FORM 1018

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

(BH)

Hawaii–Medicaid
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR EXTENSION OF PSYCHIATRIC OUTPATIENT VISIT

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS: Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered.

Medicaid ID Number	Patient's Name (Last, First, M.I.)	Date of Birth ❑ M ❑ F
Print Patient's Mailing Address (St., City, Zip)		
AXIS I		
AXIS II		
AXIS III		
AXIS IV		
AXIS V Current:		Past year:
Current Psychiatric/Psychological Findings (Subjective and Objective) For Substance Abuse, submit a copy of ASAM placement criteria.		
Prognosis		
Reason for Extension		
Treatment Plan/Goal		
Services to be provided by: ❑ Requesting Psychiatrist ❑ Requesting Psychologist ❑ Requesting LSW ❑ Requesting APRN ❑ DOH Clinic Staff		

Print Provider's Name	Signature of Provider Date
Provider Number of Treating Provider	Contact Name
Note: To help prevent overlapping approvals, be sure to fill in the "from" and "to" dates of the last extension approved. Last Extension (if any) Approved: From: To:	Telephone Number
Number of Visits/Hours Used on Last Extension: Visits: Hours:	Fax Number

To be completed by Psychiatrist/Psychologist/LSW/APRN

# of Therapy Visits Requested	Period Requested	Procedure Codes
# Individual visits:	From: To:	CPT
# Group Visits:	From: To:	CPT
# Family Visits:	From: To:	CPT

INSTRUCTIONS

MEDICAID FORM 1018

REQUEST FOR EXTENSION OF PSYCHIATRIC OUTPATIENT VISIT

I. **Purpose**: The Medicaid Form 1018 is used to obtain medical authorization of psychiatric services, which are necessary for Medicaid recipients.

II. **General Instructions**: Type or print legibly. An incomplete form will be returned to the provider.

A. Recipient Information:

Medicaid ID Number: Provide patient's Medicaid ID number (if the patient has applied for Medicaid coverage but has not yet been approved, print "DHS pending" in this field),

Patient Name: Print patient's last name, first name, and middle initial.

Date of Birth: Indicate patient's Birthdate (mm/dd/yy)

Gender: Check of patient's gender (male or female)

Mailing Address: Print patient's current mailing address, include street name, city, and zipcode.

AXIS I – V: Indicate axis, include current and past year on AXIS V.

Current Psychiatric/Psychological Findings (subjective and objective): Indicate psych finding and for substance abuse, attach a copy of ASAM placement criteria.

Prognosis/Reason for Extension/Treatment Plan: Indicate prognosis, reason for extension, treatment plan and goal.

Services provided by: Using the check-off boxes, indicate if services will be furnished by requesting psychiatrist, requesting psychologist, requesting LSW, requesting APRN, or DOH Clinic Staff

B. Provider Information:

Print Provider's Name: Print name of provider rendering services.

Signature of Provider: Signature of referring provider and date.

Provider Number of Treating Provider: Indicate the Medicaid provider number of the provider rendering services.

Contact Name / Telephone Number / Fax Number : Provide a contact name, phone number, and fax number of the provider rendering service for Medicaid consultant to process request.

Last Extension (if any) Approved: To prevent overlapping approvals, complete the "from" and "to" dates of the last extension approved.

Number of Vists/Hours Used on Last Extension: Indicate approved number of visits and hours on the last extension, if applicable.

C. Psychiatrist/Psychologist/LSW/APRN Section:

# of Therapy Visits Requested: Under "Individual," "Family" or "Group," indicate number of visits being requested.

Period Requested: Enter corresponding "from" and "to" dates of the period you are requesting services.

Procedure Codes: Enter corresponding CPT codes.

FORM 1144

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Page number: _____ of _____
☐ US – Urgent Req. for Svcs.

Hawaii–Medicaid
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR MEDICAL AUTHORIZATION

Check only 1 – Different Types of Service Must Be Requested on Separate 1144 Forms.

☐ ED – EPSDT/MF CM Svcs.
☐ OP – Outpatient Facility (UB-92)
☐ DE – Dental
☐ DM – Appl./DME/Sup.
☐ OS – Out of State Svcs.
☐ BH – Psych. Testing/ & Detox
☐ GT – Transportation
☐ LN – Sign Language Interp.
☐ IC – Incontinence Supplies
☐ LT – Long Term Care
☐ HE – Home Health
☐ MD – Professional Svcs. (CMS 1500)
☐ IP – Inpatient
☐ RE – Rehab. Svcs.
☐ Drugs – INCORRECT FORM

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS: Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. **Authorization expires 60 days from date of approval** unless otherwise noted by the consultant. **Will not approve PA if more than one supplier on form.**

Medicaid ID Number	Patient's Name (Last, First, M.I.)	Date of Birth ☐ M ☐ F
Medicare Coverage? ☐ Yes ☐ No Is patient receiving Medicare Home Health Benefits? ☐ Yes ☐ No	Currently at: ☐ Home ☐ Hospital ☐ SNF/ICF/ICF-MR Facility ☐ Other: _____ Patient's Mailing Address (St., City, Zip)	Expanded Early & Periodic Screen. Diagnosis & Trtmnt (EPSDT): ☐ Yes ☐ No

PHYSICIAN SECTION

Diagnosis(es): _____

Justification: (Attachment ☐) _____

PHYSICIAN SECTION				**SUPPLIER SECTION**			
Procedure Code	Service/Description	QTY	Period Requested From: To:	Purchase Price	Rental Price	Repair Price	Serial #
1.							
2.							
3.							
4.							

Physician Section for Incontinence Supplies

Additional justification from physician is needed for quantities exceeding 200 diapers, 50 underpads and 50 pairs of gloves.

1. Recipient requires diapers	2. Recipient requires underpads	3. Caregiver requires gloves	4. Additional justification attached
☐ Yes ☐ No # of diapers used per mo.: _____	☐ Yes ☐ No # of underpads used per mo.: _____	☐ Yes ☐ No # of pairs used per mo.: _____	☐ Yes ☐ No

Supplier Section for Incontinence Supplies

Code	**Item**	**QTY/Mo.**	**Period Requested**	
W4335	Diapers/Adult Small/All Children's		From:	To:
A4335	Diapers/Adult Medium/Large			
W4336	Diapers/Adult/Extra Large			
A4554	Underpads, Large			
A4927	Gloves, Latex (pairs)			
W4928	Gloves, Non-Latex (pairs)			

I attest that the above-named recipient is under my care and that the requested services are medically necessary.

Physician's signature		Provider #	Contact name
Physician's name (print)	Date	Telephone	Fax #

Supplier's signature		Provider #	Contact name
Supplier's name (print)	Date	Telephone	Fax #

INSTRUCTIONS

Prior Authorization Form 1144

REQUEST FOR MEDICAL AUTHORIZATION

I. General Instructions

A. Authorization Process

1) Forms must be legible, readable and complete.

2) Requests for authorization for Medical/Psychological services should be mailed to:

ACS - Hawaii Medicaid Fiscal Agent
P. O. Box 2561
Honolulu, HI 96804-2561

3) ACS will image the Form 1144 and data enter the request.

4) The Med-QUEST's Medical Standard Branch (MSB) reviews and issues determinations.

5) Urgent requests should be faxed to ACS at (808) 952-5562. Please check the US-Urgent Req for Svcs on the request write "Urgent" across the top of the form and include justification for the urgent need of the service/item. Also, please indicate "Urgent" on the fax cover sheet.

6) If the service/item requested is approved, an approval letter is mailed to both the requesting and rendering provider. If the request for authorization is denied the requesting and rendering provider will receive denial letters. In addition, the patientwill receive a letter informing him/her of the denial and appeals rights.

B. Durable Medical Equipment

1) The attending physician must complete Form 1144 and forward the request to a Medicaid-approved equipment provider for completion of the Supplier Section (purchase, rental or repair information) on the form. Equipment providers must be approved to participate under the Medicaid program or payment cannot be made. The equipment provider should forward the completed Form 1144 to ACS-Medicaid Fiscal Agent for processing. It is very important for the Supplier to indicate the date the item has been or will be provided (if approved)..

2) A request to extend a previously authorized rental or purchase an item that was previously rented, can be submitted no more than 60 days before the expiration of the item. The Form 1144 must be purchase by completing the patient and medical equipment sections of the request and forwarding it to the attending physician.

C. Home Health Services

Attach form CMS-485 (C-3)(02-94), formerly HCFA-485 (Home Health Certification and Plan of Care), with requests for authorizations for Home Health services, including Home Health Rehabilitative services.

D. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

Attach the appropriate form CMS-700(11-91) [Plan of Treatment for Outpatient Rehabilitation] or CMS-701(11-91) [Updated Plan of Progress for Outpatient Rehabilitation] with requests for authorizations for outpatient rehab therapies.

II. Content and Completion of Form 1144

Incomplete forms (missing recipient ID, name and number; provider's name, number, signature and date; supplier's name, number, signature and date; diagnosis; procedure code) will be returned to sender.

A. At the top of the 1144 form, indicate total number of pages in the field labeled: "Number of pages____ of _____".

B. If request is urgent, check off the "US- Urgent Req. for Svcs." Box. Also indicate the reason for urgent review in the Justification field.

C. Check only 1 box in the event type of service section, i.e. ED – EPSDT/MF CMS Svcs or MD – Professional Svcs (CMS 1500). If more than one category is being requested, a separate form should be completed to avoid unnecessary delays. The categories are as follows:

ED – EPSDT/MF CM Svcs (EPSDT Medically Fragile Case Management services)
OP – Outpatient Facility (UB-92)
DE – Dental
DM – Appl/DME/Sup (Appliances, Durable Medical Equipment and Supplies - Other than Incontinent Supplies)
OS – Out of State Svcs (Out of State Services)
BH – Psych Testing/ & Detox (Psychological Testing and Detoxification)
GT – Transportation
LN – Sign Language Interp (Sign Language Interpreter)
IC – Incontinence Supplies

LT – Long Term Care
HE – Home Health
MD – Professional Services (CMS 1500)
IP – Inpatient
RE – Rehab Svcs (Rehabilitation Services)
Drugs – INCORRECT FORM (Drugs should be requested on the DHS 1144b form)

D. When requesting multiple items for hyperalimentation and enteral therapy, such as supplies or DME, check DM – Appl/DME/Sup and list the different supplies in the procedure code section.

