UTILIZATION REVIEW CHECKLIST

REGIONAL CENTER _____ **DATE OF REVIEW** _____

Consumer Name:_____ **Case #:**_____

Age:_____ **URL Total $**_____ **1st year**____ **Annual**____ **Last year URL $**_____

Additional Information:_____
_____

PLANNING

_____ Does the plan document the need for each service/support?

_____ Are clear outcomes identified for each service/support?

_____ Have needs been prioritized by the person/family?

_____ How long has this level of support been in place?

_____ Has progress toward the stated outcomes been achieved?

_____ Has the person applied for Medicaid? If ineligible, why? _____

_____ If the person is Medicaid eligible, have applicable state plan services been accessed that meet the needs? **(For persons under age 21, this includes all Healthy Children & Youth Services, OT, PT, and speech therapies, most adaptive equipment, diapers, and personal care that meet the state plan definition. For adults, this includes personal care provided through Department of Health and Senior Services.)**

_____ For children, are any services/supports requested the responsibility of the local school district? **(The Division cannot supplant services/supports that are approved and funded by local school districts. The plan should note therapies the child is receiving at school, including frequency, intensity and duration. MRDD may only support ABA programs as a supplement to a school-funded ABA program.)**

_____ If additional therapies are educationally necessary, have they been pursued through the IEP process?)

FINANCIAL

Where applicable:

_____ Are prescriptions or recommendations for therapies, equipment, etc., attached?

_____ Are denial letters from insurance companies or other primary funding sources attached?

_____ Are bids attached?

_____ Is the budget page completed, including frequency and rates? Is the math correct?

_____ Were there services last year which were authorized and not invoiced? If not, why?
_____
_____
_____

_____ Did last year's authorizations/expenditures match the approved budget?

_____ Are cost projections reasonable based on ongoing service needs?

_____ Is the MRDD funding source noted? **(Waiver, POS, Choices)**

_____ Are all expenditures within the program/service cap? **(ABA $5,000; Environmental Accessibility Adaptations (Home Modifications) $5,000; Choices $3,600; Specialized Medical Equipment and Supplies (Adaptive Equipment) $5,000)**

_____Are there contracts with providers who are receiving over $3000 per year?

_____If there is a request for adaptive equipment (for example), does the plan identify the specific equipment/supplies needed, and the justification for each? **(It is not acceptable to approve "up to" the cap for a program service without justification.)** Have we looked for other services?

_____ Is there a redirection of funds involved? **(Do health and safety needs justify redirection?)**

MISSOURI VALUES

_____ Is the service a **NEED** rather than a **WANT?** What would happen without the service? **(Is this for maintenance of independent living, prevention from moving to a more restrictive setting, proactive prevention of a potentially abusive situation, etc.?)**
_____
_____

_____ Does the service facilitate a typical lifestyle vs. fostering dependence on the system?

_____ Is the amount of support based on the level of need?

_____ Have natural supports or other ways to meet the need been obtained first?

_____ Is the service/support something that families do not typically provide?

_____ Would Missouri taxpayers agree service/support should be purchased with state tax dollars?

RESIDENTIAL

_____Is this a single person ISL? If yes, why?_____
_____

_____Is the Administration fee limited to 15% or $500 maximum?

_____Are room and board costs within the financial means of the individuals living in the home?

_____Are there any additional services, equipment or supplies in the budget and are they justified with outcomes in the personal plan?

_____Are there asleep, awake, or no overnight staff? (circle one)

_____Are the hours of paid support (for example, ISL, Day Hab, Employment) limited to 24 hours per day?

_____Are there other issues of concern? _____
_____

_____ _____

Utilization Review Committee Representative Date