MR2-(1/87)
INSTRUCTIONS ON BACK

NORTH CAROLINA MEDICAID PROGRAM
MENTAL RETARDATION SERVICES

☐ PRIOR - APPROVAL ☐ ON-SITE ☐ UTILIZATION REVIEW

PATIENT - INFORMATION - PA.

1. PATIENT NAME (LAST, FIRST, MIDDLE)			7. FACILITY		8. PROVIDER NUMBER
2. BIRTH DATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)	9. TYPE OF FACILITY	10. CURRENT LEVEL	11. REC. LEVEL OF CARE
5. COUNTY	MEDICAID NUMBER		12. PRIOR APPROVAL NUMBER		13. DATE APPROVED/DENIED
6. RELATIVE			14. ATTENDING PHYSICIAN		

DIAGNOSIS

15. MENTAL RETARDATION

COGNITIVE LEVEL
_____ MILD
_____ MODERATE
_____ SEVERE
_____ PROFOUND

ADAPTIVE LEVEL
_____ MILD
_____ MODERATE
_____ SEVERE
_____ PROFOUND

16. CAUSE OF MENTAL RETARDATION _____

17. CURRENT MEDICAL DIAGNOSIS _____

18. HEIGHT _____ WEIGHT _____ BP _____ | 19. BOWELS: _____ CONT. _____ INCONT. _____ | 20. URINARY: _____ CONT. _____ INCONT. _____ CATHETER

PATIENT EVALUATION

21. MEDICAL CONCERNS
_____ OSTOMY CARE
_____ ESOPHALGEAL REFLUX
_____ HX OF DECUBITUS ULCER
_____ CONTRACTURES
_____ DIABETIC
_____ HYPERTENSION
_____ INSOMNIA
_____ OTHER _____

22. FUNCTIONAL LIMITATIONS

VISION
_____ NORMAL
_____ IMPAIRED
_____ BLIND

HEARING
_____ NORMAL
_____ DEAF
_____ OTHER

SPEECH
_____ NORMAL
_____ NON-COMMUNICATIVE
_____ GESTURES
_____ ECHOLALIC

23. NUTRITION
DIET: _____
_____ FEEDS INDEPENDENTLY
_____ W/ASSISTANCE
_____ PARENTERAL
_____ TUBE

24. SKIN
_____ NORMAL
_____ OTHER _____

25. PERSONAL CARE

BATHING
_____ INDEPENDENT
_____ W/ASSIST.
_____ TOTAL ASSIST.

DRESSING
_____ INDEPENDENT
_____ W/ASSIST.
_____ TOTAL ASSIST.

26. AMBULATION
_____ INDEPENDENT
_____ AMB: W/ASSISTANCE
_____ NON AMB/MOBILE
_____ NON-AMB/NON MOBIL

27. BEHAVIORAL PROBLEM
_____ VERBAL ABUSE
_____ COMBATIVE
_____ INAPPROPRIATE BEHAV.
_____ WANDERER
_____ RUN AWAY
INJURIOUS
_____ PROPERTY
_____ SELF
_____ OTHERS

28. BEHAVIORAL CONTROL
_____ BEHAVIORAL PLAN
___ MODERATE/MILD
___ SEVERE/PROFOUND
_____ PSYCHOTROPIC MEDS
_____ PHYSICAL RESTRAINTS
_____ TIME OUT

29. SUPPORTIVE/PROTECTIVE DEVICES
_____ NONE
_____ WHEELCHAIR
_____ WALKER/CRUTCHES/BRACES
_____ HEARING AID
_____ GLASSES
_____ ADAPTIVE CLOTHING
_____ ADAPT EATING UTENSILS
_____ HELMET
_____ SUPPORTIVE BELTS
_____ BEDRAILS
_____ LAP TRAYS
_____ MODIFIED SHOES
_____ MITTENS/SPLINTS
_____ OTHER _____

PLAN OF TREATMENT

30. CURRENT NEEDS
_____ NURSING
RESTRAINTS _____
TYPE _____
SEIZURE CONTROL _____
_____ PHYSICAL THERAPY
_____ OCCUPATIONAL THERAPY
_____ SPEECH THERAPY

31. LENGTH OF CARE
DISCHARGE PLAN
_____ OVER 180 DAYS
_____ 60-180 DAYS
_____ 30-60
_____ OTHER _____

32. PHYSICIAN VISITS
_____ 90 DAYS
_____ OTHER _____

33. MEDICATIONS: DOSAGE, ROUTE, FREQUENCY.

34. HABILITATION PLAN
GOALS/OBJECTIVES/ACTIVITIES _____

35. DIAGNOSTIC PROCEDURES _____

36. REHABILITATION POTENTIAL

37. REASON FOR LEVEL OF CARE/OTHER COMMENTS:

38. M.D. SIGNATURE _____ MA- 2280 Figure 4b 39. DATE _____

NORTH CAROLINA MEDICAID PROGRAM

Instructions for Completion of MR-2

To be used for prior approval, utilization/continued care review and on-site medical review. Complete or check (√) ONLY those blocks appropriate to the patient at the time the form is completed. Check (√) the appropriate block to indicate the type of review.

INFORMATION

Identification

1. **Patient Name:** Print last name, first name, middle initial. If no middle name, indicate NMN.
2. **Birthdate:** Enter month, day and year.
3. **Sex:** Enter Capital F to indicate female or M to indicate male.
4. **Admission Date:** (current location): Enter month, day and year.
5. **County and Medicaid Number:** Enter 2 digit county number and 9 digit and alpha suffix Medicaid number.
6. **Relative Name and Address:** Enter complete name and address.
7. **Facility Name and Address:** Enter complete name of facility and street address.
8. **Provider Number:** Enter 7 digit number for current level of care.
9. **Type of facility:** Enter ICF/MR, ICF, SNF or hospital, etc.
10. **Current Level of Care:** Enter current level of care provided.
11. **Recommended Level of Care:** Enter the level of care that is recommended.
12. **Prior Approval Number:** Enter 9 digit number for current level of care. Leave blank when requesting Prior Approval.
13. **Date Approved/Denied:** Leave blank for internal processing.
14. Attending Physician and Address: Enter complete name and address.

DIAGNOSIS

15. **Mental Retardation Level:** Check (√) the degree of cognitive and adaptive retardation.
16. **Cause of Mental Retardation:** Enter the cause of retardation.
17. **Current Medical Diagnosis:** Enter medical diagnosis that are pertinent currently.

PATIENT EVALUATION

18. **Height:** Enter height or length (infants), if available; weight, blood pressure.
19. **Bowels:** Check (√) continent or incontinent.
20. **Urinary:** Check (√) continent, incontinent or catheter.
21. - 33. **Check** (√) or complete those blocks appropriate to patient at this time.

PLAN OF TREATMENT

34. **Habilitation Plan:** Enter briefly the programs planned and/or implemented with goals / objectives.
35. **Diagnostic Procedures:** Enter procedure, date and results (for Utilization Review, enter procedures since last UR).
36. and 37. **Enter reason(s)** the patient requires placement at the recommend level of care: rehabilitation potential, and other pertinent comments about the patient's condition not indicated above.
38. **Physician's Signature:** The Physician must validate by signature the care needs presented on this patient.
39. **Date:** The MR-2 must be dated by the physician who signs the form.

MAILING INSTRUCTIONS

Utilization/Continued Care Reviews
Division of Medical Assistance
Attn: Utilization Control Section
1985 Umstead Drive
Raleigh, North Carolina 27603

MA2280 Figure 4b

Prior Approval
EDS
Attn: Prior Approval
Post Office Box 31188
Raleigh, NC 27622