E. Patient Information

Complete the all of the patient information field. Refer to the recipient's Medicaid identification card for information.

1) Medicaid ID Number: Enter the patient's 10-digit Medicaid ID number, including all leading zeros. If the patient has applied for Medicaid coverage but is not yet approved, a statement such as "DHS pending" must be entered in this field.

2) Patient's Name: Type or print legibly the patient's full name in last name, first name, and middle initial order. Do not use nicknames.

3) Date of Birth: Enter the patient's month, day, and year of birth & gender.

4) Medicare Coverage: Check appropriate boxes regarding Medicare coverage. If Medicare makes payment on the service, the Medicaid authorization is not required.

5) Currently at: The patient's current place of residence must also be provided when requesting approval for appliances or DME, supplies and home health rehabilitation services (physical therapy, occupational therapy and speech therapy). Approval may be delayed if residence is not indicated. Check the appropriate box indicating the patient's place of residence.

   a. Routine DME and supplies for recipients in SNFs/ICFs/ICF-MRs are not payable, as they are included in the facility's reimbursement for the confinement.

   b. For physical therapy, occupational therapy, speech therapy services, Form 1147C must be attached if patient is in an SNF. Maintenance physical therapy services are included in the facility room and board rates.

c. Print patient's mailing address. Deferred and denied notifications to the recipient will be sent to this address

6) Expanded EPSDT: Check appropriate box if services requested are expanded EPSDT services.

F. Physician and Medical Information

All fields must be completed unless otherwise indicated.

1) Diagnosis: Provide the condition or illness with sufficient information to justify the recommended treatment or service.

2) Justification: Provide the medical indications for requesting the services or provide a prognosis of the patient's condition or the period for which approval is requested. Justify the reason for the request.

a. For Vision Appliances:

i. Damaged, Lost, Stolen - Provide the date of the last dispensed vision eyewear and the replacement prescription.

ii. Change in Prescription - Provide the date of the last dispensed vision eyewear and both the old and new prescription. Visual acuity without correction and with the old and new corrections may help to further justify the need for minimal Rx changes of less than 0.50 diopter sphere and/or cylinder.

iii. Separate Reading and Distance Glasses - Provide the date of the last dispensed glasses, the old and new prescription, and the reason for separate glasses instead of bifocals.

b. For rehabilitative therapy services, provide the frequency and duration of the services, modalities and goals or purpose of the therapy. The actual number of treatments should be entered in the "quantity" column, #12 above.

c. For DME, indicate the duration of need and reason for special or modified equipment instead of standard models.

d. For supplies, provide itemized description, quantity, and cost per month. Also indicate whether the patient is at or is waitlisted for long term care level. Refer to the list of supplies that are included in the facility's per diem reimbursement and those for which separate reimbursements for supplies can be made.

e. Check attachment box when applicable.

3) Procedure Code: Provide the applicable HCPCS procedure code for the recommended service so that a match can be made with this authorization form and the claim.

4) Service/Description: Specify the service, name of test(s) or item being requested. A maximum of 4 line items may be requested, one item per line. If more than 4 are being requested, separate forms should be completed to avoid approval delays.

a. For home health services, enter as appropriate, "Home Health Agency PT or OT" and the frequency of therapy as specified in the plan of care (Example: 3x per week). Also, for these home health therapies, indicate the start and end dates of the initial two weeks of therapy in this field.

5) QTY: Enter the quantity being requested (even if the quantity is 1).

a. Enter the quantity per time period (example: 100/month)

b. For psychological tests, enter the number of hours needed to administer the tests.

c. For rehabilitative therapy services (PT, OT, speech therapy, audiology services), convert the frequency and duration of therapy indicated in block 16 into the total number of services (Example: 2x/week for 4 wks = quantity 8).

d. PT services for patients in LTC facilities, the quantity must be in 15-minute increments; however, for outpatient services, time increments must be as described by procedure code.

6) Period Requested: Enter the start & end date for the service period requested.

a. For psychiatric admissions, enter the date of admission. For psychological testing indicate the dates that tests are to be administered.

b. For home health services, enter start and end dates of the services as indicated in the plan of care.

c. If already performed, indicate the date of the service or date of admission. Justification for late submissions must be provided.

G. Supplier Information

All requests for specialized goods or for services to be rendered by providers other than the requesting physician must be referred to the provider of the service for completion of the supplier information (e.g., requests for supplies, equipment, rehabilitation services, appliances, etc.). Referral to rehabilitative therapist is not required if the therapy procedure code is known and entered on the form by the physician. All other services should be requested by the provider of the service.

1) Purchase Price: Conditionally required. For DME, provide the purchase price of the equipment requested. For vision services indicate the purchase price of requested eyewear.

2) Rental Price: Conditionally required. For DME rentals, provide the rental amount.

3) Repair Price: Conditionally required. For DME repairs, provide the repair charge.

4) Serial #: Conditionally required. For DME, provide the serial number of the DME item.

H. Physician Section for Incontinence Supplies

1) Recipient Requires Diapers: Check the appropriate box if the recipient requires diapers and indicate the number of diapers used per month.

2) Recipient Requires Underpads: Check the appropriate box if the recipient requires underpads and indicate the number of underpads used per month.

3) Caregiver Requires Gloves: Check the appropriate box if the caregiver requires gloves and indicate the number of pairs of gloves used per month.

4) Additional Justification attached: Check the appropriate box if additional justification is attached to the Form 1144.

5) Incontinence Supplies:

a. QTY/Mo: Indicate the appropriate quantity required per month next to the applicable procedure code/item.

b. Period Requested: Enter the service period requested.

I. Physician Information

1) Physician's Signature: The physician completing the form must hand-sign the form. A rubber-stamped signature is not acceptable and will cause approval

delays. A physician with the exception of vision appliances (which can be signed by an optometrist), podiatric services (which can be signed by the podiatrist), and applicable dental services (which can be signed by a dentist) must sign all requests for authorization. Note the attestation clause when signing.

2) Provider #: Required. Enter the Physician's Medicaid provider number.

3) Contact name: Required. Enter the Physician's contact person's name

4) Physician's name: Required. Print legibly or stamp the physician's name.

5) Date: Required. Indicate the date of request.

6) Telephone: Required. Enter the Physician's telephone number.

7) Fax #: Enter the fax number.

8) Supplier's Signature: The supplier completing the form must hand-sign the form. A rubber-stamped signature is not acceptable and will cause approval delays. Note the attestation clause when signing.

9) Provider #: Enter the Supplier's Medicaid provider number.

10) Contact name: Enter the Supplier's contact person's name

11) Supplier's name: Print legibly or stamp the supplier's name or the name of the hospital for admission requests.

12) Date: Required. Indicate the date signed.

13) Telephone: Required. Enter the telephone number.

14) Fax #: Required. Enter the fax number.

III. Timeliness of Requests

A. Authorization is strongly advised before the service is rendered for those services which experience has shown to be of questionable medical necessity or not covered under the Medicaid Program.

B. Requests for approval should not be submitted more than sixty (60) days before the service is expected to be rendered.

C. Services requiring prior authorization must be submitted before services are rendered.

D. However, if obtaining prior authorization may delay service and place the patient in jeopardy, then the Form 1144 must be submitted within five (5) working days after the service date or the request shall be denied.

E. For inpatient psychiatric admissions, the form must be received or postmarked within five (5) working days from the admission date.

F. For patients being discharged from an acute care hospital or long term care facility to home or non-institutional setting, an 1144 for certain standard DME and supplies must be submitted within ten (10) working days after discharge. Medical justification, name of facility, and date of discharge must be provided. Refer to the Conditional Approval process in Section VI.

G. If the service required prior authorization, justification for the late submission, with the Form 1144 must be submitted within thirty (30) calendar days from the date of service.

H. Services requiring medical authorization must be submitted on the Form 1144 for approval within thirty (30) days of the service date.

IV. Urgent Authorizations

A. Urgent requests for approval may be faxed to (808) 952-5562.

B. Requests for Conditional Authorizations should be limited to procedures, goods or services which medically should not be delayed for a written approval (approximately five working days), and services rendered in association with an office visit when the provider knows from experience that the authorization criteria are being met and nothing would be gained from having the patient return later.

C. Med-QUEST Medical Standards Branch (MSB) will fax or phone approval/denial of requests for authorization within two (2) working days of receipt. To ensure that MSB can meet this time frame, providers must ONLY fax requests for URGENTLY needed services, supplies or DME. MSB will defer non-urgent fax requests, as these should be submitted by hard copy.

D. Fax requirements and process:

1) The recipient must have an urgent medical need for the service/supply/DME. On the 1144 form write "Urgent" across the top of the form and check of the Urgent Request for Services box. Requests that are not clearly urgent will be deferred.

2) RENEWALS of supplies (example: diapers, underpads), DME (example: extensions of rental period), and services (example: extensions of physical therapy) should not be faxed. If received by fax, these requests will be processed as a routine authorization request and not expedited.

3) The authorization form must be fully completed with valid HCPCS codes and signed by the requesting physician (except as indicated below). The facsimile signature is acceptable as long as a permanent record of the original signature is retained on the document by the physician or supplier.

4) Send ONLY the faxed request for authorization. There is no need to send a hard copy authorization form for urgent request. If the request is approved, ACS - Medicaid Fiscal Agent will assign an authorization number, which will be recorded on the 1144 form. The approved form will be faxed back to the sender or a verbal approval will be given to the sender on the telephone.

5) The Med-QUEST MSB may PEND a faxed authorization and ask the requester to submit specific information. (Examples: x-rays, photographs)

6) Do not submit claims for services, supplies or DME authorized by fax until you receive your authorization notification letter. This letter indicates that ACS - Medicaid has entered the approval into its claims processing system so that denials of valid claims will not occur.

7) Do not submit requests for retro-authorizations. Late submissions must be submitted by hard copy with a justification for the late submission.

8) **EXCEPTION:** There are situations when the physician's signature cannot be obtained but the medical need of the service, supply or DME is urgent and the supplier is providing the service, supply or DME on the physician's prescription/order (Example: home infusion services, wheelchair repair). In these cases, a conditional authorization without a physician's signature can be given by Med-QUEST MSB.

