
- 15) Rehabilitation is defined as indicated in the following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG Group</u>
<u>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)</u>	<u>15-16</u>	<u>None</u>	<u>RAE</u>
<u>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)</u>	<u>11-14</u>	<u>None</u>	<u>RAD</u>
<u>OR</u>	<u>6-10</u>	<u>None</u>	<u>RAC</u>
<u>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</u>	<u>2-5</u>	<u>None</u>	<u>RAB</u>
	<u>0-1</u>	<u>None</u>	<u>RAA</u>

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<u>(O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3) AND at least 2 nursing rehabilitation services.</u>			
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- d) Special Care High. Documentation shall support that the following requirements were met during the observation period based on the MDS items identified:
- 1) Documentation shall support that the requirements/criteria for coding an active disease diagnosis were met.
 - 2) Documentation shall support that 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 support that 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.

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- 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 that 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) Evidence of the actual minutes the therapy was provided while a resident was in the facility;
- C) Evidence that the services are provided by a qualified professional; and
- D) Evidence 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.
- 12) Special Care High is defined as indicated in the following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG IV Group</u>
<u>Special Care High (ADL Score of ≥ 2 and at least one of the following:</u>	<u>15-16</u>	<u>Depression</u>	<u>HE2</u>
<u>• Comatose (B0100) and</u>	<u>15-16</u>	<u>No Depression</u>	<u>HE1</u>

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<u>completely ADL dependent or ADL did not occur (G0100A1, G0100B1, G0100H1, G0100I1 all = 4 or 8)</u>	<u>11-14</u>	<u>Depression</u>	<u>HD2</u>
<u>• Septicemia (I2100)</u>	<u>11-14</u>	<u>No Depression</u>	<u>HD1</u>
<u>• Diabetes (I2900) with both of the following:</u>	<u>6-10</u>	<u>Depression</u>	<u>HC2</u>
<u>• Insulin injections for all 7 days (N0350A=7)</u>	<u>6-10</u>	<u>No Depression</u>	<u>HC1</u>
<u>• Insulin order changes on 2 or more days (N0350B>2)</u>	<u>2-5</u>	<u>Depression</u>	<u>HB2</u>
<u>• Quadriplegia (I5100) with ADL score >5</u>	<u>2-5</u>	<u>No Depression</u>	<u>HB1</u>
<u>• Asthma or COPD (I6200) AND shortness of breath while lying flat (J1100C)</u>		<u>(Note: See description of depression indicators)</u>	
<u>• Fever (J1550A) and one of the following:</u>			
<u>• Pneumonia (I2000)</u>			
<u>• Vomiting (J1550B)</u>			
<u>• Weight Loss (K0300=1 or 2)</u>			
<u>• 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)</u>			
<u>• Parenteral/IV Feeding (K0510A1 or K0510A2)</u>			
<u>• Respiratory Therapy for all 7 days (O0400D2=7)</u>			

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<u>If a resident qualifies for Special Care High but the ADL score is a 1 or less, then the resident classifies as Clinically Complex</u>			
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- e) Special Care Low. Documentation shall support that the following requirements were met during the observation period based on the MDS items identified:
- 1) Documentation shall support that the requirements/criteria for coding disease diagnosis were met. This includes an active diagnosis of cerebral palsy, multiple sclerosis, and/or Parkinson's.
 - 2) Documentation shall support that 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 that 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.

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- 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/treatments 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 that 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 that the program was implemented and is monitored and reassessed to determine the effectiveness of the intervention.
- 12) Documentation shall support that 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 that the care was delivered. Documentation shall include the date/time, type of care delivered and identification of the person delivering the care.

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- 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 that 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 that 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 that 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 following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG IV Group</u>
<u>Special Care Low – ADL score of 2 or more and at least one of the following:</u>	<u>15-16</u>	<u>Depression</u>	<u>LE2</u>
	<u>15-16</u>	<u>No Depression</u>	<u>LE1</u>

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<ul style="list-style-type: none"> • <u>Cerebral Palsy (I4400) with ADL score ≥ 5</u> 	<u>11-14</u> <u>11-14</u>	<u>Depression</u> <u>No Depression</u>	<u>LD2</u> <u>LD1</u>
<ul style="list-style-type: none"> • <u>Multiple Sclerosis (I5200) with ADL score ≥ 5</u> 	<u>6-10</u>	<u>Depression</u>	<u>LC2</u>
<ul style="list-style-type: none"> • <u>Parkinson's disease (I5300) with ADL score ≥ 5</u> 	<u>6-10</u> <u>2-5</u>	<u>No Depression</u> <u>Depression</u>	<u>LC1</u> <u>LB2</u>
<ul style="list-style-type: none"> • <u>Respiratory Failure (I6300) and oxygen therapy while a resident (O0100C2)</u> 	<u>2-5</u>	<u>No Depression</u>	<u>LB1</u>
<ul style="list-style-type: none"> • <u>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)</u> 		<u>Note: See description of depression indicators</u>	
<ul style="list-style-type: none"> • <u>Two or more Stage 2 pressure ulcers (M0300B1) with two or more skin treatments</u> 			
<ul style="list-style-type: none"> • <u>Pressure relieving device for chair (M1200A) and/or bed (M1200B)</u> 			
<ul style="list-style-type: none"> • <u>Turning/ Repositioning (M1200C)</u> 			
<ul style="list-style-type: none"> • <u>Nutrition or hydration</u> 			

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<p><u>intervention (M1200D)</u></p> <ul style="list-style-type: none"> • <u>Ulcer care (M1200E)</u> • <u>Application of dressing (M1200G)</u> • <u>Application of ointments (M1200H)</u> • <u>Any Stage 3 or 4 pressure ulcer (M0300C1, D1, F1) with two or more skin treatments – See above list</u> • <u>Two or more venous/arterial ulcers (M1030) with two or more skin treatments – See above list</u> • <u>One Stage 2 pressure ulcer (M0300B1) and one venous/arterial ulcer (M1030) with two or more skin treatments – See above list</u> • <u>Foot infection (M1040A), Diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressing to feet (M1200I)</u> • <u>Radiation treatment</u> 			
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<p><u>while a resident (O0100B2)</u></p> <ul style="list-style-type: none"> • <u>Dialysis treatment while a resident (O0100J2)</u> <p><u>If a resident qualifies for Special Care Low but the ADL score is 1 or less – the resident classifies as Clinically Complex</u></p>			
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- f) Clinically Complex. Documentation shall support that the following requirements were met during the observation period based on the MDS items identified.
- 1) Documentation shall support that the requirements/criteria for coding disease diagnosis were 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 that the requirements/criteria for coding ADLs were 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

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nonsurgical dressing and/or ointments to an area other than the feet, and documentation that the intervention 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 and/or 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 that the resident received a transfusion while 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 following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG IV Group</u>
<u>Clinically Complex – At least one of the</u>	<u>15-16</u>	<u>Depression</u>	<u>CE2</u>

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<u>following:</u>	<u>15-16</u>	<u>No Depression</u>	<u>CE1</u>
• <u>Pneumonia (I2000)</u>			
• <u>Hemiplegia/hemi-</u> <u>paresis (I4900) with</u> <u>ADL score \geq5</u>	<u>11-14</u>	<u>Depression</u>	<u>CD2</u>
• <u>Surgical wounds</u> <u>(M1040E) or open</u> <u>lesion (M1040D) with</u> <u>any of the following</u> <u>selected skin</u> <u>treatments:</u>	<u>11-14</u>	<u>No Depression</u>	<u>CD1</u>
• <u>Surgical wound care</u> <u>(M1200F)</u>	<u>6-10</u>	<u>Depression</u>	<u>CC2</u>
• <u>Application of</u> <u>nonsurgical dressing</u> <u>(M1200G) not to feet</u>	<u>6-10</u>	<u>No Depression</u>	<u>CC1</u>
• <u>Application of</u> <u>ointment (M1200H)</u> <u>not to feet</u>	<u>2-5</u>	<u>Depression</u>	<u>CB2</u>
• <u>Burns (M1040F)</u>	<u>2-5</u>	<u>No Depression</u>	<u>CB1</u>
• <u>Chemotherapy while a</u> <u>resident (O0100A2)</u>	<u>0-1</u>	<u>Depression</u>	<u>CA2</u>
• <u>Oxygen therapy while</u> <u>a resident (O0100C2)</u>	<u>0-1</u>	<u>No Depression</u>	<u>CA1</u>
• <u>IV Medication while a</u> <u>resident (O0100H2)</u>			
• <u>Transfusions while a</u> <u>resident (O0100I2)</u>			
<u>If a resident qualifies for</u> <u>Special Care High or</u> <u>Special Care Low, but</u> <u>the ADL score is 1 or 0,</u> <u>the resident classifies as</u> <u>Clinically Complex CA1</u> <u>or CA2</u>			

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- 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

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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 that 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 following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>IL RUG IV GROUP</u>
<u>Behavioral Symptoms and Cognitive Performance</u>	<u>2-5</u>	<u>2 or more Restorative</u>	<u>BB2</u>
<u>BIMS score of 9 or less AND an ADL score of 5 or less</u>	<u>2-5</u>	<u>Nursing Programs</u>	<u>BB1</u>
<u>OR</u>	<u>0-1</u>	<u>0-1 Restorative Nursing Programs</u>	<u>BA2</u>
<u>Defined as Impaired Cognition by Cognitive Performance Scale AND an ADL score of 5 or less</u>	<u>0-1</u>	<u>2 or more Restorative Nursing Programs</u>	<u>BA1</u>
<u>Hallucinations (E0100A)</u>		<u>0-1 Restorative Nursing Programs</u>	
<u>Delusions (E0100B)</u>			
<u>Physical Behavioral symptom directed toward others (E0200A=2 or 3)</u>			
<u>Verbal behavioral symptom directed towards others (E0200B=2 or 3)</u>			
<u>Other behavioral symptom not directed towards others (E0200C=2 or 3)</u>			
<u>Rejection of care (E08002 or 3)</u>			

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<u>Wandering (E0900=2 or 3)</u>			
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h) Reduced Physical Function

- 1) Documentation shall support the ADL coded level.
- 2) Documentation shall 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 following chart:

<u>Category (Description)</u>	<u>ADL Score</u>	<u>End Splits or Special Requirements</u>	<u>ILL RUG IV Group</u>
<u>Reduced Physical Function</u>	<u>15-16</u>	<u>2 or more Restorative</u>	<u>PE2</u>
	<u>15-16</u>	<u>0-1 Restorative</u>	<u>PE1</u>
<u>No Clinical Conditions</u>	<u>11-14</u>	<u>2 or more Restorative</u>	<u>PD2</u>
	<u>11-14</u>	<u>0-1 Restorative</u>	<u>PD1</u>
	<u>6-10</u>	<u>2 or more Restorative</u>	<u>PC2</u>
	<u>6-10</u>	<u>0-1 Restorative</u>	<u>PC1</u>
	<u>2-5</u>	<u>2 or more Restorative</u>	<u>PB2</u>
	<u>2-5</u>	<u>0-1 Restorative</u>	<u>PB1</u>
	<u>0-1</u>	<u>2 or more Restorative</u>	<u>PA2</u>
	<u>0-1</u>	<u>0-1 Restorative</u>	<u>PA1</u>

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Illinois Specific Classification

<u>An assessment that is missing and/or submitted more than 14 days late from the due date</u>	<u>N/A</u>		<u>AA1</u>
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Additional Scoring Indicators

<u>ADL</u>	<u>Self-Performance</u>	<u>Support</u>	<u>ADL Score</u>
<u>Bed Mobility (G0100A)</u> <u>Transfer (G0110B)</u> <u>Toilet Use (G0110I)</u>	<u>Coded -, 0, 1, 7 or 8</u>	<u>Any Number</u>	<u>0</u>
	<u>Coded 2</u>	<u>Any Number</u>	<u>1</u>
	<u>Coded 3</u>	<u>-, 01 or 2</u>	<u>2</u>
	<u>Coded 4</u>	<u>-, 01 or 2</u>	<u>3</u>
	<u>Coded 3 or 4</u>	<u>3</u>	<u>4</u>
<u>Eating (G0110H)</u>	<u>Coded -, 0, 1, 2, 7 or 8</u>	<u>-, 01 or 8</u>	<u>0</u>
	<u>Coded -, 0, 1, 2, 7 or 8</u>	<u>2 or 3</u>	<u>2</u>
	<u>Coded 3 or 4</u>	<u>-, 0 or 1</u>	<u>2</u>
	<u>Coded 3</u>	<u>2 or 3</u>	<u>3</u>
	<u>Coded 4</u>	<u>2 or 3</u>	<u>4</u>

Depression Indicator

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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 $D0600 \leq 30$

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 hour period. Measurable objectives 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.

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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 positioning self in bed. Includes 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 putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body.

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 trial (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

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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.

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 \leq 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 exist:

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:

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B0700>2 Severe problem being understood
C1000>2 Severe cognitive skills problem

(Source: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

**Section 147.335 Enhanced Care Rates~~Specialized Care – Behavioral Emergencies~~
(Repealed)**

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 electrically or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

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) A facility 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

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- 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 by 77 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 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 be on call, if not on duty, at all times.
- I) No less than one 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.

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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 that 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 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 that the resident has been assessed quarterly for risk of 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 pressure 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

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monitoring the occurrence of pain. Staff shall receive in-service training on this area.

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

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

B) Documentation shall support that 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 shall be 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 (c), HFS review shall include, but not be limited to, the following:

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- 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:
 - A) Criteria – Level I
Resident has met the criteria identified and required the use of a ventilator for a minimum of 10 hours in a 24 hour period; and
 - B) Criteria – Level II
Resident has met the criteria identified and required the use of a ventilator for a minimum of 16 hours in a 24 hour period; and
 - 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.
- e) Traumatic Brain Injury (TBI)
- 1) Any facility meeting the criteria set forth in this subsection (e)(1) 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

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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 for management of behavior issues, identification and reduction of 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 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 TBI residents. Care plans shall be individualized to meet the resident's need 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

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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 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 that the resident was assessed using the Rancho Los Amigos Cognitive Assessment and scored a Level IV through 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

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receive instructions focusing on independent living skills, prevocational training and employment support.

D) Resident scores a Level VIII through X on the Rancho Los 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 through 15 (Cognitively intact, C0500 on the MDS 3.0).

G) Activities of daily living (ADLs) 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 12 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.

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- C) Resident scores a Level IV through VII on the Rancho Los 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 ADLs require limited or extensive assistance.
- G) Resident is on 2 or more of the following restoratives: 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 that there is a 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.

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- 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 a Level IV through VII on the Rancho Los 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 SP) at least 500 minutes per week and at least one 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 that 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.

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 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: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section added at 36 Ill. Reg. _____, effective _____.)

Section 147.340 Minimum Data Set On-Site Reviews~~Discharge Planning (Repealed)~~

 a) The Department shall conduct reviews to determine the accuracy of the resident assessment information 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. ~~These~~ reviews may, at the discretion of the Department, be conducted 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 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 circumstances include, but are not limited to, the following:

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- 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 a 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.

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- g) The Department shall select at least 20 percent, with a minimum of 10 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 10 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 a facility qualifies 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 140.116(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 providing 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.

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- n) Throughout the review, the Department shall identify to the facility any preliminary conclusions regarding the MDS items/areas that could not be validated. If the facility disagrees with those preliminary conclusions, it shall present the Department with any and all documentation to support its 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 items 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 Section must be presented to validate the identified area.
- p) Corrective Action. Upon conclusion of the review and 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 the Department of Public Health.
- 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 RUG-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 10 percent in addition to the rate change specified in this subsection. The direct care component of the rate

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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 reasons 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 a determination and notify the facility in writing of the final decision.

(Source: Old Section repealed at 26 Ill. Reg. 3093, effective February 15, 2002 and new Section 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

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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;

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- 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 Audiologist; 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);

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- viii) vocational or educational skills (if applicable);
 - ix) cognitive development;
 - x) medication and immunization history;
 - xi) psychological evaluation (within 5 years) that includes an assessment of the individual's emotional and intellectual status;
 - xii) capabilities and preferences relative to recreation/leisure activities;
 - xiii) other assessments indicated by the individual's needs, such as physical and occupational therapy assessments;
 - xiv) seizure disorder history (if applicable) with information regarding frequency of occurrence and classification; and
 - xv) screenings (the facility performs or obtains) in the areas of nutrition, vision, auditory and speech/language.
- d) Costs associated with specialized services programs reimbursement includes other program costs, such as consultants, inservice training, and other items necessary for the delivery of specialized services to clients in accordance with their individual program plans.

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

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

Section 147.355 Reimbursement for Residents with Exceptional Needs (Repealed)

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- a) ~~Pursuant to Public Act 96-1530, effective January 1, 2012, the Department of Healthcare and Family Services (HFS) shall allocate at least \$8 million of the funds collected from the assessment identified in 89 Ill. Adm. Code 140.84 to develop and make enhanced payments to nursing facilities for services provided to residents with exceptional needs. For purposes of this Section, an exceptional need means ventilator care, tracheotomy care, bariatric care, complex wound care and traumatic brain injury (TBI) care. The break-out of the spending will be \$2 million each for ventilator care and TBI as scored under the Minimum Data Set (MDS) 3.0, and \$4 million for tracheotomy care, bariatric care, complex wound care and TBI supply costs as scored under the MDS 2.0.~~
- b) ~~Ventilator Care~~
- 1) ~~Ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.~~
 - 2) ~~In order for an applicable rate to be assigned to a ventilator dependent resident, a 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.~~
 - 3) ~~A facility shall establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.~~
 - 4) ~~Facilities shall be equipped with technology that enables them to meet the respiratory therapy, mobility and comfort needs of their patients.~~
 - 5) ~~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.~~

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- 6) ~~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.~~
- 7) ~~Ventilators shall be equipped with internal batteries to provide a short back-up system in case of a total loss of power.~~
- 8) ~~An audible, redundant ventilator alarm systems shall be required to alert caregivers of a ventilator malfunction, failure or resident disconnect. A back-up ventilator shall be available at all times.~~
- 9) ~~Staffing~~
 - A) ~~A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health (DPH) in 77 Ill. Adm. Code 300.1240 or 250.910(e) and (f)(1), as appropriate). Additional RN staff may be determined necessary by HFS, based on the HFS review of the ventilator services.~~
 - B) ~~A minimum of the required number of LPN staff (as required by DPH in 77 Ill. Adm. Code 300.1230 and 300.1240 or 250.910(e) and (f)(1), as appropriate), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.~~
 - C) ~~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.~~
 - D) ~~A pulmonologist, or physician experienced in the management of ventilator care, shall direct the plan of care for ventilator residents on no less than a biweekly basis.~~
 - E) ~~At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator~~

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- ~~dependent individuals and the use of 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.~~
- F) ~~All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing that 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.~~
- 10) ~~Facilities shall be required to have established protocols on the following areas:~~
- A) ~~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.~~
- i) ~~Documentation shall support that the resident has been assessed quarterly for his or her risk for developing pressure ulcers.~~
- ii) ~~Interventions for pressure ulcer prevention shall be in place that include, but are not limited to, a turning and repositioning schedule, use of pressure reducing devices, hydration and nutritional interventions and daily skin checks.~~
- B) ~~Pain. A facility shall have established policies and procedures on assessing the occurrence of pain, including development of a~~

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- ~~method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.~~
- ~~i) Documentation shall support that resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.~~
 - ~~ii) Documentation shall support that an effective pain management regime is in place for the resident.~~
- ~~C) 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 training on those areas.~~
- ~~i) Documentation shall support that the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.~~
 - ~~ii) Documentation shall support that the resident was given oral care every shift to reduce the risk of infection.~~
- ~~D) Social Isolation. A facility shall have a method of assessing a resident's risk for social isolation. Intervention shall be in place to involve a resident in activities when possible.~~
- ~~E) Ventilator Weaning. A facility shall have a method or routinely assessing a resident's weaning potential and interventions shall be implemented as needed.~~
- 11) HFS staff shall conduct on-site visits on a random and targeted basis to ensure both facility and resident compliance with identified requirements. 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 (b)(11), HFS review shall include, but not be limited to, the following:

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- A) ~~Ventilator-Associated Pneumonia;~~
 - B) ~~Ventilator Weaning;~~
 - C) ~~Length of Stay and Hospital Discharge;~~
 - D) ~~Length of Stay and Discharge Destination; and~~
 - E) ~~Length of Stay and Death.~~
- 12) ~~The enhanced payment shall be added to the rate determined by MDS 2.0:~~
- A) ~~Payment shall be made for each individual resident receiving ventilator services;~~
 - B) ~~A rate for ventilator services shall be set based on geographic area for all facilities within that area; and~~
 - C) ~~The rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and \$174 supply costs.~~
- e) TBI
- 1) ~~Any facility meeting the criteria set forth in this subsection (e) for TBI care serving individuals shall receive the enhanced TBI reimbursement rate identified. This rate is in lieu of the rate received under MDS 2.0 reimbursement, and the TBI add-on shall no longer apply.~~
 - 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:~~

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- A) ~~The facility shall have policies and procedures for care of the residents with TBI and associated 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 (ST) therapy, 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 training 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 each 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 (Rancho) 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 fall into one of three tiers of payments, tier 3 being the highest reimbursement. By completing a Department designated form,~~

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~~facilities will be responsible for notifying the Department of the applicable tier into which a resident falls.~~

- ~~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 that the resident has the ability to benefit from rehabilitation and a potential for independent living.~~

- ~~B) Documentation that 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 that 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) The payment amount is \$264.17 per day, and shall not exceed six months.~~

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

- ~~C) Includes residents who have received intensive rehabilitation and are 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 Los Amigos Cognitive Scale (Purposeful, Appropriate, and stand-by assistance to Modified Independence).~~

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- ~~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 MDS 3.0).~~
 - ~~G) Activities of daily living (ADL) functioning. All ADL tasks shall be coded less than 3 (Section G on 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 MDS 3.0) or referral has been made to the local contact agency (Q0600=1 on 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) The payment amount is \$486.49 per day, and shall not exceed 12 months.~~
 - ~~B) Includes residents who have reached a plateau in rehabilitation ability, but still require services related to the TBI. Resident must have previously scored in Tier III.~~
 - ~~C) Resident scores a Level IV-VII on the Rancho Los Amigos Cognitive Scale (Confusion, may or may not be appropriate).~~

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- ~~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 ADLs requires limited or extensive assistance.~~
- ~~G) Resident is on 2 or more of the following restoratives: 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 that a one-on-one meeting with a licensed social worker is held at least twice a week to discuss potential needs, goals and any behavior issues.~~
- ~~J) At least quarterly oversight of plan of care by a neurologist.~~
- ~~K) Documentation that 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:

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- A) ~~The payment amount is \$767.46 per day and 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 a Level IV-VII on the Rancho LOS 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 MDS 3.0).~~
- F) ~~Documentation shall support that 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 rehab discipline 5 days/week (O400 on MDS 3.0). The therapy shall meet the RAI guidelines for coding.~~
- H) ~~The facility shall have trained rehab staff on site working with the resident on a daily basis. This shall include a trained rehab nurse and rehab aides.~~
- I) ~~Documentation shall support that there are weekly meetings of the interdisciplinary team to discuss the resident's rehab 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.~~

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- d) ~~Other Exceptional Need Services~~
- 1) ~~Facilities scoring tracheotomy care, bariatric care, complex wound care and TBI on MDS 2.0 shall receive an additional add-on for supply costs associated with providing those services.~~
- 2) ~~Following are the per diem add-ons for the four services identified in subsection (d)(1):~~
- A) ~~Tracheotomy Care = \$8.80~~
- B) ~~Bariatric Care = \$1.00~~
- C) ~~Complex Wound Care = \$8.80~~
- D) ~~TBI = \$8.80~~

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

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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~~

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~~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~~

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~~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~~

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~~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.

