ICF/IID FACILITIES-DMAS QUALITY REVIEW TOOL

Facility Name: Choose an item. **Provider FEIN:** Choose an item. Click here to enter text.	**Address:** Choose an item. Click here to enter text.
Beneficiary Name: Click here to enter text.	**Medicaid Number:** Click here to enter text.

WRITTEN PLANS FOR ICF UTILIZATION PLANS	**COMMENTS** Click here to enter text.
Does the provider have a written utilization review plan on file to review each beneficiary's need for services for which the ICF provides? Choose an item. Are the continued stay evaluations completed? Choose an item. Dates completed: Click here to enter text.	
REQUIRED CERTIFICATION AND ASSESSMENTS FOR BENEFICARIES	**COMMENTS** Click here to enter text.
Level of care completed as required? Choose an item. Is there certification from a physician that ICF services are needed by the beneficiary? Choose an item. Was it made at time of admission? Choose an item. Have there been re-certifications by a physician, physician's assistant or nurse practitioner every 12 months after initial certification? Choose an item. Has the ID Team made a comprehensive medical evaluation for the beneficiary? Choose an item. Has the ID Team made a comprehensive social evaluation for the beneficiary? Choose an item. Is there a psychological evaluation of need for care prior to admission and consistent with 42CFR 456.370? Choose an item.	

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PLAN OF CARE (POC) 42CFR456.380	**COMMENTS**
Demonstrated written Plan of Care Choose an item. POC includes components consistent with 456.380 Choose an item. Reviewed by QIDP every 90 days Choose an item. Signed/Dated by Interdisciplinary Team Members Choose an item. Signed/Dated by QIDP Choose an item. Appropriate/Adequate (Addresses service needs) Choose an item. Measurable Outcomes (Lists specific service/who provides and target achievement dates) Choose an item. POC participation of beneficiary Choose an item. POC participation of responsible party Choose an item.	Click here to enter text.
DISCHARGE PLANNING	**COMMENTS**
Is the beneficiary given regular opportunities to participate in community integration activities? Choose an item. Has the ID Team and/or Social Worker engaged in discussions regarding discharge planning with the family? Choose an item. Is there an agreed upon discharge plan for the beneficiary? Choose an item. Is the CSB involved? Choose an item. Is an RST Referral required? Choose an item. Has an RST Referral been completed? Choose an item.	Click here to enter text.

REVIEWER OBSERVATION OF BENEFICIARY
Click here to enter text.

RECOMMENDATION OF REVIEW STAFF: (LEVEL OF CARE APPROPRIATE/CRITERIA MET)
Click here to enter text.

REVIEWER: _____ DATE: _____