E. Procedures for Conditional Authorizations:

1) State clearly on the fax cover sheet and on the 1144 that a "Conditional Authorization" is being requested and briefly explain why the physician's signature could not be obtained. Clearly print the name of the prescribing/ordering physician (Example: physician orders for discharge from hospital; physician has no fax machine; Dr. John Doe)

2) The authorization form must be complete (valid HCPCS) except for the physician's signature.

3) Med-QUEST MSB will provide a conditional authorization and will notify the requestor of that authorization.

4) When the physician's signature is obtained, the form with the physician's signature must be faxed back to ACS – Medicaid Fiscal Agent. Please indicate on the 1144 the date the conditional authorization was given. The completed form should not be mailed.

5) Final approval will be given and providers (prescribing physician and supplier) will receive an authorization letter.

6) The form with the physician's signature must be received by fax by ACS - Medicaid Fiscal Agent within one month of the Conditional Approval.

7) In order for this process to operate efficiently, the form on which the conditional authorization was given and the form with the physician's signature must be identical. Except for the absence of the physician's signature and the date the conditional authorization was given, no codes should be changed or added and no modifications should be made to the original request.

V. Authorization Inquiries

Inquiries regarding the authorization determination on a completed request or the status of a request may be addressed to:

ACS – Hawaii Medicaid Fiscal Agent	
Oahu	952-5570
Neighbor Islands	1-800-235-4378

VI. Exclusions to Authorization Requirement

Authorization is not required for patients with both Medicare and Medicaid coverage when Medicare will pay for the service. Authorization must be obtained when requesting DME for which the cumulative rental or total purchase price exceeds $50.00.

VII. Authorization Period

Medical authorization expires sixty (60) days from the date of approval unless otherwise noted. If the authorization period expires before the requested service has begun or services have not been completed, a new Form 1144 should be submitted with a copy of the old form attached.

VIII. Payment Requirements

Approval of the procedures or equipment is not an authorization for payment or an approval of the charges. The provider must check the patient's ID card to insure that the patient is eligible under the Medicaid Program at the time the services are rendered. The provider must also be

approved by the Department of Human Services to participate under the Medicaid Program. Payment cannot be made to a nonapproved provider even if the patient was eligible and the services were approved.

IX. Form Availability

The Request for Medical Authorization Form 1144 may be obtained by calling:

ACS – Hawaii Medicaid Fiscal Agent
Oahu 952-5570
Neighbor Islands 1-800-235-4378

or through the Med-QUEST website at:

www.medquest.us

or by writing to:

ACS – Hawaii Medicaid Fiscal Agent
P. O. Box 1220
Honolulu, HI 96807-1220

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS – Hawaii Sate Medicaid Fee for Service Program
365 Northridge Rd, Suite 400
Atlanta, GA 30350

REQUEST FOR MEDICAL AUTHORIZATION

Check only One – Different Types of Services Must Be Requested on Separate 1144B Forms. [ ] Home Infusion PA [ ] Non-home infusion (Medication only) PA

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

[1] Medicaid ID Number	[2] Patient's Name (Last, First, M.I.)	[3] Gender [ ] M [ ] F	[4] Date of Birth / /
[5] Medicare Coverage? [ ] Yes [ ] No Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No	[6] Currently at: [ ] Home [ ] Hospital [ ] SNF/ICF/ICF-MR Facility Patient's Mailing Address (St., City, Zip Code)	[7] Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [ ] Yes [ ] No	

Physician Section			**Supplier Section (Circle Rent or Repair)**			
	[8] NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code	[9] QTY	[10] Purchase Price	[11] Rent/Repair	[12] Period Requested From:	To:
1						
2						
3						
4						
5						

Physician Section

[13] Diagnosis or ICD-9 code [14] BMI (for anorexiants):

[15] Period Requested [16] Prognosis

[17] Justification (include history of previous treatment) ([ ] Attachment)

[18] Print Physician's Name/Mailing Address	[19] Physician's Signature	
	[20] DEA or Medicaid Provider #	[21] Date
	[22] Telephone #	
	[23] Fax #	[24] Contact Name

Supplier Section

[25] Print Supplier's Name/Mailing Address			[26] Comments
[27] Contact Name	[28] Telephone #	[29] Fax #	
[30] Supplier's Signature	[31] NABP #	[32] Date	

DHS 1144B (08/02)

INSTRUCTIONS

DHS 1144B

HAWAII STATE MEDICAID FEE FOR SERVICE PROGRAM

REQUEST FOR MEDICAL AUTHORIZATION

1. **Medicaid ID Number :** Enter the Medicaid ID.
2. **Patient's Name:** Enter the patient's name (last, first, MI).
3. **Gender:** Check the patient's gender.
4. **Date of Birth:** Enter the member's date of birth: mm/dd/yyyy.
5. **Medicare Coverage:** Check whether the patient has Medicare coverage and is receiving Medicare Home Health Benefits.
6. **Currently At:** Check where the patient is currently located and enter the mailing address.
7. **Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT):** Check whether the patient has received expanded early and periodic screening diagnosis & treatment.
8. **NDC Number or Drug Name, Strength, Units, or Global Code, or HCPCS:** Enter the NDC Number, Drug Code, or HCPCS code.
9. **QTY:** Enter the quantity.
10. **Purchase Price:** Enter the purchase price.
11. **Rent/Repair:** Circle whether this request is for rent or repair and enter the amount.
12. **Period Requested:** Enter the Period Requested From: and To:.
13. **Diagnosis or ICD-9 code:** Enter the diagnosis code or the ICD-9 code.
14. **BMI (for anorexiants):** Enter the BMI.
15. **Period Requested:** Enter the period requested.
16. **Prognosis:** Enter the prognosis.
17. **Justification:** Enter the justification and include any history of previous treatment. Check if any attachments are included.
18. **Print Physician's Name / Mailing Address:** Print the physicians name and mailing address.
19. **Physician's Signature:** Physicians: Sign the form.
20. **DEA# or Medicaid Provider #:** Enter the physician DEA number or the Medicaid Provider number.
21. **Date:** Enter the date of signature.
22. **Telephone #:** Enter the physician's telephone number.
23. **Fax #:** Enter the physician's fax number.
24. **Contact Name:** Enter the name of the person to contact.
25. **Print Supplier's Name / Mailing Address:** Print the supplier's name and mailing address.
26. **Comments:** Enter any comments.
27. **Contact Name:** Enter the name of the person to contact.
28. **Telephone #:** Enter the supplier's telephone number.
29. **Fax#:** Enter the supplier's fax number.
30. **Supplier's Signature:** Sign the request.
31. **NABP#:** Enter the NABP number.
32. **Date:** Enter the date of signature.

Form 1147

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Mountain Pacific Quality Health Foundation
1360 Beretania St., Ste. 500
Honolulu, Hawaii 96814

SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION

APPLICANT INFORMATION: (Please print or Type)

1. NAME (Last, First, MI)	2. BIRTHDATE MONTH/DAY/YEAR	3. AGE	4. SEX	5. MEDICARE STATUS Part A ❑ YES ❑ NO Part B ❑ YES ❑ NO ID #	6. MEDICAID STATUS ❑ YES ID# _____ ❑ NO Date Applied _____

7. PRESENT ADDRESS (Specify Facility Name When Applicable)

Present Address is ❑ Home ❑ Hospital ❑ SNF ❑ ICF ❑ Waitlisted ❑ Care Home ❑ Other _____

8. ATTENDING PHYSICIAN

Print Last, First, MI

Phone: _____ Fax: _____

9. RETURN FORM TO: ❑ VIA FAX (Print Fax Number Below) ❑ BY MAIL (Print Address Below)

Attention _____

Phone _____ Provider Medicaid ID # _____ (Enter provider # for level of care on effective date.)

10. REFERRAL INFORMATION (To Be Completed by Referring Party)

A. CONTACT PERSON _____
B. TITLE _____
C. PHONE _____ FAX _____
D. SOURCE(S) OF INFORMATION
❑ CLIENT ❑ RECORDS ❑ OTHER _____
❑ RESPONSIBLE PERSON

Name _____
Last, First, MI

Relationship _____

PHONE _____ FAX _____

Language ❑ English ❑ Other _____

E. Requesting ❑ Nursing Facility (NF) ❑ Acute Waitlisted
❑ PACE Program ❑ Hospice
❑ Home & Community Based Services (HCBS)
❑ NHWW ❑ RACCP ❑ HCCP

11. (To Be Completed by RN or Physician)

A. ASSESSMENT DATE ____/____/____
B. ASSESSOR'S NAME

Last, First, MI

TITLE _____

SIGNATURE _____

PHONE _____ FAX _____

C. HCBS Option Counseling provided ❑ Yes ❑ No

If NO explain _____

If YES, by whom (Name) _____

Title/Relationship _____

TO BE COMPLETED BY STATE OF HAWAII MEDICAL CONSULTANT OR DESIGNEE ONLY

12. MEDICAL NECESSITY/LEVEL OF CARE ACTION

I. ❑ LOC APPROVED EFFECTIVE DATE _____
❑ SUBACUTE ❑ Level I ❑ Level II ❑ SNF ❑ ICF ❑ HOSPICE
❑ ACUTE WAITLISTED SNF from _____ to _____
❑ ACUTE WAITLISTED ICF from _____ to _____
❑ ACUTE WAITLISTED SUB-ACUTE from _____ to _____
Next Review in ❑ 1 Month ❑ 3 Months ❑ 6 Months ❑ Annual (specify mm/yy) _____ ❑ Other _____
NEXT 1147/1147a due on (date) _____
II. ❑ DEFERRED
III. ❑ DENIED
Comments _____

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S/DESIGNEE'S SIGNATURE _____ DATE _____

13. DISPOSITION

❑ Home and Community-Based Services
❑ Nursing Home Without Walls (NHWW)
❑ Residential Alternatives Community Care Program (RACCP)
❑ Level 1 _____ ❑ Level 2 _____
❑ HIV Community Care Program (HCCP)
❑ PACE Program
❑ Nursing Facility
❑ Hospice
❑ Own Home
❑ Extended Care ARCH
❑ Other _____

Comments _____

Signature Date

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

APPLICANT/CLIENT BACKGROUND INFORMATION (Please print or Type)

1. NAME (PRINT Last, First, MI)

2. BIRTHDATE

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

_____

_____

II. COMATOSE ❑ No ❑ Yes If "Yes," go to XIV.

III. VISION/HEARING/SPEECH

[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ❑ Hearing ❑ Vision ❑ Speech
[1] b. Individual has impairment (with/without corrective device) of: ❑ Hearing ❑ Vision ❑ Speech
[2] c. Individual has complete absence of: ❑ Hearing ❑ Vision ❑ Speech

IV. COMMUNICATION

[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MENTAL BEHAVIOR (circle all that apply)

[0] a. Oriented (mentally alert and aware of surroundings).
[1] c. Disoriented (partially or intermittently; requires supervision).
[2] d. Disoriented and/or disruptive.
[3] f. Aggressive and/or abusive.
[4] g. Wanders at ❑ Day ❑ Night ❑ Both, or in danger of self-inflicted harm or self-neglect.