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- 1) ~~Coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period.~~
- 2) ~~MDS-coded level of resident self-performance and support has been met.~~
- 3) ~~When there is a widespread lack of supporting documentation as described in subsections (1) and (2) of this item (2), the ADL scores for the residents lacking documentation will be reset to zero.~~
- 4) ~~When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.~~

Level	Composite Scores	Unlicensed	Licensed	Social Worker	Activity
I	Composite 7-8	50	7.5 RN 7.5 LPN		
II	Composite 9-11	62	9.5 RN 9.5 LPN		
III	Composite 12-14	69	10.5 RN 10.5 LPN		
IV	Composite 15-29	85	12.5 RN 12.5 LPN		

~~ADL Scoring Chart for the above Composite Levels~~

~~MDS values equal to "-" denote missing data.~~

ADL	MDS items	Description	Score
Bed Mobility	G1aA = - or G1aA = 0 or G1aA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1aA = 2.	Self-Performance = limited assistance	3

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	G1aA = 3 or G1aA = 4 or G1aA = 8 AND G1aB = — or G1aB = 0 or G1aB = 1 or G1aB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1aB = 3 or G1aB = 8.	Support = 2+ person physical assist Support = activity did not occur	5
Transfer	G1bA = — or G1bA = 0 or G1bA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1bA = 2.	Self-Performance = limited assistance	3
	G1bA = 3 or G1bA = 4 or G1bA = 8 AND G1bB = — or G1bB = 0 or G1bB = 1 or G1bB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1bB = 3 or G1bB = 8.	Support = 2+ person physical assist Support = activity did not occur	5
Locomotion	G1eA = — or G1eA = 0 or G1eA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1eA = 2.	Self-Performance = limited assistance	3

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	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

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Hygiene	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 = 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	

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	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~~

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- 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.~~

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- ~~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.~~

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- 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.~~

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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	Lie	SW	Aet
	G4aA > 0 or	Any function limits in ROM of neck				
	G4bA > 0 or	Any function limits in ROM of arm				
	G4cA > 0 or	Any function limits in ROM of hand				
	G4dA > 0 or	Any function limits in ROM of leg				
	G4eA > 0 or	Any function limits in ROM of foot				
	G4fA > 0 or	Any function limits in ROM of other limitation or loss				
	G4aB > 0 or	Any function limits in voluntary movement of neck				

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	G4bB > 0 or	Any function limits in voluntary movement of arm				
	G4cB > 0 or	Any function limits in voluntary movement of hand				
	G4dB > 0 or	Any function limits in voluntary movement of leg				
	G4eB > 0 or	Any function limits in voluntary movement of foot				
	G4fB > 0	Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3a ≤ 5	3 to 5 days of PROM rehab	10	3 RN 3 LPN		
II	6 ≤ P3a ≤ 7	6 to 7 days of PROM rehab	15	3 RN 3 LPN		

Active Range of Motion (AROM)

The following documentation shall support the following for scoring AROM.

- ~~1) The restorative program meets the definition of AROM as identified in the RAI Manual.~~
- ~~2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.~~
- ~~3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~
- ~~4) AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.~~

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Lev	MDS-items	Description	Unl	Lie	SW	Act
	G4aA > 0 or	Any function limits in ROM of neck				
	G4bA > 0 or	Any function limits in ROM of arm				
	G4cA > 0 or	Any function limits in ROM of hand				
	G4dA > 0 or	Any function limits in ROM of leg				
	G4eA > 0 or	Any function limits in ROM of foot				
	G4fA > 0 or	Any function limits in ROM of other limitation or loss				
	G4aB > 0 or	Any function limits in voluntary movement of neck				
	G4bB > 0 or	Any function limits in voluntary movement of arm				
	G4cB > 0 or	Any function limits in voluntary movement of hand				
	G4dB > 0 or	Any function limits in voluntary movement of leg				
	G4eB > 0 or	Any function limits in voluntary movement of foot				
	G4fB > 0	Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3b ≤ 5	3 to 5 days of AROM rehab	8	2 RN 2 LPN		

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H	6 ≤ P3b ≤ 7	6 to 7 days of AROM rehab	12	2 RN 2 LPN		
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~~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	Lie	SW	Act
I	3 ≤ P3e ≤ 5	3 to 5 days of assistance	8	2 RN 2 LPN		
H	6 ≤ P3e ≤ 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	Lie	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		

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				LPN		
H	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	Lie	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		
H	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	Lie	SW	Act
	0 < G1cA < 8 or	Need assistance in walking in room				

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	0 < G1dA < 8 or 0 < G1eA < 8 or 0 < G1fA < 8 AND G7 = 1	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	Lie	SW	Act
	0 < G1gA < 8 or 0 < G1jA < 8 AND	Need assistance in dressing Need assistance in personal hygiene				

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	G7=1 AND	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	Lie	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		

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H	6 ≤ P3h ≤ 7	6 to 7 days of rehab or restorative techniques	20	3 RN 3 LPN		
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Amputation/Prosthetic Care

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

Lev	MDS items	Description	Unl	Lie	SW	Act
I	3 ≤ P3i ≤ 5	3 to 5 days of assistance	10	3 RN 3 LPN		
H	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	Lie	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		

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H	6 ≤ P3j ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		
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~~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	Lie	SW	Aet
I	P3k=3 or greater AND Q2 < 2 AND B2a=0 AND B4=0 or 1 AND C6=0 or 1 AND S1=0	Other Restorative Improved or no change in care needs Short term memory okay Cognitive skills for decision making Ability to understand others Does not meet IDPH Subpart S criteria	6	5 RN 5 LPN		
II	P3k=3 or greater AND Q1c=1 or 2 AND	Other restorative Stay projected to be of a short duration—discharge expected to be within 90 days	6	7.5 RN 7.5 LPN		

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Q2 < 2	Improved or no change in care needs				
AND					
P1ar = 1	Provide training to return to the community				
AND					
B2a = 0	Short-term memory				
AND					
B4 = 0 or 1	Cognitive skills for decision making				
AND					
C6 = 0 or 1	Ability to understand others				
AND					
S1 = 0	Does not meet IDPH Subpart S criteria				

Scheduled Toileting

Documentation shall support the following for scoring scheduled toileting.

- ~~1) The program shall have documentation to support that all the requirements identified in the RAI Manual are met.~~
- ~~2) The description of the plan, including: frequency, reason, and response to the program.~~
- ~~3) The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.~~
- ~~4) This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, where there is no participation in the plan by the resident.~~
- ~~5) There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.~~
- ~~6) A resident scoring S1 = 1 (meets Subpart S criteria) shall have corresponding diagnosis of CVA or multiple sclerosis to qualify for reimbursement in scheduled toileting.~~

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Lev	MDS-items	Description	Unl	Lie	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				
	G1A > 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.

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Lev	MDS-items	Description	Unl	Lie	SW	Act
I	Catheter Care H3d = 1 AND H3a = 0	Indwelling catheter present No scheduled toileting plan	12	.5 RN .5 LPN		
II	Bladder Retraining H3b = 1 AND H3a = 0 AND H1b > 1 AND B4 = 0 or 1 OR H3b = 1 AND H3a = 0 AND H1b ≤ 1 AND H4 = 1 AND B4 = 0 or 1	Bladder retraining program No scheduled toileting plan Incontinent at least 2 or more times a week Cognitive skills for decision making Bladder retraining program No scheduled toileting plan Bladder continence Change in continence Cognitive skills in decision making	32	.5 RN .5 LPN		

Pressure Ulcer Prevention

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~~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	Aet
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				
	M5e	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.~~

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- 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	Lie	SW	Act
I		Moderate Skin Care Services	5	5 RN		

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M1a > 0 or	Stage 1 ulcers		5	
			LPN	
M1b > 0 or	Stage 2 ulcers			
Any of:	Other Skin Problems (below):			
M4b = 1	Burns			
M4e = 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	Surgical wounds			
AND				
4 of the following:	Skin Treatments (below):			
M5a = 1	Pressure relieving devices for chair			
M5b = 1	Pressure relieving devices for bed			
M5e = 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)			

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	<p>M5i = 1 OR (M6b = 1 or M6c = 1) AND M6f = 1</p>	<p>Other prevention for skin (other than feet) Infection of the foot Open lesion of the foot And application of a dressing</p>				
H	<p>M1e > 0 or M1d > 0 AND 4 of the following: M5a = 1 M5b = 1 M5c = 1 M5d = 1 M5e = 1 M5f = 1 M5g = 1 M5h = 1 M5i = 1</p>	<p>Intensive Skin Care Services Stage 3 ulcers Stage 4 ulcers Skin Treatments (below): Pressure relieving devices for chair Pressure relieving devices for bed Turning or repositioning program Nutrition or hydration intervention for skin Uleer care Surgical wound care Application of dressings (other than feet) Application of ointments (other than feet) Other prevention for skin (other than feet)</p>	<p>5</p>	<p>15 RN 15 LPN</p>		

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Ostomy Services

Lev	MDS-items	Description	Unl	Lie	SW	Act
1	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	Lie	SW	Act
1	P1ac=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	Lie	SW	Act
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I	O3-7	Number of injections in last 7 days		3 RN 3 LPN		
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Oxygen Therapy

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

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

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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	Lie	SW	Aet
I	Ha=1 AND	Diabetes mellitus		1 RN 1 LPN		
	K5e=1 or	Therapeutic diet				
	K5f=1 or	Dietary supplement				
	O3=7	Injections daily				

End Stage Care

Lev	MDS items	Description	Unl	Lie	SW	Aet
I	J5e=1	End stage disease, 6 or fewer months to live	10	6 RN 6 LPN	8	
		Restoratives including scheduled toileting and bladder retraining sets to level '0' except AROM, PROM, splint/brace. Limit of 4 quarters				

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~~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	Lie	SW	Act
I	I2a = 1 or	Antibiotic resistant infection	18	8.5 RN 8.5 LPN	1	
	I2b = 1 or	Clostridium Difficile				
	I2e = 1 or	Pneumonia				
	I2g = 1 or	Septicemia				
	I2i = 1 or	TB				
	I2j = 1 or	Urinary Tract infection present				
	I2k = 1 or	Viral hepatitis				
	I2l = 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.~~

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- ~~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	Lie	SW	Act
I	J5b=1 AND P1ae=1 AND P1ao=0 OR (J5a=1 AND P1ao=0 AND P1ae=1) OR (B5a=2 or B5b=2 or	Acute episode or flare-up of chronic condition Monitoring acute medical condition Not hospice care Condition makes resident's cognitive, ADL, mood or behavior patterns unstable Not hospice care Monitoring acute medical condition Easily distracted over last 7 days Periods of altered perceptions or awareness of surroundings over last 7 days	1	11.5 RN 11.5 LPN	1	

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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	Lie	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.~~

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~~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 S1 = 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 calorie 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.~~

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

Lev	MDS items	Description	Unl	Lie	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	

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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	Lie	SW	Act
I	H2b=1	Constipation	10	2-RN 2 LPN		1
	AND					
	K5a=0	No parenteral/IV				
	AND					
	K5b=0	No feeding tube				
	OR					

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<p>Any two of the following separate conditions: 1 ≤ 04e ≤ 7 or 11o = 1 or 13 a,b,c,d,e = 276.5 or 276.52 or 11e = 1 or 11d = 1 or 11h = 1 or 11j = 1 AND K5a = 0 AND K5b = 0</p>	<p>Received a diuretic medication in last 7 days Vomiting Volume depletion Hypovolemia Dehydrated Did not consume most fluids provided (3 days) Fever Internal bleeding Not have parenteral/IV No feeding tube</p>				
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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~~

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~~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.~~

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- 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.~~

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- ~~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	Lie	SW	Act
1	(P2a = 1 or	Behavior symptom evaluation	12	3 RN 3 LPN	8	2
	P2e = 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-e = 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				

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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(1), Unnecessary drugs (State Operations Manual F-tag F329).~~

Lev	MDS items	Description	Unl	Lie	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.~~

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- ~~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	Lie	SW	Act
I	S1=1 AND ADL Index=4 AND One or more of the following are coded M1c or M1d >0 or K5b=1 or K5a=1 or Plab=1 or J5e=1 or Plaa=1 or Plaj=1 or Plal=1 AND	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	

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	Psychiatric Services Level II, Level III, Level IV skills training, close and constant observation, dressing/grooming and other restorative, cognitive performance, dementia care unit and discharge planning reset to zero					
II	S1=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	S1=1 AND ADL Index=3 or 4 AND (AA3-A3a)/365.25 ≥ 65	Meets IDPH Subpart S criteria ADL composite score between 12-29 Resident is 65 years of age or older at time of the assessment	13	4.5 RN 4.5 LPN	20	

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	AND	reference date				
	Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero					
IV	S1=1 AND S8=0 AND Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero	Meets IDPH Subpart S criteria Ancillary provider services delivered by facility providers	16	5 RN 5 LPN	25	

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.

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- ~~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.~~

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Lev	MDS-items	Description	Unl	Lie	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	Lie	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:~~

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- 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	Lie	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

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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

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6	G1hA = 4 or 8 And Not (B4 = 0, 1, 2)	Toilet Use Self Performance = total dependence or did not occur Not have cognitive skills independent to moderately impaired
6	B4 = 3 And G1hA = 4 or 8	Cognitive skills severely impaired Eating Self Performance = total dependence or did not occur
5	B4 = 3 And G1hA = — or ≤ 3	Cognitive skills severely impaired Eating Self Performance = missing to extensive assistance
4	If IC code = 2 or 3 And SIC code = 2	Some dependence in cognitive skills Usually understood to rarely or never understood 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 period.~~
- ~~3) Activity programming is planned and provided seven days a week for an average of eight hours per day.~~
- ~~4) If the resident has a CPS score of five, care planning shall address the resident's participation in the unit's activities.~~

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- ~~5) If a particular resident does not participate in a least an average of four activities per day over a one week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.~~
- ~~6) Staff's efforts to involve the resident.~~
- ~~7) Required assessments were completed on the resident.~~

Lev	MDS items	Description	Unl	Lie	SW	Act
I	P1a=1 AND Hq=1 or Hu=1 AND S1=0 AND CPS 2,3,4,5 AND Dementia care unit is IDPH certified	Alzheimer's/Dementia special care unit Alzheimer's Disease Dementia other than Alzheimer's Does not meet IDPH Subpart S criteria CPS score	15	4 RN 4 LPN	10	10

~~7) Exceptional Care Services~~

~~Respiratory Services~~

~~Documentation shall support the following for scoring respiratory services.~~

- ~~1) A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.~~
- ~~2) Respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.~~

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- 3) ~~Physician's order for the treatments.~~
- 4) ~~Respiratory therapy in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.~~
- 5) ~~Suctioning, including type, frequency and results of suctioning.~~
- 6) ~~Trach care, including type, frequency and description of the care provided.~~

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

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

~~**Weaning From Ventilator**~~

~~Documentation shall be in place to support weaning from ventilator.~~

Lev	MDS-items	Description	Unl	Lie	SW	Aet
I	P1a1 = 0 on current MDS AND	Resident no longer on ventilator	5	15 RN 15 LPN		

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P1a1 = 1 on previous MDS	Resident previously on ventilator				
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~~**Morbid Obesity**~~

~~Documentation shall support the following for scoring morbid obesity.~~

- ~~1) A dietician's evaluation was completed with evidence of on-going consultation.~~
- ~~2) On-going monitoring of weight shall be evident.~~
- ~~3) The psychosocial needs related to weight issues shall be identified and addressed.~~

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

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P3d=7	On bed mobility restorative				
or					
P3e=7	On transfer restorative				
or					
P3f=7	On walking restorative				

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

~~Complex Wounds~~

~~Facilities shall follow documentation guidelines as directed by 42 CFR 483.25(e) (State Operations Manual F tag F314). All documentation requirements listed in F314 shall be met.~~

~~There are no minutes assigned to this area. It is strictly a \$15.00 add-on applied to residents meeting the following criteria.~~

MDS item	Description
M1c or M1d >= 0	Presence of stage 3 or 4 PU
AND	
M2a >= 0 or	Type of ulcer, pressure
M2b >= 0	Type of ulcer, stasis
AND	
B1 = 1 or	Comatose
G1Aa = 3 or 4 or	Bed mobility (extensive)
G1Ab = 3 or 4	Transfer (extensive)
AND any 3 of the follow:	
ICD-9 codes of (260, 261, 262, 263.0, 263.1, 263.2, 263.8, 263.9)	ICD-9 Malnutrition
ICD-9 585	ESRD
Ha = 1	Diabetes Mellitus
Hqq = 1	Renal Failure
Hj = 1	Peripheral vascular disease
Hx = 1	Paraplegia
Hz = 1	Quadriplegia

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Hw-1	Multiple Sclerosis
J5e-1	End-stage disease
H1a-4	Incontinence of bowel
H1b-4	Incontinence of bladder
J1e-1	Dehydration
G6a-1	Bedfast
J2a-2	Pain daily
M3-1	History of resolved ulcers
AND all of the following:	
M5a-1 and/or	Pressure relieving device/chair
M5b-1	Pressure relieving device/bed
AND	
M5c-1	Turn and position
AND	
M5d-1	Nutrition or hydration
AND	
M5e-1	Ulcer care

~~Traumatic Brain Injury~~

~~Documentation shall support the following for scoring traumatic brain injury:~~

- ~~1) Psychological therapy shall be delivered by licensed mental health professionals as described in the RAI Manual.~~
- ~~2) A special symptom evaluation program shall be an on-going, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI Manual.~~
- ~~3) Evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder or other mental health problems by a qualified clinical professional as described in the RAI Manual.~~
- ~~4) Care plan shall address the behaviors of the resident and the interventions used.~~

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

MDS item	Description
Hec = 1 AND	Traumatic brain injury
B1 = 0 AND	Not comatose
S1 = 0 AND	Does not meet Subpart S criteria
E4aA = 3 and E4 a B = 1 or	Wandering daily and alterability
E4bA = 3 and E4bB = 1 or	Verbally abusive behavioral symptoms daily and alterability
E4cA = 3 and E4cB = 1 or	Physically abusive behavioral symptoms daily and alterability
E4dA = 3 and E4dB = 1 or	Socially inappropriate/disruptive behavioral symptoms daily and alterability
E4eA = 3 and E4eB = 1 AND	Resists care daily and alterability
P1beA ≥ 1 AND	Psychological therapy
P2a = 1 AND	Special behavior symptom evaluation
P2b = 1	Evaluation by a mental health specialist in last 90 days

8) Special Patient Need Factors

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

Communication

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

Vision Problems

Count	MDS items	Description	Staff Minutes
I	D1 > 0 or	Vision impaired to Severely impaired	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	D2a = 1 or	Decreased peripheral vision	
	D2b = 1	Experience halos around lights, light flashes	

Accident/Fall Prevention

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

- 1) The resident has the risk factor identified on the MDS.
- 2) The resident has been assessed for fall risks.
- 3) If the resident is identified as high risk for falls, interventions have been identified and implemented.

