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Clinical Standards Office
P.O. Box 700190
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December 29, 2021

MEMORANDUM

MEMO NO.
QI-2149 [Replaces QI-1927]

TO: QUEST Integration Health Plans, Physicians and Pharmacy

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: QUEST INTEGRATION COVERAGE FOR OUR CARE, OUR CHOICE ACT (END OF LIFE CARE OPTION

The purpose of this memorandum is to notify the health plans that this memo replaces QI-1927 which was previously issued on September 27, 2019. The following updated content will apply under the QI contract RFP-2022-008.

Effective January 1, 2019, Hawaii residents with a terminal illness and six (6) months or less to live can now voluntarily request medical aid-in-dying medication to end their life. Governor David lge signed into law the "Our Care, Our Choice Act" (OCOCA) on April 5, 2018 (Act 2, Session Laws of Hawaii 2018).

The Hawaii Medicaid program will cover the medications of Medicaid recipients used for the purpose of the OCOCA under our Fee-For-Service program utilizing 100% State funds. The QUEST Integration (QI) health plans will be responsible to cover the required physician, counseling, and consulting visits under current capitation payments.

Only Food and Drug Administration (FDA) approved drugs will be reimbursed by the Med-QUEST Division (MQD). Unapproved drugs, including foreign-made versions of FDA-approved drugs that have not been manufactured pursuant to FDA approval, will not be reimbursed.

Each QI plan shall be responsible for notifying providers within its network of the requirements for the OCOCA and the process to request and bill MQD for the self-administered medications that would be used by a qualified Medicaid patient for the purpose of OCOCA.

Information on the OCOCA requirements and required forms for the OCOCA can be found on the State Department of Health's website at: http://health.hawaii.gov/opppd/ococ/.

Med-QUEST Division Requirements

In order to have the prescription reimbursed by Hawaii Medicaid, the prescribing provider must fill out the DHS 1144B Request for Medical Authorization form and the dispensing pharmacy must fill out a hard copy of the CMS 1500 Health Insurance Claim form. The process below, and the instructions for completing the forms (Attachment A), shall be followed:

1) Prior Authorization Requirement: Submit the DHS 1144B form (Attachment B) for review and approval by the MQD Clinical Standards Office. The DHS 1144B form and the instructions for completing the DHS 1144B form are also available on the MQD website at: https://medquest.hawaii.gov. Click on the "Resources" tab at the top of the page then click on "Forms". Providers to fill out sections #2-6 and physician sections of the DHS 1144B form. Not required to fill out supplier section.

2) Dispensing Pharmacy: A hard copy CMS 1500 form is required and must identify and match the same drug(s) and quantity(ies) on the DHS 1144B form submitted by the prescribing physician. If there is a discrepancy between the request on the DHS 1144B form and the CMS 1500 form, it will result in a delay. The pharmacy must use NDC numbers and NCPDP units to identify the medications on the claim. Point of Service (POS) claims will be denied.

3) To expedite processing, of the prior authorization approval and claim, **BOTH** the completed DHS 1144B and completed CMS 1500 forms are to be submitted together to:

Med-QUEST Division/Clinical Standards Office
Fax: (808} 692-8131

Should you have questions, please contact the Clinical Standards Office at (808) 692-8124.

All submissions must conform with the Health Insurance Portability and Accountability Act of 1996 and any other applicable privacy and security law, rule, and regulation.

Attachments:
Attachment A
Attachment B

ATTACHMENT A

PRIOR AUTHORIZATION and BILLING INSTRUCTIONS

DHS 1144B REQUEST FOR MEDICAL AUTHORIZATION FORM INSTRUCTIONS:

The DHS 1144B form must be completed and faxed to MQD Clinical Standards Office (MQD/CSO) along with the completed CMS 1500 form for approval. Turnaround time for review will be two (2) business days. Upon approval, MQD/CSO will forward the approved DHS 1144B and CMS 1500 forms to our fiscal agent for processing. DO NOT send/fax the forms to the Medicaid Fiscal Agent for OCOCA authorization as it will result in a delay or denial.

Prescribing Provider:

a) The prescribing provider must be an active Hawaii Medicaid provider who is a managed care provider.
b) Write/indicate on the top of the DHS 1144B form "Medications for Our Care Our Choice".
c) Under the Physician Section the prescribing physician shall complete the applicable sections and sign. List the medical aid-in-dying self-administered medication(s), strength(s), and quantity(ies) intended to be dispensed to fulfill the OCOCA.
d) Complete diagnosis and prognosis.
e) Under the Justification Section, indicate that the patient has fulfilled all the requirements of the OCOCA.
f) In the Supplier Section, all fields must be completed.

Dispensing Pharmacy Billing Instructions:

a) The dispensing pharmacy must be an active Hawaii Medicaid fee-for-service and managed care provider.
b) Write/indicate on the top of the CMS 1500 form "Medications for Our Care Our Choice".
c) If the patient has commercial insurance, the Explanation of Benefits (EOB) indicating denial shall be submitted with the CMS 1500 form.
d) Enter the product ID qualifier N4, the National Drug code (NDC), name of the drug, strength of the drug, two-character unit of measure qualifier followed by the numeric quantity administered to the patient in the shaded area of Box 24A-E.

    1. Valid unit of measure qualifiers are as follows for self-administered drug(s):

Qualifier	Unit of Measure
F2	International Unit
GR	Gram
ML	Milliliter

    2. For the quantity, provide the exact quantity dispensed to three (3) decimal places.

e) Complete Box 24A, B, E, F, G (days are equal to 1) and J.
f) Add "21A" in Box 24E to reference the diagnosis code in field 21A.
g) The pharmacy supplying the drugs(s) shall sign (Box 31) and complete the provider information and phone number (Box 33).

ATTACHMENT B

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Hawaii Medicaid Fiscal Agent
Attn: DUR, P.O. Box 967
Henderson, NC 27536-0967

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] Recipient'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-DD/ID Facility Recipient'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-10 code [14] BMI (for anorexiants):

[15] Period Requested [16] Prognosis

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

[18] Print Prescriber's Name/Mailing Address	[19] Prescriber's Signature	
	[20] Prescriber's NPI	[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] Supplier's NPI	[32] Date	