VI. FEEDING/MEAL PREPARATION

[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon/syringe/tub fed, does not participate.

VII. TRANSFERRING

[0] a. Independent with or without a device.
[2] b. Transfers with minimal/stand-by help of another person.
[3] c. Transfers with supervision and physical assistance of another person.
[4] d. Does not assist in transfer or is bedfast.

VIII. MOBILITY/AMBULATION (check a maximum of 2 for a through d)

[0] a. Independently mobile with or without device.
[1] b. Ambulates with or without device but unsteady/subject to falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one assist.
[4] e. Able to walk/be mobile with more than one assist.
[5] f. Unable to walk.

IX. BOWEL FUNCTION/CONTINENCE

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

X. BLADDER FUNCTION/CONTINENCE

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

XI. BATHING

[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XII. DRESSING AND PERSONAL GROOMING

[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes.)
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing and grooming.

XIII. TOTAL POINTS

Total Points Indicated _____

XIV. MEDICATIONS/TREATMENTS (List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)	Requires Supervision and/or monitoring	PRNs Only Actual
_____	❑	_____
_____	❑	_____
_____	❑	_____
_____	❑	_____
_____	❑	_____

XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS

_____

_____

_____

_____

_____

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

1. NAME (PRINT Last, First, MI)	2. BIRTHDATE

XVI. SKILLED PROCEDURES **D**=Indicate number of times per day (Check L or N if appropriate) **L**=Less than once per day **N**=Not applicable/Never

D(#)	L	N	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
_____	❑	❑	Tracheostomy care/suctioning in ventilator dependent person.
_____	❑	❑	Tracheostomy care/suctioning in non-ventilator dependent person.
_____	❑	❑	Nasopharyngeal suctioning in persons with no tracheostomy.
_____	❑	❑	Total Parenteral Nutrition (TPN) Specify number of hours per day. _____
_____	❑	❑	Maintenance of peripheral/central IV lines.
_____	❑	❑	IV Therapy – Specify agent & frequency. _____
_____	❑	❑	Decubitus ulcers – Stage III and above.
_____	❑	❑	Decubitus ulcers – Less than Stage III; Wound care – Specify nature of ulcer/wound and care prescribed.
			_____
_____	❑	❑	Instillation of medications via indwelling urinary catheters – Specify agent.
			_____
_____	❑	❑	Intermittent urinary catheterization.
_____	❑	❑	IM/SQ Medications – Specify agent. _____
_____	❑	❑	Difficulty with administration of oral medications – Explain.
			_____
_____	❑	❑	Swallowing difficulties and/or choking.
_____	❑	❑	Stable Gastrostomy/Nasogastric/Jejunostomy tub feedings; Enteral Pump? ❑ Yes ❑ No
_____	❑	❑	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration.
			_____
_____	❑	❑	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.
_____	❑	❑	Complicating problems of patients on renal dialysis, chemotherapy, radiation therapy, with orthopedic traction. Circle problem(s) and describe.
			_____
_____	❑	❑	Behavioral problems related to neurological impairment. Describe.
			_____
_____	❑	❑	Other – Specify condition and describe nursing intervention.
			_____

❑ Yes Therapeutic Diet – Describe.

_____

❑ Yes Restorative Therapy: PT/OT/Speech – Circle therapy and submit/attach evaluation and treatment plan.

XVII. SOCIAL SITUATION

A. Caregiving support system is willing to provide/continue to provide care with assistance. ❑ Yes ❑ No

State assistance needed by Caregiver _____

If YES, complete B & C. If NO, go to D.

B. Name _____ Relationship _____
Last, First, MI

Address _____

_____ Phone _____

_____ Fax _____

C. Person currently has a home and can return home ❑ Yes ❑ No Residential setting can be considered as an alternative to facility. ❑ Yes ❑ No

D. Patient is appropriate for ❑ Care Home ❑ Assisted Living ❑ Hospice Residence
Check all appropriate site(s) ❑ Foster Care ❑ Shelter ❑ Other _____

XVIII. RECOMMENDATIONS/DISCHARGE PLANS

A. Requested LOC _____ D. Hospice Elected ❑ Yes ❑ No

B. Requested Effective Date of Medicaid Coverage. _____ E. Appropriate for HCBS ❑ Yes ❑ No

C. Effective Date of LOC _____

XIX. PHYSICIAN'S SIGNATURE _____ DATE _____

Physician's Name _____
Please Print

Comments _____

_____

INSTRUCTIONS

DHS FORM 1147

SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION

PAGE 1 - APPLICANT INFORMATION

1. ***NAME:*** *Self-explanatory*

2. ***BIRTHDATE:*** *Self-explanatory*

3. ***AGE:*** *Self-explanatory*

4. ***SEX:*** *Self-explanatory*

5. ***MEDICARE STATUS****:*
Answer questions specific to coverage by Medicare. Check Yes or No for Part A coverage. Check Yes or No for Part B Coverage. Enter the Medicare I.D. Number, if the patient is has Part A and B coverage, only Part A, or only Part B.

6. ***MEDICAID STATUS****:*
If the person is eligible for Medicaid, check Yes and enter his/her Medicaid I.D. Number. If the patient has applied for Medicaid but has not yet been deemed eligible, check No and enter date applied. DO NOT COMPLETE THE 1147 FORM UNLESS THE PATIENT HAS APPLIED FOR MEDICAID. When the person becomes eligible for Medicaid and has a valid number, a 1147a must be generated and approved by Mountain Pacific in order for that facility to be paid.

7. ***PRESENT ADDRESS:***
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code. Check appropriate box, which describes the address given.

8. ***ATTENDING PHYSICIAN:***
Print name of the attending physician and give his/her phone and fax numbers. The attending physician can be the hospital-based physician responsible for the person's inpatient acute care, the nursing facility medical director, or the patient's primary care physician or physician specialist.

9. ***RETURN FORM TO:***
State how you wish the form sent back to you--by mail or fax--and to whose attention this should be directed. The form may not be mailed or faxed back to you with a cover

sheet. Therefore, it is critical that this information is accurate. For reimbursement of the level of care, enter your facility's provider number for level of care on effective date. If a facility wants a level of care determination ONLY and will not bill for the services, it must submit the 1147 without a provider number.

10. REFERRAL INFORMATION:

A. Contact person: *

B. Title: *

C. Phone/Fax: *

*The name of the person (also, title, and phone and fax numbers) who should be contacted if DHS or its designee require additional information or clarification of information submitted on the 1147 form.

D. Source(s) of Information: *Self-explanatory*

Responsible Person:
The name, relationship, phone and fax numbers, and language spoken of the family member/personal agent who would make decisions for the patient if he/she were not able to act.

E. Requesting:
Check the setting which person or his/her agent requests that long term care (LTC) be provided.

11. ASSESSMENT INFORMATION:

A. Assessment Date:
The date the assessment was completed.

B. Assessor's Name, Title, Signature, Phone and Fax Numbers:
A Registered Nurse (RN) or physician must perform the assessment. The name, title signature, and phone and fax numbers of the assessor should be entered.

C. HCBS Option Counseling provided:
Enter Yes or No as to whether or not the person was given information about home and community based programs and counseling about how his/her needs could be met in the home and community setting. Provide an explanation if the person did not receive information and/or counseling. If a person did receive information and

counseling, provide the name, title or relationship of the person who provided the information and counseling.

12. MEDICAL NECESSITY / LEVEL OF CARE ACTION
Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

DISPOSITION
Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 - APPLICANT/CLIENT BACKGROUND INFORMATION

1. NAME: *Self-explanatory*

2. BIRTHDATE: *Self-explanatory*

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS:

I. LIST SIGNIFICANT CURRENT DIAGNOSIS (ES): Primary and Secondary.
List the main diagnosis (ses) or medical conditions related to person's need for long term care. List the most important diagnosis first.

II. COMATOSE:
If the patient is comatose, enter Yes. Do not complete sections III. To XIII. Go directly to section XIV. If the patient is not comatose, enter No and complete entire page.

III. to XII.
Circle the description that best describes the person's functional ability in each section. These sections require an assessment of the patient's activities of daily living. To provide accurate information, the assessor should consult the patient or nursing staff, physicians, caregivers, etc. familiar with the patient. Completion of these sections requires direct knowledge of the patient's functional abilities on the date the assessment is done. Therefore, these sections cannot be completed from medical record review alone.

XIII. TOTAL POINTS:
Enter the score by totaling the points circled in sections III. To XII.

XIV. MEDICATIONS/TREATMENTS:

List the significant medications the patient is currently receiving. These are medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term medications (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (5) significant medications, attach orders or treatment sheet.

XV. ADDITIONAL INFORMATIONCONCERNING PATIENT'S FUNCTIONAL STATUS:

Provide any additional clinical information, which will clarify his/her functional status and support his/her need for long term care.

PAGE 3

1. NAME: *Self-explanatory*

2. BIRTHDATE: *Self-explanatory*

XVI. SKILLED PROCEDURES:

If the services listed are provided daily, state the number of times they are performed. Check if they are provided less than daily or never provided. Provide explanation, details when requested.

XVII. SOCIAL SITUATION:

A. Caregiving support system is willing to provide/continue to provide care with assistance:

Answer Yes or No and then state the help the caregiver needs in order for him/her to continue in the role of caregiver.