Count	MDS items	Description	Staff Minutes
I	Haa = 1 or	Seizure disorder	3% of all staff time accrued in all categories from ADLs through Exceptional Care
	O4a-d = 7 or	Medications	
	H1b > 0 or	Incontinent urine	
	J1f = 1 or	Dizziness	

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J4a = 1 or	Fell in past 30 days
J4b = 1 or	Fell in past 31-180 days
J1n = 1 or	Has unsteady gait
E4aA > 0	Wandered in last 7 days

Restraint Free

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

Count	MDS items	Description	Staff Minutes
1	P4c > 1 or	In last assessment: Used trunk restraint daily in last 7 days	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	P4d > 1 or	Used limb restraint daily in last 7 days	
	P4e > 1	Used chair that prevents rising daily in last 7 days	
	And	And in current assessment:	
	P4c = 0 and	Not used trunk restraint in last 7 days	
	P4d = 0 and	Not used limb restraint in last 7 days	
	P4e = 0	Not used chair that prevents rising in last 7 days	

Activities

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

Count	MDS items	Description	Staff Minutes
1	N2 = 0 or 1 AND Any of the following checked:	Average time involved in activities	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	G6a = 1 or	Bedfast all or most of the time	
	C4 > 1 or	Sometimes too rarely understood	
	C6 > 1 or	Sometimes too rarely understands others	
	E1e > 0 or	Withdrawal from activity	
	AA3 ≤ 50 or	Age is 50 or younger at assessment reference date	
	E1p > 0 or	Reduced social interactions	
	E4a-eA > 0 or	Any behavioral symptoms	
	G4b-dB > 0 OR	Any limited ROM	
	N2 = 0 or 1 AND	Average time involved in activities	

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E2 > 0 AND	Mood persistence	
E1a > 0 or	Negative statements	
E1n > 0 or	Repetitive physical movements	
E4eA > 0 or	Resists care	
E1o > 0 or	Withdraws from activity	
E1p > 0 or	Reduced social interaction	
E1j > 0 or	Unpleasant mood in morning	
N1d = 1 or	Not awake all or most of the time	
E1g > 0 or	Statements that something terrible will happen	
K3a = 1 or	Weight loss	
(N1a,b,c ≤ 1 AND	Not awake all or most of the time	
B1 = 0)	Not comatose	

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

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**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	Hygiene 1	8	1		1	3
G1=3	Hygiene 2	12	1		1	3
G1b=3 or G1c=3	Mobility 1	12		1	1	1
G1b=4 or G1b=5 or G1c=4 or G1c=5	Mobility 2	17		1	1	1
G1d=2	Toilet 1	10	1		1.5	1
G1d=3	Toilet 2	14	1	1	1	1
G1e=2	Eating 1	10	1			2
G1e=3	Eating 2	16	1	1	1	1
G1f=2	Bathing 1	10	2			3
G1f=3	Bathing 2	14	1	1	1	2
H1=2 or H1=3	Hearing 1	3			1	3
H2=2	Vision 1	3			1	3
H2=3 or H2=4	Vision 2	3	1		1	3

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H3=2 or H3=3	Expression 1	6	2			4
H3=4	Expression 2	8	2			7
H4=2 or H4=3	Understanding 1	6	2			4
H4=4	Understanding 2	8	2			7
ICD-9=250 to 250.9	Diabetes 1	8		2	4	2
N2a=1 or N2b=1 or N2e=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 L2e=1	Nursing Interventions 1	2		0.5	0.5	
L2a=2 or L2b=2 or L2e=2	Nursing Interventions 2	2.5	1	0.5	0.5	1
L2a=3 or L2b=3 or L2e=3	Nursing Interventions 3	3.5	1	1.5	1.5	1
L2a=4 or L2b=4 or L2e=4	Nursing Interventions 4	4.5	1	1.5	1.5	2
L2a=5 or L2b=5 or L2e=5	Nursing Interventions 5	5.5	1	2	2	2
L2a=6 or L2b=6 or L2e=6	Nursing Interventions 6	6	2	2	2	2
L2a=7 or L2b=7 or L2e=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

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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		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	Violence 1	2				2
D2a=2	Violence 2	3	2			5
D2a=3 or D2a=4	Violence 3	10	5	1	2	10
D2b=1	Intimidation Threats to Others 1	2				2
D2b=2	Intimidation Threats to Others 2	3	2			5
D2b=3 or D2b=4	Intimidation Threats to Others 3	10	5			10
D2e=2	Violent Ideation 1	2				1
D2e=3 or D2e=4	Violent Ideation 2	4	2			7
K2b=1	Medication Support 1	6	1	1	1	5
K5>0	Acute Control	2	1	2	2	5

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	Medications-1					
M3a>0	Required Staff Accompaniment	5				2
A5a=1 or 2	Hx-Crim-Justice Viol-1		2			3
A5a=3 or 4	Hx-Crim-Justice Viol-2		4			5
A5b=1 or 2	Hx-Crim-Justice Nonviol-1		1			2
A5b=3 or 4	Hx-Crim-Justice Nonviol-2		2			4
M2a>0 or M2b>0	Close or Constant Observation-1	15	5			5
M2c>0 or M2d>0 or M2e>0	Close or Constant Observation-2	30	10			10
P3≤5 and L4a>1	Discharge Planning-1		10			25
L1i≥3	PRS-Director or Coordinator Counseling					5
L3a or L3b=2 or 3 and L4aA=2 or 3 and P3<5	Community Reintegration	3	3			5
L3b=2 or 3 and L4bA=2 or 3	Social/Family Functioning	3	3			12
L3b or L3d+2 or 3 and L4cA=2 or 3	Psych-Rehab/Recover-Readiness and Support	3	4			15
L3b=2 or 3 and L4dA=2 or 3	Skills-Training and Generalization	5	5			20

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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 D2e=3 or E1e>1	Aggression/Anger Management		5			15
L3a or L3b=2 or 3 and L4hA=2 and E1b or E1d or E1e>0	Behavior Management	2	3			13
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 L4lA=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	10				

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	mandated by the outside medical provider					
Psychotropic Medications as Listed in Section R	Psychotropic Medication Monitoring	7		8	8	

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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 _____)

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- 1) Heading of the Part: Hospital Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 152
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
152.150	Amendment
152.200	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete Description of the Subjects and Issues Involved: The proposed amendment eliminates additional reimbursement for long term acute care hospitals. There will be an annual savings of \$30 million with implementation of the rule. In addition, the proposed amendment gives the Department the flexibility to reduce hospital inpatient or outpatient reimbursement rates to the extent necessary to meet federal upper payment limitation requirements.
- 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
- 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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded long term acute care hospitals
 - 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: January 2012

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

PART 152

HOSPITAL REIMBURSEMENT CHANGES

Section

152.100	Reimbursement Add-on Adjustments (Repealed)
152.150	Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
152.200	Non-DRG Reimbursement Methodologies
152.250	Appeals (Repealed)

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Sections 12-13 and 14-8 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and Sections 12-13 and 14-8].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2150, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10141, effective June 17, 1994; emergency amendment at 19 Ill. Reg. 6706, effective May 12, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10236, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16272, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9272, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15712, effective November 27, 1996; emergency amendment at 21 Ill. Reg. 9544, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16153, effective November 26, 1997; emergency amendment at 25 Ill. Reg. 218, effective January 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6966, effective May 28, 2001; emergency amendment at 25 Ill. Reg. 16122, effective December 3, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 7309, effective April 29, 2002; emergency amendment at 29 Ill. Reg. 10299, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19997, effective November 23, 2005; emergency amendment at 30 Ill. Reg. 11847, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18703, effective November 27, 2006; emergency amendment at 32 Ill. Reg. 529, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8730, effective May 29, 2008; amended at 35 Ill. Reg. 10114, effective June 15, 2011; amended at 36 Ill. Reg. _____, effective _____.

Section 152.150 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

- a) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 149, the changes

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described in subsections (b) and (c) of this Section will be effective January 18, 1994.

- b) For the rate periods, as described in 89 Ill. Adm. Code 148.25(g)(2)(B), the DRG weighting factors shall be adjusted by a factor, the numerator of which is the statewide weighted average DRG base payment rate in effect for the base period, as described in 89 Ill. Adm. Code 148.25(g)(2)(A), and the denominator of which is the statewide weighted average DRG base payment rate for the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(B). For this adjustment, DRG base payment rate means the product of the PPS base rate, as described in 89 Ill. Adm. Code 149.100(c)(3), and the indirect medical education factor, as described in 89 Ill. Adm. Code 149.150(c)(3).
- c) All payments calculated under 89 Ill. Adm. Code 149.140 and 149.150(c)(1), (c)(2) and (c)(4), in effect on January 18, 1994, shall remain in effect hereafter.
- d) For hospital inpatient services rendered on or after July 1, 1995, the Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated pursuant to the methodology described in this Section, that were in effect on June 30, 1995, less the portion of such rates attributed by the Department to the cost of medical education.
- e) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 149 (DRG PPS), the changes described in this subsection (e) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 149.105 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).
- f) Notwithstanding the provisions of 89 Ill. Adm. Code 149, payment for outlier cases pursuant to 89 Ill. Adm. Code 149.105 shall be determined by using the following factors that were in effect on June 30, 1995:
 - 1) The marginal cost factor (see 89 Ill. Adm. Code 149.5(c)(4)),
 - 2) The Metropolitan Statistical Area (MSA) wage index (see 89 Ill. Adm.

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Code 148.120(b)),

- 3) The Indirect Medical Education (IME) factor (see 89 Ill. Adm. Code 148.260(a)(1)(B)(iv)),
- 4) The cost to charge ratio (see 89 Ill. Adm. Code 149.105(c)(3)), and
- 5) Outlier Threshold
 - A) For admissions on December 3, 2001 through June 30, 2005, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.22.
 - B) For admissions on or after July 1, 2005 through June 30, 2006, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.40.
 - C) For admissions on or after July 1, 2006 through December 31, 2007, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.47.
 - D) For admissions on or after January 1, 2008, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.64.
 - E) For admissions on or after January 1, 2011, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.99.

g) Notwithstanding any other provisions set forth in 89 Ill. Adm. Code 149 (DRG PPS) and subsections (a) through (f) of this Section, total inpatient and outpatient payments may be reduced by the Department to the extent necessary to comply with Illinois Medicaid upper limits approved by the federal Department of Health and Human Services Centers for Medicare and Medicaid Services.

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

Section 152.200 Non-DRG Reimbursement Methodologies

- a) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148, the changes described in subsection (b) of this Section will be effective January 18, 1994.

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- b) All per diem payments calculated under 89 Ill. Adm. Code 148, except for those described in 89 Ill. Adm. Code 148.120, 148.160, 148.170, 148.175 and 148.290(a), (c) and (d), in effect on January 18, 1994, less the portion of such rates attributed by the Department to the cost of medical education, shall remain in effect hereafter.
- c) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 148, Hospital Services, and 89 Ill. Adm. Code 146, Subpart A, Ambulatory Surgical Treatment Centers, the changes described in this subsection (c) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 148.130 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).
- d) Notwithstanding the provisions of subsections (a), (b) and (c) of this Section, payment for outlier adjustments provided for exceptionally costly stays pursuant to 89 Ill. Adm. Code 148.130 shall be determined using the following factors:
- 1) For admissions on December 3, 2001 through June 30, 2005, a factor of 0.22 in place of the factor 0.25 described at 89 Ill. Adm. Code 148.130(b)(3)(D).
 - 2) For admissions on or after July 1, 2005 through June 30, 2006, a factor of 0.20 in place of the factor 0.22 as described in subsection (d)(1) of this Section.
 - 3) For admissions on or after July 1, 2006 through December 31, 2007, a factor of 0.18 in place of the factor 0.20 as described in subsection (d)(2) of this Section.
 - 4) For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described in subsection (d)(3) of this Section.

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- e) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148 or any other provisions of this Section, long term acute care hospitals that previously received reimbursement rates as defined in law shall not receive those add-on payments for dates of service on or after July 1, 2012.
- f) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148 or any other provisions of this Section, total inpatient and outpatient payments may be reduced by the Department to the extent necessary to comply with Illinois Medicaid upper payment limits approved by the federal Department of Health and Human Services Centers for Medicare and Medicaid Services.

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

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- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.126 Proposed Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and PA 96-1530
- 5) Complete Description of the Subjects and Issues Involved: Pending adoption of the FY 2013 Budget, the Department must meet federal public notice requirements regarding any modifications of Medicaid rate methodologies for institutional providers. Thus the Department is proposing amendments that reduce the 11% to 4% rate of return on capital investments for nursing facilities for an annual reduction of \$71 million, eliminating a \$10 add-on payment for clients with developmental disabilities for a savings of \$472 thousand, and removing the nurses aid training component from ICF/DDs but adding a standard amount to individual providers in order to reduce administrative costs.
- 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
- 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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

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: 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: January 2012

The text of the Proposed Amendment is on the next page.

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TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

PART 153

LONG TERM CARE REIMBURSEMENT CHANGES

Section

153.100	Reimbursement for Long Term Care Services
153.125	Long Term Care Facility Rate Adjustments
153.126	Long Term Care Facility Medicaid Per Diem Adjustments
153.150	Quality Assurance Review (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 and VI and 12-13].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2159, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10154, effective June 17, 1994; emergency amendment at 18 Ill. Reg. 11380, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16669, effective November 1, 1994; emergency amendment at 19 Ill. Reg. 10245, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16281, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9306, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14840, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 9568, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13633, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 13114, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16285, effective August 28, 1998; amended at 22 Ill. Reg. 19872, effective October 30, 1998; emergency amendment at 23 Ill. Reg. 8229, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12794, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13638, effective November 1, 1999; emergency amendment at 24 Ill. Reg. 10421, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15071, effective October 1, 2000; emergency amendment at 25 Ill. Reg. 8867, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 14952, effective November 1, 2001; emergency amendment at 26 Ill. Reg. 6003, effective April 11, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 12791, effective August 9, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11087, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17817, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 11088, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18880, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 10218,

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effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15584, effective November 24, 2004; emergency amendment at 29 Ill. Reg. 1026, effective January 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 4740, effective March 18, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 6979, effective May 1, 2005; amended at 29 Ill. Reg. 12452, effective August 1, 2005; emergency amendment at 30 Ill. Reg. 616, effective January 1, 2006, for a maximum of 150 days; emergency amendment modified pursuant to the Joint Committee on Administrative Rules Objection at 30 Ill. Reg. 7817, effective April 7, 2006, for the remainder of the maximum 150 days; amended at 30 Ill. Reg. 10417, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11853, effective July 1, 2006, for a maximum of 150 days; emergency expired November 27, 2006; amended at 30 Ill. Reg. 14315, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 18779, effective November 28, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 6954, effective April 26, 2007; emergency amendment at 32 Ill. Reg. 535, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 4105, effective March 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 7761, effective May 5, 2008; amended at 32 Ill. Reg. 9972, effective June 27, 2008; amended at 33 Ill. Reg. 9347, effective July 1, 2009; emergency amendment at 34 Ill. Reg. 17462, effective November 1, 2010, for a maximum of 150 days; amended at 35 Ill. Reg. 6171, effective March 28, 2011; amended at 35 Ill. Reg. 19524, effective December 1, 2011; amended at 36 Ill. Reg. _____, effective _____.

Section 153.126 Long Term Care Facility Medicaid Per Diem Adjustments

- a) Notwithstanding the provisions set forth in Section 153.100, the socio-development component for facilities that are federally defined as Institutions for Mental Disease (see 89 Ill. Adm. Code 145.30) shall be increased by 253 percent beginning with services provided on and after March 1, 2008.
- b) Notwithstanding the provisions set forth in Section 153.100, daily residential rates effective on March 1, 2008, for intermediate care facilities for persons with developmental disabilities (ICF/DD), including skilled nursing facilities for persons under 22 years of age (SNF/Ped), for which a patient contribution is required, shall be increased by 2.2 percent.
- c) Notwithstanding the provisions set forth in Section 153.100, developmental training rates effective on March 1, 2008 shall be increased by 2.5 percent.
- d) Notwithstanding the provisions set forth in Section 153.100, effective July 1, 2012, developmental training rates for ICF/DD, including SNF/Ped, shall be increased by \$1.00 per billable day, per resident for staff training reimbursement.

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- e) Notwithstanding the provisions set forth in Section 153.100, developmental training rates for ICF/DD, including SNF/Ped, effective July 1, 2012, shall be increased by \$3.81 per month, per resident for staff training reimbursement.
- f) Notwithstanding the provisions set forth in Sections 153.100, 153.125 and 153.126, for dates of service provided on or after July 1, 2012, the nursing component for SNF/ICF shall be reimbursed through RUGs methodology described in 89 Ill. Adm. Code 147.
- g) Notwithstanding the provisions set forth in Sections 153.100, 153.125 and 153.126, for dates of service provided on or after July 1, 2012, the \$10 per day per individual payment for individuals with developmental disabilities in nursing facilities as described in 89 Ill. Adm. Code 147.350 shall be eliminated.
- h) Notwithstanding the provisions set forth in Sections 153.100, 153.125 and 153.126, effective July 1, 2012, the return on capital investment shall be 4% as described in 89 Ill. Adm. Code 140.570 and 144.325.

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

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- 1) Heading of the Part: Retailers' Occupation Tax
- 2) Code Citation: 86 Ill. Adm. Code 130
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
130.410	Amendment
130.415	Amendment
- 4) Statutory Authority: 20 ILCS 2505/2505-90
- 5) A Complete Description of the Subjects and Issues Involved: Section 130.410, Cost of Doing Business Not Deductible, is amended to provide that beginning October 1, 2012, shipping and handling costs are part of a retailer's costs of doing business, and may never be deducted from a retailer's taxable gross receipts, regardless of whether such charges are separately agreed upon or separately stated on the invoice to the customer.

Section 130.415, Transportation and Delivery Charges, is amended to provide that the current provisions regarding when transportation and delivery charges are taxable will continue through September 30, 2012, and the new provisions of Section 130.410 will begin October 1, 2012.
- 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
- 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 Objective: This rulemaking does not create a State mandate, nor does it modify any existing State mandates.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rulemaking may submit them in writing by no later than 45 days after publication of this Notice to:

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Debra M. Boggess
Associate Counsel, Sales & Excise Taxes
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794

217/782-2844

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Businesses that charge its customers outgoing transportation and delivery costs on sales to those customers.
 - 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: January 2012

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

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TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUEPART 130
RETAILERS' OCCUPATION TAX

SUBPART A: NATURE OF TAX

Section	
130.101	Character and Rate of Tax
130.105	Responsibility of Trustees, Receivers, Executors or Administrators
130.110	Occasional Sales
130.111	Sale of Used Motor Vehicles, Aircraft, or Watercraft by Leasing or Rental Business
130.115	Habitual Sales
130.120	Nontaxable Transactions

SUBPART B: SALE AT RETAIL

Section	
130.201	The Test of a Sale at Retail
130.205	Sales for Transfer Incident to Service
130.210	Sales of Tangible Personal Property to Purchasers for Resale
130.215	Further Illustrations of Sales for Use or Consumption Versus Sales for Resale
130.220	Sales to Lessors of Tangible Personal Property
130.225	Drop Shipments

SUBPART C: CERTAIN STATUTORY EXEMPTIONS

Section	
130.305	Farm Machinery and Equipment
130.310	Food, Soft Drinks and Candy
130.311	Drugs, Medicines, Medical Appliances and Grooming and Hygiene Products
130.315	Fuel Sold for Use in Vessels on Rivers Bordering Illinois
130.320	Gasohol, Majority Blended Ethanol, Biodiesel Blends, and 100% Biodiesel
130.321	Fuel Used by Air Common Carriers in International Flights
130.325	Graphic Arts Machinery and Equipment Exemption
130.330	Manufacturing Machinery and Equipment
130.331	Manufacturer's Purchase Credit
130.332	Automatic Vending Machines

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- 130.335 Pollution Control Facilities and Low Sulfur Dioxide Emission Coal-Fueled Devices
- 130.340 Rolling Stock
- 130.341 Commercial Distribution Fee Sales Tax Exemption
- 130.345 Oil Field Exploration, Drilling and Production Equipment
- 130.350 Coal Exploration, Mining, Off Highway Hauling, Processing, Maintenance and Reclamation Equipment
- 130.351 Aggregate Manufacturing

SUBPART D: GROSS RECEIPTS

Section

- 130.401 Meaning of Gross Receipts
- 130.405 How to Avoid Paying Tax on State or Local Tax Passed on to the Purchaser
- 130.410 Cost of Doing Business Not Deductible
- 130.415 Transportation and Delivery Charges
- 130.420 Finance or Interest Charges – Penalties – Discounts
- 130.425 Traded-In Property
- 130.430 Deposit or Prepayment on Purchase Price
- 130.435 State and Local Taxes Other Than Retailers' Occupation Tax
- 130.440 Penalties
- 130.445 Federal Taxes
- 130.450 Installation, Alteration and Special Service Charges
- 130.455 Motor Vehicle Leasing and Trade-In Allowances

SUBPART E: RETURNS

Section

- 130.501 Monthly Tax Returns – When Due – Contents
- 130.502 Quarterly Tax Returns
- 130.505 Returns and How to Prepare
- 130.510 Annual Tax Returns
- 130.515 First Return
- 130.520 Final Returns When Business is Discontinued
- 130.525 Who May Sign Returns
- 130.530 Returns Covering More Than One Location Under Same Registration – Separate Returns for Separately Registered Locations
- 130.535 Payment of the Tax, Including Quarter Monthly Payments in Certain Instances
- 130.540 Returns on a Transaction by Transaction Basis

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130.545	Registrants Must File a Return for Every Return Period
130.550	Filing of Returns for Retailers by Suppliers Under Certain Circumstances
130.551	Prepayment of Retailers' Occupation Tax on Motor Fuel
130.552	Alcoholic Liquor Reporting
130.555	Vending Machine Information Returns
130.560	Verification of Returns

SUBPART F: INTERSTATE COMMERCE

Section	
130.601	Preliminary Comments
130.605	Sales of Property Originating in Illinois
130.610	Sales of Property Originating in Other States

SUBPART G: CERTIFICATE OF REGISTRATION

Section	
130.701	General Information on Obtaining a Certificate of Registration
130.705	Procedure in Disputed Cases Involving Financial Responsibility Requirements
130.710	Procedure When Security Must be Forfeited
130.715	Sub-Certificates of Registration
130.720	Separate Registrations for Different Places of Business of Same Taxpayer Under Some Circumstances
130.725	Display
130.730	Replacement of Certificate
130.735	Certificate Not Transferable
130.740	Certificate Required For Mobile Vending Units
130.745	Revocation of Certificate

SUBPART H: BOOKS AND RECORDS

Section	
130.801	General Requirements
130.805	What Records Constitute Minimum Requirement
130.810	Records Required to Support Deductions
130.815	Preservation and Retention of Records
130.820	Preservation of Books During Pendency of Assessment Proceedings
130.825	Department Authorization to Destroy Records Sooner Than Would Otherwise be Permissible

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SUBPART I: PENALTIES AND INTEREST

- Section
130.901 Civil Penalties
130.905 Interest
130.910 Criminal Penalties

SUBPART J: BINDING OPINIONS

- Section
130.1001 When Opinions from the Department are Binding

SUBPART K: SELLERS LOCATED ON, OR SHIPPING TO, FEDERAL AREAS

- Section
130.1101 Definition of Federal Area
130.1105 When Deliveries on Federal Areas Are Taxable
130.1110 No Distinction Between Deliveries on Federal Areas and Illinois Deliveries Outside Federal Areas

SUBPART L: TIMELY MAILING TREATED AS TIMELY FILING AND PAYING

- Section
130.1201 General Information
130.1205 Due Date that Falls on Saturday, Sunday or a Holiday

SUBPART M: LEASED PORTIONS OF LESSOR'S BUSINESS SPACE

- Section
130.1301 When Lessee of Premises Must File Return for Leased Department
130.1305 When Lessor of Premises Should File Return for Business Operated on Leased Premises
130.1310 Meaning of "Lessor" and "Lessee" in this Regulation

SUBPART N: SALES FOR RESALE

- Section
130.1401 Seller's Responsibility to Determine the Character of the Sale at the Time of the

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- Sale
- 130.1405 Seller's Responsibility to Obtain Certificates of Resale and Requirements for Certificates of Resale
- 130.1410 Requirements for Certificates of Resale (Repealed)
- 130.1415 Resale Number – When Required and How Obtained
- 130.1420 Blanket Certificate of Resale (Repealed)

SUBPART O: CLAIMS TO RECOVER ERRONEOUSLY PAID TAX

Section

- 130.1501 Claims for Credit – Limitations – Procedure
- 130.1505 Disposition of Credit Memoranda by Holders Thereof
- 130.1510 Refunds
- 130.1515 Interest

SUBPART P: PROCEDURE TO BE FOLLOWED UPON
SELLING OUT OR DISCONTINUING BUSINESS

Section

- 130.1601 When Returns are Required After a Business is Discontinued
- 130.1605 When Returns Are Not Required After Discontinuation of a Business
- 130.1610 Cross Reference to Bulk Sales Regulation

