State of Illinois Department of Human Services
Division of Developmental Disabilities

EXCEPTIONAL CARE PROGRAM LICENSED LABOR COST ANALYSIS

☐ Annual Review ☐ New Admit Review ☐ Quarterly Review

Facility Name: _____ Date of Request: _____

Individual Name: _____ Date of Review: _____

RIN#: _____ Pending Medicaid: Yes ☐ No ☐ Age: _____ DOB: _____

Admit Date to Facility: _____ Hospital Release Date: (if applicable) _____

Medical/Nursing Service	**Minutes Awarded at Last Rate Change** **Date**: (DD/MM/YY) _____ (Completed by Facility)	**Minutes Requested this Review** (Completed by Facility)	**Minutes Awarded this Review** (Completed by DHS/DDD Nurse)
TRACHEOSTOMY/High Respiratory Care Needs			
Respiratory Assessment			
Trach Change			
String Change			
Stoma Care			
Canula Care/Cuff Management			
Suctioning			
Pre-Oxygenate/Bag			
Respiratory Treatments			
Oxygen			
Aerosol Therapy			
Chest Physiotherapy/Vest			
Cool/Heater Humidification			
SAO2 Monitoring (Intermittent/continuous)			
Passey-Muir			
ETCO2			
Capping/Weaning			
Other (specify):			
VENTILATOR			
Respiratory Assessment			
Parameter Check			
Equipment Check			
Circuit Replacement			
Other (specify):			
TOTAL:			

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Completed by Facility

Supporting Documentation Attached:

☐ H&P ☐ RRT/CRT Assessment, Notes ☐ Respiratory Assessment Notes

☐ Nurses Notes ☐ MAR ☐ TAR ☐ POS ☐ Physician Notes

☐ Other(specify): _____

Completed By:
(Printed Name/Title) _____

Completed By:
(Signature) _____ Date Completed: _____

Completed by DHS/DDD Nurse

Are there any other medical condition(s) that qualify the Exceptional Care person for a specialized services Medical Add-On Level III?

☐ Yes ☐ No

Specify Conditions:

Comments:

Completed by Name: _____

Completed by Signature: _____ Date: _____

For DDD Use Only

RATE PROCESS: Total Minutes: _____ Over 150%: _____ Other Medical Level 3: Yes ☐ No ☐

Quarterly Review 15% Change: _____

Current Exceptional Care Minutes: _____ Previous Exceptional Care Minutes: _____

Facility Base Rate: _____ Add-on Amount: _____ Total Rate Amount: _____

Effective Date: _____

Completed by Name: _____

Completed by Signature: _____ Date: _____

EXCEPTIONAL CARE PROGRAM LICENSED LABOR COST ANALYSIS

Guidelines

Top portion of page 1 is completed by SNF/Ped Executive Director or designee for new request for Exceptional Care or quarterly or annual reviews of individuals with treatment changes over or fewer than 15% of their minutes as reflected on the Exceptional Care Program Desk or Waived Quarterly Review Facility Roster [IL462-0050 N-12-14].

1) Annual Review, New Admit Review, or Quarterly Review: Check one.

2) Facility: Enter the name of SNF/Ped as recorded with the Illinois Secretary of State.

3) Date of Request: Record date information received by DHS/DDD-Bureau of Community Reimbursement.

4) Individual's Name: Record official name of each individual as recorded with Medicaid.

5) Date of Review: Record date of new admit, quarterly, or annual.

6) RIN: Record each individual's nine digit Recipient Identification Number (RIN) number assigned by Medicaid.

7) Pending Medicaid Yes or No: Check one. If RIN number is not available because of pending Medicaid application, provide copy of application. If individual is not Medicaid eligible, Exceptional Care review process stops.

8) Age: Record current age of individual.

9) DOB: Record date of birth of individual.

10) Admit Date to Facility: Record date individual officially admitted to SNF/Ped noted above.

11) Hospital Release Date: Record official release date from hospital, if applicable.

12) Medical/Nursing Services: List of services covered by Exceptional Care.

13) Minutes Awarded At Last Rate Change (optional) and Minutes Requested This Review (required): Record minutes. Both sections completed by the facility.

14) Minutes Awarded This Review: Record authorized minutes awarded. Section completed by DHS/DDD with total.

15) Completed by Facility: Check document(s) that are attached to Exceptional Care request for the individual being reviewed. Title: Record title of facility representative completing this section.

16) Completed by DHS/DDD Nurse: Check Yes or No as to whether there are any other medical condition(s) that qualify the Exceptional Care person for a specialized service Medical Add On Level III. Signature: DHS/DDD representative completes this section. Date: Record date of completion of this section.

17) For DDD Use Only: Completed by DHS/DDD Bureau of Community Reimbursement. Applicable information will be recorded in the following area: Total Minutes, Over 150%. Other Medical Level 3 [Yes/No], Quarterly Review 15% Change, Current Exceptional Care Minutes, Previous Exceptional Care Minutes, Facility Base Rate, Add-on Amount, Total Rate Amount, and Effective Date. Date: Record date of completion of this section.