HEALTH CARE AUDIT/UTILIZATION REVIEW PROCEDURE

Audit Period Covered: **Completed by:**

Participant's Name: **MA #:** **Date:**

PART I **REVIEW & ASSESSMENT**		
A. OUTCOME ASSESSMENT: (See Plan of Care) **No. of Goals** **Avg. Score Goal Achievement**		
B. SERVICES ASSESSMENT	**Yes**	**No**
1. Multidisciplinary Team Plan of Care (a) Was the plan based on a comprehensive assessment by all Team members?	☐	☐
(b) Did the plan reflect findings from initial or updated medical orders, medical history documentation, interviews & ADCAPS assessments?	☐	☐
(c) Did the plan take into account the participant's potential for restoration, rehabilitation and or maintenance of level of functioning?	☐	☐
(d) Was there participation in the care planning process from the participant and or participant's representative?	☐	☐
2. If indicated, was the participant referred to outside health care services?	☐	☐
3. Did all documented notes support the appropriateness of the care plans?	☐	☐
4. Was the discharge summary or plan appropriate and adequate?	☐	☐
PART II **UTILIZATION REVIEW SUMMARY**	**Yes**	**No**
A. Was some progress made toward meeting the goals outlined in the plan?	☐	☐
1. If yes, list the most relevant factors:		
2. If no, is this due to one or more of the following selections? ☐ coordination of care ☐ need other health care ☐ appropriate goals ☐ program resources ☐ participant behavior ☐ participant attendance ☐ other		
B. Is this participant benefiting from this service?	☐	☐
1. If yes, continue with current plan 2. If no, update the plan of care to reflect changes or initiate discharge planning if appropriate		
C. Is there a current freedom of choice form for the participant? **Yes** ☐ **No** ☐		
PART III **COMMENT:**		
ATTESTATION: I attest that the center did not provide ANY type of incentive at any time to the participant or participant's family to attend this center, as prohibited by the Federal Anti-Kickback Statute.		

Director/Designee's Name/Signature Date: