

471-000-16 Instructions for Completing Form DM-28-MR, "ICF/MR Utilization Review"

USE: The information entered on Form DM-28-MR, "ICF/MR Utilization Review", is used to determine continued Medicaid funding of ICF/MR Services for the individual on Nebraska Medicaid. The form is designed to provide facility staff input to the utilization review process.

NOTE: Form DM-28-MR is available on CD-ROM. A completed form may NOT be transmitted across the Internet. Smaller font size and changes in margins allow for additional 8-9 lines to be added where needed before the information goes to another page. All medications and treatments can be included in this format. Another page may be used. However, the Section #5, must be on one piece of paper. If more than nine lines are needed, add at least five more lines so " Recommendations of this...." through "SIGN HERE and Date" are on the same piece of paper. NO ATTACHMENTS are to be used with forms completed on computer.

Form DM-28-MR is completed for each Nebraska Medicaid eligible individual who is currently funded for ICF/MR Care and who:

1. Is physically present and occupies a licensed bed certified for ICF/MR services; or
2. Is temporarily not present due to a home visit or hospitalization, is expected to return directly to the ICF/MR and for whom the facility continues to reserve a licensed bed, certified for ICF/MR Services.

Examples of those who do not need the completed Form DM-28:

1. Those who are not currently Nebraska Medicaid-eligible;
2. Those who are eligible for Nebraska Medicaid, but have been denied ICF/MR funding from Nebraska Medicaid;
3. Those who reside in a bed not currently licensed and certified for ICF/MR services; or
4. Those who are temporarily receiving services in another long term care services (SNF, NF, Swingbed) even if the facility continues to hold a licensed and certified ICF/MR bed for the person.

NUMBER PREPARED:

- 1 copy of the form - if computer-generated.
- 1 copy of the form and up to three pages attached - if completed by hand.

COMPLETION: The ICF/MR staff are responsible for completing the entire Form DM-28-MR, except for section 5. The ICF/MR staff complete the form as follows:

Facility Name: Enter the name of the facility in which the individual resides; Client Name: Enter the name of the individual;

Social Security Number: Enter the individual's Social Security number; Date of Birth: Enter the individual's date of birth;

Admission Date: Enter the individual's date of admission to the ICF/MR.

NE Medicaid Eligibility –

Enter "yes" if the individual is currently eligible for Nebraska Medicaid Services.  
Enter "no" if the individual is not eligible for Nebraska Medicaid Services; stop further completion of this form until Nebraska Medicaid eligibility is established for the individual.

Primary Diagnosis: Enter the individual's primary diagnosis; use of ICD9-CM codes are acceptable.

Secondary Diagnosis: Enter the individual's secondary diagnosis; use of ICD9-CM codes are acceptable.

Attending Physician: Enter the name of the individual's primary physician.

- 1A. Physician's plan of Care Includes: Mark all areas included in the physician's plan of care (physician's orders) for the individual.
- 1 B. Team's Plan Also Includes: Mark all area included in the individual's current IPP. Note: items in section 1A are also considered part of the IPP and not repeated in 1 B.
2. List Medications: List all prescribed medications and dosage. If medications are ordered PRN, list only significant (for the individual) PRN medications, dosage, and frequency given over the last 6 months. Information is to be entered on the form, if completed on computer. Information may be attached on a separate sheet ONLY if form is completed by hand. The licensed professional nurse is responsible for the medical information on Form DM28-MR. The nurse responsible for the individual must sign this section, whether completed by computer or by hand.
3. Indicate Individual's Needs/Strengths:  
\*Special skin care/TX: If completed on computer, no attachments are to be used. If completed by hand, attachments are acceptable  
Mark the most descriptive terms that best fits the individual: (self-explanatory).
  - Indicate interventions needed for Skills, using these abbreviations or descriptive words: use any words that best describe the interventions needed; abbreviations are included for frequently used terms.
  - Describe - seizures: indicate the frequency and type of seizures the individual has.
  - Describe - supervision: indicate the duration and type of supervision the individual needs in any 24 hour period.
  - Describe - inappropriate/maladaptive behaviors: indicate the types/examples of behaviors the individual exhibits.

QMRP is responsible for the accuracy and completion of the information on the form. The individual's QMRP must sign the form by hand whether completed on computer or by hand.

4. Describe Current Habilitative Training: List descriptions of the programs currently implemented for the individual. This can be done using a short descriptive phrase or word indicating the training concept. Broad categories such as 'Sensory Motor', or 'behavior management' are not acceptable. Universally accepted common abbreviations of those on this form may be used, such as, 'TP use', 'follow AM. routine with VO'. Abbreviations that are exclusive to the facility or have multiple meanings are not acceptable, such as, 'BMP', "OH", or "PFD".