SUBPART Q: NOTICE OF SALES OF GOODS IN BULK

Section

- 130.1701 Bulk Sales: Notices of Sales of Business Assets

SUBPART R: POWER OF ATTORNEY

Section

- 130.1801 When Powers of Attorney May be Given
- 130.1805 Filing of Power of Attorney With Department
- 130.1810 Filing of Papers by Agent Under Power of Attorney

SUBPART S: SPECIFIC APPLICATIONS

Section

- 130.1901 Addition Agents to Plating Baths

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- 130.1905 Agricultural Producers
- 130.1910 Antiques, Curios, Art Work, Collectors' Coins, Collectors' Postage Stamps and Like Articles
- 130.1915 Auctioneers and Agents
- 130.1920 Barbers and Beauty Shop Operators
- 130.1925 Blacksmiths
- 130.1930 Chiropodists, Osteopaths and Chiropractors
- 130.1934 Community Water Supply
- 130.1935 Computer Software
- 130.1940 Construction Contractors and Real Estate Developers
- 130.1945 Co-operative Associations
- 130.1950 Dentists
- 130.1951 Enterprise Zones
- 130.1952 Sales of Building Materials to a High Impact Business
- 130.1953 Sales of Building Materials to be Incorporated into a Redevelopment Project Area within an Intermodal Terminal Facility Area
- 130.1954 River Edge Redevelopment Zones
- 130.1955 Farm Chemicals
- 130.1960 Finance Companies and Other Lending Agencies – Installment Contracts – Bad Debts
- 130.1965 Florists and Nurserymen
- 130.1970 Hatcheries
- 130.1971 Sellers of Pets and the Like
- 130.1975 Operators of Games of Chance and Their Suppliers
- 130.1980 Optometrists and Opticians
- 130.1985 Pawnbrokers
- 130.1990 Peddlers, Hawkers and Itinerant Vendors
- 130.1995 Personalizing Tangible Personal Property
- 130.2000 Persons Engaged in the Printing, Graphic Arts or Related Occupations, and Their Suppliers
- 130.2004 Sales to Nonprofit Arts or Cultural Organizations
- 130.2005 Persons Engaged in Nonprofit Service Enterprises and in Similar Enterprises Operated As Businesses, and Suppliers of Such Persons
- 130.2006 Sales by Teacher-Sponsored Student Organizations
- 130.2007 Exemption Identification Numbers
- 130.2008 Sales by Nonprofit Service Enterprises
- 130.2009 Personal Property Purchased Through Certain Fundraising Events for the Benefit of Certain Schools
- 130.2010 Persons Who Rent or Lease the Use of Tangible Personal Property to Others

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- 130.2011 Sales to Persons Who Lease Tangible Personal Property to Exempt Hospitals
- 130.2012 Sales to Persons Who Lease Tangible Personal Property to Governmental Bodies
- 130.2013 Persons in the Business of Both Renting and Selling Tangible Personal Property – Tax Liabilities, Credit
- 130.2015 Persons Who Repair or Otherwise Service Tangible Personal Property
- 130.2020 Physicians and Surgeons
- 130.2025 Picture-Framers
- 130.2030 Public Amusement Places
- 130.2035 Registered Pharmacists and Druggists
- 130.2040 Retailers of Clothing
- 130.2045 Retailers on Premises of the Illinois State Fair, County Fairs, Art Shows, Flea Markets and the Like
- 130.2050 Sales and Gifts By Employers to Employees
- 130.2055 Sales by Governmental Bodies
- 130.2060 Sales of Alcoholic Beverages, Motor Fuel and Tobacco Products
- 130.2065 Sales of Automobiles for Use In Demonstration (Repealed)
- 130.2070 Sales of Containers, Wrapping and Packing Materials and Related Products
- 130.2075 Sales To Construction Contractors, Real Estate Developers and Speculative Builders
- 130.2076 Sales to Purchasers Performing Contracts with Governmental Bodies
- 130.2080 Sales to Governmental Bodies, Foreign Diplomats and Consular Personnel
- 130.2085 Sales to or by Banks, Savings and Loan Associations and Credit Unions
- 130.2090 Sales to Railroad Companies
- 130.2095 Sellers of Gasohol, Coal, Coke, Fuel Oil and Other Combustibles
- 130.2100 Sellers of Feeds and Breeding Livestock
- 130.2101 Sellers of Floor Coverings
- 130.2105 Sellers of Newspapers, Magazines, Books, Sheet Music and Musical Recordings, and Their Suppliers; Transfer of Data Downloaded Electronically
- 130.2110 Sellers of Seeds and Fertilizer
- 130.2115 Sellers of Machinery, Tools and Special Order Items
- 130.2120 Suppliers of Persons Engaged in Service Occupations and Professions
- 130.2125 Trading Stamps, Discount Coupons, Automobile Rebates and Dealer Incentives
- 130.2130 Undertakers and Funeral Directors
- 130.2135 Vending Machines
- 130.2140 Vendors of Curtains, Slip Covers and Other Similar Items Made to Order
- 130.2145 Vendors of Meals
- 130.2150 Vendors of Memorial Stones and Monuments
- 130.2155 Tax Liability of Sign Vendors
- 130.2156 Vendors of Steam

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- 130.2160 Vendors of Tangible Personal Property Employed for Premiums, Advertising,
Prizes, Etc.
130.2165 Veterinarians
130.2170 Warehousemen

SUBPART T: DIRECT PAYMENT PROGRAM

Section

- 130.2500 Direct Payment Program
130.2505 Qualifying Transactions, Non-transferability of Permit
130.2510 Permit Holder's Payment of Tax
130.2515 Application for Permit
130.2520 Qualification Process and Requirements
130.2525 Application Review
130.2530 Recordkeeping Requirements
130.2535 Revocation and Withdrawal
- 130.ILLUSTRATION A Examples of Tax Exemption Card
130.ILLUSTRATION B Example of Notice of Revocation of Certificate of Registration
130.ILLUSTRATION C Food Flow Chart

AUTHORITY: Implementing the Illinois Retailers' Occupation Tax Act [35 ILCS 120] and authorized by Section 2505-25 of the Civil Administrative Code of Illinois [20 ILCS 2505/2505-25].

SOURCE: Adopted July 1, 1933; amended at 2 Ill. Reg. 50, p. 71, effective December 10, 1978; amended at 3 Ill. Reg. 12, p. 4, effective March 19, 1979; amended at 3 Ill. Reg. 13, pp. 93 and 95, effective March 25, 1979; amended at 3 Ill. Reg. 23, p. 164, effective June 3, 1979; amended at 3 Ill. Reg. 25, p. 229, effective June 17, 1979; amended at 3 Ill. Reg. 44, p. 193, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 52, effective November 2, 1979; amended at 4 Ill. Reg. 24, pp. 520, 539, 564 and 571, effective June 1, 1980; amended at 5 Ill. Reg. 818, effective January 2, 1981; amended at 5 Ill. Reg. 3014, effective March 11, 1981; amended at 5 Ill. Reg. 12782, effective November 2, 1981; amended at 6 Ill. Reg. 2860, effective March 3, 1982; amended at 6 Ill. Reg. 6780, effective May 24, 1982; codified at 6 Ill. Reg. 8229; recodified at 6 Ill. Reg. 8999; amended at 6 Ill. Reg. 15225, effective December 3, 1982; amended at 7 Ill. Reg. 7990, effective June 15, 1983; amended at 8 Ill. Reg. 5319, effective April 11, 1984; amended at 8 Ill. Reg. 19062, effective September 26, 1984; amended at 10 Ill. Reg. 1937, effective January 10, 1986; amended at 10 Ill. Reg. 12067, effective July 1, 1986; amended at 10 Ill. Reg. 19538, effective November 5, 1986; amended at 10 Ill. Reg. 19772, effective

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November 5, 1986; amended at 11 Ill. Reg. 4325, effective March 2, 1987; amended at 11 Ill. Reg. 6252, effective March 20, 1987; amended at 11 Ill. Reg. 18284, effective October 27, 1987; amended at 11 Ill. Reg. 18767, effective October 28, 1987; amended at 11 Ill. Reg. 19138, effective October 29, 1987; amended at 11 Ill. Reg. 19696, effective November 23, 1987; amended at 12 Ill. Reg. 5652, effective March 15, 1988; emergency amendment at 12 Ill. Reg. 14401, effective September 1, 1988, for a maximum of 150 days, modified in response to an objection of the Joint Committee on Administrative Rules at 12 Ill. Reg. 19531, effective November 4, 1988, not to exceed the 150 day time limit of the original rulemaking; emergency expired January 29, 1989; amended at 13 Ill. Reg. 11824, effective June 29, 1989; amended at 14 Ill. Reg. 241, effective December 21, 1989; amended at 14 Ill. Reg. 872, effective January 1, 1990; amended at 14 Ill. Reg. 15463, effective September 10, 1990; amended at 14 Ill. Reg. 16028, effective September 18, 1990; amended at 15 Ill. Reg. 6621, effective April 17, 1991; amended at 15 Ill. Reg. 13542, effective August 30, 1991; amended at 15 Ill. Reg. 15757, effective October 15, 1991; amended at 16 Ill. Reg. 1642, effective January 13, 1992; amended at 17 Ill. Reg. 860, effective January 11, 1993; amended at 17 Ill. Reg. 18142, effective October 4, 1993; amended at 17 Ill. Reg. 19651, effective November 2, 1993; amended at 18 Ill. Reg. 1537, effective January 13, 1994; amended at 18 Ill. Reg. 16866, effective November 7, 1994; amended at 19 Ill. Reg. 13446, effective September 12, 1995; amended at 19 Ill. Reg. 13568, effective September 11, 1995; amended at 19 Ill. Reg. 13968, effective September 18, 1995; amended at 20 Ill. Reg. 4428, effective March 4, 1996; amended at 20 Ill. Reg. 5366, effective March 26, 1996; amended at 20 Ill. Reg. 6991, effective May 7, 1996; amended at 20 Ill. Reg. 9116, effective July 2, 1996; amended at 20 Ill. Reg. 15753, effective December 2, 1996; expedited correction at 21 Ill. Reg. 4052, effective December 2, 1996; amended at 20 Ill. Reg. 16200, effective December 16, 1996; amended at 21 Ill. Reg. 12211, effective August 26, 1997; amended at 22 Ill. Reg. 3097, effective January 27, 1998; amended at 22 Ill. Reg. 11874, effective June 29, 1998; amended at 22 Ill. Reg. 19919, effective October 28, 1998; amended at 22 Ill. Reg. 21642, effective November 25, 1998; amended at 23 Ill. Reg. 9526, effective July 29, 1999; amended at 23 Ill. Reg. 9898, effective August 9, 1999; amended at 24 Ill. Reg. 10713, effective July 7, 2000; emergency amendment at 24 Ill. Reg. 11313, effective July 12, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15104, effective October 2, 2000; amended at 24 Ill. Reg. 18376, effective December 1, 2000; amended at 25 Ill. Reg. 941, effective January 8, 2001; emergency amendment at 25 Ill. Reg. 1792, effective January 16, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 4674, effective March 15, 2001; amended at 25 Ill. Reg. 4950, effective March 19, 2001; amended at 25 Ill. Reg. 5398, effective April 2, 2001; amended at 25 Ill. Reg. 6515, effective May 3, 2001; expedited correction at 25 Ill. Reg. 15681, effective May 3, 2001; amended at 25 Ill. Reg. 6713, effective May 9, 2001; amended at 25 Ill. Reg. 7264, effective May 25, 2001; amended at 25 Ill. Reg. 10917, effective August 13, 2001; amended at 25 Ill. Reg. 12841, effective October 1, 2001; amended at 26 Ill. Reg. 958, effective January 15, 2002; amended at 26 Ill. Reg. 1303, effective January 17, 2002; amended at 26 Ill. Reg. 3196,

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effective February 13, 2002; amended at 26 Ill. Reg. 5369, effective April 1, 2002; amended at 26 Ill. Reg. 5946, effective April 15, 2002; amended at 26 Ill. Reg. 8423, effective May 24, 2002; amended at 26 Ill. Reg. 9885, effective June 24, 2002; amended at 27 Ill. Reg. 795, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 11099, effective July 7, 2003, for a maximum of 150 days; emergency expired December 3, 2003; amended at 27 Ill. Reg. 17216, effective November 3, 2003; emergency amendment at 27 Ill. Reg. 18911, effective November 26, 2003, for a maximum of 150 days; emergency expired April 23, 2004; amended at 28 Ill. Reg. 9121, effective June 18, 2004; amended at 28 Ill. Reg. 11268, effective July 21, 2004; emergency amendment at 28 Ill. Reg. 15193, effective November 3, 2004, for a maximum of 150 days; emergency expired April 1, 2005; amended at 29 Ill. Reg. 7004, effective April 26, 2005; amended at 31 Ill. Reg. 3574, effective February 16, 2007; amended at 31 Ill. Reg. 5621, effective March 23, 2007; amended at 31 Ill. Reg. 13004, effective August 21, 2007; amended at 31 Ill. Reg. 14091, effective September 21, 2007; amended at 32 Ill. Reg. 4226, effective March 6, 2008; emergency amendment at 32 Ill. Reg. 8785, effective May 29, 2008, for a maximum of 150 days; emergency expired October 25, 2008; amended at 32 Ill. Reg. 10207, effective June 24, 2008; amended at 32 Ill. Reg. 17228, effective October 15, 2008; amended at 32 Ill. Reg. 17519, effective October 24, 2008; amended at 32 Ill. Reg. 19128, effective December 1, 2008; amended at 33 Ill. Reg. 1762, effective January 13, 2009; amended at 33 Ill. Reg. 2345, effective January 23, 2009; amended at 33 Ill. Reg. 3999, effective February 23, 2009; amended at 33 Ill. Reg. 15781, effective October 27, 2009; amended at 33 Ill. Reg. 16711, effective November 20, 2009; amended at 34 Ill. Reg. 9405, effective June 23, 2010; amended at 34 Ill. Reg. 12935, effective August 19, 2010; amended at 35 Ill. Reg. 2169, effective January 24, 2011; amended at 36 Ill. Reg. 6662, effective April 12, 2012; amended at 36 Ill. Reg. _____, effective _____.

SUBPART D: GROSS RECEIPTS

Section 130.410 Cost of Doing Business Not Deductible

- a) In computing Retailers' Occupation Tax liability, no deductions shall be made by a taxpayer from gross receipts or selling prices *on account of the cost of property sold, the cost of materials used, labor or service costs, or any other expense whatsoever, including, but not limited to,* idle time charges, incoming freight or transportation costs, overhead costs, processing charges, clerk hire or salesmen's commissions, or interest paid by the seller, ~~or any other expenses whatsoever.~~ [35 ILCS 120/1] Costs of doing business are an element of the retailer's gross receipts subject to tax and cannot be deducted from the retailer's gross receipts even if separately stated on the bill to the customer. On or after October 1, 2012, transportation and delivery costs are considered part of the retailer's costs of doing

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business. See subsection (e).

a) EXAMPLES:

1) Credit card or debit card charges or fees. AFor example, a retailer may choose to accept payment from a customer through the use of a credit or debit card, and the retailer may not receive the full amount charged to the customer's credit card or debit card accountof payment due to the service charges or fees charged by the credit or debit card company. These charges or fees are part of the retailer's costs of doing business and cannot be deducted from the gross receipts subject to tax.

2) Idle time charges. A cement retailer is hired by a construction contractor to deliver a load of cement for \$1,800 to a job site. Upon arriving at the job site, the cement truck is delayed for an hour. The cement retailer charges the construction contractor for the cement and also charges the construction contractor an additional \$100 idle time charge due to the delay. Costs for idle time are part of the retailer's costs of doing business and any amounts the retailer charges the contractor for the idle time are part of the retailer's gross receipts from that sale (\$1,900) and cannot be deducted.

3) Processing charges. An automobile dealer sells an automobile for \$24,000 and charges a \$150 "Doc fee" for processing the paperwork necessary to complete the sale. Documentation costs are part of the retailer's costs of doing business and any amounts the retailer charges the customer for providing or processing documents are a part of the retailer's gross receipts from that sale (\$24,150) and cannot be deducted.

4) Fuel surcharge. A retailer sells landscape timber for \$200, patio pavers for \$350, and 15 bags of mulch for \$60 to be delivered to the customer's home. The retailer charges \$50 for delivery and charges an additional fuel surcharge of \$12.95. The amounts the retailer charges the customer for the delivery charge and the fuel surcharge are part of the retailer's gross receipts from that sale (\$672.95) and cannot be deducted.

b) Through September 30, 2012, toTo determine whether outgoing shipping and handling charges are deductible from gross receipts that are subject to tax, see Section 130.415 of this Part.

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- c) Handling charges represent a retailer's cost of doing business and are subject to tax. Handling charges, however, are often stated in combination with shipping charges ("shipping and handling"). Through September 30, 2012, when stated in combination, they will be considered part of the delivery charges and taxed according to Section 130.415. On and after October 1, 2012, they will be considered part of the retailer's costs of doing business regardless of whether they are stated in combination with delivery charges, and are not deductible from the gross charges subject to tax. However, such charges are often stated in combination with shipping charges. In this case, charges designated as "shipping and handling" as well as delivery or transportation charges in general, are not taxable if it can be shown that they are both separately contracted for and that such charges are actually reflective of the costs of shipping. To the extent that shipping and handling charges exceed the costs of shipping, the charges are subject to tax. (See Section 130.415 of this Part.)
- d) Incoming Transportation and Delivery Costs. Incoming transportation and delivery costs incurred by a retailer in acquiring property for sale are merely costs of doing business to the retailer and may not be deducted from the retailer's gross receipts from sales of tangible personal property at retail, even though the retailer may pass those costs on to his or her customer's by quoting and billing the costs separately from the price of the tangible personal property sold. Incoming freight charges include, for example, transportation or delivery costs incurred by the retailer in moving property to a location from which it will be either picked up by a customer or delivered to a customer.

EXAMPLES:

- 1) A customer purchases books for \$25 on the internet. The retailer charges \$10 for delivery to the customer. Alternatively, the retailer offers to make the books available for pickup at its brick-and-mortar store. The customer decides to pick up the books at the store. The retailer charges the customer \$5 to recover the costs incurred getting the books to the store. The \$5 charge the retailer passes on to the customer is part of the costs of doing business and may not be deducted from the gross receipts from that sale (\$30).
- 2) A customer goes to an appliance store (Store A) to purchase an oven for \$300. Store A only has the display model at that location, but there are

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several in stock at a second store (Store B). Store B ships the oven to the retailer at Store A for \$25. The retailer at Store A passes that \$25 charge on to the customer. The \$25 charge the retailer passes on to the customer is part of the costs of doing business and may not be deducted from the gross receipts from that sale (\$325).

- e) Outgoing Transportation and Delivery Costs (e.g., Shipping and Handling). Outgoing transportation and delivery charges include, but are not limited to, charges for freight, express, mail, truck or other carrier, conveyance or delivery expenses, and shipping and handling. On and after October 1, 2012, outgoing transportation and delivery costs that the retailer charges its customer on sales are considered part of a retailer's costs of doing business and may not be deducted from a retailer's gross receipts, regardless of whether those charges are separately agreed upon or separately stated to the customer. If a retailer accepts any funds from a customer for transportation and delivery of the merchandise that the retailer sells, those funds are part of the retailer's gross receipts from the sale, even if the retailer subsequently pays all or part of those funds to a third party.

EXAMPLES:

- 1) Internet purchase from a retailer who also has a brick-and-mortar store. A customer selects merchandise totaling \$200 from a retailer's website on the Internet. The online retailer prompts the customer to click on the box corresponding to the method by which the customer prefers to obtain the merchandise (e.g., UPS for \$12.99, Federal Express for \$18.50, USPS for \$4.99, or pickup at the store for no extra charge). The customer clicks on the USPS box for delivery to the customer's home, rather than choosing to pick up the merchandise at the store. The transportation and delivery charges the retailer charges the customer are a part of the retailer's gross receipts from that sale (\$204.99) and cannot be deducted.
- 2) Price includes delivery. A customer telephones a retailer who sells propane. The retailer offers to sell propane to the customer for \$2 per pound if the retailer delivers the propane or \$1 per pound if the customer arranges for the delivery with a third party. If the customer chooses to have the retailer deliver the propane for \$2 per pound, then the gross receipts for the delivered propane are \$2 per pound, and the retailer may not make any deductions for transportation and delivery.

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- 3) Delivery by a retailer. A customer purchases furniture for \$2,000 from a local furniture retailer. The retailer delivers the furniture to the customer and charges the customer \$75 for the delivery. The retailer's outgoing transportation and delivery costs are part of the retailer's costs of doing business and any amounts the retailer charges the customer for the delivery may not be deducted from the gross receipts from that sale (\$2,075).
- f) If a retailer has determined that the delivery charges are part of its gross receipts, then the retailer must determine if any exemptions apply and, if not, determine the appropriate tax rate for that transaction by observing the following rules:
- 1) Delivery of all exempt tangible personal property. If the retailer determines that either the purchaser or all of the tangible personal property being sold is tax exempt, then the entire gross receipts from the sale, including delivery charges, are not taxable.

EXAMPLE:

A church with an active exemption identification number purchases new choir robes for \$600. The retailer charges the church \$20 to deliver the robes. All amounts the retailer charged the church, including delivery charges, are not taxable because the sale to the church was a tax-exempt sale.

- 2) Delivery of exempt tangible personal property with taxable tangible personal property. If a retailer makes a sale of multiple items of tangible personal property, some of which are exempt and some of which are taxable, the delivery charges are exempt if the total selling price of the exempt tangible personal property is greater than the selling price of the taxable tangible personal property.

EXAMPLE:

A customer places an order for subscriptions to 3 magazines for a total of \$36 and purchases 2 children's books for a total of \$12 through an online retailer. The retailer charges \$4 for shipping and handling. The magazines qualify for the newsprint and ink exemption, but the books do not. As a result, the total selling price of the exempt tangible personal

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property (\$36) is greater than the total selling price of the taxable tangible personal property (\$12) and the shipping and handling charges (\$4) are exempt.

- 3) Delivery of tangible personal property taxed entirely at the low rate of tax or entirely at the high rate of tax. If a retailer makes a sale of multiple items of tangible personal property that are either all taxable at the high rate of tax or all taxable at the low rate of tax, it must apply that rate to all the gross receipts from the sale, including delivery charges.

EXAMPLE:

A customer purchases a wheelchair from the local medical appliance store for \$500, and the retailer charges the customer \$40 for delivery. The delivery charges are taxed at the low rate of tax.

- 4) Delivery of multiple items of tangible personal property some of which are taxed at the high rate and some of which are taxed at the low rate. In order to qualify for the low rate, the total selling price of the tangible personal property that is taxed at the low rate must be greater than the total selling price of the tangible personal property that is taxed at the high rate.

