**Section 148.40 Special Requirements**

Effective for dates of discharge on or after July 1, 2014:

a) Inpatient Psychiatric Services

1) Payment for inpatient hospital psychiatric services shall be made only to:

A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or

B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in Section 148.25(d)(1).

2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.

3) Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his or her 21st birthday, psychiatric services shall be reimbursable by the Department until the earliest of the following:

A) The date the patient no longer requires the services.

B) The date the patient reaches 22 years of age.

4) A psychiatric hospital must be accredited by TJC or another Health and Human Services Approved Accreditation Organization to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in Illinois, or within 100 miles of Illinois, must execute an agreement with an Illinois Department of Human Services (DHS) operated mental health center (State-operated facility) for coordination of services including, but not limited to, crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a)(5).

5) Coordination of Care − Purpose. The Coordination of Care Agreement shall set forth an agreement between the State-operated facility and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

6) Coordination of Care – General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a)(5) are as follows:

A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by TJC or another Health and Human Services Approved Accreditation Organization.

B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated under those Acts prohibit discrimination on the grounds of sex, race, color, national origin or handicap.

C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 USCA 2000e, 29 USCA 203 et seq. and 775 ILCS 25.

D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given 30 days prior notification.

7) Coordination of Care – Special Requirements. The hospital shall:

A) Provide on its premises, the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care or assessment of mental status, mental illness, emotional disability, and other psychiatric problems.

B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission.

C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission.

D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process.

E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital.

F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he or she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.

8) Coordination of Care – Special Requirements of the State-Operated Facility. The State-operated facility shall:

A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.

B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.

C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.

9) Coordination of Care – Special Requirements for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program. For individuals under 21 years of age, all inpatient admissions must be authorized through the SASS Program. The hospital shall:

A) Prior to admission, contact the Crisis and Referral Entry Service (CARES), the Department's Statewide centralized intake and referral point for a mental health screening and assessment of the patient, pursuant to 59 Ill. Adm. Code 131.40;

B) For admissions authorized through a SASS screening, involve the SASS provider in the patient's treatment plan during the inpatient stay and in the development of a discharge plan in order to facilitate linkage to appropriate aftercare resources.

10) A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

b) Inpatient Rehabilitation Services

1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in Section 148.25(d)(2), which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.

2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

3) For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified for participation under the Medicare Program and must be licensed and/or certified by DPH to provide comprehensive physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.

4) A rehabilitation facility must meet the following criteria:

A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation.

B) Have an organized medical staff.

C) Have available consultants qualified to perform services in appropriate specialties.

D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services.

E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results.

F) Submit reports as required by the Department.

5) A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:

A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing.

B) Full-time physical therapy and occupational therapy services.

C) Social casework services as an integral part of the rehabilitation program.

6) A rehabilitation facility must have available the following minimal services:

A) Psychological evaluation services.

B) Prosthetic and orthotic services.

C) Vocational counseling.

D) Speech therapy.

E) Clinical laboratory and x-ray services.

F) Pharmacy services.

7) The director of rehabilitation must meet the following criteria:

A) Provide services to the hospital and its patients as specified in subsection (b)(4).

B) Be a doctor of medicine or osteopathy.

C) Be licensed under State law to practice medicine or surgery.

D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

8) Personnel of the rehabilitation facility must meet the following minimum standards:

A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.

B) Physical therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.

C) Occupational therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.

D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.

E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.

F) Psychologists shall have a Master's Degree in clinical psychology.

G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.

H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.

c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:

1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease.

2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (2013).

3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (2013).

d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following two categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:

1) Psychiatric Clinic Services

A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting.

B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task‑oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12 month period.

C) Approval. The Department and DHS are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must have previously been enrolled with the Department for the provision of inpatient psychiatric services on or after June 1, 2002 or must be currently enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DHS and the Department, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:

i) The hospital must be accredited by, and be in good standing with, TJC or another Health and Human Services Approved Accreditation Organization.

ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated DHS State-operated facility serving the mentally ill in the appropriate geographic area.

iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services.

iv) The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by the Department.

D) Duration of Approval. The approval described in subsection (d)(1)(D) of this Section shall be in effect for a period of two years from the date HFS approves the psychiatric clinic's enrollment. The approval may be terminated by HFS or DHS with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to HFS and DHS when terminating delivery of psychiatric clinic services.

2) Physical Rehabilitation Clinic Services

Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

e) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an individual enrolled in any of the Medical Assistance Programs administered by the Department, including newborns, regardless of payer. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information may be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 39 Ill. Reg. 10824, effective July 27, 2015)