1	CH	TITLE 89: SOCIAL SERVICES
2 3	Сн	APTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES SUBCHAPTER d: MEDICAL PROGRAMS
4		
5		PART 147
6	RE	IMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES
7		
8	Section	
9	147.5	Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System
10		(Repealed)
11	147.15	Comprehensive Resident Assessment (Repealed)
12	147.25	Functional Needs and Restorative Care (Repealed)
13	147.50	Service Needs (Repealed)
14	147.75	Definitions (Repealed)
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16	147.105	Midnight Census Report
17	147.125	Nursing Facility Resident Assessment Instrument (Repealed)
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19	147.175	Minimum Data Set (MDS) Integrity (Repealed)
20	147.200	Minimum Data Set (MDS) On-Site Review Documentation (Repealed)
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24	147.300	Payment to Nursing Facilities Serving Persons with Mental Illness
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27		Illness in Residential Facilities (Repealed)
28	147.310	Implementation of a Case Mix System
29	147.315	Nursing Facility Resident Assessment Instrument
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32	147.330	Resource Utilization Groups (RUGs) Case Mix Requirements
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39		Facilities
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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].

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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

68 maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, 69 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

71 April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg.

72 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991;

emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150

days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479,

effective March 20, 1992; emergency amendment at 16 III. Reg. 13361, effective August 14,

76 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992;

77 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

81 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944,

of 25, 1994, afficitive June 5, 1995; amended at 20 III. Reg. 6053, effective May 6, 1996; amended at 21 III.

82 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. 2003, effective February 15

Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15,

2002; emergency amendment at 27 III. 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

87 July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 88 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 89 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 90 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 91 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; 92 emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 93 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended 94 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 95 150 days; emergency amendment modified in response to the objection of the Joint Committee 96 97 on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 98 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 99 14, 2010; amended at 35 Ill. Reg. 19514, effective December 1, 2011; amended at 36 Ill. Reg. 100 7077, effective April 27, 2012; emergency amendment at 38 III. Reg. 1205, effective January 1, 101 2014, for a maximum of 150 days; Sections 147.335(a)(7)(B) and 147.355(b) of the emergency 102 amendment suspended by the Joint Committee on Administrative Rules at 38 Ill. Reg. 3385, 103 effective January 14, 2014; suspension withdrawn at 38 Ill. Reg. 5898, effective March 7, 2014; 104 emergency amendment modified in response to JCAR Objection at 38 Ill. Reg. 6707, effective March 7, 2014, for the remainder of the 150 days; amended at 38 Ill. Reg. 12173, effective May 105 106 30, 2014; emergency amendment at 38 Ill. Reg. 15723, effective July 7, 2014, for a maximum of 107 150 days; amended at 38 Ill. Reg. 23778, effective December 2, 2014; amended at 45 Ill. Reg. 8326, effective June 28, 2021; emergency amendment at 46 Ill. Reg. 12156, effective July 1, 108 109 2022, for a maximum of 150 days; amended at 46 Ill. Reg. 19682, effective November 28, 2022; 110 amended at 49 Ill. Reg. 1849, effective January 30, 2025; amended at 50 Ill. Reg. 111 effective _____ 112

Section 147.335 Enhanced Care Rates

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An additional enhanced rate is applied for certain categories of residents that are in need of more resources.

a) Ventilator Services - Requests for ventilator services enhanced care rate must be submitted within 45 calendar days from the requested start date in accordance with Section 513 of 89 Ill. Adm. Code 140. Renewal requests for ventilator services enhanced care rate shall be submitted every 12-months for renewal (365 days from last approval date). Renewal requests must be submitted within 45 days or may be subject to suspension or discontinuation of the enhanced rate. The following criteria shall be met to be eligible for enhanced rates.

- 1) Eligible Criteria for Ventilator Services Enhanced Care Rate
 - A) The ventilator enhanced care rate provides reimbursement to residents requiring mechanical ventilation through a functioning

130			tracheostomy. Invasive mechanical ventilation (IMV) is defined as
131			any type of electrically or pneumatically powered closed-system
132			mechanical ventilator support device that ensures adequate
133			ventilation in the resident who is or who may become (such as
			•
134			during weaning attempts) unable to support their own respiration.
135			During invasive mechanical ventilation the resident's breathing is
136			controlled by the ventilator.
137			
138		<u>B)</u>	Participants must have a functioning tracheostomy and require the
139			use of invasive ventilation for no less than 75% of the day, or at
140			least 18 hours daily, 7 days a week.
141			
142	<u>2)</u>	<u>Non - </u>	Eligible Criteria for Ventilator Services Enhanced Care Rate
143			
144		<u>A)</u>	Non-invasive ventilation (NIV) or Non-invasive Positive Pressure
145			Ventilation (NIPPV) is defined as any type of respiratory support
146			device that prevent airways from closing by delivering slightly
147			pressurized air continuously or via electronic cycling throughout
148			the breathing cycle. This includes but not limited to Continuous
149			Positive Airway Pressure (CPAP), Bi-level Positive Airway
150			Pressure (BiPAP), Pressure Support Ventilation (PS or PSV) or
151			Volume Support (VS). Non-invasive ventilator mode and devices
152			enables the individual to support their own spontaneous respiration
153			by providing enough pressure when the individual inhales to keep
154			their airways open, unlike invasive ventilation that delivers a
155			controlled breath for the individual.
156			controlled bloddl for the marvadal.
157		<u>B)</u>	Ventilator or respiratory devices used to deliver non-invasive
158		<u>D)</u>	modes of ventilation such as CPAP and its various settings, BiPAP
159			and its various settings, PSV or VS shall not be counted as
160			ventilator services for the enhanced care rate, with the exception of
161 162			approved active weaning from invasive mechanical ventilation.
162		α	Non-the-state and the form of the desire of the desire of the
163		<u>C)</u>	Non-invasive ventilation modes utilized during the day, with
164			ventilator use at night, are not eligible for the enhanced care rate
165			with the exception of approved active weaning from invasive
166			mechanical ventilation.
167			
168		<u>D)</u>	The ventilator enhanced care rate is not available for those
169			participants requiring mechanical ventilation during sleep hours
170			<u>only.</u>
171			