EXAMPLE:

A customer orders crackers, cheeses and fruit for \$200 and 6 bottles of wine at \$75 per bottle (\$450). The retailer charges the customer \$20 for delivery. The retailer's outgoing transportation and delivery charges are part of the retailer's costs of doing business and may not be deducted from its gross receipts from that sale. These transportation and delivery costs are taxable at the high rate of tax because the total selling price for tangible personal property taxed at the high rate (\$450) is greater than the total selling price for the tangible personal property sold at the low rate (\$200).

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

Section 130.415 Transportation and Delivery Charges

The provisions of this Section are valid through September 30, 2012. For information regarding

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transportation and delivery charges on and after October 1, 2012, see Section 130.410.

- a) Transportation and delivery charges are considered to be freight, express, mail, truck or other carrier, conveyance or delivery expenses. These charges are also many times designated as shipping and handling charges.
- b) The answer to the question of whether or not a seller, in computing ~~itshis~~ Retailers' Occupation Tax liability, may deduct, from ~~itshis~~ gross receipts from sales of tangible personal property at retail, amounts charged ~~by him to his~~ customers on account of ~~the retailer'shis~~ payment of transportation or delivery charges in order to secure delivery of the property to ~~thesueh~~ customers, or on account of ~~his~~ incurrence of expense in making ~~thesueh~~ delivery ~~itselfhimself~~, depends not upon the separate billing of ~~sueh~~ transportation or delivery charges or expense, but upon whether the transportation or delivery charges are included in the selling price of the property ~~thatwhich~~ is sold or whether the seller and the buyer contract separately for ~~sueh~~ transportation or delivery charges by not including ~~thosesueh~~ charges in ~~thesueh~~ selling price. In addition, charges for transportation and delivery must not exceed the costs of transportation or delivery. If those charges do exceed the cost of delivery or transportation, the excess amount is subject to tax.
- c) If ~~sueh~~ transportation or delivery charges are included in the selling price of the tangible personal property ~~which is~~ sold, the transportation or delivery expense is an element of cost to the seller within the meaning of Section 1 of the Retailers' Occupation Tax Act, and may not be deducted by the seller in computing ~~itshis~~ Retailers' Occupation Tax liability.
- d) If the seller and the buyer agree upon the transportation or delivery charges separately from the selling price of the tangible personal property ~~which is~~ sold, then the cost of the transportation or delivery service is not a part of the "selling price" of the tangible personal property ~~which is sold~~, but instead is a service charge, separately contracted for, and need not be included in the figure upon which the seller computes ~~his~~ Retailers' Occupation Tax liability. Delivery charges are deemed to be agreed upon separately from the selling price of the tangible personal property ~~being sold~~ so long as the seller requires a separate charge for delivery and so long as the charges designated as transportation or delivery or shipping and handling are actually reflective of the costs of ~~thesueh~~ shipping, transportation or delivery. To the extent that ~~thesueh~~ charges exceed the costs of shipping, transportation or delivery, the charges are subject to tax. The

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best evidence that transportation or delivery charges were agreed to separately and apart from the selling price, is a separate and distinct contract for transportation or delivery. However, documentation ~~that~~~~which~~ demonstrates that the purchaser had the option of taking delivery of the property, at the seller's location, for the agreed purchase price, or having delivery made by the seller for the agreed purchase price, plus an ascertained or ascertainable delivery charge, will suffice.

e) Incoming Transportation Costs

Transportation or delivery charges paid by a seller in acquiring property for sale are merely costs of doing business to the seller and may not be deducted by ~~the~~~~sueh~~ seller in computing ~~his~~-Retailers' Occupation Tax liability, even though ~~the seller~~~~he~~ passes ~~those~~~~sueh~~ costs on to ~~his~~-customers by quoting and billing ~~the~~~~sueh~~ costs separately from the selling price of tangible personal property ~~it~~~~which~~ ~~he~~ sells. The same is true of transportation or delivery charges paid by the seller in moving property to some point from which the property (when subsequently sold) will be delivered or shipped to the purchaser.

f) On and after October 1, 2012, see Section 130.410.

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

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NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Service Occupation Tax
- 2) Code Citation: 86 Ill. Adm. Code 140
- 3) Section Number: 140.301 Proposed Action:
Amendment
- 4) Statutory Authority: 20 ILCS 2505/2505-90
- 5) A Complete Description of the Subjects and Issues Involved: Section 140.301, Cost Price, is amended to provide that, beginning October 1, 2012, the new shipping and handling requirements set forth more fully in 86 Ill. Adm. Code 130.410, apply.
- 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
- 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 Objective: This rulemaking does not create a State mandate, nor does it modify any existing State mandates.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rulemaking may submit them in writing by no later than 45 days after publication of this Notice to:

Debra M. Boggess
Associate Counsel, Sales & Excise Taxes
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794

217/782-2844

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- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Businesses that charge its customers outgoing transportation and delivery costs on sales to those customers.
 - 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: January 2012

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

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TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUEPART 140
SERVICE OCCUPATION TAX

SUBPART A: NATURE OF TAX

Section	
140.101	Basis and Rate of the Service Occupation Tax
140.105	Calculation of Tax Incurred by Servicemen – Threshold Determination of Cost Ratio
140.106	When Cost Ratio is 35% or Greater, Service Occupation Tax Liability Is Incurred by Servicemen on Their Selling Price
140.108	"De Minimis" Servicemen Who Incur Use Tax on Their Cost Price
140.109	"De Minimis" Servicemen Who Incur Service Occupation Tax on Their Cost Price
140.110	Example of Methods Used by Servicemen to Determine Liability
140.115	Occasional Sales to Servicemen by Suppliers (Repealed)
140.120	Meaning of Serviceman
140.124	Commercial Distribution Fee Sales Tax Exemption
140.125	Examples of Nontaxability
140.126	Taxation of Food, Drugs and Medical Appliances
140.127	Service Provided to Persons Who Lease Tangible Personal Property to Exempt Hospitals
140.128	Persons Who Lease Tangible Personal Property to Governmental Bodies
140.129	Taxation of Seminar Materials
140.130	Suppliers of Printers (Repealed)
140.135	Sales of Drugs and Related Items, to or by Pharmacists (Repealed)
140.140	Other Examples of Taxable Transactions
140.141	Warranty Repairs
140.145	Multi-Service Situations

SUBPART B: DEFINITIONS

Section	
140.201	General Definitions

SUBPART C: BASE OF THE TAX

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- Section
- 140.301 Cost Price
- 140.305 Refunds by Supplier or Serviceman

SUBPART D: TAX RETURNS

- Section
- 140.401 Monthly Returns When Due – Contents of Returns
- 140.405 Annual Tax Returns
- 140.410 Final Return
- 140.415 Taxpayer's Duty to Obtain Form
- 140.420 Annual Information Returns by Servicemen
- 140.425 Filing of Returns for Serviceman Suppliers by their Suppliers Under Certain Circumstances
- 140.430 Incorporation by Reference

SUBPART E: INTERSTATE COMMERCE

- Section
- 140.501 Sales of Service Involving Property Originating in Illinois
- 140.505 Sales of Service Involving Property Originating Outside of Illinois (Repealed)

SUBPART F: REGISTRATION UNDER THE SERVICE OCCUPATION TAX ACT

- Section
- 140.601 General Information

SUBPART G: BOOKS AND RECORDS

- Section
- 140.701 Requirements

SUBPART H: PENALTIES, INTEREST AND PROCEDURES

- Section
- 140.801 General Information

SUBPART I: WHEN OPINIONS FROM THE DEPARTMENT ARE BINDING

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Section
140.901 Written Opinions

SUBPART J: COLLECTION OF THE TAX

Section
140.1001 Payment of Tax
140.1005 Receipt to be Obtained for Tax Payments
140.1010 Payment of Tax Directly to the Department (Repealed)
140.1015 Itemization of the Tax by Suppliers (Repealed)
140.1020 Use of Bracket Chart
140.1025 Advertising in Regard to the Tax

SUBPART K: TIMELY MAILING TREATED AS TIMELY FILING AND PAYING –
MEANING OF DUE DATE WHICH FALLS ON
SATURDAY, SUNDAY OR A HOLIDAY

Section
140.1101 Filing of Documents with the Department

SUBPART L: LEASED PORTIONS OF LESSOR'S BUSINESS SPACE

Section
140.1201 When Lessee of Premises May File Return for Leased Department
140.1205 When Lessor of Premises Should File Return for Leased Department
140.1210 Meaning of "Lessor" and "Lessee" in this Regulation

SUBPART M: USE OF EXEMPTION CERTIFICATES

Section
140.1301 When Purpose of Serviceman's Purchase is Known (Repealed)
140.1305 When Purpose of Serviceman's Purchase is Unknown
140.1310 Blanket Percentage Exemption Certificates (Repealed)

SUBPART N: CLAIMS TO RECOVER ERRONEOUSLY PAID TAX

Section
140.1401 Claims for Credit – Limitations – Procedure
140.1405 Disposition of Credit Memoranda by Holders Thereof

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140.1410 Refunds
140.1415 Interest

SUBPART O: DISCONTINUATION OF A BUSINESS

Section
140.1501 Procedures

SUBPART P: NOTICE OF SALES OF GOODS IN BULK

Section
140.1601 Requirements and Procedures

SUBPART Q: POWER OF ATTORNEY

Section
140.1701 General Information

AUTHORITY: Implementing the Service Occupation Tax Act [35 ILCS 115] and authorized by Section 2505-100 of the Civil Administrative Code of Illinois [20 ILCS 2505/2505-100].

SOURCE: Adopted May 21, 1962; amended at 3 Ill. Reg. 23, p. 161, effective June 3, 1979; amended at 3 Ill. Reg. 44, p. 198, effective October 19, 1979; amended at 4 Ill. Reg. 24, pp. 526, 536 and 550, effective June 1, 1980; amended at 5 Ill. Reg. 822, effective January 2, 1981; amended at 6 Ill. Reg. 2879, 2883, 2886, 2892, 2895 and 2897, effective March 3, 1982; codified at 6 Ill. Reg. 9326; amended at 9 Ill. Reg. 7941, effective May 14, 1985; amended at 11 Ill. Reg. 14090, effective August 11, 1987; emergency amendment at 12 Ill. Reg. 14419, effective September 1, 1988, for a maximum of 150 days; emergency expired January 29, 1989; amended at 13 Ill. Reg. 9388, effective June 6, 1989; amended at 14 Ill. Reg. 262, effective January 1, 1990; amended at 14 Ill. Reg. 15480, effective September 10, 1990; amended at 15 Ill. Reg. 5834, effective April 5, 1991; amended at 18 Ill. Reg. 1550, effective January 13, 1994; amended at 20 Ill. Reg. 5379, effective March 26, 1996; amended at 20 Ill. Reg. 7008, effective May 7, 1996; amended at 20 Ill. Reg. 16211, effective December 16, 1996; amended at 24 Ill. Reg. 8125, effective May 26, 2000; emergency amendment at 25 Ill. Reg. 1811, effective January 16, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 4971, effective March 23, 2001; amended at 25 Ill. Reg. 6531, effective May 3, 2001; amended at 26 Ill. Reg. 4905, effective March 15, 2002; amended at 27 Ill. Reg. 812, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 11187, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; emergency amendment at 28 Ill. Reg. 15257, effective November 3, 2004,

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for a maximum of 150 days; emergency expired April 1, 2005; amended at 29 Ill. Reg. 1940, effective January 24, 2005; amended at 29 Ill. Reg. 7070, effective April 26, 2005; amended at 32 Ill. Reg. 13845, effective August 11, 2008; amended at 36 Ill. Reg. _____, effective _____.

SUBPART C: BASE OF THE TAX

Section 140.301 Cost Price

- a) "Cost Price" means the consideration paid by the serviceman for a purchase valued in money, whether paid in money or otherwise, including cash, credits and services, and shall be determined without any deduction on account of the supplier's cost of the property sold or on account of any other expense incurred by the supplier; but does not include charges ~~that~~~~which~~ are added to prices by suppliers on account of the purchaser's tax liability under ~~the~~~~this~~ Act or the Service Use Tax Act [35 ILCS 110]. Except as provided in Section 140.145(a), when a serviceman contracts out part or all of the services required in his ~~or her~~ sale of service, it shall be presumed that the cost price to the serviceman of the property transferred to ~~the serviceman~~~~him~~ by ~~the~~~~his~~ subcontractor is equal to 50% of the subcontractor's charges to the serviceman in the absence of proof of the consideration paid by the subcontractor for the purchase of ~~the~~~~such~~ property.
- b) The following listing describes the taxation of various charges that may be made by servicemen.
- 1) Transportation and Delivery Charges
- A) Dates for Determining What Constitutes Transportation and Delivery Charges
- i) ~~Through September 30, 2012, transportation~~Transportation and delivery charges are considered to be freight, express, mail, truck or other carrier, conveyance or delivery expenses. Many times these charges are designated as shipping and handling charges.
- ii) On or after October 1, 2012, transportation and delivery charges include, but are not limited to, charges for freight, express, mail, truck or other carrier, conveyance or

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delivery, and shipping and handling expenses.

- B) Whether amounts charged by a serviceman to ~~his~~ customers in order to secure delivery of the property to his customers are taxable depends upon the method used by the serviceman to calculate ~~his~~ tax liability. Delivery charges made by a de minimis serviceman paying either Use Tax (see Section 140.108) or Service Occupation Tax (see Section 140.109) on ~~the~~ cost price are not taxable, since tax in these instances is incurred only on the cost price of the tangible personal property transferred to the service customer incident to a sale of service. If, however, the serviceman remits Service Occupation Tax on ~~the~~ selling price, as provided in Section 140.106, delivery charges made to ~~the~~ customer may be taxable. ~~Through September 30, 2012, if~~ the serviceman calculates ~~his~~ tax liability on the basis of the separately stated selling price of tangible personal property transferred to service customers, ~~those~~ delivery charges are not taxable. ~~On and after October 1, 2012, see 86 Ill. Adm. Code. 130.410.~~ However, if the serviceman does not separately state the selling price of the tangible personal property transferred to the customer and, rather, calculates ~~tax~~ liability on 50% of the entire service bill, delivery charges will become part of the tax base.
- C) Incoming Transportation Costs – Servicemen Who Incur Service Occupation Tax on Their Selling Price. Incoming freight or other delivery expense incurred by a serviceman remitting Service Occupation Tax on ~~the~~ selling price in acquiring property for sale may not be deducted from the selling price charged by the serviceman for the tangible personal property transferred to the customer even if this type of delivery expense is priced and billed separately on the bill to the customer. It represents a serviceman's cost of doing business, which is never deductible from gross receipts subject to tax.
- D) Incoming Transportation Costs – De Minimis Servicemen Who Incur Either Use Tax or Service Occupation Tax on Their Cost Price. In contrast to servicemen paying tax on their selling price, de minimis servicemen generally pay Use Tax on the cost price of the tangible personal property they acquire for transfer to service

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customers. ~~Through September 30, 2012, whether~~ Whether de minimis servicemen paying Use Tax to their suppliers are subject to tax on shipping charges made by their suppliers depends upon whether the supplier and the de minimis serviceman have a separate contract for delivery charges and whether the delivery charges are actually reflective of the costs of shipping, transportation and delivery. ~~Through September 30, 2012, if~~ If ~~these~~ such charges are shown to be separately contracted for and reflective of actual shipping costs, they are not considered part of the cost price of the tangible personal property purchased by the serviceman. The same rule applies to de minimis servicemen paying Service Occupation Tax on their cost price. (See 86 Ill. Adm. Code 130.415.) ~~On and after October 1, 2012, see 86 Ill. Adm. Code~~ 130.410.

- 2) Finance or Interest Charges – Penalties – Discounts
 - A) ~~When~~ Where any tangible personal property is sold by a supplier to a serviceman under an installment contract, the interest or finance charges on account of credit so extended are not considered to be a part of the cost price. The books and records of suppliers must clearly reflect ~~the~~ such finance or interest charges. In the absence of an adequate showing of what ~~the~~ such charges actually are, the Department will presume that ~~the~~ such charges are not in excess of like charges ~~that~~ which are customarily made in connection with similar installment sales.
 - B) If a "penalty" is added to the base cost price, in the event that the serviceman does not pay ~~that~~ such price within a specified time and if ~~a~~ such penalty is paid to the supplier, ~~the~~ such "penalty" is considered to be a part of the cost price.
 - C) If a discount is allowed for a payment in cash within a stated period of time, any amounts realized by suppliers through failure of a serviceman to take advantage of such a discount will be considered to be a part of the cost price. Conversely, if the supplier allows the serviceman a discount from the base cost price (such as a discount for prompt payment) and the serviceman avails himself ~~or herself~~ of the discount so that the supplier does not

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receive any receipts from that source, the amount of ~~thesueh~~ discount is not a part of the cost price.

- 3) Maintenance Agreements. If a serviceman enters into an agreement to provide repair service for a particular piece of equipment for a stated period for a predetermined fee, the serviceman shall pay Use Tax to ~~thehis~~ supplier (or to the Department if the supplier is not registered to collect tax) on the cost price of tangible personal property purchased for transfer by the serviceman incident to completion of the maintenance agreement (see Section 2 of the Act and Section 3-75 of the Use Tax Act [\[35 ILCS 105\]](#)). However, a serviceman will incur no tax liability on repairs made under a maintenance agreement for a person that is able to claim an exemption, either because of that person's exempt status (e.g., the person possesses an exemption identification number issued by the Department, such as the Federal or State government) or because the tangible personal property being repaired is exempt from tax (e.g., due to the manufacturing machinery, graphic arts or pollution control equipment exemptions).

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

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: School Bus Driver's Pretrip Inspection Requirements
- 2) Code Citation: 92 Ill. Adm. Code 458
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
458.1000	Amend
458.1020	Amend
458.1030	Amend
458.ILLUSTRATION A	Amend
- 4) Statutory Authority: Implementing and authorized by Section 13-115 of the Illinois Vehicle Inspection Law [625 ILCS 5/13-115]
- 5) A complete description of the subjects and issues involved: By this rulemaking, the Department is proposing to update this Part pursuant to industry's request to clarify time frames and procedures for school bus pretrip inspections. Therefore, the Department is, among other things, amending this Part to allow equipment located under-the-hood of a school bus (e.g., fluids, belts and wiring) to be inspected once every 24 hours when the bus is being used to transport students. The current rule requires equipment under-the-hood to be inspected either before the bus is to be used for its first trip of the day or the night before the bus is to be used. The Department has had numerous requests from school districts and contractors to reconsider this requirement as time constraints prevent fluid/wiring checks to be performed each morning. Moreover, union contracts require overtime to be paid to mechanics when they perform the inspections during evening hours. These factors are especially problematic for school districts and contractors that operate large fleets of school buses. Therefore, in consideration of the above, the Department has determined that fluid/wiring checks can be performed at any time, as long as the fluid/wiring check is performed at least once every 24 hours when the bus is being used to transport students, without jeopardizing the safe operation of the bus.

Throughout this Part the term "components" is being replaced with "equipment," which is a more accurate description of what is being inspected.

At **Section 458.1000, Purpose**, the following change is being made:

Section 458.1000(b), the Department is adding language prescribing that the procedures in this Part are minimum requirements, and that a school bus owner or operator may adopt more stringent policies, at the discretion of the district/company/private school management. An example of a more stringent

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requirement includes, but is not limited to, a school district requiring the equipment listed in the renumbered Section 458.1030(g) to be inspected every Monday morning regardless of the provision in this Part that allows the equipment to be inspected by noon on Monday (if the "under-the-hood" equipment check was performed at noon on the previous Friday).

At **Section 458.1020, Definitions**, the following definitions are being added or amended:

"Department" is being amended to update the statutory language and citation.

"Exempt Time" is being added and means any time the bus is not being used to transport students (e.g., weekends, holidays, and when school is not in session).

"Officer" is being amended to clarify that an officer of the Department is either a vehicle inspector or Department management.

"School Bus" is being amended to reflect changes made pursuant to PA 96-0410, effective July 1, 2010, regarding multifunction school-activity buses.

"School Bus Pretrip Inspection" is being amended to clarify that the inspection is to be performed each day the school bus is used to transport students.

"School Bus Pretrip Inspection Form" or "the Form" is being amended to add the option that someone other than the driver is allowed to inspect the applicable equipment located under-the-hood of the vehicle.

At **Section 458.1030, Driver Requirements**, the following changes are being made:

Section 458.1030(b), the Department is adding language describing the Form.

New **Section 458.1030(c)**, the Department is further describing the format and content of the Form. Retention requirements for the Form are also addressed. The Department's address and phone number are being updated and moved to subsection (c) to provide, upon request, vendor options for purchasing the Form.

Renumbered **Section 458.1030(d)**, the Department is clarifying that the pretrip inspection is to be performed each day a school bus is operated to transport students.

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Renumbered **Section 458.1030(f)**, the Department is clarifying that the Form must be completed in full.

Renumbered **Section 458.1030(g)**, the Department is establishing new procedures that a school bus owner/operator can choose to follow by inspecting the equipment listed in this subsection once every 24 hours when the bus is being used to transport students. The Department is also clarifying that "exempt time," as defined in Section 458.1020, is excluded from the 24-hour period.

Renumbered **Section 458.1030(h)**, the Department is clarifying that someone other than the driver (e.g., school bus mechanic) can inspect the equipment listed in subsection (g)(1-9) provided that person takes responsibility for the inspection of the equipment and signs his or her name on the Form.

Renumbered **Section 458.1030(i)**, the Department is clarifying that the school bus driver must notify the bus owner/operator of any defects "each day before the trip is started."

Section 458.1030(l), the Department is adding language to clarify that the Form must be presented to the school bus owner/operator before a trip is started each day.

Section 458.1030(o), the Department is clarifying that duplicate copies of the Form that are more than 30 days old must be removed from the bus.

Renumbered **Section 458.1030(s)**, the Department is adding an emphasis that each individual piece of equipment listed on the form must be checked or marked with 'individual checkmarks.'

Renumbered **Section 458.1030(u)**, the Department is adding a cross reference to subsection (c) concerning the Division of Traffic Safety's new street address.

New **Section 458.1030(w)**, the Department is adding a new subsection prescribing requirements for obtaining a variance from the procedures in this Part.

Renumbered **Section 458.1030(x)**, the Department is establishing criteria to allow school bus owners or operators to vary the procedures in this Part. For example, a school district that operates hundreds of school buses at one facility employ mechanics who perform the fluid/wiring checks and they have asked for approval

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to record this information on a supplemental form. In that case, the supplemental form will reflect that fluid/wiring checks were performed but not recorded on the Form. The Department acknowledges that variances are sometimes necessary to accommodate different size fleets but will review and approve all variances.

