Centers for Medicare & Medicaid Services, HHS § 456.400

§ 456.372 Medicaid agency review of need for admission.

Medical and other professional personnel of the Medicaid agency or its designees must evaluate each applicant’s or beneficiary’s need for admission by reviewing and assessing the evaluations required by § 456.370.

PLAN OF CARE

§ 456.380 Individual written plan of care.

(a) Before admission to an ICF or before authorization for payment, a physician must establish a written plan of care for each applicant or beneficiary. (b) The plan of care must include—

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any orders for—

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Therapies;

(vi) Social services;

(vii) Diet; and

(viii) Special procedures designed to meet the objectives of the plan of care;

(5) Plans for continuing care, including review and modification of the plan of care; and

(6) Plans for discharge.

(c) The team must review each plan of care at least every 90 days.

§ 456.381 Reports of evaluations and plans of care.

A written report of each evaluation and plan of care must be entered in the applicant’s or beneficiary’s record—

(a) At the time of admission; or

(b) If the individual is already in the ICF, immediately upon completion of the evaluation or plan.

UTILIZATION REVIEW (UR) PLAN: GENERAL REQUIREMENT

§ 456.400 Scope.

Sections 456.401 through 456.438 of this subpart prescribe requirements for a written utilization review (UR) plan.