172		<u>E)</u>	Sleep ap	onea, obesity, or other non-ventilator dependent diagnoses
173			are not e	eligible for the enhanced rate.
174		T	5	
175		<u>F)</u>	_	ants that transition into Hospice coverage are not eligible
176 177			for the v	rentilator enhanced care rate.
178		G)	Physicia	in Order Sheets (POS) orders such as PRN, as needed, or
179		<u>0)</u>		ventilator orders are not eligible for the enhanced care
180			rate.	
81				
182	<u>3)</u>	<u>Ventil</u>	ator Wear	ning Guidelines for Enhanced Rate Approval.
183				
184		<u>A)</u>		ning process is eligible for enhanced rates with approved
185			•	reaning from invasive mechanical ventilation to a non-
186 187				ventilation mode. Residents are considered actively
188				when the facility is making active attempts to liberate the from invasive mechanical ventilation. Non-invasive
189			•	on used in active ventilator weaning may be considered
190				uired documentation.
191				
192		<u>B)</u>	Weaning	g shall be documented daily in the clinical record and
193			submitte	ed with the request for payment. Requirements for eligible
194			weaning	must include but are not limited to:
195				~
196			<u>i)</u> (Continuous pulse oximetry.
197			::\ T	Daily anantanagus hugathing tuigle
199			<u>ii)</u> <u>I</u>	Daily spontaneous breathing trials.
200			iii) <u>I</u>	Daily weaning log or documentation showing ventilator
201				weaning start time and weaning end time.
202			_	
203			<u>iv)</u> <u>I</u>	Daily documentation of successful ventilator weaning or
204			<u>f</u>	<u>ailed weaning attempts.</u>
205				
206				Daily documentation of barriers to weaning or lack of
207			7	weaning progression during the weaning process.
208 209			vi) I	Daily documentation of significant change from maximum
210				ventilator settings to lower ventilator settings.
211			7	remainder settings to lower ventuator settings.
212		<u>C)</u>	A reside	ent must be weaning on the ventilator to be eligible for
213				l of ventilator weaning. Weaning such as but not limited to,
214				llar, high-flow oxygen, nasal cannula, trach capping,

215			speaking valve trials (PMV) or weaning for decannulation are not
216			eligible for approval of ventilator weaning.
217		D)	All almost the and amost demanded and a control of a decidentic
218		<u>D)</u>	All physician and provider progress notes must clearly identify active ventilator weaning from invasive mechanical ventilation to
219 220			non-invasive ventilation.
221			non-myasive ventuation.
222		<u>E)</u>	Ventilator or respiratory devices used to deliver non-invasive
223		<u>L)</u>	modes of ventilation such as but not limited to CPAP and its
224			various settings, BiPAP and its various settings, PSV or VS
225			without clear documentation that identifies active weaning from
226			invasive mechanical ventilation are not eligible for weaning
227			approval.
228			
229	<u>4)</u>	Reside	ent Approval Requests for Ventilator Services Enhanced Care Rate.
230			
231		<u>A)</u>	Authorized providers shall notify the Department of Healthcare
232			and Family Services using a Department designated form for all
233			ventilator services enhanced care rate start and discontinue
234			requests and shall provide all required documentation with the start
235			or discontinue requests. Start and discontinue requests must be
236			submitted within the time frame specified on the form or in other
237			communications (e.g., Provider Notice) from the Department
238			specifying submission timeframes. The form and supporting
239			documentation must be Health Insurance and Accountability Act
240 241			(HIPAA) compliant and submitted through secure electronic scan.
242		<u>B)</u>	Notification of admission and changes in resident status shall be
242		<u>D)</u>	submitted in accordance with Section 513 of 89 Ill. Adm. Code
244 244			140. Delayed start requests submitted over 45 calendar days past
245			the requested start date, will have a new effective date when the
246			email request was received by the Department.
247			email request was received by the Beparement.
248		<u>C)</u>	The ventilator enhanced care rate start request must include
249			Physician Order Sheets (POS) that identifies the need for and
250			delivery of eligible ventilator services. The effective date of the
251			POS must correspond to the ventilator services effective start date
252			requested on the form. Physician orders must be written, signed,
253			and dated within 24 - 72 hours of the order date. The POS must
254			also identify the ventilation mode, settings, and parameters along
255			with duration. Physician orders must be current and within 90 days
256			of the requested start date. In addition, all other required
257			documentation specified on the form must be included with the

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- request. Inconsistent or incomplete documentation of ventilator use is subject to denial.
- D) All respiratory therapy (RT) documentation must also correspond exactly to the ventilator services effective start date requested.

 Documentation must clearly and accurately document full ventilator services (including mode, settings, treatments, etc.). It must also document actual (correct) times placed on and removed from the ventilator. RT documentation must also correspond to the POS and other directives documented in the clinical record by the pulmonologist or physician experienced in the management of ventilator care. If the resident is weaning from the ventilator, the start request must include a weaning order with full weaning directives. Inconsistent or incomplete documentation of ventilator use is subject to denial.
- E) Additional information may be requested for completion of the review. Providers must submit all additional documentation by the required due date. A facility will be given no more than 10 days to provide the requested information.
- <u>F)</u> The medical records shall contain POS for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning.
- G) If anytime during the pre-approval process, the resident is discharged to the hospital and returns after 24-hours, a new POS is required with an effective date that corresponds to the return date in addition to all supporting documentation.
- H) In the case where a ventilator service request is submitted on a resident who was only in the facility for one day prior to discharging to the hospital, the request will be held until the resident returns from the hospital or until a discontinuation form is submitted. A new POS is required with an effective date that corresponds to the return date in addition to all supporting documentation.
- In the case where a ventilator service request is submitted on a resident that discharges to the hospital during the pre-approval process, the ventilator service request will be held until the resident returns from the hospital or until a discontinuation form is submitted. A new POS is required with an effective date that