Section 458.1030(y), the Department is moving language currently found in an Agency Note and labeling it as a subsection.

New **Section 458.1030(z)**, the Department is adding a subsection that addresses electronic pretrip inspection systems. Prior approval must be granted by the Department before an electronic pretrip system is implemented by a school bus owner or operator.

Section 458.1030(aa), the Department is adding a subsection that allows the use of existing preprinted forms until they are depleted from the school bus owner's or operator's current inventory and not destroyed or wasted.

At the end of **Section 458.1030**, the Department is adding an Agency Note to recommend that school bus drivers may need to be equipped with a flashlight and may find working in a two-person system helpful.

At **Section 458.Illustration A, School Bus Driver's Pretrip Inspection Form**, the Form is being amended to:

Require that the driver verify that a valid certificate of safety is affixed to the windshield of the school bus. The following equipment is also being added pursuant to the corresponding Public Acts:

- 1) Two-way radio or cell phone and a child check system - PA 96-1066, effective July 6, 2010;
 - 2) Crossing control arm - PA 90-108, effective July 1, 1997; and
 - 3) Strobe lamp (for vehicles manufactured on or after January 1, 2000) – PA 91-0679, effective January 1, 2000.
- 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 affects units of local government that own or operate school buses.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Any interested party may submit written comments or arguments concerning these proposed amendments. Written submissions shall be filed with:

By U.S. Mail:

Ms. Catherine Allen
Illinois Department of Transportation
Division of Traffic Safety
P.O. Box 19212
Springfield, Illinois 62794-9212

217/785-3031

JCAR requests, comments and concerns regarding this rulemaking should be addressed to:

Ms. Christine Caronna-Beard
Illinois Department of Transportation
Office of Chief Counsel
2300 South Dirksen Parkway, Room 317
Springfield, Illinois 62764

217/524-3838

Comments received within 45 days after the date of publication of this *Illinois Register* will be considered. Comments received after that time will be considered, time permitting.

- 13) Initial Regulatory Flexibility Analysis:

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- A) Types of small businesses affected: This rulemaking affects small businesses that operate school buses and employ school bus drivers.
 - B) Reporting, bookkeeping or other procedures required for compliance: Procedures necessary to complete the School Bus Driver Pretrip Inspection Form are covered by this rulemaking.
 - C) Types of professional skills necessary for compliance: No professional skills are necessary for compliance.
- 14) Regulatory Agenda on which this rulemaking was summarized: These proposed amendments were not included on either of the two most recent agendas because the Department could not anticipate the timing of the need for the amendments.

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

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TITLE 92: TRANSPORTATION
 CHAPTER I: DEPARTMENT OF TRANSPORTATION
 SUBCHAPTER e: TRAFFIC SAFETY (EXCEPT HAZARDOUS MATERIALS)

PART 458
 SCHOOL BUS DRIVER'S PRETRIP INSPECTION REQUIREMENTS

Section

458.1000	Purpose
458.1010	Applicability
458.1020	Definitions
458.1030	Driver Requirements
458.ILLUSTRATION A	School Bus Driver's Pretrip Inspection Form

AUTHORITY: Implementing and authorized by Section 13-115 of the Illinois Vehicle Inspection Law [625 ILCS 5/13-115].

SOURCE: Adopted at 21 Ill. Reg.13664, effective October 1, 1997; amended at 36 Ill. Reg. _____, effective _____.

Section 458.1000 Purpose

- a) This Part prescribes the pretrip inspection requirements a school bus driver must follow each day a school bus is operated.
- b) The procedures prescribed in this Part are minimum requirements. School bus owners or operators may dictate more stringent requirements for the pretrip inspections of school buses.

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

Section 458.1020 Definitions

"Code" – The Illinois Vehicle Code [625 ILCS 5].

"Department" – *The Department of Transportation of the State of Illinois, acting directly or through its authorized officers and agents. (Section 1-115.05 ~~agents or officers.~~ (Section 13-100 of the Code)*

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"Exempt Time" – The time when a school bus is not being used to transport school children (e.g., weekends, holidays, school not in session).

"Officer" – An employee of the Illinois Department of Transportation designated as a vehicle inspector or Department management.

"School Bus" – Every motor vehicle, except as provided below, owned or operated by or for any of the following entities for the transportation of persons regularly enrolled as students in grade 12 or below in connection with any activity of such entity:

Any public or private primary or secondary school;

*Any primary or secondary school operated by a religious institution; or
Any public, private or religious nursery school.*

This definition shall not include the following:

A bus operated by a public utility, municipal corporation or common carrier authorized to conduct local or interurban transportation of passengers when such bus is not traveling a specific school bus route but is:

On a regularly scheduled route for the transportation of other fare paying passengers;

Furnishing charter service for the transportation of groups on field trips or other special trips or in connection with other special events; or

Being used for shuttle service between attendance centers or other educational facilities.

A motor vehicle of the first division.

~~*A multifunction school-activity bus. A motor vehicle designed for the transportation of not less than 7 nor more than 16 persons that is operated by or for a public or private primary or secondary school, including any primary or secondary school operated by a religious institution, for the*~~

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~~purpose of transporting not more than 15 students to and from interscholastic athletic or other interscholastic or school sponsored activities.~~ (Section 1-182 of the Code.)

"School Bus Driver" – Any person who is licensed to operate a school bus pursuant to Section 6-106.1 of the Illinois Vehicle Code [625 ILCS 5/6-106.1].

"School Bus Pretrip Inspection" – The inspection performed by a school bus driver on his/her school bus prior to the bus being operated each day to transport students. Some ~~equipment~~components may be inspected by persons other than the driver. The inspection consists of checking mechanical and safety ~~equipment~~items on the bus.

"School Bus Driver Pretrip Inspection Form" or "the Form" – The form prescribed by the Department to be used by school bus drivers to perform the required pretrip inspection. The form contains all of the vehicle's equipment that~~components which~~ must be inspected by the driver or persons other than the driver (e.g., school bus mechanic). (See ~~Section 458~~-Illustration A)

"School Bus Mechanic" – Any person authorized by the school bus owner/operator to make necessary repairs and adjustments on a school bus. May also be responsible for inspecting mechanical ~~equipment~~components during the pretrip inspection.

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

Section 458.1030 Driver Requirements

- a) *Each day that a school bus is operated the driver shall conduct a pretrip inspection of the mechanical and safety equipment on the bus as prescribed by this Part. A person other than the driver may perform portions of the pretrip inspection as prescribed by this Part.* (Section 13-115 of the Illinois Vehicle Inspection Law, ~~as amended by Public Act 89-658~~)
- b) The pretrip inspection shall consist of inspecting mechanical and safety equipment on the school bus. The Form lists all equipment required to be inspected during the pretrip inspection. (See ~~Section 458~~-Illustration A – School Bus Driver Pretrip Inspection Form for specific equipment listed.)

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- c) The Form shall be completed in duplicate. Forms are typically organized in a booklet format with 30 duplicate Forms in each booklet. Each bus shall have one booklet assigned to it. The booklet must remain on the bus until each duplicate copy has been on the bus for at least 30 days (see subsection (o)). School bus owners or operators can either create the booklets in-house or purchase them from an outside vendor. Vendor options are available by contacting the Vehicle Inspection Unit Manager, Illinois Department of Transportation, Division of Traffic Safety, 1340 North 9th Street, P.O. Box 19212, Springfield IL 62794-9212 or by calling 217/785-3031.
- de) The pretrip inspection shall be performed each day a school bus is operated to transport students. If the same driver operates the same bus more than once a day, a new inspection is not required for each subsequent trip.
- ed) If a bus is operated by a different driver for any subsequent trips during the day, an additional pretrip inspection is required. If a driver is required to complete his/her route in a bus different than the one he/she started the route in, a complete pretrip inspection must be performed on the replacement bus.
- fe) The driver is required to complete a School Bus Driver's Pretrip Inspection Form in full(~~the Form~~) each time an inspection is performed. Any defects found on the bus must be recorded on the Form.
- gf) The following equipment must be inspected at least once every 24 hours when the bus is being operated to transport students. When the driver inspects this equipment, he or she is responsible for verifying that these and all other equipment listed on the Form have been inspected, as required. The driver's signature on the Form is verification~~The following items can be inspected during the pretrip by someone other than the driver (e.g., school bus mechanic). The driver is responsible for verifying~~ that these items have been inspected, as required. Exempt times are excluded from the 24-hour period requirement (see definition of Exempt Time in Section 458.1020)~~Verification is provided by the driver's signature on the Form.~~
- 1) Oil;
 - 2) Coolant;
 - 3) Battery;

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- 4) Transmission Fluid;
- 5) Master Cylinder Brake Fluid;
- 6) Power Steering Fluid;
- 7) Washer Fluid;
- 8) All belts (e.g., fan, alternator, power steering); and
- 9) Wiring.

hg) The equipment listed in subsection (g) may be inspected by someone other than the driver (e.g., school bus mechanic). If any person other than the driver inspects the equipment listed in subsection (g), that person is responsible for the inspection of the equipment and must provide his or her signature on the Form, along with the date and time the equipment was inspected. (Writing "Shop" on the signature line is not acceptable.) That person's signature is valid for a 24 hour period (i.e., the corresponding line may be blank on the next day's Form). Exempt times are excluded from the 24 hour period (see definition of Exempt Time in Section 458.1020).~~If any person other than the driver inspects any item listed in subsection (f) of this Section, that person must provide his or her signature on the Form. Items listed in subsection (f) may be inspected the evening prior to the day the bus will be used for a trip. The Form must indicate the date the components listed in subsection (f) are inspected. If items listed in subsection (f) are inspected on the previous day, the bus cannot be driven between the time the components listed in subsection (f) are inspected and the first trip of the day.~~

ih) If defects are discovered, the driver must notify the school bus owner/operator each day before the trip is started so the defects can be corrected.

ji) The Department recommends that all defects be corrected before any bus is used to transport children. Each school district or contractor must establish policies to govern procedures that are to be followed when any equipment component is found to be unsatisfactory.

kj) Each day before a school bus is operated, the driver must examine the previous Form to verify all defects have been corrected. If all defects have not been

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corrected, the driver must immediately notify the school bus owner/operator or his or her designee.

- ~~k)~~ ~~The Form shall be completed in duplicate.~~
- l) The original Form shall be presented to the school bus owner/operator, or his or her designee, before the trip is started each day an inspection is completed. The owner/operator, or his or her designee, shall be responsible for insuring the repairs/adjustments are made as soon as practicable.
- m) After any repairs are made, the school bus mechanic performing the repairs/adjustments must sign and date the Form.
- n) The original copy shall be maintained by the owner/operator for 180 one hundred and eighty days from the date of inspection.
- o) The duplicate copy shall remain in the bus for 30thirty days from the date of inspection. Duplicate copies more than 30 days old must be removed from the bus.
- p) The original Forms shall be organized in an orderly fashion and made available for inspection at any time by officers of the Department as authorized by 92 Ill. Adm. Code 456.60(mmH).
- q) The owner/operator is responsible for providing Forms to the drivers.
- r) Each school bus must be equipped with an adequate supply of Forms.
- ~~s)~~ ~~Forms are typically organized in a booklet format. Each booklet contains a number of Forms. Each bus shall have one booklet assigned to it. The booklet must stay on the bus until each duplicate copy has remained on the bus for at least 30 days (see subsection (o) of this Section).~~
- ~~s)~~ Forms must not be filled out in advance and each individual equipmentcomponent must be checked or marked with individual checkmarks while the Form is being completed. If any equipmenta component listed on the Form in Section 458.Illustration A was not present on the bus at the time of manufacture (e.g., clutch), the equipmentitem must be marked out and "Not Applicable" or "N/A" must be written beside the equipmentcomponent.

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- ~~tu~~) A copy of ~~Section 458~~.Illustration A can be used or a form can be developed which contains all the information found in Section 458.Illustration A. Additional ~~equipment~~~~components~~ may be added to the ~~equipment~~~~components~~ listed in Section 458.Illustration A as the bus owner/operator deems necessary (e.g., wheelchair lift).
- ~~uv~~) The Department must approve all variations of ~~the Form~~~~Section 458.Illustration A~~ before ~~they~~~~a form other than Section 458.Illustration A~~ can be used. Forms submitted for approval must be submitted to ~~the address provided in subsection (c): Vehicle Inspection Unit Manager, Illinois Department of Transportation, Division of Traffic Safety, 3215 Executive Park Drive, P.O. Box 19212, Springfield, IL 62794-9212.~~
- ~~vw~~) The Form shall contain general information about the bus ~~and must~~~~as well as~~ list the ~~equipment~~~~items~~ that ~~is~~~~are~~ required to be inspected by the driver (see ~~Section 458~~.Illustration A). A Remarks Section must be provided for the driver to detail specific defects. A signature line must be provided for the driver and, if applicable, the mechanic who performed any inspection of mechanical ~~equipment~~~~components~~. A signature and date line must also be provided for the school bus mechanic performing any repairs/adjustments.
- ~~w~~) ~~The Department must approve any variance from the procedures prescribed in this Part. A request for a procedural variance must be submitted in writing to the address provided in subsection (c).~~
- ~~x~~) ~~Procedural changes may include, but are not limited to, recording the inspection of the equipment listed in subsection (g) on a supplemental form. This type of variance may help expedite the inspection of larger fleets when an employee may be responsible for inspecting the equipment listed in subsection (g). The supplemental form must list each piece of equipment (i.e., fluids and belts) listed in subsection (g) and whether the equipment is in satisfactory or unsatisfactory condition. The supplemental form must provide space for each school bus to be listed by unit number along with the date and time of the fluids/belts inspection. The person who performs the inspection must provide his or her signature on the supplemental form that confirms he or she is responsible for the inspection of the fluids and belts. The supplemental form must provide the school bus owner's or operator's name. The Form shall also be modified to indicate that the inspection of the equipment listed in subsection (g) has been recorded on a supplemental~~

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~~form. Department officers must be provided access to all inspection information, when requested. Inventory of preprinted Forms may be used, in the manner previously authorized, until depleted or until August 1, 1998.~~

- y) ~~If the bus is not being used as a school bus (e.g., if it is being driven to obtain maintenance/repair work), this Part does not apply. The Form shown in Section 458. Illustration A may be used on or after October 1, 1997; however, use of the Form shown in Section 458. Illustration A is mandatory on or after August 1, 1998.~~
- z) ~~Electronic pretrip inspection systems may be used to meet the requirements of this Part. This variance must be approved, upon request, before an electronic system is implemented. The request must be submitted in writing to the address provided in subsection (c). Provided prior approval is granted, electronic systems may be exempt from recordkeeping procedures (e.g., pretrip forms stored on the bus and/or data stored on electronic readers for 30 days). Electronic pretrip inspections must include the equipment listed on the Form. Upon request, Department officers must be provided access to all data collected and stored.~~
- aa) ~~Inventory of existing preprinted forms may be used until depleted. Illustration A must be used after all existing forms are depleted from a school bus owner's or operator's inventory.~~

~~AGENCY NOTE: School bus drivers may need to be equipped with a flashlight in order to perform pretrip inspections before sunrise or after sunset. A two-person system may also be helpful when performing pretrip inspections to verify the lights on the rear of the bus are functioning properly.~~

~~Agency Note: If the bus is not being used as a school bus (e.g., is being driven to obtain maintenance/repair work), this Part does not apply.~~

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

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Section 458. ILLUSTRATION A School Bus Driver's Pretrip Inspection Form

School District or Contractor's Name _____

Bus Identification No. _____ Date _____ Time _____

PLEASE CHECK "S" FOR SATISFACTORY OR "U" FOR UNSATISFACTORY. (✓) EACH COMPONENT CAREFULLY AND INDIVIDUALLY.

Open Hood and Check:

- S U Oil, Coolant, Battery, Transmission Fluid, Master Cylinder Brake Fluid, Power Steering Fluid, Washer Fluid, All Belts, Wiring

With Engine Running, Driver Activates All Exterior Lights, Walks Around the Bus and Checks:

- S U Right Front Wheel and Tire, Right Side Marker and Turn Signal, Right Side Reflectors, Right Side Rear View and Safety Mirrors, Crossing Control Arm, Headlights (high/low beams), Front Turn Signal Lights, Front Clearance Lights, Front Identification/Cluster Lights, Front Eight Light Flashing System, Front Reflectors, Windshield, Underside of Chassis, Crossover Mirror(s), Left Side Rear View and Safety Mirrors, Left Front Wheel and Tire, Driver's Side Window, Stop Arm Panel, Left Side Marker and Turn Signal Lights, Left Side Reflectors, Side Emergency Door (open/close) (if applicable), Left Rear Wheels and Tires, Exhaust System (tail pipe clear?), Rear Tail/Brake Lights, Rear Turn Signal Lights, Rear Clearance Lights, Rear Identification/Cluster Lights, Strobe Lamp (if applicable), Rear Reflectors, Rear Emergency Door (open/close) (if applicable), Right Rear Wheels and Tires, Fuel Tank Filler Caps

Signature of person performing above inspection if not the driver/Date _____

Driver Enters Bus and Checks:

- S U Steps, Cleanliness, Seats, Seat Belts (if applicable), Windows, Warning Devices, Fuses, First Aid Kit, Fire Extinguisher, Lettering, Two-way Radio or Cell Phone

Record odometer reading and confirm that the reading is not greater than the miles recorded on the back of the Certificate of Safety. (If odometer reading is greater, the Certificate of Safety has expired.)

Driver Starts Engine, Activates All Interior Lights and Checks:

- S U Valid Certificate of Safety, Steering Wheel, Windshield Wipers and Washers, Heater and Defroster, All Interior Lights, Horn, Service Door (open/close), All Mirrors (adjustments), Sun Visor, Emergency Exits (windows/doors), Child Check System (electronic or manual), Braking Warning Alarm, Controls and Indicators, Ammeter (voltmeter), Gear Shift Lever, Neutral Safety Switch, Water Temperature Gauge, Fuel Gauge, Vacuum or Air Pressure Gauge, Odometer

Drive Bus Forward and Apply Brakes

S U

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- | | | |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> <input type="checkbox"/> Braking Warning Alarm | <input type="checkbox"/> <input type="checkbox"/> Rear Clearance Lights |
| <input type="checkbox"/> <input type="checkbox"/> Windshield Wipers and Washers | <input type="checkbox"/> <input type="checkbox"/> Controls and Indicators | <input type="checkbox"/> <input type="checkbox"/> Rear Identification/Cluster Lights |
| <input type="checkbox"/> <input type="checkbox"/> Heater and Defroster | <input type="checkbox"/> <input type="checkbox"/> Ammeter (voltmeter) | <input type="checkbox"/> <input type="checkbox"/> Rear Eight Light Flashing System |
| <input type="checkbox"/> <input type="checkbox"/> All Interior Lights | <input type="checkbox"/> <input type="checkbox"/> Gear Shift Lever | <input type="checkbox"/> <input type="checkbox"/> Rear Reflectors |
| <input type="checkbox"/> <input type="checkbox"/> Horn | <input type="checkbox"/> <input type="checkbox"/> Neutral Safety Switch | <input type="checkbox"/> <input type="checkbox"/> Rear Emergency Door (open and close) (if applicable) |
| <input type="checkbox"/> <input type="checkbox"/> Service Door (open & close) | <input type="checkbox"/> <input type="checkbox"/> Water Temperature Gauge | <input type="checkbox"/> <input type="checkbox"/> Right Rear Wheel(s) and Tire(s) |
| <input type="checkbox"/> <input type="checkbox"/> All Mirrors (adjustments) | <input type="checkbox"/> <input type="checkbox"/> Fuel Gauge | <input type="checkbox"/> <input type="checkbox"/> Fuel Tank Filler Caps |
| <input type="checkbox"/> <input type="checkbox"/> Sun Visor | <input type="checkbox"/> <input type="checkbox"/> Vacuum or Air Pressure Gauge | Drive Bus Forward and Apply Brakes |
| <input type="checkbox"/> <input type="checkbox"/> Emergency Exits (windows & doors) and Alarms | <input type="checkbox"/> <input type="checkbox"/> Odometer | <input type="checkbox"/> <input type="checkbox"/> S U |
| <input type="checkbox"/> <input type="checkbox"/> Clutch (if applicable) | <input type="checkbox"/> <input type="checkbox"/> Switches | <input type="checkbox"/> <input type="checkbox"/> Service and Emergency Brake Operation |
| | <input type="checkbox"/> <input type="checkbox"/> Driver's Seat Belt | |

REMARKS

Signature of Driver _____

Signature of Mechanic Making Report/Adjustments _____

Date Repairs/Adjustments Completed _____

IS2332 (rev 9/97)

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Health Care Data Collection and Submission Code
- 2) Code Citation: 77 Ill. Adm. Code 1010
- 3)

<u>Section Numbers:</u>	<u>Adopted Action:</u>
1010.10	Repealed
1010.20	Amended
1010.40	Amended
1010.60	Amended
1010.70	Amended
1010.APPENDIX A	Amended
1010.APPENDIX B	Amended
1010.APPENDIX C	Amended
1010.APPENDIX E	Amended
1010.APPENDIX K	New
- 4) Statutory Authority: Illinois Health Finance Reform Act [20 ILCS 2215] and Sections 2310-33 and 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310-33 and 20 ILCS 2310-57]
- 5) Effective Date of Amendment: May 8, 2012
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? Yes
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendments Published in Illinois Register: January 27, 2012; 36 Ill. Reg. 1009
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version:

The following changes were made in response to comments and suggestions of JCAR:

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In Section 1010.60(8)(d) text in the 2nd Sentence was changed from "internal or external data sets" to "data sets internal or external"

Section 1010.40(a)(1)(A)(iii) text in the last sentence originally reading "discharged in the third calendar quarter of 2012, beginning on July 1, 2012" was changed to read "discharged on October 1, 2012".

Section 1010.40(a)(1)(B)(iii) text in the last sentence originally reading "discharged in the third calendar quarter of 2012, beginning on July 1, 2012" was changed to read "discharged on October 1, 2012".

Section 1010.40(b)(2) text in the second sentence originally reading "third calendar quarter 2012 (July 1, 2012) discharges" was changed to read "patients discharged on October 1, 2012".

Section 1010.40(b)(3) text in the last sentence originally reading "third calendar quarter 2012 (July 1, 2012) discharges" was changed to read "patients discharged on October 1, 2012".

Section 1010.60(b)(3) "analysis" was stricken and "analyses" was added.

