**Section 147.340 Minimum Data Set On-Site Reviews**

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. Such reviews may, at the discretion of the Department, be conducted electronically or onsite in the facility.

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

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

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

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

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

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

4) A criminal indictment alleging fraud; and

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

e) 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.

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

g) 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.

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.

h) 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.

i) If more than 25 percent of the RUG-IV classifications are changed as a result of the initial review, the review may 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.

j) If the facility qualifies for an expanded review, the Department may review the facility again within 6 months. If a facility has 2 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) of this Section.

k) Pursuant to 89 Ill. Adm. Code 140.12(f), the facility shall provide Department staff with access to residents, professional and non-licensed direct care staff, facility assessors, clinical records and completed resident assessment instruments, as well as other documentation regarding the residents' care needs and treatments. Failure to provide timely access to records may result in suspension or termination of a facility's provider agreement in accordance with 89 Ill. Adm. Code 140.l16(a)(4).

l) Department staff shall request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDS 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 4 hours after the initial request. The team will request no more than 2 records per reviewer to begin the review process. If the facility chooses to have HFS staff review the electronic health record, at least 2 computer terminals with read-only access will be made available to the review team within one hour. Within 4 hours after the team's arrival and for the remainder of the review, the facility shall provide a computer terminal for each reviewer or hard copies shall be provided.

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

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

o) 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 they shall present the Department with any and all documentation to support their position. It is up to the facility to determine what documentation is needed to support both the Resident Assessment Instrument (RAI) Manual and rule requirements regarding the MDS items identified.

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

q) Corrective Action. Upon 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. The Department shall reclassify a resident if the Department determines that the resident was incorrectly classified.

r) 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 Department of Public Health.

s) Recalculation of Reimbursement Rate. The Department shall determine if the reported MDS data that was 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.

t) A facility's rate shall be subject to change if the recalculation of the direct care component rate, as a result of using RUGs-IV data that is 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 (t). The direct care component of the rate may be reduced, retroactive to the beginning of the rate period, by $1.00 for each whole percentage decrease in excess of 2 percent.

u) 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 shall 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.

v) 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 147.340 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.340 added at 38 Ill. Reg. 12173, effective May 30, 2014)