301 302 303 304 305 306 307 308 309		corresponds to the return date in addition to all supporting documentation. Ventilator service requests will not be held more than 30 days pending a hospital return. If a resident is discharged to the hospital with return anticipated and does not return within 30 days after discharge or resident returns and discharges again, the ventilator service request will be determined based on the information provided and only through the last day on eligible ventilator services in the facility. The facility can reapply if the resident returns to the facility on eligible ventilator services.
310 311 312 313 314 315 316 317 318 319 320 321	<u>T</u>)	A facility shall also use the designated form to notify the Department when a resident is no longer receiving ventilator services. Providers are required to submit a discontinue request within the time frame specified on the form or in other communications (e.g., Provider Notice) from the Department specifying submission timeframes. All required documentation specified on the form must be included with the discontinue request. Additional information may be requested for the review, and providers must submit all additional documentation within the time frame required by the Department.
322 323 324 325	<u>K)</u>	A submission with a same-day start request and hospital discontinuation is not eligible for ventilator services enhanced care rate.
326 327 328	<u>L)</u>	The discontinue date is always the last date the resident was on eligible ventilator services in the facility.
329 330 331 332 333 334 335	<u>M)</u>	All ventilator start and discontinue requests will be compared to Minimum Data Set (MDS) assessment admit, discharge, and Medicare dates. The MDS assessment reference data and the relevant Section S item response data must document that the resident is on eligible ventilator services in the facility for the requested date.
336 337 338 339 340 341 342 343	<u>N)</u>	If the Department review determines that the ventilator service request does not meet the enhanced care rate requirements in this rule, the request will be denied. Providers will be emailed a letter specifying the reasons for the denial and will be given 30 calendar days to submit a written appeal and supporting documentation for review, except in cases where the requested additional information was not received. A response to the appeal will be returned within 120 days after the date the appeal was received by the Department,

344			except in cases where the Department requires additional
345			information from the facility. In such case, the 120-day clock is
346			paused until the additional information is received, and then
347			restarts upon receipt of the additional information. A facility will
348			be given no more than 10 days to provide the requested
349			information. If the facility fails to submit an appeal as required
350			within 30 calendar days, or if the facility fails to provide any
351			additional required documentation, or if the appeal does not
352			document full compliance with the rule requirements, the denial
353			will stand and there will be no further appeal or recourse.
354			
355		<u>O)</u>	Ventilator service requests that result in denial due to information
356			not received are not eligible for appeal and the denial will be final
357			
358	<u>5)</u>	Proces	ss for Facility to Become Authorized for Ventilator Services
359		Enhar	nced Care Rate.
360		Provid	ders must be authorized by the Department of Healthcare and Famil
361		Service	ces as a ventilator services facility to submit requests for enhanced
362		care ra	ate for eligible ventilator residents. To be considered for ventilator
363		facilit	y status, the provider must submit a request for an application; this
364		requir	red for both new facility applicants (not previously authorized) and
365		for the	e new owner(s) of a previously authorized facility that has had a
366		chang	e of ownership (CHOW). New facility applicants must have a fully
367		functi	oning ventilator unit at the time of their application, and all
368		<u>requir</u>	rements of this Section must be met prior to the effective date
369		reques	sted for ventilator facility status. CHOW applicants need to ensure
370		that al	Il rule requirements have been met by the new owner at the time of
371		the ap	plication.
372			
373		<u>A)</u>	The initial application and all required documentation must be
374			submitted within 45 days of the date it was emailed. A full international
375			review of the facility's application will determine if the applicant
376			meets all requirements detailed in this rule, or if additional or
377			missing documentation is required to complete the review.
378			
379		<u>B)</u>	On-site reviews will be conducted when a new facility application
380			is submitted and every one to three years thereafter. Facilities wil
381			be notified by the Department prior to the on-site review.
382			
383		<u>C)</u>	Facilities must provide documentation that clearly and accurately
384		•	identifies their facility on company letterhead. The use of other
385			facilities policies, procedures, protocols, or documentation will no
386			be accepted.
			-

- nial due to information the denial will be final.
- f Healthcare and Family requests for enhanced nsidered for ventilator for an application; this is ously authorized) and cility that has had a cants must have a fully ication, and all he effective date
 - umentation must be emailed. A full internal ermine if the applicant or if additional or lete the review.
 - new facility application nereafter. Facilities will on-site review.
 - clearly and accurately ead. The use of other documentation will not

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- D) Facilities that fail to provide full documentation in the time required, or facilities that do not document full compliance with all rule requirements, are subject to denial of ventilator facility status.
- E) The facility's requested start date may also be adjusted to correspond with the date the Department determines the facility was compliant with the rule and provided a complete application documenting full rule compliance. This will be determined by the dates the provider application fully documents compliance with all rule requirements, including but not limited to approved and dated policies, procedures, and all required in-service trainings as specified in this rule. The facility's effective date can be no sooner than 30 days from the application submission date.
- Once authorized as an approved facility, backdated resident requests and all required documentation must be submitted within 45 calendar days of the facility approval notification. Delayed start requests submitted over 45 calendar days past the requested start date, will have a new effective date when the email request was received by the Department.
- Process to Appeal a Facility Denial of Authorization for Ventilator
 Services Enhanced Care Rate.

 Facilities may file an appeal within 30 calendar days of the date the
 facility was notified of the denial or the start date adjustment. The facility
 must include a cover letter detailing the specific reasons for the appeal and
 must provide all documentation required to support the appeal. A response
 to the appeal will be returned within 120 days after the date the appeal was
 received in our office, except in cases where the department requires
 additional information from the facility. In such case, the 120-day clock is
 paused until the additional information is received, and then restarts upon
 receipt of the additional information. A facility will be given no more than
 10 days to provide the requested information.
 - A) If the facility fails to submit an appeal as required within 30 calendar days, or if the facility fails to provide any additional required documentation, the denial or start date adjustment will stand and there will be no further appeal or recourse.
 - B) A facility that was denied may submit a new application request no sooner than 90 days from the date of the Department's final determination of the appeal.