B. Name, Relationship, Address, Phone and Fax Numbers of Caregiver: (Self-explanatory)

C. Person currently has a home and can return home:

Answer Yes or No. If No, answer if, based on his/her clinical status, residential setting is or is not appropriate for the patient.

D. Patient is appropriate for:
Check all the residential settings in which the patient's needs can be appropriately met.

XVIII. RECOMMENDATIONS / DISCHARGE PLANS:

A. Requested LOC:
Enter the LOC the assessor feels most appropriate for the patient and is requesting.

B. Requested Effective Date of Medicaid Coverage:
This is the date being requested as the start of the Medicaid long-term care benefit. For a patient dually eligible for Medicare and Medicaid, enter the date that Medicare coverage will terminate—assuming that the patient has a continuing need for long term care after the Medicare benefit ends.

C. Effective Date of LOC:
This is the date the patient was deemed appropriate for a long term care (LTC) LOC. It does NOT have to be the assessment date provided on Page 1 as the assessment might have been completed while the person was at the acute LOC or after a person who has been at a LTC LOC with Medicare or other health insurance coverage becomes eligible for Medicaid. However, if no date is entered, the assessment date is considered to be the effective date.

D. Hospice Elected: *Self-explanatory*

E. Appropriate for HCBS: *Self-explanatory*

XIX. PHYSICIAN'S SIGNATURE:

A physician who has either prepared or reviewed the 1147 should sign and enter the date of signature. The physician's name should be printed.

Comments:
Comments by the signing physician, or assessor can be entered here. Additional information which would clarify the requested LOC, explain any discrepancies with effective date of LOC, assessment date, and effective date of Medicaid coverage, contribute to a clearer understanding of the patient's medical or social condition, etc. can be entered.

FORM 1147a

Department of Human Services
Med-QUEST Division
Medical Standards Branch

STATE OF HAWAII
Level of Care (LOC) Reevaluation
LT

Mountain Pacific Quality Health Foundation
1360 Beretania St., Ste. 500
Honolulu, Hawaii 96814

(Please Type)

1. Patient Name (Last, First, M.I.)	2. Medicaid ID Number	3. Date of Birth Month/Day/Year	4. Sex ☐ F ☐ M	5. Admission Date Month/Day/Year
6. Present address/facility (Specify facility name when applicable)			7. Medicaid Provider I.D. Number	
8. Attending Physician (PRINT Last, First, M.I.)		9. Contact Person (Last, First AND Title) Phone Number		

10. Return form to: _____ Via Fax: _____

Attention _____ Phone _____ Via Mail: _____

Reason(s) – Check all that apply

☐ Admission/Readmission after acute hospitalization to NF – Name: _____ Date: _____

☐ Admission/Readmission after acute hospitalization to home and community-based program. Date: _____

☐ Nursing Home Without Walls (NHWW) ☐ HIV Community Care Program (HCCP)

☐ PACE Program ☐ Other – Name: _____

☐ Residential Alternatives Community Care Program (RACCP) (Case Management Agency)

Transfer from NF to NF – Name: _____ Date: _____

☐ Changes in LOC.

☐ Annual LOC Determination for home and community-based program.

☐ DHS required evaluation (example: Annual LOC Determination for Nursing Facility ICF LOC).

☐ Extension of Acute Waitlisted NF status (date of initial determination) _____ Period requested From (mmddyy):_____ To (mmddyy):_____

☐ At home, waitlisted for NF bed.

☐ At home, waitlisted for home and community-based program.

☐ In Nursing Facility, Requesting Home or Home & Community-Based Program.

☐ Home & Community-Based Program placement not found/not suitable, requesting Nursing Facility.

Approved LOC on most current form – Date: _____			LOC BEING REQUESTED – Effective Date: _____		
☐ Subacute Level I	☐ SNF	☐ ICF	☐ Subacute Level I	☐ SNF	☐ ICF
☐ Subacute Level II	☐ Acute Waitlisted ICF	☐ Acute Waitlisted Subacute	☐ Subacute Level II	☐ Acute Waitlisted ICF	☐ Acute Waitlisted Subacute
☐ Acute Waitlisted SNF	☐ Hospice		☐ Acute Waitlisted SNF	☐ Hospice	

Current Status – Check all that apply

☐ No change in diagnoses – Specify primary diagnoses: _____

☐ Additional diagnoses – List: _____

☐ Functional capabilities ☐ No change ☐ Change(s) – Specify: _____

☐ Nursing needs ☐ No change ☐ Change(s) – Specify: _____

☐ Change in LOC ☐ No change ☐ Change(s) – Specify: _____

Document need for continuing LTC services at level of care being requested: _____

Anticipated time needed at LOC being Requested – Dates From: _____ To: _____ **Effective Date:** _____

Physician's signature: _____ **Date:** _____

Physician's name (PRINT): _____

To Be Completed By State of Hawaii – DHS/DHS Designee Only

Approved for: ☐ Subacute
☐ Level 1 ☐ Level 2
☐ SNF
☐ ICF
☐ Hospice
☐ Acute Waitlisted ICF (approved dates) _____ to _____
☐ Acute Waitlisted SNF (approved dates) _____ to _____
☐ Acute Waitlisted Subacute (approved dates) _____ to _____

Length of approval: ☐ 1 year
Approved LOC effective date
☐ 6 months
Approved LOC effective date
☐ Other – Specify:

Deferred: ☐ New 1147 needed.

DHS Reviewer's/Designee's Signature: _____ Date: _____

INSTRUCTIONS
DHS 1147a

LEVEL OF CARE (LOC) REEVALUATION

APPLICANT INFORMATION

1. ***Patient Name:*** *Self-explanatory*

2. ***Medicaid I.D. Number***:
The Medicaid I.D. Number and check digit should be entered; if the patient has applied for Medicaid but has not yet been deemed eligible please write in "Pending."

3. ***Birthdate: Self-explanatory***

4. ***Sex:*** *Self-explanatory*

5. ***Admission Date:***
Date of admission to the current level of care (LOC).

6. ***Present Address/Facility:***
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code.

7. ***Medicaid Provider ID:***
Medicaid Provider I.D. number specific to the LOC (example, if waitlisted in an acute hospital, provide the appropriate waitlisted number)--if unknown, state "waitlisted SNF.")

8. ***Attending Physician:*** *Self-explanatory*

9. ***Contact Person: and Phone Number:***
The name and phone number of the person able to provide additional information about the patient if needed.

10. ***Return Form***:
State how you wish the form sent back to you--by mail or fax and to whose attention this should be directed. The form will not be mailed or faxed back to you with a cover sheet. Therefore, it is critical that this information is accurate.

REASON(S): (Check all that apply) S*elf-explanatory; except, as follows:*

Change in LOC
Check this if a LOC change is being requested. The blocks "Approved LOC on Most Current Form" and "LOC Being Requested" specify the specific LOC change being requested.

In Nursing Facility, Requesting Home and Community Based Program
Do not check this unless the patient needs information on home and community based options. A direct referral to the Home and Community Based Program in which the patient is interested should be done.

APPROVED LOC ON MOST CURRENT FORM (date): The LOC approved in Section 12. Page 1 of the most current 1147 form or on the most current 1147a should be checked and the effective date of the LOC should be entered.

LOC BEING REQUESTED (effective date). The LOC being requested should be checked and the requested effective date should be entered.

CURRENT STATUS: (Check all that apply)

No change in diagnoses: *(List diagnoses)*
Diagnoses should be taken from the most current 1147 Form (page 2), or on the most current 1147a. The primary diagnosis should be listed first.

Additional Diagnoses: *(List diagnoses)*
Any new diagnosis (ses) which affect(s) the medical care and NOT listed on the most current 1147/1147a Form should be entered. If more than one, the most important diagnosis should be listed first.

Changes in Functional Capabilities: *(Specify)*
These refer to increases/decreases/ in ADLs, behavioral, and cognitive functioning.

Changes in Nursing Needs: *(Specify)*
These refer to increases/decreases in skilled nursing needs

Changes in LOC: *(Specify current LOC and explain the change)*
These refer to increases/decreases in functional capabilities or skilled nursing needs sufficient to change a person's LOC.

DOCUMENT NEED FOR CONTINUING LTC SERVICES:
This is an assessment of the individual and his/her current status and why LTC services need to be continued. If the answers to "current status" are sufficient to document the need, you may enter "see above."

ANTICIPATED TIME NEEDED AT CURRENT LOC: *Self-explanatory*

EFFECTIVE DATE:
This is the effective date of the LOC being requested.

PHYSICIAN'S SIGNATURE: *Self-explanatory*

DATE is the date the physician signature was obtained.

PHYSICIAN'S NAME: S*elf-explanatory*

DHS 1147c

Department of Human Services
Med-QUEST Division
Medical Standards Branch

Mountain Pacific Quality Health Foundation
1360 Beretania St., Ste. 500
Honolulu, Hawaii 96814

STATE OF HAWAII

Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) Report

Name:	**Birthdate:**	**Date:**

Restorative Therapy(ies) being considered: ❑ **PT** ❑ **OT** ❑ **ST**

Primary diagnosis or medical condition for which the therapy(ies) is/are to be provided: _____

_____

List applicable secondary diagnosis(es): _____

_____

List the 3 main goals of therapy:

1. _____
2. _____
3. _____

Anticipated period of time therapy is to be provided:

❑ Less than 1 month *(indicate # of weeks)* _____

❑ 1 month ❑ 2 months ❑ 3 months

❑ More than 3 months *(explain)*: _____

_____

Check ALL that apply:

❑ The patient has received/is receiving therapy under the Medicare benefit. *Dates:* from _____ to _____

❑ Patient has completed approved therapy (one or more of the above blocks has been checked); additional therapy is needed. (explain): _____

_____

❑ The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

❑ The patient is NOT able to participate in therapy a minimum of 45 minutes per session. (explain): _____

_____

Additional justification for restorative therapy: _____

_____

_____

Recommended effective dates of restorative therapy: from _____ to _____

Print Name and Title	**Signature**	**Date**

Disposition:	**To be completed by Med-QUEST division staff or designee**

Restorative ❑ PT ❑ OT ❑ ST ❑ Approved ❑ Not approved Effective dates: from _____ to _____

DHS Reviewer's/Designee's Signature _____ Date _____

This form is for use in reporting PT, OT, ST for patients in Nursing Facilities (NFs) and in Acute Hospitals when patients are waitlisted for long-term care beds. This form should be completed by the therapist and faxed with the 1147 or 1147a forms and ALL PT/OT/ST assessments previously done by a facility's therapist(s) when restorative therapy services are being considered.