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: These rules implement the Health Finance Reform Act as amended by Public Act 97-0180, effective January 1, 2012. The Health Care Data Collection and Submission Code requires individual hospitals and ambulatory surgical treatment centers to electronically submit claims and encounter data related to inpatient discharges and selected outpatient cases. Data collected from hospitals and ambulatory surgical treatment centers are used in part to compile the "Consumer Guide to Health Care" component of the Department's Hospital Report Card web site, a report of conditions and procedures demonstrating the widest variation in charges and quality of care. National standard measures are applied to Illinois data in the development of this public report available on the Department's web site. The "Consumer Guide to Health Care" includes inpatient and outpatient data with current comparison information related to, but not limited to, volume of cases, median charges, risk-adjusted mortality rates,

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complications and patient safety measures. The "Consumer Guide to Health Care" includes additional information appropriate for interpretation of report content, explanation of causes of variation from provider to provider and a description of

standards that facilities meet under voluntary accreditation and state and federal law. The Department will evaluate additional methods of comparing the performance of hospitals and ambulatory surgical treatment centers using accepted national standard measures and methodologies. Data collected under PA 97-180 shall be made available to government agencies, academic research organizations and private sector organizations for clinical performance measures and analyses. Additional data elements will allow improved analyses of health care delivery systems in Illinois while supporting the Department mission of promoting the health of the people of Illinois. The Department of Public Health Powers and Duties Law of the Civil Administration Code of Illinois authorizes the Department to establish a fee schedule for the sale of this data to requesting agencies and organizations.

- 16) Information and questions regarding these adopted amendments shall be directed to:

Susan Meister
Division of Legal Services
Department of Public Health
535 West Jefferson, 5th Floor
Springfield, Illinois 62761
e-mail: dph.rules@illinois.gov

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH
 CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
 SUBCHAPTER x: HEALTH STATISTICS

PART 1010
 HEALTH CARE DATA COLLECTION AND SUBMISSION CODE

Section

1010.10	Purpose (Repealed)
1010.20	Definitions
1010.30	Incorporated and Referenced Materials
1010.40	Data Submission Requirements
1010.50	Common Data Verification, Review, and Comment Procedures
1010.60	Data Dissemination
1010.70	Data Customer Categories and Data Product Fee Schedule
1010.APPENDIX A	Uniform Inpatient Discharge Data
1010.APPENDIX B	Ambulatory Surgical Categories Reported by CPT Procedure Codes
1010.APPENDIX C	Ambulatory Surgical Data Elements
1010.APPENDIX D	Research Oriented Dataset (RODS) Data Elements
1010.APPENDIX E	Universal Dataset (UDS) Data Elements
1010.APPENDIX F	State Inpatient Dataset (SIDS) Data Elements
1010.APPENDIX G	State Ambulatory Surgery Dataset (SASDS) Data Elements
1010.APPENDIX H	Revenue Code Dataset (RCDS) Data Elements
1010.APPENDIX I	Data Product Price List
1010.APPENDIX J	Data Product Preparation Cost Table
1010.APPENDIX K	Diagnostic and Therapeutic Imaging Categories

AUTHORITY: Implementing and authorized by the Illinois Health Finance Reform Act [20 ILCS 2215] and Sections 2310-33 and 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310/2310-33 and 2310-57].

SOURCE: Adopted at 31 Ill. Reg. 9848, effective June 26, 2007; amended at 36 Ill. Reg. 8017, effective May 8, 2012.

Section 1010.10 Purpose ~~(Repealed)~~

~~This Part is promulgated under the authority of Section 4-2 of the Illinois Health Finance Reform Act [20 ILCS 2215/4-2] and Section 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310/2310-57]. Its purpose is~~

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~~to provide to consumers, health care providers, insurers, purchasers, governmental agencies, and others information to make valid comparisons among health care facilities of prices and performance of services provided and to support ongoing analysis of the health care delivery system in Illinois.~~

(Source: Repealed at 36 Ill. Reg. 8017, effective May 8, 2012)

Section 1010.20 Definitions

~~Unless otherwise indicated, in this Part:~~

~~"Act" means the Health Finance Reform Act.~~

~~"Affirmation statement" means a document that, when signed by a hospital or ambulatory surgical treatment center administrator or an authorized representative of a hospital or ambulatory surgical treatment center submitting data to the Department, affirms, to the best of the signer's knowledge, that all of the following: That any necessary corrections to data submitted to the Department have been made; and that ~~That~~ the data submitted are complete and accurate.~~

~~"AHRQ" means the Agency for Healthcare Research and Quality" or "AHRQ" means a federal agency that is; a part of the U.S. Department of Health and Human Services.~~

~~"Ambulatory patient classification" or "APC" means a definition by the Centers for Medicare and Medicaid Services (CMMS) for the prospective payment system (PPS) under Medicare for hospital outpatient services. All services paid under the PPS are classified into groups called APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC based on the resources involved in treatment.~~

~~"Ambulatory surgical treatment center" means a facility licensed under has the meaning ascribed to that term under Section 3 of the Ambulatory Surgical Treatment Center Act [210 ILCS 5].~~

~~"APC" means ambulatory patient classification, as defined by the Centers for Medicare and Medicaid Services (Medicare), for the prospective payment system (PPS) under Medicare for hospital outpatient services. All services paid under the PPS are classified into groups called APCs. Services in each APC are similar~~

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~~clinically and in terms of the resources they require. A payment rate is established for each APC based on the resources involved in treatment.~~

~~"CCS" means Clinical Classification Software, a diagnosis and procedure categorization scheme developed by the Healthcare Cost and Utilization Project.~~

"CCYYMMMD" means a calendar date in the format of century, year, month and day of the week, where 1 = Sunday, 2 = Monday, etc.

"CCYYMMDD" means a calendar date in the format of century, year, month and day, without separators.

"Claims and encounter" means either ~~a~~of the following: A request to obtain payment, and necessary accompanying information, from a health care provider to a health plan, for health care; or ~~an~~An inpatient stay or outpatient visit in which a claim is not generated.

"Cleaned claims data" means data that have passed validity tests that edit for individual element content and comparison with related elements for appropriate context within the time periods and value ranges appropriate for the data file.

~~"Clinical Classification Software" or "CCS" means a diagnosis and procedure categorization scheme developed by the Healthcare Cost and Utilization Project.~~

"Compliance percentage" means the value obtained when the number of cleaned and unduplicated claims and encounters per calendar month is divided by the reported discharge count for the same calendar month, with the dividend of this calculation multiplied by 100.

~~"Computed tomographic scan" or "CT scan" means a computed tomographic scan of the head and other parts of the human body.~~

"Consumer Guide to Health Care" means a comparative health care information report showing conditions and procedures that demonstrate the widest variation in charges and quality of care in inpatient and outpatient services provided in hospitals and ambulatory surgical treatment centers.

~~"CPT" means~~ Current Procedural Terminology "or "CPT" means, a listing of descriptive terms and identifying codes providing a consistent and standardized

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language for reporting medical services and procedures performed by physicians. These codes are maintained and distributed by the American Medical Association (515 North State Street, Chicago IL 60610).

"Custom dataset" means requests for specific data elements for particular research or reporting tasks. This may include specific aggregations or combinations of data values into categories or groups.

"Data submission manual" means the Department's Technical Reference for Data Submission document specifying the details of the record layout, the outpatient surgical procedure code range, specifications of identification of emergency department and observation cases and contact information for questions related to data submission.

"Data submission profile" means a set of validation and verification reports containing accumulated statistical summaries of all data submitted to the Department by the facility for each month of the current collection period. These reports contain information identifying claims and encounters that fail Departmental edits, as well as data quality statistics showing data accepted up to and including the latest submission.

~~"Data submission manual" means the Department's Technical Reference for Data Submission document specifying the details of the record layout, the outpatient surgical procedure code range, specifications of identification of emergency department and observation cases and contact information for questions related to data submission.~~

"Data use agreement" means a written contract between parties that defines the care and handling of sensitive or restricted use data, including, but not limited to, the terms of the agreement, ownership of the data, security measures and access to the data, uses of the data, data confidentiality procedures, duration of the agreement, disposition of the data at the completion of the contract, and any penalties for violation of the terms of the agreement.

"De-identified" means data that do not contain directly identifiable individual patient health information as defined in HIPAA privacy regulations (Security and Privacy: ~~45 CFR 164~~); or data that, through analysis by an experienced expert statistician or by the use of probability software, can be shown to have a low probability of individual identification.

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"Department" means the Illinois Department of Public Health.

~~"DRG" means~~ "Diagnosis Related Group" or "DRG" means, a patient classification scheme that provides a means of categorizing hospital inpatients according to the resources required in treatment, developed for the Centers for Medicare and Medicaid Services for use in the Medicare Prospective Payment System.

"Diagnostic" means the process used to identify or characterize, as accurately as possible, the details of a medical condition or injury.

"Electronically submit" means that required data submission will be carried out by the transfer of appropriate files to the Department's secure web server. Physical media of any form or type will not be used in the transfer of these data.

"Emergency Department" or "ED" means the location within hospitals where persons receive initial treatment by health care professionals for conditions of an immediate nature caused by injury or illness. The person treated may or may not be admitted to the hospital as an inpatient.

"Emerging technology" means new approaches to the treatment of medical conditions through the use of existing machines and equipment in new and different ways or the development of new machines and equipment for a specific form of medical treatment.

"Ethnicity" means the classification of a person's ethnic background. Classification categories collected will follow the Federal Office of Management and Budget (OMB) Statistical Policy Directive Number 15, "Race and Ethnic Standards for Federal Statistics and Reporting".

"Facility" means a hospital, as defined in the Hospital Licensing Act and the University of Illinois Hospital Act, or an ambulatory surgical treatment center, as defined in the Ambulatory Surgical Treatment Center Act.

"Final closing date" means the final day, 65 days after the end of each calendar quarter, on which electronically submitted corrections and missing data are accepted for each quarterly data submission period.

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~~"FIPS" means~~ "Federal Information Processing Standards" ~~or~~ "FIPS" means, a standardized set of numeric or alphabetic codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies.

"Fully populated test data" means that each field or individual element specified in each record of the file contains data values. Complete data allowallows the exercise of all parts of the computer program used to produce the file. This will provide more robust testing outcomes, reduce the number of test runs necessary, and improve the quality of data submissions.

~~"HCPCS" means the~~ "Healthcare Common Procedure Coding System" ~~or~~ "HCPCS" means; a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). The HCPCS was established to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. HIPAA made the HCPCS mandatory for Medicare and Medicaid billings. HCPCS includes three levels of codes:

Level I consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric.

Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices.

Level III consists of temporary codes for emerging technologies, services and procedures.

~~"HCUP" means the~~ "Healthcare Cost and Utilization Project" ~~or~~ "HCUP" means; a group of health care databases and software tools and products created by a government and industry partnership and sponsored by AHRQ.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. Further explanation can be found in HIPAA privacy regulations (~~Security and Privacy: 45 CFR 164~~).

"HH" means clock time in hours using 24-hour time from 00 to 23 rounded to the nearest hour.

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~~"HIPAA" means Health Insurance Portability and Accountability Act of 1996 (42 USC 1936).~~

"Health Insurance Portability and Accountability Act privacy regulations" or "HIPAA privacy regulations" means regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"Hospital" means any institution, place, building, or agency, public or private, whether organized for profit or not for profit, that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, and the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Imaging" means the technique and process used to create images of the human body or its parts or functions for clinical purposes seeking to reveal, diagnose or examine disease or injury.

"Initial closing date" means the date, 60 days after the end of each calendar quarter, established for all hospitals and ambulatory surgical treatment centers to electronically submit inpatient and outpatient claims and encounter data to the Department.

"Invasive" means a medical procedure that penetrates or breaks the skin or a body cavity by means of a perforation, incision, catheterization or other methods into a patient's body.

"Limited datasets" means data containing protected health information (PHI) that excludes certain direct identifiers of the individual or of relatives, employers or household members of the individual, as defined in HIPAA privacy regulations.

"Magnetic resonance imaging" or "MRI" means a technology used to visualize internal body structures by using strong magnet fields in conjunction with radio frequency fields to analyze deep soft tissue without the use of harmful radiation.

~~"MDC" means "Major Diagnostic Category" or "MDC" means;~~ a collection of DRGs for categorizing specifically defined interventions and illnesses related to an organ or a body system, not to the cause of an illness or injury.

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"Mammography" means the process of utilizing low-dose X-rays to examine the human breast as a diagnostic and screening tool for the detection of cancer.

"Minimally invasive" means a medical procedure carried out by entering the body through the skin or through a body cavity or anatomical opening, but with the smallest disturbance possible to these structures. Special medical equipment may be used, such as fiber optic cables, miniature video cameras, and special surgical instruments handled via tubes inserted into the body through small openings in its surface.

"National Provider Identifier" or "NPI" means a unique identification number assigned to all health care providers to be used by all health plans. The NPI will be issued and maintained by the National Provider System.

"National Uniform Billing Committee" or "NUBC" means the group including all major national provider and payer organizations formed to develop and maintain the national standard health care uniform bill.

"Non-invasive surgery" means a medical procedure using highly focused beams of radiation when the nature or location of the condition is not amenable to mechanical intervention.

~~"NPI" means National Provider Identifier, a unique identification number assigned to all health care providers to be used by all health plans. The NPI will be issued and maintained by the National Provider System.~~

"Observation care" or "OC" means services furnished to a person by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. In general, the duration of observation care services does not exceed 24 hours, although, in some circumstances, patients may require a second day.

"Outpatient" means any health care service provided in a hospital to a patient who is not admitted ~~as an inpatient~~ to the hospital as an inpatient, or any health care service provided to a patient in a licensed ambulatory surgical treatment center.

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"Outpatient surgery" means specific procedures performed on an outpatient basis in a hospital or licensed ambulatory surgical treatment center. Specific ranges of required procedure codes can be found in the Department's data submission manual.

"Personal"PHI" means personal health information" or "PHI" means the information ~~as~~ defined in HIPAA privacy regulations.

"Positron emission tomography scan" or "PET scan" means a nuclear medicine imaging technology that creates a three dimensional view of functional body processes.

"Public use data" means any form of data from the Department's comprehensive discharge database or facility-level database that contains de-identified data.

"Race" means the classification of a person's racial background. Classification categories collected will follow the Federal Office of Management and Budget (OMB) Statistical Policy Directive Number 15, "Race and Ethnic Standards for Federal Statistics and Reporting".

"Raw data" means any file, individual record, or any subset thereof that contains information about an individual health care service provided to a single patient and is released by the Department in data products or custom data files.

"Reciprocal data availability" means that, if a data requester controls the discharge data of another state, release of Illinois discharge data to that state entity would be contingent on the availability of discharge data from that state of comparable quantity, quality, and content at a similar price point.

"Research" means a systematic investigation, including ~~research~~ development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities.

"Small number" means any number that is small enough to be useful in an attempt to determine the identity of a specific individual patient when used in conjunction with other elements in the data file or when the data file is linked with

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information from other sources. The Department considers a small number to be any cell size fewer than 10.

"Sonography" and "Ultrasonography" mean the use of sound waves at frequencies above the audible range of human hearing as a diagnostic tool for visualizing internal body structures, including tendons, muscles, joints, organs and other internal masses.

"Surgery" means treatment of diseases or injuries by manual and/or instrumental methods. ~~The Such~~ methods may include invasive, minimally invasive, or non-invasive procedures, depending on the condition treated and the nature of the instruments and technology used.

"Therapeutic" means medical activities designed to treat or cure a disease, condition or injury.

"Uniform" means related unique data values that are combined into a smaller number of common categories.

"Uniform bill" means the uniform electronic billing form pursuant to the Health Insurance Portability and Accountability Act, which is developed as a standard instrument for use by institutions and payers in the handling of health care claims. (Section 4-2(d)(1) of the Act)

~~"UPIN" means~~ "Unique Physician Identification Number" or "UPIN" means, a unique identification number assigned to all Medicare providers. The UPIN Registry is maintained by the National Heritage Insurance Company under contract from the Centers for Medicare and Medicaid Services.

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

Section 1010.40 Data Submission Requirements

- a) Inpatient and Outpatient Claims and Encounter Data
 - 1) Hospitals and ambulatory surgical treatment centers shall electronically submit patient claims and encounter data, as outlined in this subsection (a), to the Department no later than the initial closing date, 60 calendar days after the last day of each calendar quarter. Calendar quarters shall

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begin on January 1, April 1, July 1, and October 1 and shall end on March 31, June 30, September 30, and December 31. Beginning no later than 45 days after the last day of each calendar quarter, hospitals and ambulatory surgical treatment centers shall begin an internal review of all quarterly data accepted by the Department. The quarterly review shall involve detailed evaluation of data quality feedback reports by facility staff with sufficient general knowledge of patient mix and services provided to allow identification of unreasonable or incomplete submission statistics.

A) Hospitals shall submit to the Department:

- i) Claims and encounter data pertaining to each inpatient discharged. Production ~~data shall be submitted in the current format~~ and test data shall be submitted as specified in Appendix A ~~starting with third quarter 2007 discharges. The transition period will encompass two complete calendar quarters of discharge data submission, third and fourth quarter 2007. The transition period shall begin on July 1, 2007, the first date of submission of third quarter discharges, and end on the closing date of fourth quarter 2007. Mandatory submission of data elements as specified in Appendix A shall begin with the submission of data for patients discharged on January 1, 2008; and~~
- ii) Claims and encounter data pertaining to case data for each emergency department (ED) visit (wherever care is administered) and each observation case (OC) in the outpatient format specified in Appendix C, ~~beginning with a transition submission period starting on April 1, 2008, the first day of submission of second quarter 2008 cases. This transition period shall encompass three complete calendar quarters, second, third and fourth quarter 2008, ending on the final date of submission of fourth quarter 2008 cases. Each facility shall participate in the transition period by submitting and evaluating test data as necessary to meet the requirements. Each facility shall complete at least one successful test submission of a fully populated test file prior to the beginning of the mandated submission period. Mandatory submission of ED and OC data as specified in~~

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~~Appendix C shall begin with the cases for patients discharged in first calendar quarter 2009, beginning on January 1, 2009; and~~

- iii) Claims and encounter data related to diagnostic or therapeutic imaging conducted during or related to an inpatient stay that may include, but are not limited to, techniques described in Appendix K. These data may include, but are not limited to, events occurring during a visit for surgery or scheduled imaging for purposes of evaluating the need for treatment, determining the nature or extent of necessary treatment, or evaluating the outcomes of treatment. Data elements for these cases, specified in Appendix C, shall begin with the cases for patients discharged on October 1, 2012.

- B) Hospitals and ambulatory surgical treatment centers shall report to the Department:
- i) Information relating to any patient treated with an ambulatory surgical procedure within any of the general types of surgeries as specified in Appendix B; ~~and~~
- ii) Claims and encounter data for each surgical or invasive procedure outlined in subsection (a)(1)(B)(i) of this Section, as specified in Appendix C; ~~beginning with a transition submission period encompassing two complete calendar quarters, third and fourth quarter 2007, starting on the first date of submission for third quarter discharges, July 1, 2007. This transition period will end on the final date of submission for fourth quarter 2007 discharges. During the transition period, production data will be accepted only in the current 800-byte format while testing with the new format will be accepted and evaluated. Mandatory submission of elements as specified in Appendix C and detailed in the Department's data submission manual shall begin with patients discharged in first calendar quarter 2008, beginning on January 1, 2008.~~

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- iii) Claims and encounter data related to diagnostic or therapeutic imaging that may include, but are not limited to, techniques described in Appendix K. These data may include, but are not limited to, events occurring during a visit for surgery or scheduled imaging for purposes of evaluating the need for treatment, determining the nature or extent of necessary treatment, or evaluating the outcomes of treatment. Data elements for these cases, specified in Appendix C, shall begin with the cases for patients discharged on October 1, 2012.
- ~~C) Only Hospitals and ambulatory surgical treatment centers shall report data to the Department using the current submission format as specified in the Department's data submission manual for patients discharged up to and including June 30, 2007. Beginning with the start of the transition period on July 1, 2007, production data will be accepted only in the current format with test data accepted in the new format outlined in Appendices A and C and detailed in the Department's data submission manual. The transition period shall include all patients discharged during third and fourth quarter 2007, with the transition period ending on the last date of submission of discharges for fourth quarter 2007. Throughout the transition period, test data will be accepted in the new expanded formats. Test data shall be developed to populate each variable in the expanded layout to allow full evaluation of the data file submitted. Each facility shall participate in the transition period by submitting and evaluating test data as necessary to meet the requirements. Each facility shall complete at least one successful test submission prior to the beginning of the mandated submission period. Beginning with electronic submissions received for patients discharged in first calendar quarter 2008, starting on January 1, 2008, only data consisting of the elements listed in Appendices A and C in the expanded format, as detailed in the Department's data submission manual, will be accepted.~~
- 2) Each hospital and ambulatory surgical treatment center shall electronically submit to the Department all patient claims and encounter data pursuant to this subsection (a). These submissions shall be in accordance with the uniform electronic transaction standards and code set standards adopted by

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the Secretary of Health and Human Services under the Social Security Act (~~42 USC 1320d-2~~) and the physical specifications, format and record layout specified in the Department's data submission manual. ~~Ambulatory surgical treatment centers that are unable to electronically submit data shall submit required data in the specified format on 3.5-inch diskette or CD-ROM disc through the closing date of submission for second quarter 2008 discharges. Beginning with patients discharged for third quarter 2008, starting on July 1, 2008, ambulatory surgical treatment centers shall electronically submit all data to the Department.~~

- 3) To be considered compliant with this Section, a hospital's or ambulatory surgical treatment center's data submission shall:
 - A) Be submitted to the Department electronically, as specified in the data submission manual;
 - B) Consist of an individual facility data file; and
 - C) Meet the Department's minimum level of data submission compliance on or before the data submission due date. ~~i) Hospitals and ambulatory surgical treatment centers shall maintain a compliance percentage of no less than 98% for each calendar month beginning with the calendar month of July 2007.~~
 - ii) ~~Ambulatory surgical treatment centers shall maintain a compliance percentage of no less than 90% during the period beginning with calendar month of July 2007. Beginning with the calendar month of April 2008, ambulatory surgical treatment centers shall maintain a monthly compliance percentage of no less than 95%. Thereafter, beginning with the calendar month of April 2009, ambulatory surgical treatment centers shall maintain a monthly compliance percentage of no less than 98%.~~
- 4) Failure to comply with this Section may subject the facility to penalties as provided in the Ambulatory Surgical Treatment Center Act and the Hospital Licensing Act.