430		C	A facility that was denied and does not submit an annual may
431 432		<u>C)</u>	A facility that was denied and does not submit an appeal may request a new application no sooner than 90 days from the date of
432 433			the Department's original denial letter.
434			the Department's original demar letter.
435		D)	Once a facility application is denied, resubmission of a new facility
436		<u>D)</u>	application will not be backdated to the previous application date
437			of noncompliance.
			of noncomphance.
438		E	Once a facility application is denied desympatotion submitted
439 440		<u>E)</u>	Once a facility application is denied, documentation submitted
440			with a previously denied application cannot be reprocessed with a
441			new application submission. All required documentation must be
442			submitted with a new facility application.
443	7)	Chita ni	6- 6- 7- 114- A-4- 11-4- 4- D'11 6- W-41-4- C
444	<u>7)</u>	•	a for Facility Authorization to Bill for Ventilator Services Enhanced
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446			bllowing criteria shall be met for a facility to qualify for the
447		ventila	ator services enhanced care rate reimbursement.
448		A >	
449		<u>A)</u>	Facilities shall be equipped with technology that enables it to meet
450 451			the respiratory therapy, mobility and comfort needs of its ventilator
451 452			dependent patients.
452 453		D)	
453		<u>B)</u>	Clinical assessment of oxygenation and ventilation-arterial blood
454 455			gases or other methods of monitoring carbon dioxide and
455			oxygenation shall be available on-site for the management of
456 457			ventilator dependent residents. Documentation shall support
457 450			clinical monitoring of oxygenation stability is completed at least
458 450			twice a day.
459		C)	
460		<u>C)</u>	The facility's dated emergency policies and procedures must
461 462			clearly document the continued operation of all equipment needed
462			to maintain the health and safety of ventilator dependent residents
463			in the event of all emergency situations. The facility must also
464			provide policies if/when the facility may lose power or unable to
465			operate safely. Emergency and life support equipment, including
466 467			mechanical ventilators, shall be connected to electrical outlets with
467			back-up generator power in the event of a power failure and shall
468			comply with Section 2940 of 77 Ill. Adm. Code 300.
469 470		D)	The constitution of all bears developed to 1000 and 1000
470		<u>D)</u>	The provider shall have dated policies, procedures, and
471 472			documented transfer agreements ensuring the safe transfer of
472			ventilator dependent residents. Transfer procedures must be with

473 474		local qualified hospitals or nursing facilities capable of providing the ventilator care required to maintain and ensure the safety of
475 476		these residents in the event of an emergency.
477 478	<u>E)</u>	The provider shall have dated policies, documentation, and agreements in place to ensure maintenance and testing of the back-
479 480		up generator, as well as provision of a supplemental generator in the event the back-up generator fails to operate. Facilities shall
481 482		comply with the requirements of 77 Ill. Adm. Code 300 regarding emergency power requirements.
483 484 485	<u>F)</u>	An audible ventilator alarm system shall be required to alert staff
485 486 487		of a ventilator malfunction, failure or resident disconnect. The alarm system shall be connected to a centralized notification
487 488 480		system located at a 24-hour monitored location such as the nursing staff desk on the ventilator unit and may include additional
489 490 401		notifications connected to staff phones or beepers. Backup ventilators shall be available at all times to ensure continuous
491 492 493		ventilation in case of a power failure or equipment failure. The exact number of backup ventilators should be based on the
494 495		facility's size and the number of ventilated patients. The facility must ensure the backup ventilators are fully serviced and
493 496 497	G)	maintained properly. Facilities licensed under the Nursing Home Care Act [210 ILCS]
498 499	<u>G)</u>	45] shall have a minimum of one Registered Nurse (RN) on duty for 8 consecutive hours, 7 days per week, as required by Section
500 501 502		300.1240 of 77 Ill. Adm. Code 300. For facilities licensed under the Hospital Licensing Act [210 ILCS 85], an RN shall be on duty at all times, as required by Section 250.910 of 77 Ill. Adm. Code
503 504		250.
505 506	<u>H)</u>	<u>Licensed nursing staff shall be on duty in sufficient numbers to</u> meet the needs of residents as required by Section 300.1230 of 77
507 508 509		Ill. Adm. Code 300. For facilities licensed under the Nursing Home Care Act, the Department requires that an RN shall be on call, if not on duty, at all times.
510 511 512	<u>I)</u>	No less than one licensed Respiratory Care Practitioner (RCP) licensed in Illinois shall be available on duty on every shift seven
513 514		days per week. The RCP shall provide care, monitor life support systems, administer medical gases and aerosol medications, and

515		perform diagnostic testing as determined by the needs and number
516		of the ventilator dependent residents being served by a facility.
517		
518	<u>J)</u>	The respiratory care practitioner shall fully assess, evaluate, and
519		document the respiratory status of a ventilator dependent resident
520		on no less than a weekly basis. All care and treatments given to
521		every ventilator dependent resident shall be fully documented on
522		each shift by the respiratory care practitioner. Full weaning
523		documentation, including all successful and failed weaning
524		attempts, shall be documented on every shift where the respiratory
525		care practitioner attempted to wean the ventilator dependent
526		resident from the ventilator.
527		TOST CONT CONT CONT.
528	<u>K)</u>	Documentation shall support the ventilator dependent resident
529	11/	receives tracheostomy care at least daily.
530		receives tracine ostority vare at reast daily.
531	<u>L)</u>	A pulmonologist, or physician experienced in the management of
532	<u>27</u>	ventilator care, shall direct the care plan for ventilator dependent
533		residents on no less than a weekly basis and this must be
534		documented in the clinical record. Any changes to the resident's
535		ventilator dependent status, including weaning directives, must be
536		kept current & updated in the clinical record. Physician orders for
537		ventilator services must be kept current and shall be routinely
538		updated, even if there are no changes, at minimum every 90 days.
539		<u> </u>
540	M)	At least two of the current, full-time licensed nursing staff
541	<u> </u>	members shall have successfully completed a course in the care of
542		ventilator dependent individuals and the use of the ventilators,
543		conducted and documented by a licensed respiratory care
544		practitioner or a qualified registered nurse who has at least one-
545		year experience in the care of ventilator dependent individuals.
546		This must be a regularly scheduled course, such as a continuing
547		education class, and must include training materials, post-training
548		assessment or exam, and a certificate documenting successful
549		completion of the course.
550		
551	<u>N)</u>	All staff caring for ventilator dependent residents shall have
552		documented in-service training in ventilator care prior to providing
553		such care. In-service training shall be conducted at least annually
554		by a licensed respiratory care practitioner or qualified registered
555		nurse who has at least one-year experience in the care of ventilator
556		dependent individuals. Training shall include, but is not limited to,
557		status and needs of the resident, infection control techniques,