INSTRUCTIONS
DHS 1147c

PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH THERAPY (ST) REPORT

Name, Birthdate, Date: *Self-explanatory*

Restorative Therapy (ies) being considered:
Therapy is "restorative" when it is medically needed and there is a significant likelihood that the therapy will restore or improve function(s) and improve the person's ability to perform activities of daily living (ADL). If more than one therapy is being requested and the goals, anticipated period of time therapy is needed, effective dates of therapy, etc. vary significantly, an 1147c form for each therapy should be sent.

Primary diagnosis or medical condition for which the therapy (ies) is/are to be provided:
State the primary diagnosis or medical condition for which the therapy (ies) are indicated. Examples: fracture of left hip; below knee amputation, etc.

List applicable secondary diagnosis (s3es):
List diagnosis (ses)/medical condition(s) which clarify the primary diagnosis or contribute to the understanding of the patient's rehabilitative needs. Examples: for fracture of left hip; applicable secondary diagnoses can be osteoporosis or stress fractures.

List the 3 main goals of therapy:
Clearly list no more than the 3 most important, realistically achievable short-term rehabilitative goals. If more than one therapy is being requested, at least one goal should be reported for each therapy being sought.

Anticipated period of time therapy is to be provided: *(Self-explanatory)*

Check ALL that apply: *(Self-explanatory)*

Additional justification for restorative therapy:
Additional clinical information should be provided if the therapist does not feel that the answers given above clearly justify a person's need for restorative PT, OT, or ST.

Recommended effective date of restorative therapy:
Medicaid will provide that restorative therapy the effective dates. For patients covered by both Medicare and Medicaid, if restorative therapy is covered under Medicare, this form is not needed unless therapy beyond the period covered by Medicare is being requested.

Print Name and Title, Signature, Date.
The form should be completed and signed by a therapist (PT, OT, ST). The Date is the signature date.

I. BIOGRAPHICAL (Please Type)

PATIENT (SURNAME, FIRST NAME, M.I.)	MQD ID NUMBER √ DIGIT	BIRTHDATE MONTH / DAY / YEAR / /	SEX	EFFECTIVE ADMISSION DATE MONTH/DAY/YEAR / /

PRESENT ADDRESS/FACILITY	CONTACT PERSON (ADDRESS/PHONE NO.)
PLACEMENT ADDRESS/FACILITY	CONTACT PERSON (ADDRESS/PHONE NO.)

II. DIAGNOSES: _____

III. VISION: _____
HEARING _____
SPEECH: _____
SUPPLIES, DME: _____

IV. INTELLIGENCE TEST SCORE: _____ **ADAPTIVE BEHAVIOR SCORE:** _____

V. FUNCTIONAL ASSESSMENT:

NOTE: Using scale (1 through 7), score blocks "C" (current functioning level) and "G" (goal functioning level attempting to achieve):
1 – totally dependent; 2 – maximum assist (hand over hand required); 3 – moderate touch (touch required); 4 – minimal assist (verbal cues/reminders only); 5 – supervision (visual monitor required); 6 – modified independent (with device); 7- independent.

BEHAVIOR	YES	NO	CURRENT	GOAL
SEXUALLY/SOCIALLY APPROPRIATE	☐	☐		
SELF ABUSIVE	☐	☐		
AGGRESSIVE	☐	☐		
HEALTHY, SAFETY, AND/OR COMMUNITY RISK	☐	☐		

COMMUNICATION	YES	NO	CURRENT	GOAL
ADEQUATELY COMMUNICATES NEEDS/WANTS	☐	☐		
UNDERSTANDS SIMPLE INSTRUCTIONS	☐	☐		
USES OTHER COMMUNICATION TECHNIQUE/DEVICE	☐	☐		

TRANSFER	YES	NO	CURRENT	GOAL
TRANSFERS FROM BED	☐	☐		
TRANSFERS FROM CHAIR/TOILET	☐	☐		
DOES NOT TRANSFER OR IS BEDFAST	☐	☐		

MOBILITY	YES	NO	CURRENT	GOAL
MOVES ABOUT THE COMMUNITY	☐	☐		
AMBULATES	☐	☐		
WALKS WITH DEVICE	☐	☐		
DOES NOT WALK	☐	☐		
MOVES ABOUT IN A WHEELCHAIR	☐	☐		

DRESSING	YES	NO	CURRENT	GOAL
PUTS ON ALL ITEMS OF CLOTHING	☐	☐		
REMOVES ALL ITEMS OF CLOTHING	☐	☐		

FEEDING	YES	NO	CURRENT	GOAL
FEEDS SELF USING UTENSILS	☐	☐		
ASSISTS IN MEAL PREPARATION	☐	☐		
FEEDS SELF WITH ADAPTIVE DEVICE	☐	☐		
SPOON/SYRINGE FED (DOES NOT PARTICIPATE)	☐	☐		

BOWEL AND BLADDER FUNCTION	YES	NO	CURRENT	GOAL
CONTINENT	☐	☐		
PERFORMS STEPS IN BLADDER ELIMINATION	☐	☐		
PERFORMS STEPS IN BOWEL ELIMINATION	☐	☐		

PERSONAL HYGIENE	YES	NO	CURRENT	GOAL
BATHES SELF (ALL NECESSARY STEPS)	☐	☐		
GROOMS SELF (COMBS HAIR, ETC.)	☐	☐		

COGNITIVE/SOCIAL SKILLS	YES	NO	CURRENT	GOAL
MAKES OWN CHOICES	☐	☐		
MANAGES MONEY	☐	☐		
DOES HOUSEHOLD CHORES	☐	☐		
DOES SHOPPING	☐	☐		
CHOOSES/INITIATES LEISURE ACTIVITY	☐	☐		
AWARE OF GENDER SIMILARITIES/ DIFFERENCES	☐	☐		
ACCESSES COMMUNITY RESOURCES	☐	☐		
SOCIALLY INTERACTS WITH OTHERS	☐	☐		

VI. MEDICAL/HEALTH PROCEDURES Check "D" if required daily, or "L" if less than daily	D	L
1. Intravenous or intramuscular therapy	☐	☐
2. Catheter feeding (N/G or gastrostomy)	☐	☐
3. Nasopharyngeal and tracheotomy aspiration	☐	☐
4. Dressings	☐	☐
5. Urinary Catheter with irrigation	☐	☐
6. Decubitis or skin disorders	☐	☐
7. Medical gases	☐	☐
8. Therapy: P.T., O.T., Speech	☐	☐
9. Other (Specify): _____	☐	☐

VIII. HABILITATION	YES	NO
Needs active treatment 24-hours per day & facility services required	☐	☐
Does not need active treatment and waiver HCB services required	☐	☐
The placement facility the least restrictive alternative environment available	☐	☐

VII. MEDICATIONS	Supervision Required		Administration on More Than One Shift	
DESCRIPTION OF MEDICATION	YES	NO	YES	NO
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

IX. THERAPEUTIC DIET _____

PLACEMENT DESIRED: ☐ **ICF-DD/ID FACILITY**

X. RECOMMENDED LEVEL OF CARE (LOC): ☐ **ICF-DD/ID FACILITY** ☐ **OTHER** _____

_____ PHYSICIAN — ____/____/____ EVALUATION DATE

_____ REGISTERED NURSE — ____/____/____ EVALUATION DATE

_____ PSYCHOLOGIST — ____/____/____ EVALUATION DATE

_____ SOCIAL WORKER — ____/____/____ EVALUATION DATE

_____ QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL — ____/____/____ IDPE CONFERENCE DATE

XI. MEDICALLY APPROVED: ☐ **ICF-DD/ID FACILITY** ☐ **DEFERRED** ☐ **DENIED** ____/____/____ EFFECTIVE DATE

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE. AUTHORIZATION FOR THE INDIVIDUAL'S ADMISSION EXPIRES THIRTY (30) DAYS FROM THE DATE OF APPROVAL.

REVIEWER'S SIGNATURE: _____ DATE: _____

INSTRUCTIONS
DHS 1150

INTERMEDIATE CARE FACILITY-MENTALLY RETARDED (ICF-MR) EVALUATION

PURPOSE

The DHS 1150, Intermediate Care Facility-Mentally Retarded (ICF-MR) Evaluation form, shall be used to substantiate the need to ICF-MR services for the mentally related (MR) and/or person with developmental disabilities (DD) and recommend admission to the most appropriate program to best meet the needs of the individual.

GENERAL INSTRUCTIONS

1. This form shall be completed by the Qualified Mental Retardation Professional (QMRP) of the Interdisciplinary (ID) Team representing the individual in need of these services and submitted to Med-QUEST Division (MQD), Medical Standards Branch (MSB) for approval/disposition.

2. This form shall be completed based on individual professional evaluations completed by the following: Physician, Psychologist, Nurse, Social Worker and other appropriate professionals.

INSTRUCTIONS

1. BIOGRPAHICAL:

Line 1:

- Blocks 1 – 4 Self-explanatory.
- Block 5 Date of requested admission into expected program.

Line 2:

- Block 1 Address and name of current residence.
- Block 2 Self-explanatory. Include agency affiliation as needed.

Line 3:

- Block 1 Address and name of current residence.
- Block 2 Self-explanatory. Include agency affiliation as needed.

II. DIAGNOSIS

- List major diagnosis using ICD-9 codes.

III. **VISION; HEARING; SPEECH; SUPPLIES, DURABLE MEDICAL EQUIPMENT (DME):**

Lines 1 – 3:

- List diagnosis using ICD-9 codes whenever applicable.

Line 4:

- List items whenever applicable.

IV. **INTELLIGENCE TEST SCORE; ADAPTIVE BEHAVIOR SCORE:**

- Enter most recent test scores and dates.

V. **FUNCTIONAL ASSESSMENT:**

- Check yes or no whichever is applicable. Following instructions in shaded box, score current level and goal level for each functional item listed.