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- b) Inpatient and Outpatient Report of Monthly Discharge and Outpatient Surgery Counts
- 1) Each hospital shall, within 30 calendar days following the last day of each calendar month, submit:
 - A) The actual total number of hospital inpatient discharges for that calendar month. In the case of multiple births, each child is counted as a discharge. This number shall include those inpatient cases receiving diagnostic or therapeutic imaging as defined in subsection (a)(1)(A)(iii); and
 - B) The actual number of hospital outpatient cases with a surgical procedure as defined in this Part for that calendar month.
 - 2) ~~Each~~ Effective beginning with calendar month April 2008, each hospital shall, within 30 calendar days following the last day of each calendar month, submit for each category the actual number of hospital outpatient cases with an emergency department visit, observation stay, or ~~surgery, surgical procedure~~ as defined in this Part for that calendar month. Beginning with patients discharged on October 1, 2012, each hospital shall submit the actual number of cases with an outpatient visit for diagnostic or therapeutic imaging as defined in subsection (a)(1)(B)(iii) Each patient shall be counted only once, except that imaging-only visits shall be counted separately. Outpatient surgical cases, regardless of other services, shall be counted as surgical cases. Non-surgical cases, excluding imaging-only visits, shall ~~may~~ be counted ~~as combined ED and OC or~~ separately as ED ~~and~~ OC, based on. ~~Patients receiving both services should be counted only once in both counting methods: as combined ED and OC in the combined method or counted as OC (the last service received) in the separate method.~~
 - 3) Each ~~licensed~~ ambulatory surgical treatment center shall, within 30 calendar days following the last day of each calendar month, submit the actual total number of licensed ambulatory surgical treatment center outpatient cases with ~~surgery a surgical procedure~~ for that calendar month as defined in this Part. Beginning with patients discharged on October 1, 2012, this count shall include the actual number of cases with a visit for diagnostic or therapeutic imaging as defined in subsection (a)(1)(B)(iii).

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- 4) All filings required in this Section shall be reported using the Department's electronic submission systems.
- 5) Effective 60 days after the end of each calendar quarter, monthly reported discharge count acceptance for that calendar quarter will end. If any facility finds it necessary to change monthly reported counts after the initial closing date and before the final closing date, the facility administrator shall submit the revised monthly count ~~shall be submitted by the facility administrator~~ with a written justification.
- e) ~~Content and quality of new data elements collected as noted in Appendices A and C will be monitored for completeness and accuracy during the transition period and the first two quarters of mandated submission. This data will be released in public reports and data products when appropriate levels of data quality and quantity are attained.~~

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

Section 1010.60 Data Dissemination

- a) The Department will provide facilities the opportunity to review the Consumer Guide to Health Care (Guide) prior to public release. The entire report will be made available to each facility on the Department's secure web server for review before publication. This review period will end 15 working days after the availability date of the review material. During the review period, each facility may submit written comments concerning its report content to the Department. Comments shall be submitted on facility letterhead and shall be signed by the administrator or designee. All comments received by the Department will be kept on file. No comments will be accepted after the end of the review period and no changes to the content of the Guide will be accepted. If any facility or the Department finds erroneous or incomplete data in the Guide, these data will be identified and footnoted prior to publication. If the Department makes an error in the preparation or presentation of the Guide, the error will be corrected.
- b) Limited Data Product and Report requests approved by the Department shall result in the creation of the minimum necessary data set from the population of data elements available to the requester and accompanying data use agreement covering access, usage, distribution and confidentiality of the data.

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- 1) The Department will charge fees to the requesting entity for providing access to data files or producing studies, data products or analyses of ~~such~~ data. A schedule of fees for standard and custom datasets and products according to category of purchaser is presented in Section 1010.70 of this Part. In determining fees, the Department will consider all of the following:
 - A) Type of data and specified usage;
 - B) Record count and computer time required;
 - C) Access fees for computer time;
 - D) Staff time expended to process the request; and
 - E) Handling and shipping charges.
- 2) All requests for data files, data products, aggregations or reports containing limited data elements shall be made in writing to the Department using ~~Department~~~~Departmental~~ forms. All data obtained from the Department shall be used solely for the purpose identified by the requesting entity and for use by the requesting entity. The scope and term of this usage will be detailed in a data use agreement specific to each request. Use of the data for any other purpose shall require a separate and specific written request, approval, and data use agreement.
- 3) When ~~the Department prepares~~ facility-specific data, ~~reports~~~~reporting~~ or comparative ~~analyses~~~~analysis is prepared by the Department~~ for public release, affected facilities will be given the opportunity to review and comment on the data, studies or reports and their content prior to release to the public. Facilities will be provided access to the entire report on the Department's secure web server for review prior to publication. The review period will end 15 working days after the availability date of the review material. While no changes to previously submitted data will be accepted, the Department will accept written comments and explanations from facilities during the review period. The Department will keep these comments and explanations on file and, as appropriate and reasonable, will incorporate them into the text description of the published report,

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study or ~~analysis~~analyses. If a ~~Department~~Departmental error is found in the publication, the error will be corrected.

c) De-identified Data Files and Reports

- 1) Public use data files, reports and studies based on information submitted by hospitals and ambulatory surgical treatment centers shall contain de-identified data and shall comply with State and federal law, including, but not limited to, the Gramm-Leach-Bliley Act and the HIPAA privacy regulations ~~(Security and Privacy: 45 CFR 164)~~.
- 2) All requests for public use files or special compilations, reports, studies or analyses derived from public use files shall be made in writing to the Department. The release of data related to an approved public use data request shall not require a detailed data request form or comprehensive data use agreement. However, each request will be evaluated and, if necessary, ~~will require~~accompanied by a signed ~~or agreed to~~ data use agreement appropriate to the content of the data requested. The data use agreement will include, but not be limited to, restrictions on patient identification and sale or release of the data to third parties.

d) Patient Confidentiality and Data Security

- 1) Patient name, address, any part of the Social Security number, unique patient identifier based on the last four digits of the patient's Social Security number, or any other data that the Department believes could be used to determine the identity of an individual patient shall be stored and processed in the most secure manner possible. (Section 4-2(d)(4) of the Act) Only authorized staff will have access to these data, with all computers and databases secured by password. Only computers located in controlled Department work sites will allow access to these data.
- 2) Patient name, address, and any part of the Social Security number will not be released publicly. These data may be used to link discharge data with other data sets internal or external to the Department, with linkage results released under guidelines of appropriate Department controls. The patient name, address, and any part of the Social Security number will not be released as part of these linkage results. The Department will evaluate any request for access to any or all of these three specific identifiers by

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authorized staff of other Illinois State agencies, local health departments, or approved research project participants individually. Evaluation criteria include need and security of patient confidentiality. The unique patient identifier may be released to State agencies, local health departments and approved data requesters using appropriate guidelines.

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

Section 1010.70 Data Customer Categories and Data Product Fee Schedule

This Section establishes customer categories, data product descriptions, and data product fees. The release of any patient level or small number data by the Department shall be contingent on the approval of the request and execution of an appropriate data use agreement.

- a) Customer categories are established as follows:
 - 1) Category I: Resellers
 - A) Any corporation, association, coalition, person, entity or individual that redistributes in any form any of the data or products (or any subset ~~of the data or products thereof~~) obtained from the Department for any revenue is engaged in reselling of the data or products and shall pay for the data or products at the reseller rate.
 - B) All redistribution shall be restricted to de-identified data as defined by HIPAA privacy regulations (~~Security and Privacy: 45 CFR 164~~).
 - 2) Category II: Commercial, Private, For-Profit Organizations and Non-Illinois State and Local Government Entities
 - A) Any corporation, association, coalition, person, entity or individual that functions in whole or in part for the benefit of the owners, members, or sponsors of the corporation or organization seeking to obtain data or products (or any subset thereof) from the Department is presumed to be acquiring the data or products for a commercial use:-

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- B) Any non-profit organization that purchases data materials on behalf of, either in whole or in part, or receives payment from, for-profit organizations for work done is presumed to be acquiring the data or products for a commercial use;~~-~~
- C) Non-Illinois state and local government data release will be contingent on reciprocal data availability; ~~and-~~
- D) The Department will waive established data fees to non-Illinois government entities when entering into data sharing agreements for exchange of data of similar content. Discharge data received from non-Illinois data sources will be accepted in lieu of the fees shown in Appendix I. This waiver of fees will be contingent upon the non-Illinois entity waiving any fees charged, with acceptance of Illinois data in lieu of payment.
- 3) Category III: Federal government, educational institutions, all non-profit organizations, and college students enrolled in non-Illinois educational institutions, including:
- A) The federal government;~~-~~
- B) Other non-state or local political subdivisions outside of the State of Illinois that are not covered under Category II; ~~and-~~
- C) All educational institutions (Illinois and non-Illinois), all non-profit organizations, and all college students enrolled in non-Illinois educational institutions.
- 4) Category IV: Illinois General Assembly, Executive Office of the Governor, State of Illinois Constitutional Officers, Agencies of Illinois State Government, Illinois county and local government, and college students enrolled in Illinois educational institutions.
- b) The following data products are available at rates established by the Department:
- 1) Standard datasets are defined sets of data elements consisting of the minimum necessary group of elements for a specific request identified from the list of elements available to each category of requester.

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- A) Research Oriented Dataset (RODS) containing data elements listed in Appendix D of this Part.
 - B) Universal Dataset (UDS) containing data elements listed in Appendix E of this Part.
 - C) State Inpatient Dataset (SIDS) containing elements derived for the purposes of the HCUP, Appendix F of this Part.
 - D) State Ambulatory Surgery Dataset (SASDS) containing elements derived for the purposes of the HCUP, Appendix G of this Part.
 - E) Revenue Code Dataset (RCDS), a supplement to datasets A through D containing data elements listed in Appendix H of this Part.
- 2) The Department will evaluate requests for custom datasets and make the determination of complex or simple based on details of the request.
- A) Complex dataset: a subset of RODS, UDS, SIDS or SASDS (with or without RCDS) that contains the majority of significant data elements, or an intricate aggregation or report that includes many significant data elements and compound relationships.
 - B) Simple dataset: a subset of RODS, UDS, SIDS or SASDS (without RCDS) that contains a small number of significant data elements, or a straightforward aggregation or report that includes few significant data elements and no, or a single, relationship.
- c) Standard data product fees by category are set forth in Appendix I of this Part. In addition to standard data product fees, the Department will assess data request processing and data product preparation fees as follows:
- 1) The Department will assess a non-refundable data request application fee of \$100. The application fee shall be applied to the final cost of approved and completed data products.

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- 2) The Department will assess fees for the costs of preparing requested data products, including, but not limited to, programming, research, administrative, media and shipping as described in Appendix J of this Part. The minimum charge will be one unit per resource factor, with additional units as necessary for more complicated requests.

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

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Section 1010.APPENDIX A Uniform Inpatient Discharge Data

Data elements affected by implementation of the ICD-10 coding scheme on October 1, 2013 (or as stipulated by CMMS) are noted when necessary and appropriate.

Header Data

1. ~~Hospital ID (federal tax identification number/Department assigned/NPI)~~
2. ~~Facility name and address (in the header record for verification)~~
3. ~~Facility city~~
4. ~~Facility zip code~~
5. ~~Contact person~~
6. ~~Telephone number~~
7. ~~Period covered: first day~~
8. ~~Period covered: last day~~

Detail Data

1. Hospital identifier (federal tax identification number/Department assigned/NPI)
2. Patient account number
3. Discharge time (HH)
4. Patient zip code and Plus 4
5. Patient birth date (MMDDCCYY)
6. Patient sex
7. Admission date (MMDDYY) and time (HH)

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8. Type of admission
9. Source of admission
10. Patient discharge status
11. Type of bill
12. Total patient charges and components of charges (by revenue code, units of service and charges)
13. Primary payer ID and health plan name
14. Secondary and tertiary payer ID and health plan name (required when present)
15. Principal and secondary diagnosis codes, when present (up to 25 per data record and up to 50 with record pagination when necessary)

ICD-9 codes required: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 codes required: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
16. Principal and secondary procedure codes and dates (MMDDYY), when present (up to 25 per data record and up to 50 with record pagination when necessary)

ICD-9 codes required: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 codes required: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
17. Attending clinician ID number/NPI
18. Other clinician ID number/NPI (up to two required when present)
19. Patient race (according to OMB guidelines)

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20. Patient ethnicity (according to OMB guidelines)
21. Patient county code (~~five~~5 digits: state and county codes for Illinois and border state residents (FIPS code))
22. Diagnosis present at admission for each diagnosis
23. External cause of injury codes (required when present)

ICD-9 Ecodes: three required if available: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 Ecodes: eight required if available: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
24. Newborn birth weight value code and birth weight in grams
25. Admitting diagnosis code

ICD-9 code required: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 code required: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
26. Do not resuscitate indicator (entered in first 24 hours of stay)
27. Prior stay occurrence code and prior stay from and through dates (required when present)
28. Operating clinician ID number/NPI (required when surgical procedures present as a component of treatment)
29. Accident state abbreviation (required when present)
30. Condition employment related (required when present)
31. Accident employment related occurrence code and date of accident (required when present)

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32. Crime victim occurrence code and date of crime (required when present)
33. Statement covers period (from and through [discharge date] dates)
34. Insurance group numbers (up to ~~three~~ required when present)
35. Page number and total number of pages
36. Diagnoses code version qualifier (~~9=ICD-9, ICD-10 not yet implemented~~)
ICD-9 indicator required = 9: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)
ICD-10 indicator required = 0: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
37. Condition code indicating patient admitted directly from this facility's emergency room/department
38. Patient name (first, middle, last, suffix)
39. Patient address (PO Box or street address, apartment number, city and state)
40. Unique patient identifier based on the last four digits of patient Social Security number
41. Primary insured's unique identifier (beneficiary/policy #)
42. Any element or service adopted for use by the the National Uniform Billing Committee pursuant to Section 4-2(d)(14) of the Act. Elements or services would be added as a submission requirement accompanied by sufficient notification to all submitting facilities and health care systems. Notice would be provided no less than 90 days in advance of the submission requirement.

Trailer Data

1. Hospital identifier (Federal tax identification number/Department assigned/NPI)

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2. ~~Number of physical records in the file excluding header and trailer~~

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

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Section 1010. APPENDIX B Ambulatory ~~Surgical~~ Categories Reported by CPT Procedure Codes

1. Surgeries on the integumentary system
2. Surgeries on the musculoskeletal system
3. Surgeries on the respiratory system
4. Surgeries on the cardiovascular system
5. Surgeries on the hemic and lymphatic systems
6. Surgeries on the mediastinum and diaphragm
7. Surgeries on the digestive system
8. Surgeries on the urinary system
9. Surgeries on the male genital system
10. Intersex surgery
11. Surgeries on the female genital system
12. Surgeries on the female reproductive system
13. Surgeries on the endocrine system
14. Surgeries on the nervous system
15. Surgeries on the eye and ocular adnexa
16. Surgeries on the auditory system
17. Emergency department visits
18. Diagnostic imaging

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(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

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Section 1010.APPENDIX C Ambulatory Surgical Data Elements

Data elements affected by implementation of ICD-10 coding scheme October 1, 2013 (or as stipulated by CMMS) are noted when necessary and appropriate.

Header Data

1. ~~Facility identifier (federal tax identification number/Department assigned/NPI)~~
2. ~~Facility name and address (in the header record for verification)~~
3. ~~Facility city~~
4. ~~Facility zip code~~
5. ~~Contact person~~
6. ~~Telephone number~~
7. ~~Period covered: first day~~
8. ~~Period covered: last day~~
9. ~~Surgical site identifier (Department assigned)~~

Detail Data

1. Facility identifier (Federal tax identification number/Department assigned/NPI)
2. Surgical site identifier (Department assigned)
3. Patient account number
4. Patient zip code and Plus 4
5. Patient birth date (MMDDCCYY)
6. Patient sex

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7. Date (MMDDYY) and time (HH) of visit
8. Time (HH) of discharge
9. Type of admission/visit
10. Source of admission/visit
11. Patient discharge status
12. Type of bill
13. Total patient charges and components of those charges (revenue codes, HCPCS codes with modifiers, date of service, units of service and charges)
14. Primary payer ID and health plan name
15. Secondary and tertiary payer ID and health plan name (required when present)
16. Principal and secondary diagnosis codes, when present (up to 25 per data record and up to 50 with record pagination when necessary)

ICD-9 codes required: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 codes required: discharges on and after October 1, 2013 (or first date of revised CMMS acceptance of ICD-10 codes)
17. Principal and secondary procedure codes and dates (MMDDYY), when present (up to 25 per data record and up to 50 with record pagination when necessary); only the values of the CPT coding scheme will be accepted as procedure codes for outpatient data submissions
18. Attending clinician ID number/NPI
19. Operating clinician ID number/NPI
20. Other clinician ID number/NPI (up to 2 required when present)

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21. Patient race (according to OMB guidelines)
22. Patient ethnicity (according to OMB guidelines)
23. External cause of injury codes (required when present)

ICD-9 Ecodes: three required if available: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 Ecodes: eight required if available: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
24. Patient county code (5 digits: state and county codes for Illinois and border state residents (FIPS code))
25. Patient reason for visit (diagnosis codes up to ~~three~~ required when present)
26. Accident state abbreviation (required when present)
27. Condition employment related (required when present)
28. Accident employment related occurrence code and date of accident (required when present)
29. Crime victim occurrence code and date of crime (required when present)
30. Page number and total number of pages of this claim
31. Insurance group number (up to ~~three~~ required when present)
32. Diagnoses code version qualifier (~~9=ICD-9, ICD-10 not yet implemented~~)

ICD-9 indicator required = 9: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 indicator required = 0: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)
33. Statement covers period (from and through [discharge date] dates)

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34. Patient name (first, middle, last, suffix)
35. Patient address (PO Box or street address, apartment number, city and state)
36. Unique patient identifier based on the last four digits of patient Social Security number
37. Primary insured's unique identifier (beneficiary/policy #)
38. Any element or service adopted for use by the National Uniform Billing Committee pursuant to Section 4-2(d)(14) of the Act. Elements or services would be added as a submission requirement accompanied by sufficient notification to all submitting facilities and health care systems. Notice would be provided no less than 90 days in advance of the submission requirement.

~~Trailer Data~~

- ~~1. Facility identifier (federal tax identification number/Department assigned/NPI)~~
- ~~2. Surgical site identifier (Department assigned)~~
- ~~3. Number of physical records in file excluding header and trailer~~

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

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Section 1010.APPENDIX E Universal Dataset (UDS) Data Elements

1. Facility identifier (federal tax identification number/Department assigned/NPI)
2. Patient sex
3. Admission/visit type
4. Admission/visit source
5. Length of stay (in whole days) (inpatient only)
6. Patient discharge status
7. Principal diagnosis code and up to 14 secondary codes
8. Principal procedure code and up to 9 secondary codes
9. DRG (or successor category grouping) code inpatient/APC outpatient
10. MDC (or successor) code inpatient/body system outpatient
11. Total charges
12. Room/board charges (inpatient only)
13. Ancillary charges
14. Anesthesiology charges
15. Pharmacy charges
16. Radiology charges
17. Clinical lab charges
18. Labor/delivery charges (inpatient only)
19. Operating room charges

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20. Oncology charges
21. Other charges
22. Combined bill indicator (inpatient only)
23. Primary health plan type
24. Secondary health plan type
25. Tertiary health plan type
26. Patient county
27. Patient planning area
28. Patient Health Service Area
29. Hospital Health Service Area
- | 30. Patient age (in whole years or days if less than one year)
31. Admission date (CCYYMMD)
- | 32. Patient zip code (zip may be masked when hospital/zip cell size less than 10)
33. Newborn birth weight in grams
34. Do Not Resuscitate (DNR) (inpatient only)
35. Hospitalization employment related
36. Admitting diagnosis code
37. Diagnosis present at admission for each diagnosis code (inpatient only)
38. Ecodes (when present)

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39. Number of days between admission and primary procedure (inpatient only)
(if present)
40. Row ID (when necessary: provides linkage to Revenue Code Dataset)

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)

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Section 1010.APPENDIX K Diagnostic and Therapeutic Imaging Categories

1. X-Ray
2. CT Scan
3. Mammography (diagnostic or screening)
4. Sonography
5. Ultrasonography
6. PET Scans
7. MRI (with and without contrast)
8. Nuclear Medicine

(Source: Added at 36 Ill. Reg. 8017, effective May 8, 2012)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

1. Statutory Authority: 5 ILCS 100/5-70(c)
2. Summary of information: The Department of Healthcare and Family Services (HFS) is considering changes by which hospitals and nursing facilities are reimbursed for providing medical services, for dates of service on or after July 1, 2012.

For hospital inpatient and outpatient services, the HFS proposes to reduce reimbursement rates by twelve percent. These proposed reductions are estimated to reduce spending by \$497.0 million on an annual basis (\$300.7 million during State fiscal year 2013).

For nursing facilities services, the HFS proposed to reduce reimbursement rates by twelve percent. These proposed reductions are estimated to reduce spending by \$203.3 million on an annual basis (\$123.9 million in State fiscal year 2013).

3. Name and address of person to contact concerning this information:

Any interested party may submit comments, data, views, or arguments concerning these proposed changes. All comments must be in writing and should be addressed to:

Greg Wilson
Illinois Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
201 South Grand Ave E. 2nd Fl
Springfield, Illinois 62794
E-mail address: hfs.bpra@illinois.gov

This notice is being provided in accordance with federal requirements provided at 42 *CFR* 447.205. Hearings related to these proposed changes will be considered during legislative hearings. The time and locations of such hearings will be announced through the website of the Illinois General Assembly at: www.ilga.gov

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of May 8, 2012 through May 14, 2012 and have been scheduled for review by the Committee at its June 12, 2012 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start Of First Notice</u>	<u>JCAR Meeting</u>
6/14/12	<u>Department of Central Management Services, Merit and Fitness (80 Ill. Adm. Code 302)</u>	3/16/12 36 Ill. Reg. 3990	6/12/12
6/20/12	<u>Illinois Commerce Commission, Standards of Service for Local Exchange Telecommunications Carriers (83 Ill. Adm. Code 730)</u>	10/7/11 35 Ill. Reg. 15695	6/12/12
6/20/12	<u>Department of Natural Resources, Illinois Youth Recreation Corps Grant Program (17 Ill. Adm. Code 3075)</u>	3/9/12 36 Ill. Reg. 3618	6/12/12
6/22/12	<u>Secretary of State, Department of Personnel (80 Ill. Adm. Code 420)</u>	3/9/12 36 Ill. Reg. 3625	6/12/12
6/24/12	<u>Department of Financial and Professional Regulation, Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004 (68 Ill. Adm. Code 1240)</u>	3/23/12 36 Ill. Reg. 4215	6/12/12

ILLINOIS ADMINISTRATIVE CODE
Issue Index - With Effective Dates

Rules acted upon in Volume 36, Issue 21 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquiries about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

PROPOSED RULES

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89 - 153	7966
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ADOPTED RULES

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