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communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

- Ventilator Approved Facilities Policies and Training Requirements.

 To be eligible to receive the ventilator services enhanced care rate, facilities shall be required to implement written and dated facility-specific policies and protocols, as well as related in-service trainings in the areas listed below. All in-service training must be provided by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Inservice training documentation shall include at minimum: the name and title of the in-service director; the duration of the presentation; the content of presentation; and the printed name, signature, and position description of all participants. The in-service trainings require a minimum of 30 minutes per topic and all materials provided to participants and used in the training must be provided upon request to the Department. The required areas are:
 - A) Pressure Ulcers. A facility shall have established, dated policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers for the ventilator dependent resident. Staff assigned to care for the ventilator dependent resident shall receive in-service training on this area prior to providing care and annually thereafter.
 - <u>Documentation shall support the ventilator dependent</u> resident has been assessed weekly for their risk for developing pressure ulcers.
 - ii) Documentation shall support that interventions for pressure ulcer prevention were implemented and include, but are not limited to, a turning and repositioning schedule every 2 hours according to best medical practices, use of pressuring reducing devices, hydration and nutritional interventions and daily skin checks.
 - B) Pain. A facility shall have established, dated policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain for

501 502 503		the ventilator dependent resident. Staff assigned to care for the ventilator dependent resident shall receive in-service training on this area prior to providing care and annually thereafter.
504 505 506 507		i) Documentation shall support the ventilator dependent resident has been assessed daily for the presence of pain and the risk factors for developing pain.
508 509		ii) Documentation shall support an effective pain management regimen is in place for the resident.
511 512 513 514 515	<u>C)</u>	Immobility. A facility shall have established, dated policies and procedures to assess the possible effects of immobility for the ventilator dependent resident. These shall include, but not be limited to, range of motion techniques, contracture risk. Staff
516 517 518 519		assigned to care for the ventilator dependent resident shall receive in-service training on this area prior to providing care and annually thereafter.
520 521 522 523		i) Documentation shall support the ventilator dependent resident's risk for contractures were assessed on admission within 14 days and thereafter weekly and interventions are in place to reduce the risk.
524 525 526 527		ii) Effects of immobility will be monitored, and interventions implemented as needed.
528 529 530 531 532 533 534	<u>D)</u>	Risk of infection. A facility shall have established, dated policies and procedures on assessing risk for developing infection and prevention techniques for the ventilator dependent resident. These shall include, but are not limited to proper hand washing techniques, aseptic technique in delivery care to a resident, and proper care of equipment and supplies. Staff assigned to care for the ventilator dependent resident shall receive in-service training on this area prior to providing care and annually thereafter.
536 537 538 539		i) Documentation shall support the ventilator dependent resident was given oral care every shift to reduce the risk of infection.
540 541 542 543		ii) Documentation shall support the facility has a method to monitor and track infections.

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644	<u>E)</u>	Social Isolation. A facility shall have established
645		and procedures as well as a method of assessing
646		dependent resident's risk for social isolation. In
647		in place to involve the resident in activities whe
648		assigned to care for the ventilator dependent res
649		in-service training on this area prior to providing
650		thereafter.
651		
652	<u>F)</u>	Communication. A facility shall have establish
653		and procedures on assessing communication ne
654		for the ventilator dependent resident. These sha
655		not limited to Passy-Muir Valve (PMV) use as
656		non-verbal communication. Staff assigned to c
657		ventilator dependent resident shall receive in-se
658		this area prior to providing care and annually th
659		
660		<u>i)</u> <u>Documentation shall support the ventila</u>
661		resident is assessed on admission and w
662		up assessment within 14 days to determine
663		Resident shall be assessed weekly there
664		swallowing treatment.
665		
666		ii) The assessment shall be completed by a
667		and interventions should be in place to a
668		communication and swallow status.
669		
670	<u>G)</u>	Status and Needs. A facility shall have establis
671		and procedures to include monitoring expectation
672		dependent resident, routinely assessing the resident
673		needs, and specific staff training related to vent
674		care. Staff assigned to care for the ventilator de
675		shall receive in-service training on this area price

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- ed, dated policies g a ventilator terventions shall be en possible. Staff sident shall receive g care and annually
- ed, dated policies eds and techniques all include but are well as methods for are for the ervice training on ereafter.
 - tor dependent rill receive a followine needs and goals. after for speech and
 - Speech Therapist assist with
- shed, dated policies ons of the ventilator dent's status and ilator settings and pendent resident shall receive in-service training on this area prior to providing care and annually thereafter.
- H) Equipment. A facility shall have established, dated policies and procedures to maintain quality standards and reduce cross contamination. The facility shall have an established, dated policy for cleaning and maintaining all ventilators and related equipment required for the care of the ventilator dependent resident. Staff assigned to care for the ventilator dependent resident shall receive in-service training on this area prior to providing care and annually thereafter.