If training programs have been added, graduated, or terminated since the IPP; to clarify only use (A) for added, (G) for graduated, and (T) for terminated, if needed. List those conducted in the residence and at various training areas.

Interdisciplinary Team's Summary of Exploration of Alternatives: Enter a brief description of the results in exploring alternatives for the individual from the time of the IPP to the date form is completed.

For those completing this on computer, after all is entered, print out the form, and sign it. These printed copies are to be forwarded to the ICF/MR Medicaid Review Team.

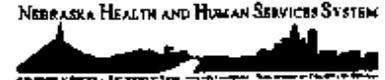
If completed by hand, staple attachments to the form. Attachments are only on medications and treatments and limited to a maximum of three pages. Sign completed forms. These forms and attachments are to be forwarded to the ICF/MR Medicaid Review Team.

5. ICF/MR Medicaid Review Team Use ONLY: The review team members must review, make a determination, sign, and date the form in this section.

**DISTRIBUTION:** The ICF/MR Medicaid Review Team retains the original form in their files. The ICF/MR is sent a photocopy of the original DM-28-MR form to retain in the individual's permanent medical record.

**RETENTION:** The Nebraska Health and Human Services System retains the forms in a current file for the last 2 years plus the current year. Earlier forms are sent to storage for 3 years. ICF/MR's must retain these as part of the individual's permanent medical record until 7 years past the last activity on the individual.

ICF/MR – UTILIZATION REVIEW  
 HEALTH AND HUMAN SERVICES  
 AGING AND DISABILITY



*Facility Name	NE Medicaid Eligibility	Date of Birth
Client's Name	Primary Diagnosis	Admission Date
Social Security Number	Secondary Diagnosis	Attending Physician
<b>*1. A. PHYSICIAN'S PLAN OF CARE INCLUDES:</b>		
<input type="checkbox"/> Medications <input type="checkbox"/> Psychotropic Medications <input type="checkbox"/> Medical Treatments <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Diet <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Dental Evaluation <input type="checkbox"/> Speech/Audiology Evaluation/Therapy <input type="checkbox"/> Social Services <input type="checkbox"/> Activities		
<b>B. TEAM'S PLAN ALSO INCLUDES:</b>		
<input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Behavior Management Training <input type="checkbox"/> Habilitative Training <input type="checkbox"/> Recreation <input type="checkbox"/> Social Services Evaluation		
<b>*2. LIST MEDICATIONS</b>		
List/attach prescribed medications and dosage (If PRN, list frequency the client has required the medication.)		
Signature of Nurse <b>SIGN HERE</b> ▶		
<b>*3. INDICATE INDIVIDUAL'S NEEDS/STRENGTHS (be descriptive)</b>		
Special skin care/tx:		
Check the most descriptive terms that best fits the individual:		
<input type="checkbox"/> Contractures <input type="checkbox"/> Functional Movement of Upper Extremities <input type="checkbox"/> Functional Movement of Lower Extremities <input type="checkbox"/> Functional Sight <input type="checkbox"/> Blind <input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Functional Hearing <input type="checkbox"/> Suctioning <input type="checkbox"/> Catheter <input type="checkbox"/> Functional Eating <input type="checkbox"/> Specialized OT Feeding Procedures	<input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Trach <input type="checkbox"/> Colostomy <input type="checkbox"/> Tube Fed
Indicate Interventions Needed for Skills, Using these Abbreviations or Descriptive Words:		
B = Bracing D = Positioning Devices HOH = Hand Over Hand PI = Physical Intervention VQ = Verbal Cues I = Independent of Staff NA = Does Not Do	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Movement of Arms, Hands and Fingers Movement of Legs and Feet Sit Upright Mobility Inside 50 ft. Mobility Outside 50 ft. Toileting Dressing Handwashing Shampoo Hair
Describe – Seizures (Frequency and Type):		
Describe – Supervision (Hours and Type):		
Describe – Inappropriate/Maladaptive Behaviors:		
Signature of QMRP <b>SIGN HERE</b> ▶		
<b>*4. DESCRIBE CURRENT HABILITATIVE TRAINING</b>		
On Living Unit:		
Off Living Unit:		
Interdisciplinary Team's Summary of Exploration of Alternatives:		
<b>5. ICF/MR MEDICAID REVIEW TEAM USE ONLY</b>		
The recommendation of this Utilization Review Team for the above-mentioned client is:		
<input type="checkbox"/> ICF-MR Level of Care Approved (6 months) <input type="checkbox"/> ICF-MR Level of Care Not Approved		
Signature of Utilization Review Coordinator <b>SIGN HERE</b> ▶		Date