VI. **MEDICAL/HEALTH PROCEDURES**

- Numbers 1 – 9, self explanatory; to be completed by MD or RN only.

VII. **MEDICATIONS:**

- List all current medications and check boxes to the right as applicable.

VIII. **THERAPEUTIC DIET:**

- Name specific diet.

IX. **HABILITATION:**

- Self-explanatory. (Complete all items)

X. **RECOMMENDED LEVEL OF CARE (LOC):**

- Indicate the level of care (LOC) the Interdisciplinary Professional Evaluation (IDPE) identifies as the most appropriate.
- Required professional signatures, with date which indicates an evaluation was completed are: physician and/or nurse; psychologist, and social worker.
- Signature of qualified mental retardation professional (QMRP) with date indicates IDPE conference was held.

STATE OF HAWAII
Department of Human Services

Med-QUEST Division
Clinical Standards Office

PATIENT EVALUATION FOR RE-ADMISSION TO ICF-DD/ID

Section I: To Be Completed By Attending Physician

NAME: _____

BIRTH DATE: _____

ACUTE FACILITY TO WHICH ADMITTED:

Name of Facility: _____

Admission Date: _____

Diagnosis: _____

_____

_____

_____

Discharge Date: _____

I have evaluated the patient medically and psychologically and conclude that he/she meets the criteria for ICF-ID/DD care. The previous care plan should remain in effect:

With Changes: _____ **Without Changes:** _____

Comments: _____

_____

_____

_____

_____ _____

Physician's Signature **Date**

Section II: To Be Completed By MQD Staff

MQD Decision:

Approved _____ **Denied** _____ **Deferred** _____

Comments: _____

_____

_____

_____

_____ _____

Signature of Med-QUEST Consultant **Date**

INSTRUCTIONS
DHS 1150A (Rev. 08/13)

PATIENT EVALUATION FOR RE-ADMISSION TO ICF-DD/ID

PURPOSE

The DHS 1150A, Patient Evaluation For Re-Admission To ICF-DD/ID form, is to be used to substantiate the continuing need for active treatment for an individual with intellectual disabilities and/or developmental disabilities by expediting their return to the ICF- DD/ID from any short term acute hospitalizations of less than two (2) weeks.

GENERAL INSTRUCTIONS

Section I To be completed by the attending physician of the ICF-DD/ID facility to which the beneficiary is returning and submitted to DHS, Med-QUEST.

1. NAME: Enter surname, first name and middle initial of beneficiary.
2. BIRTH DATE: Enter birth month, day, and year of beneficiary
3. ACUTE FACILITY TO WHICH ADMITTED: Enter acute hospitalization data as follows:
   - a. Name of facility: Enter name of acute care facility beneficiary is admitted.
   - b. Admission date: Enter date beneficiary is admitted.
   - c. Diagnosis: Enter significant diagnosis related to the need for acute care admission.
   - d. Discharge date: Enter date beneficiary discharged from the acute care facility.
4. Attending physician to provide supportive comments relative to beneficiary's medical disposition indicating whether the beneficiary is able to continue with previous ICF-DD/ID programming, with or without changes.
   - a. With changes: Self-explanatory
   - b Without changes: Self-explanatory
   - c. Comments: Complete as appropriate.
   - d. Physician's Signature: Enter physician's full signature & title.
   - e. Date: Enter date form is completed.

Section II To be completed by DHS Med-QUEST consultant staff.

1. MQD staff to initial reviewed section and indicate date the form was completed.
   - a. Approved: Initial as appropriate.
   - b. Denied: Initial as appropriate
   - c. Deferred: Initial as appropriate
   - d. Signature of Med-QUEST Consultant: Enter MQD staff signature.
   - e. Date: Enter date review is completed.

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Health Care Services Branch
601 Kamokila Blvd. Room 506A
Kapolei, HI 96707

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES OR INTELLECTUAL DISABILITIES (ICF-DD/ID) LEVEL OF CARE (LOC) AUTHORIZATION

1. PATIENT NAME (Surname, First Name, Middle Initial)		
2. MEDICAID ID NUMBER - √ Digit	3. BIRTHDATE (Month/Day/Year)	4. GENDER

To be Completed by Developmental Disabilities Division

LEVEL OF CARE AUTHORIZATION REQUEST

Intelligence Test Score (as appropriate):

The Developmental Disabilities Division (DDD) has determined that the above individual needs services at the ICF-DD/ID level of care. The DDD has reviewed appropriate records and has summarized pertinent information and determined the individual to be:

☐ Intellectually Disabled ☐ Developmentally Disabled

_____ _____
Qualified Intellectual Disabilities Professional Date

To be Completed by Applicant/Beneficiary

Read and Initial A. to acknowledge.

A. _____ I understand that if I am found to have a disability for one year or more, the Department of Human Services will look at my assets to determine if I am still Medicaid eligible. If I go over my asset limit, I may lose my Medicaid eligibility.

_____ _____
Signature of Applicant/Beneficiary Date

_____ _____ _____
Signature of Person Applying for Applicant/Beneficiary Relationship Date

To be Completed by DHS Medical Consultant or Designee Only

ICF-DD/ID LEVEL OF CARE DETERMINATION

ICF-DD/ID Level of Care:

☐ Approved ☐ Disapproved

Comments:

_____ _____
DHS/Designee Physician Signature Date

INSTRUCTIONS
DHS 1150C (Rev. 02/18)

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES OR INTELLECTUAL DISABILITIES (ICF-DD/ID) LEVEL OF CARE (LOC) AUTHORIZATION

PURPOSE:

This form shall be used to obtain authorization of the ICF-DD/ID level of care. If the applicant/beneficiary elects to receive services in an ICF-DD/ID facility, a Form DHS 1150, Intermediate Care Facility – Intellectual Disabilities/Developmental Disabilities (ICF-DD/ID) Evaluation, is needed.

GENERAL INSTRUCTIONS:

Type or print legibly.

1. Patient Name	Self-explanatory
2. Medicaid ID Number	Provide the individual's Medicaid Number
3. Birthdate	Provide the individual's birthdate using the format mm/dd/yy – e.g. May 1, 1950 would be written as 05/01/50.
4. Gender	M for Male or F for Female
5. Level of Care Authorization Request	This section is to be completed by the case manager/QIDP (Qualified Intellectual Disabilities Professional) of the Department of Health, Developmental Disabilities Division, Case Management and Information Services Branch.
i. Intelligence Test Score (as appropriate):	Fill in the full scale IQ score as determined by a licensed psychologist. If multiple psychological evaluations are available, use the most current evaluation score which is indicative of the intelligence level of the individual.
ii. Intellectual Disability/ Developmental Disability:	Check off the appropriate box as defined in HRS 333F.
iii. Signature of QIDP:	Signature of QDIP who reviewed the information which are the basis for DD/ID determination or need for services funded under HCBS-DD/ID waiver.
iv. Date	Date of QDIP signature.

6. Applicant/Beneficiary

   This section is completed only by Applicant/Beneficiary.

   i. Read and Initial to acknowledge "A".

A. “I understand that if I am found to have a disability for one year or more the Department of Human Services will look at my assets to determine if I am still Medicaid eligible. If I go over my asset limit, I may lose my Medicaid eligibility.”

ii. Signature of Applicant/Beneficiary

iii. Date of Applicant/Beneficiary signature

iv. Signature of Person Applying for Applicant/Beneficiary

v. Relationship to Applicant/Beneficiary

vi. Date of Person Applying for Applicant/Beneficiary signature

7. **ICF-DD/ID Level Of Care Determination:**

This section is completed only by the DHS Medical Consultant or Designee.

i. ICF-DD/ID Level of Care:	Check off the appropriate box to indicate approval or disapproval for level of care.
ii. Comments:	Comments by the DHS Medical Consultant or Designee.
iii. Signature of DHS Medical Consultant or Designee:	Signature of DHS Medical Consultant or Designee who reviewed the information for determination and authorization of level of care.

8. **Attachments:**

The Department of Health Developmental Disabilities Division Case Manager must attach the following:

i. Psychological Evaluation (Current within three years);

ii. PMD/LOC: Physicians Recommendation for ICF/MR Level of Care; and

iii. DHS 1180 ADRC Referral and Determination.

FILING/DISTRIBUTION INSTRUCTIONS:

Original to Health Care Services Branch (HCSB)

USE OF CLOZAPINE, OLANZAPINE, RISPERIDONE, QUETIAPINE AND ZIPRASIDONE

(Circle One)

I. CRITERIA

A. For Olanzapine, Risperidone, Quetiapine and Ziprasidone
   1. The patient is actively symptomatic with positive and/or negative schizophrenic symptoms.
   2. The patient is functionally disabled.
   3. The patient is participating in appropriate concomitant treatment and rehabilitation.
   4. The patient has been treated for a reasonable period of time with at least two different classes of neuroleptics without satisfactory results, or is unable to be treated with neuroleptic medications due to severe adverse effects.

B. For Clozapine (for Schizophrenia)
   1. The patient has been treated with Olanzapine, Risperidone or Quetiapine for a reasonable period of time without satisfactory results or has severe adverse effects from them.

C. For Clozapine (for movement disorders)
   1. The patient is actively symptomatic with dyskinesia(s).
   2. The patient has been treated for a reasonable period of time with two different antitremor medications without satisfactory results, or is unable to be treated with antitremor medications due to severe adverse effects.

II. PATIENT DATA (Every item must be completed, use 'None' or 'N/A' if not applicable)

_____ DOB_____/_____/_____ Sex_____M _____F
(Last Name, First Name)

_____ Diagnosis :_____ DSM-IV Code: ____ ____ ____ . ____ _____
(Medical ID #)

How long have you treated this patient?_____

Name(s) of previous psychiatrist(s)/neurologist(s)_____

_____

Describe patient's positive schizophrenic or movement disorder symptoms:_____

_____

Describe patient's negative schizophrenic symptoms:_____

_____

List patient's previous antipsychotic or antitremor medication(s):

NAME OF MEDICATION	DOSAGE/FREQUENCY	DATE USED:
_____	_____	_____ to_____
_____	_____	_____ to_____
_____	_____	_____ to _____
_____	_____	_____to _____

Have symptoms of Tardive Dyskinesia ever been present? _____Yes _____No

Psychiatric hospitalizations within the past five years:

HOSPITAL	LOCATION	DATE
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

III. PROCEDURES:

A. The following forms and information shall be submitted:

1. DHS 1144 Request For Prior Medical Authorization

2. DHS 1162 Revised 03/01

3. Brief Psychiatric Rating Scale (BPRS) report (Not required for movement disorders)

FAX all completed forms to:

ACS
PA Desk
Fax number: 1-888-335-8474

B. Brief Psychiatric Rating Scale (BPRS) reports are required with every DHS 1162 that is submitted (Not required for movement disorders). When the BPRS is stable (little or no change from last report), a narrative report (indicating that the patient is stabilized and reason(s) for continuing the medication) must be submitted in lieu of the BPRS.