687	<u>9)</u>	Ventila	tor Service Facility Audits.
688		Departr	ment staff shall conduct desk audits and on-site visits on a random
689		or targe	ted basis to ensure both facility and resident compliance with
690		require	ments. All records shall be accessible to determine that the needs
691		of a res	ident are being met and to determine the appropriateness of
692		ventilat	or services. In addition to the requirements of this subsection (a),
693		Departr	ment review shall include, at a minimum, the following:
694		_	-
695		<u>A)</u>	The tracking of Ventilator Associated Pneumonia;
696			
697		<u>B)</u>	Documentation to track hospitalizations, reason for
698			hospitalizations, and interventions aimed at reducing
699			hospitalizations for ventilator dependent residents; and
700			<u>-</u>
701		<u>C)</u>	Ventilator Weaning.
702		<u>C)</u>	ventuator venturg.
703	10)	Ventila	tor Services Enhanced Care Rate
704	10)	_	lator services enhanced care rate shall be added to the facility daily
705			ermined by the methodology at (list rule citation):
706		rate det	erinined by the methodology at (list full citation).
707		<u>A)</u>	Payment shall be made for each individual ventilator dependent
708			resident receiving eligible ventilator services.
709			resident receiving engible ventuator services.
710		D)	Effective January 1, 2024, the add-on rate for eligible ventilator
711			•
			services is \$481 per day.
712 713	Vantil	oton Com	rices The following criteria shall be met to be eligible for
	*	ator serv ced rates	
714	ennan	sea rates	.
715	1)	Vantile.	tous one defined as any type of electrical an analysis tipelly necessari
716	1)		tors are defined as any type of electrical or pneumatically powered
717			mechanical system for residents who are, or who may become,
718			to support their own respiration. It does not include Continuous
719			Airway Pressure (CPAP) or Bi-level Positive Airway Pressure
720			c) devices. When ventilators are used to deliver CPAP or BiPAP
721		they sha	all not be counted as ventilator services for enhanced rates.
722			
723	2)		tors set to PEEP or CPAP to aid in weaning a resident from the
724			or are included. The weaning process shall be documented in the
725			record. Ventilators used to deliver CPAP or BiPAP services for
726		the resi	dent with Sleep Apnea are not included.
727			
728	3)	Nursing	g facility shall notify the Department using a Department
729		designa	ted form that includes a physician order sheet that identifies the
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730		need	and delivery of ventilator services. A facility shall also use the		
731		designated form to notify the Department when a resident is no longer			
732			ving ventilator services. In addition, a Section S item response of the		
733		MDS	may be used.		
734					
735	4)	The f	following criteria shall be met in order for a facility to qualify for		
736		venti l	lator care reimbursement.		
737					
738		A)	A facility shall establish admission criteria to ensure the medical		
739			stability of patients prior to transfer from an acute care setting.		
740					
741		B)	Facilities shall be equipped with technology that enables it to meet		
742			the respiratory therapy, mobility and comfort needs of its patients.		
743					
744		C)	Clinical assessment of oxygenation and ventilation-arterial blood		
745			gases or other methods of monitoring carbon dioxide and		
746			oxygenation shall be available on site for the management of		
747			residents. Documentation shall support clinical monitoring of		
748			oxygenation stability was completed at least twice a day.		
749					
750		D)	Emergency and life support equipment, including mechanical		
751			ventilators, shall be connected to electrical outlets with back-up		
752			generator power in the event of a power failure.		
753					
754		E)	Ventilators shall be equipped with internal batteries to provide a		
755			short term back-up system in case of a total loss of power.		
756					
757		F)	An audible, redundant ventilator alarm system shall be required to		
758			alert staff of a ventilator malfunction, failure or resident		
759			disconnect. A back-up ventilator shall be available at all times.		
760					
761		G)	Facilities licensed under the Nursing Home Care Act [210 ILCS		
762			45] shall have a minimum of one RN on duty for 8 consecutive		
763			hours, 7 days per week, as required by 77 Ill. Adm. Code		
764			300.1240. For facilities licensed under the Hospital Licensing Act,		
765			an RN shall be on duty at all times, as required by 77 Ill. Adm.		
766			Code 250.910. Additional RN staff may be determined necessary		
767			by the Department, based on the Department's review of the		
768			ventilator services.		
769					
770		H)	Licensed nursing staff shall be on duty in sufficient numbers to		
771			meet the needs of residents as required by 77 Ill. Adm. Code		
772			300.1230. For facilities licensed under the Nursing Home Care		

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Act, the Department requires that an RN shall be on call, if not on duty, at all times.

- I) No less than one licensed respiratory care practitioner licensed in Illinois shall be available at the facility or on call 24-hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility. The practitioner shall evaluate and document the respiratory status of a ventilator resident on no less than a weekly basis.
- J) A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a twice per week basis.
- K) At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator dependent individuals and the use of the ventilators, conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one year experience in the care of ventilator dependent individuals.
- All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing such care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In service training documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.
- M) Documentation shall support the resident has a health condition that requires medical supervision 24 hours a day of licensed nursing care and specialized services or equipment.
- N) The medical records shall contain physician's orders for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning, when applicable.

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- O) Documentation shall support the resident receive tracheostomy care at least daily.
- 5) To be eligible to receive ventilator add-on, facilities shall also be required to implement the established written 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 the resident has been assessed quarterly for their risk for developing pressure ulcers.
 - ii) Documentation shall support that interventions for pressure ulcer prevention were implemented and include, but are not limited to, a turning and repositioning schedule, use of pressuring 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 method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.
 - i) Documentation shall support the resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.
 - ii) Documentation shall support 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. These shall include, but not be limited to, range of motion techniques, contracture risk. Staff shall receive in service training on this area.
 - Documentation shall support the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.

