Utilization Review – 1: Medical Therapy Program Utilization Review Checklist

Acronyms used: CCS (California Children's Services), DOB (Date of Birth), MTP (Medical Therapy Program), MTU (Medical Therapy Unit), OT (Occupation Therapy), PT (Physical Therapy), PTR (Patient Therapy record), UR (Utilization Review)

CCS County: _____

MTU: _____

Date of Review: _____

1) Beneficiary Information

Last Name:	**First Name:**	**Middle Initial:**
DOB: (MM/DD/YYYY)	**CCS Number:**	
MTP Eligible Diagnosis (es):		
Date opened to MTP (MM/DD/YYYY):		

2) Documentation Review

Review of Therapy Plans	**Yes**	**No**	**Comments**
Initial MTP eligibility report in chart	☐	☐	

3) Physician's Report

Prescribing Managing Physician's Report	**Yes**	**No**	**Comments**
From physician signing OT/PT Prescriptions	☐	☐	
Current	☐	☐	
Information relevant/complete	☐	☐	

☐ Items above reviewed by UR Team Physician

4) Therapy Plans

Review of Therapy Plans	OT			PT		
OT/PT Evaluation Summary	**YES**	**NO**	**N/A**	**YES**	**NO**	**N/A**
Current	☐	☐	☐	☐	☐	☐
All required elements documented	☐	☐	☐	☐	☐	☐

5) Medical Therapy Plan

Review of Therapy Plans	OT			PT		
OT/PT Evaluation Summary	**YES**	**NO**	**N/A**	**YES**	**NO**	**N/A**
Current	☐	☐	☐	☐	☐	☐
Signed and dated by physician	☐	☐	☐	☐	☐	☐
Functional status	☐	☐	☐	☐	☐	☐
Functional/measurable goals	☐	☐	☐	☐	☐	☐
Benefits of previous therapy	☐	☐	☐	☐	☐	☐
Rehab potential	☐	☐	☐	☐	☐	☐
Treatment methods	☐	☐	☐	☐	☐	☐
Treatment frequency	☐	☐	☐	☐	☐	☐
Treatment duration	☐	☐	☐	☐	☐	☐

6) PTR

PTR / Running Notes	OT			PT		
OT/PT Evaluation Summary	**YES**	**NO**	**N/A**	**YES**	**NO**	**N/A**
Documentation meets standards	☐	☐	☐	☐	☐	☐

7) Therapy Services

Review of Therapy Services Delivered	OT			PT		
OT/PT Evaluation Summary	**YES**	**NO**	**N/A**	**YES**	**NO**	**N/A**
Services relate to goal(s) in Medical Therapy Plan	☐	☐	☐	☐	☐	☐

Review of Therapy Services Delivered	OT			PT		
OT/PT Evaluation Summary	**YES**	**NO**	**N/A**	**YES**	**NO**	**N/A**
Progress achieved toward goal(s)	☐	☐	☐	☐	☐	☐
Evidence of continued potential for functional	☐	☐	☐	☐	☐	☐

☐ Items above reviewed by UR Team Occupational and Physical Therapist.

8) UR Team Findings: (Findings due to the MTU within five business days)

☐ No Deficiencies Identified-No MTU response to UR Team needed. Review process complete.

☐ Deficiencies identified:

UR Team Representative:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

9) MTU response to UR Team Finding/Plan to Correct Deficiencies: (MTU Plan due to UR Team within 30 business days. UR Team response to plan due to the MTU within five business days.)

MTU Supervising/Lead Therapist:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

☐ MTU Plan Accepted- UR Team's response due to the MTU within five business days. Review process complete.

UR Team Representative:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

☐ MTU Plan Not Approved (UR Team response due to the MTU within five business days.)

UR Team Representative:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

10) MTU Revised Plan to Correct Deficiencies: (Revised MTU Plan due to UR Team within 30 business days. UR Team response to plan due to the MTU within five business days.)

MTU Supervising/Lead Therapist:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

☐ MTU Plan Approved- UR Team response due to the MTU within five business days. No MTU response to UR Team needed (if corrections are not completed by the anticipated due date the MTU will notify the UR Team of a revised anticipated date of completion.)
Review process complete.

UR Team Representative:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

☐ MTU Revised Plan Not Approved* (UR Team response due to the MTU within five business days.)

UR Team representative:

Last Name: _____ First Name: _____
Date (MM/DD/YYYY): _____

*Continue cycle of revised plans by the MTU and review by UR Team until the MTU Plan is approve by the UR Team and the review process completed.

11) Comments