C. The use of Clozapine, Olanzapine, Risperidone, Quetiapine or Ziprasidone may be suspended if the patient has not improved or for other good reason(s).

I certify that the above information is true and will carefully monitor the patient's condition.

_____ _____ _____
(Physician's Signature) (Type or print Physician's Name) Date

---

(For Consultant's Use Only)

Approved _____ Denied_____

_____ _____
Consultant's Signature Date

NAME _____

DATE:

BRIEF PSYCHIATRIC RATING SCALE

Place the number which best describes the patient's condition in the column to right of statement
NOTE: 1 Not Present; 2 Very Mild; 3 Mild; 4 Moderate; 5 Moderate/Severe; 6 Severe; 7 Extremely Severe

TOPIC	DESCRIPTION	RATING
1. Somatic Concern	Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.	
2. Anxiety (Subjective)	Worry, fear or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanism.	
3. Emotional Withdrawal	Deficiency in relating to the interviewer and to the interview situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people.	
4. Conceptual Disorganization	Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient, do not rate on the basis of patient's subjective impression o f his level of functioning.	
5. Guilt Feelings	Over-Concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidence by verbal report with appropriate affect, do not infer guilt feelings from depression, anxiety or neurotic defenses.	
6. Tension (Objective)	Physical and motor manifestations of tension "nervousness" and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.	
7. Mannerism and Posturing	Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements, do not rate simple heightened motor activity here.	
8. Grandiosity	Exaggerated self-opinion, convictions of unusual ability of powers. Rate only on the basis of patient's statements about himself or self-in-relation-to others not on the basis of his demeanor in the interview situation.	
9. Depressive Mood	Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.	
10. Hostility	Animosity, contempt, belligerence disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward other, do not infer hostility from neurotic defenses, anxiety nor somatic complaints. (Rate attitude toward interviewer under "uncooperativeness")	
11. Suspiciousness	Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicious which are currently held whether they concern past or present circumstances.	
12. Hallucinatory Behavior	Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery process of normal people.	
13. Motor Retardation	Reduction of energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only, do not rate on basis of patient's subjective impression of own energy level.	
14. Uncooperativeness	Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interview. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situations, do not rate on basis of reported resentment or uncooperativeness outside the interview situation.	
15. Unusual Thought Content	Unusual, odd, strange, or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought process.	
16. Blunted Affect	Reduced emotional tone, apparent lack of normal feeling or involvement.	
17. Excitement	Heightened emotional tone, agitation, increased reactivity.	
18. Disorientation	Confusion or lack of proper association for person place or time.	

INSTRUCTIONS

DHS 1162

USE OF CLOZAPINE, OLANZAPINE, RISPERIDONE, QUETIAPINE AND ZIPRASIDONE

PURPOSE:

DHS 1162 is an authorization form requesting the use of Clozapine, Olanzapine, Risperidone Quetiapine and Ziprasidone for patients who are Medicaid recipients.

GENERAL INSTRUCTIONS:

The conditions under Part I, Criteria must be met for all patients for whom a request for the above medications is made.

Part II, Patient Data, is to be filled out by the physician.

Part III, Procedures. The steps to obtain DHS authorization and compliance with progress reporting are specified.

DISTRIBUTION:

Original – ACS PA Desk
Approved Copy – Provider
Approved Copy – MQD/MSB File

PROCEDURE FOR THE AUTHORIZATION AND PAYMENT OF SIGN LANGUAGE INTERPRETER SERVICES BY THE MED-QUEST DIVISON (MQD)

GENERAL

- Sign language interpreter (SLI) services are only covered by the MQD for Medicaid recipients who are seeking medical care through Medicaid physicians. Payment for sign language interpretation for educational, social, job related services, eligibility for Department of Human Services (DHS) non-medical programs, etc., are not covered by this procedure.

- This procedure does not apply when SLI services are provided in the hospital, the hospital outpatient department or the hospital emergency room because hospitals are responsible for providing SLI services in those situations.

The MQD provides SLI services to the following populations:

- Persons who are Medicaid recipients in the fee-for-service Hawaii Medicaid Program for the Aged, Blind, and Disabled (ABD) (The procedures DO NOT apply to persons who are enrolled in a Hawaii QUEST medical plan). Medicaid providers should verify Medicaid/QUEST eligibility.

- Persons who are dually eligible for Medicare and Medicaid.

Interpreter Referral

1. Indirect: Physician's Office Contacts Disability and Communication Access Board (DCAB) orHSOD

The DCAB of the Department of Health (DOH) is a state agency that maintains a listing of SLIs who are qualified to provide SLI services to Medicaid recipients. DCAB can provide names and phone numbers of SLIs whom you can contact. DCAB does not charge any fee for this list or other assistance in locating qualified SLIs. DCAB's phone number is 586-8121, Voice or 586-8130, TTY. For voice to TTY relay services, dial 711 or (808) 643-8833.

The Medicaid recipient's physician may also contact Hawaii Services on Deafness (HSOD). HSOD is an independent non-profit agency providing SLI referral services. HSOD is not a state agency and will charge a fee if you utilize its services. HSOD's telephone number is (808) 926-4763.

2. Direct: Physician Contacts the SLI

The Medicaid recipient asks his/her medical service provider to contact the patient's preferred SLI.

Notification of Authorization Procedures

1. Indirect**:** When the physician contacts DCAB or HSOD service:

The DCAB will provide the names of qualified SLIs, including their current level of certification, to the physician. The physician must contact a SLI directly. The physician must complete the DHS 1144 Request for Medical Authorization and submit it to the Fiscal Agent (See Appendix 1 for the address information).

The HSOD will contact a SLI from its list of qualified SLIs.

The HSOD will provide the physician with a copy of the MQD Authorization Procedure shown below and inform the physician that payment authorization must be obtained directly from the MQD.

2.) Direct: When the physician contacts the SLI:

The SLI confirms the appointment, instructs the physician to follow the procedure shown below and provides the physician with a copy of the Form 1144 Request for Medical Authorization Form and instructions or the contact phone number at the MQD. The interpreter informs the physician that payment authorization must be obtained directly from the MQD.

MQD Payment Authorization Procedure

- The physician must complete an 1144 Request for Medical Authorization Form stating the date of the appointment. The 1144 form requires a diagnosis and (brief) reason for the need of a SLI.
- The physician should mail the 1144 form to the Fiscal Agent (Address is listed in Appendix 1). The physician must include his/her telephone number and fax number.
- The physician will receive notification of approved requests.
- The SLI will receive the approved 1144 form from the physician when the patient and the SLI go to the physician's office.
- The individual interpreter will inform the physician that the 1144 form authorization is essential and if not submitted and approved, the SLI will bill the physician.
- If the physician is not aware of this Medicaid procedure for the authorization of SLI services, the SLI may assist the physician with information or have the physician contact the MSB directly at 692-8120.

Payment for SLI Services

- After the completion of the authorized SLI services, the SLI fills in his/her name, address and phone number as the "supplier" of the SLI services on the 1144 form.
- All invoices submitted to MQD must include a completed 1144 form. Payment for services and reimbursement for expenses are based on the Hawaii Administrative Rules (HAR), Title II, Chapter 218 currently in force on the date of service. Original receipts for all expenses (i.e., parking) to be reimbursed must be attached to the invoice.
- Unless there is specific authorization for payment in excess of the Recommended Fee Schedule for Communication Access Providers, payment to SLI will be made in accordance with the most current Recommended Fee Schedule included in 11-HAR-218.
- The 1144 is enclosed with the SLI's invoice and mailed to:

  Department of Human Services
  Med-QUEST Division
  Medical Standard Branch
  P.O. Box 700190
  Kapolei, HI 96709-0190

- Please allow six weeks for processing of the invoice. To obtain assistance in expediting payments that have not been received in 6 weeks, please call the MSB at 692-8120.

Urgently Needed SLI Services

- The MQD defines "urgently needed SLI services" to mean SLI services requested by a Medicaid recipient's physician when a medically needed visit is required in less than two (2) working days. Generally, these visits are to evaluate new conditions or a complication of an exisiting problem in which delay in seeing the patient may compromise his/her well being.

- Failure to obtain timely authorization for SLI services needed for visits scheduled more than five (5) working days in advance are not considered urgent by the MQD.

Authorization for Urgently Needed SLI Services

- If the physician believes that his/her request meets the above definition, he/she completes the 1144 form and indicates the date of the visit and checks the box labeled US-Urgent Req for Svcs.

- The physician gives a copy of the Form 1144 to the SLI. The SLI submits this copy with his/her invoice. The MQD consultant will sign it upon receipt of the invoice and attached Form 1144.

EMERGENCY INTERPRETER REFERRAL

- Hawaii Services on Deafness operates an independent (non-state agency) emergency interpreter referral service in partnership with the Verizon Hawaii Telecommunications Relay Service. This service is not part of the MQD.

- If a medical service provider needs emergency SLI services because a person's condition is a medical emergency, the provider can call (711) 643-8255. As emergency medical services are generally provided in hospitals, no specific procedures have been made to address authorization and payment for Emergency Interpreter Services.

- However, if services directed at the emergency condition are being provided by a physician in the office setting, the physician should follow the procedures outlined above for Urgently Needed SLI Services.

- Hospitals and Physicians using the HSOD emergency referral service should note that the medical service provider has the primary responsibility for payment of interpreters contracted through the service. If approval for payment is not obtained from MQD, the physician is responsible for payment to the interpreter.