359			ii)	Effects of immobility will be monitored and interventions
360				implemented as needed.
361				
362		D)		of infection. A facility shall have established policies and
363			proce	edures on assessing risk for developing infection and
364				ention techniques. These shall include, but are not limited to
365				er hand washing techniques, aseptic technique in delivery care
366				resident, and proper care of equipment and supplies. Staff
367			shall	receive in-service training on this area.
368				
369			i)	Documentation shall support the resident was given oral
370				care every shift to reduce the risk of infection.
371				
372			ii)	Documentation shall support the facility has a method to
373				monitor and track infections.
374				
375		E)	Socia	al Isolation. A facility shall have a method of assessing a
376			resid	ent's risk for social isolation. Interventions shall be in place to
377			invo!	lve a resident in activities when possible.
378				
379		F)	Vent	ilator Weaning. A facility shall have a method of routinely
880			asses	ssing a resident's weaning potential and interventions
381			impl	emented as needed. Documentation shall support the weaning
382				ess and the use of mechanical ventilation for a portion of each
383			day f	for stabilization.
384				
385		G)	Polic	cies shall include monitoring expectations of the ventilator
386				ent, routine maintenance of equipment and specific staff
387				ing related to ventilator settings and care.
888				
389		H)	In or	der to maintain quality standards and reduce cross
390			conta	amination, the facility shall have a policy for cleaning and
391				taining equipment.
392				
393	6)	Depai	rtment	staff shall conduct on-site visits on a random or targeted basis
394	,	to ens	ure bo	th facility and resident compliance with requirements. All
395				l be accessible to determine that the needs of a resident are
896		being	met ar	nd to determine the appropriateness of ventilator services. In
897				he requirements of this subsection (a), Department review
398				e, at a minimum, the following:
399				
900		A)	The '	tracking of Ventilator Associated Pneumonia;
901		,		5

902			B)	Documentation to track hospitalizations, reason for
903				hospitalizations, and interventions aimed at reducing
904				hospitalizations for ventilator residents;
905				
906			$\stackrel{\mathbf{C}}{}$	Ventilator weaning.
907				
908		7)		hanced payment shall be added to the rate determined by the
909			meth	odology currently in place:
910				
911			A)	Payment shall be made for each individual resident receiving
912				ventilator services;
913				
914			B)	The rate add on for ventilator service is \$208 per day.
915				
916	b)	Traun	natic B	rain Injury (TBI) – The following criteria shall be met to be eligible
917		for en	hanced	rates.
918				
919		1)	A fac	fility shall meet all the criteria set forth in this subsection for TBI care
920			to a r	esident in order to receive the enhanced TBI reimbursement rate
921			ident	ified.
922				
923		2)	TBI i	s a nondegenerative, noncongenital insult to the brain from an
924			exter	nal mechanical force, possibly leading to permanent or temporary
925			impa	irment of cognitive, physical, and psychosocial functions, with an
926			assoc	riated diminished or altered state of consciousness.
927				
928		3)	The f	following criteria shall be met in order for a facility to qualify for TBI
929			reimb	pursement.
930				
931			A)	The facility shall have written policies and procedures for care of
932				the residents with TBI and behaviors that include, but are not
933				limited to, monitoring for behaviors, identification and reduction of
934				agitation, safe and effective interventions for behaviors, and
935				assessment of risk factors for behaviors related to safety of
936				residents, staff and staff shall be in-serviced on these policies.
937				
938			B)	The facility shall have staff to complete the required physical (PT),
939			,	occupational (OT) or speech therapy (SP), as needed. Additionally,
940				a facility shall have staffing sufficient to meet the behavior,
941				physical and psychosocial needs of the resident.
942				
943			C)	Staff shall receive in-service for the care of a TBI resident and
944			,	dealing with behavior issues identifying and reducing agitation,

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and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

- D) The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, lack of privacy, seclusion, and social isolation.
- E) Care plans on all residents shall address the physical, behavioral, and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs, and shall be revised as necessary.
- F) The facility shall use the "Rancho Los Amigos Cognitive Scale" to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse. Based on the level of functioning, and the services and interventions implemented, a resident will be placed in 1 of 3 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 Los Amigos Scale as well as the delivery of coded interventions.

4) Admission Criteria

- A) Documentation by a neurologist that the resident has a severe and extensive TBI diagnosis.
- B) The diagnosis meets <u>Resident Assessment Instrument (RAI)</u>
 Manual requirements for coding.
- C) There shall be documentation the diagnosis has resulted in significant deficits and disabilities that required intense rehabilitation therapy. In addition, documentation from the neurologist shall identify the resident has the ability to benefit from rehabilitation and a potential for independent living.

988			
989		D)	Diagnostic testing shall support the presence of a severe and
990		,	extensive TBI as a result of external force as defined in subsection
991			(b)(2).
992			
993		E)	Documentation the resident was assessed using the Rancho Los
994		,	Amigos Cognitive Scale and scored a Level IV through X.
995			Residents scoring a Level I, II or III on the Rancho Los Amigos
996			Cognitive Scale shall not be eligible for TBI reimbursement.
997			
998		F)	Documentation the resident is medically stable and has been
999		,	assessed for potential behaviors and safety risk to self, staff, and
1000			others.
1001			
1002	5)	Docu	mentation supports the Tier I requirements are as follows:
1003	- /		The same of the sa
1004		A)	Tier I shall not exceed 6 months.
1005		,	
1006		B)	The resident shall have previously scored in Tier II or Tier III.
1007		,	The state of the s
1008		C)	The resident has received intensive rehabilitation and is preparing
1009		,	for discharge to the community. The resident shall receive
1010			intervention and training focusing on independent living skills,
1011			prevocational training, and employment support. This includes,
1012			but is not limited to, community support options, substance abuse
1013			counseling, as appropriate, time management and goal setting.
1014			
1015		D)	Resident scores a Level VIII through X on the Rancho Los Amigos
1016		,	Cognitive Scale (Purposeful, Appropriate, and stand-by assistance
1017			to Modified Independence).
1018			1 /
1019		E)	No behaviors or Behaviors present, but less than 4 days (E0200A-
1020		,	C<2 AND E0500A-C=0 AND E0800< 2 and E1000A+B=0). If
1021			behaviors are present, resident receives behavior management
1022			training to address the specific behaviors identified.
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1024		F)	Cognition. Brief Interview for Mental Status (BIMS) is 13 through
1025		,	15 (Cognitively intact, C0500).
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1027		G)	Activities of daily living (ADL) functioning. All ADL tasks shall
1028		,	be coded less than 3 (Section G).
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- H) An assessment shall be completed quarterly 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 and grooming, health and safety issues, social and 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) or referral has been made to the local contact agency (Q0600=1). There shall be weekly documentation by a licensed social worker related to discharge potential and progress. This shall include working with the resident on community resources and prevocational employment options.
- J) The resident shall receive interventions and/or training related to their specific discharge needs.
- 6) Documentation supports the 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 shall have previously scored in Tier III. The resident continues to receive restorative nursing services.
 - 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) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3).
 - E) Resident has behaviors (E0300=1 or E1000=1) and these behaviors impact resident (E0500A-C=1) or impact others (E0600A-C=1). Behaviors shall be tracked daily, and interventions implemented. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and to implement revisions as necessary.

1072		F)	ADL function (Section G) 3 or more ADL require limited or
1073 1074			extensive assistance.
1074		G)	Resident is on 2 or more of the following restoratives:
1076		U)	Bed Mobility (O0500D=1), Transfer (O0500E=1), Walking
1077			(O0500F=1), Dressing/Grooming (O0500G=1), Eating
1077			(O0500H=1) or Communication (O0500J=1).
1079			(0030011-1) of Communication (003003-1).
1080		H)	Resident receives either Psychological (O0400E2>1) or
1081		11)	Recreational Therapy (O0400F2>1) at least 2 or more days a week.
1082			Documentation shall include a summary of the sessions, resident's
1083			progress, and potential goals, and identify any revisions needed.
1084			progress, and potential goals, and identify any revisions needed.
1085		I)	Documentation shall support one to one meeting with a licensed
1086		1)	social worker at least twice a week to discuss potential needs,
1087			goals, and any behavior issues.
1088			godis, and any behavior issues.
1089		J)	Documentation of at least quarterly oversight of care plan by a
1090		3)	neurologist.
1091			neurologist.
1092		K)	Documentation the resident has received instruction and training at
1093		11)	least twice per week that includes, but is not limited to, behavior
1094			modification, anger management, time management goal setting,
1095			life skills and social skills.
1096			me same and social same.
1097		L)	Behavioral rehabilitation assessment and evaluations shall be
1098		_,	completed quarterly and shall include cognition, behaviors,
1099			interventions, and outcomes.
1100			
1101		M)	Documentation shall support the residents requires intensive
1102		/	counseling, behavioral management, and neuro-cognitive therapy.
1103			The resident behaves in such a manner as to indicate an inability,
1104			without ongoing supervision and assistance of others, they would
1105			be unable to satisfy the need for nourishment, personal care,
1106			medical care, shelter, self-protection, and safety.
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1108	7)	Docum	nentation supports the Tier III requirements are as follows:
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1110		A)	Tier III shall not exceed 9 months.
1111		,	
1112		B)	The injury resulting in a TBI diagnosis must have occurred within
1113		,	the prior 6 months to score in Tier III.
1114			•

1115 1116	C)	Includes the acutely diagnosed resident with extensive deficits in physical functioning and identifies intensive rehabilitation needs.
1117		physical functioning and identifies intensive reliabilitation needs.
1118	D)	Resident scores an IV through VII on the Rancho Los Amigos
1119	D)	Cognitive Scale.
1120		Cognitive Searc.
1121	E)	Cognition. BIMS is less than 13 (C0500) or Cognitive Skills for
1122		decision making are moderately to severely impaired (C1000=2 or
1123		3).
1124		-,
1125	F)	Documentation shall support the facility is monitoring behaviors
1126	,	and has implemented interventions to identify the risk factors for
1127		behaviors and to reduce the occurrence of behaviors.
1128		
1129	G)	Resident receives Rehabilitation therapy (PT, OT, or ST) at least
1130	,	500 minutes per week and at least one rehabilitation discipline 5
1131		days per week (O0400). The therapy shall meet the RAI Manual
1132		guidelines for coding. The resident shall continue to show the
1133		potential for improvement in the therapy programs.
1134		
1135	H)	The facility shall have trained rehabilitation staff on-site working
1136		with the resident on a daily basis. This shall include a trained
1137		rehabilitation nurse and rehabilitation aides. The resident requires
1138		a minimum of 6 to 8 hours per day of one-to-one support as a
1139		result of functional issues.
1140		
1141	I)	Documentation shall support there are weekly meetings of the
1142		interdisciplinary team to discuss the resident's rehabilitation
1143		progress and potential.
1144		
1145	J)	Resident receives Psychological Therapy (O0400E2>1) at least 2
1146		days per week. Documentation shall include a summary of the
1147		sessions, resident's progress and potential goals, and identify any
1148		revisions needed.
1149		
1150	K)	There shall be documentation to support monthly oversight by a
1151		neurologist.
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1153	L)	A comprehensive medical and neuro-psychological assessment is
1154		done upon admission and quarterly. It shall include, but is not
1155		limited to, the following:
1156		N DI C 1 199 1 199
1157		i) Physical ability and mobility;

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1159			ii)	Motor coordination;	
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1161			iii)	Hearing, vision and speech;	
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1163			iv)	Behavior and impulse control;	
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1165			v)	Social functionality;	
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1167			vi)	Cognition;	
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1169			vii)	Safety and medical needs; and	
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1171			viii)	Communication needs.	
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1173	8)	Rates	s of payr	ment for each Tier are as follows:	
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1175		A)	The p	ayment amount for Tier I is \$264.17 per day.	
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1177		B)	The p	ayment amount for Tier II is \$486.49 per day.	
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1179		C)	The p	ayment amount for Tier III is \$767.46 per day.	
1180					
1181	9)	Effective for services on or after January 1, 2015, facilities licensed by the			
1182		-		of Public Health under the Nursing Home Care Act and	
1183			-	ne care and services requirements of this Part will receive a	
1184		-		-on of \$5.00 for each resident scoring as TBI on the MDS 3.0	
1185		but o	therwise	e not qualifying for Tier 1, 2 or 3.	
1186					
1187	(Source: Amended at 50 Ill. Reg, effective)				