

## 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	<input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Requesting Psychiatrist <input type="checkbox"/> Requesting Psychologist <input type="checkbox"/> Requesting LSW <input type="checkbox"/> Requesting APRN <input type="checkbox"/> 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:		Telephone Number	
		To:	
Number of Visits/Hours Used on Last Extension: Visits:		Hours:	
		Fax Number	
<b>To be completed by Psychiatrist/Psychologist/LSW/APRN</b>			
# 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.

## REQUEST FOR MEDICAL AUTHORIZATION

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

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

**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.**

<b>Medicaid ID Number</b>	<b>Patient's Name (Last, First, M.I.)</b>	<b>Date of Birth</b> <input type="checkbox"/> M <input type="checkbox"/> F
Medicare Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient receiving Medicare Home Health Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently at: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> SNF/ICF/ICF-MR Facility <input type="checkbox"/> Other: _____ Patient's Mailing Address (St., City, Zip) _____	Expanded Early & Periodic Screen. Diagnosis & Trtmnt (EPSDT): <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No # of diapers used per mo.: _____	2. Recipient requires underpads <input type="checkbox"/> Yes <input type="checkbox"/> No # of underpads used per mo.: _____	3. Caregiver requires gloves <input type="checkbox"/> Yes <input type="checkbox"/> No # of pairs used per mo.: _____	4. Additional justification attached <input type="checkbox"/> Yes <input type="checkbox"/> No
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### Supplier Section for Incontinence Supplies

Code	Item	QTY/Mo.	Period Requested From: To:
W4335	Diapers/Adult Small/All Children's		
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 patient will 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:

<u>ACS – Hawaii Medicaid Fiscal Agent</u>	
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](http://www.medquest.us)

or by writing to:

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

## 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.

<sup>1</sup> Medicaid ID Number		<sup>2</sup> Patient's Name (Last, First, M.I.)			<sup>3</sup> Gender [ <input type="checkbox"/> ] M [ <input type="checkbox"/> ] F		<sup>4</sup> Date of Birth / /		
<sup>5</sup> Medicare Coverage? [ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No Is Patient receiving Medicare Home Health Benefits? [ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No		<sup>6</sup> Currently at: [ <input type="checkbox"/> ] Home [ <input type="checkbox"/> ] Hospital [ <input type="checkbox"/> ] SNF/ICF/ICF-MR Facility Patient's Mailing Address (St., City, Zip Code)			<sup>7</sup> Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [ <input type="checkbox"/> ] Yes [ <input type="checkbox"/> ] No				
Physician Section					Supplier Section (Circle Rent or Repair)				
<sup>8</sup> NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code			<sup>9</sup> QTY	<sup>10</sup> Purchase Price		<sup>11</sup> Rent/Repair		<sup>12</sup> Period Requested	
1								From:	To:
2									
3									
4									
5									
Physician Section									
<sup>13</sup> Diagnosis or ICD-9 code					<sup>14</sup> BMI (for anorexians):				
<sup>15</sup> Period Requested					<sup>16</sup> Prognosis				
<sup>17</sup> Justification (include history of previous treatment) ([ <input type="checkbox"/> ] Attachment)									
<sup>18</sup> Print Physician's Name/Mailing Address					<sup>19</sup> Physician's Signature				
					<sup>20</sup> DEA or Medicaid Provider #			<sup>21</sup> Date	
					<sup>22</sup> Telephone #				
					<sup>23</sup> Fax #		<sup>24</sup> Contact Name		
Supplier Section									
<sup>25</sup> Print Supplier's Name/Mailing Address					<sup>26</sup> Comments				
<sup>27</sup> Contact Name		<sup>28</sup> Telephone #		<sup>29</sup> Fax #					
<sup>30</sup> Supplier's Signature		<sup>31</sup> NABP #		<sup>32</sup> Date					



**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 anorexiant)**: 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.

**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                      Part B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO ID # _____	6. MEDICAID STATUS <input type="checkbox"/> YES ID# _____ <input type="checkbox"/> NO Date Applied _____
7. PRESENT ADDRESS (Specify Facility Name When Applicable) _____ _____ _____ Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Waitlisted <input type="checkbox"/> Care Home <input type="checkbox"/> Other _____				8. ATTENDING PHYSICIAN _____ Print Last, First, MI _____ Phone: _____ Fax: _____	
9. RETURN FORM TO: <input type="checkbox"/> VIA FAX (Print Fax Number Below) <input type="checkbox"/> 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 <input type="checkbox"/> CLIENT <input type="checkbox"/> RECORDS <input type="checkbox"/> OTHER _____ <input type="checkbox"/> RESPONSIBLE PERSON  Name _____ Last, First, MI _____  Relationship _____  PHONE _____ FAX _____  Language <input type="checkbox"/> English <input type="checkbox"/> Other _____  E. Requesting <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Acute Waitlisted <input type="checkbox"/> PACE Program <input type="checkbox"/> Hospice <input type="checkbox"/> Home & Community Based Services (HCBS) <input type="checkbox"/> NHWW <input type="checkbox"/> RACCP <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No  If NO explain _____  If YES, by whom (Name) _____  Title/Relationship _____		
<b>TO BE COMPLETED BY STATE OF HAWAII MEDICAL CONSULTANT OR DESIGNEE ONLY</b>					
<b>12. MEDICAL NECESSITY/LEVEL OF CARE ACTION</b>					
I. <input type="checkbox"/> LOC APPROVED                                      EFFECTIVE DATE _____ <input type="checkbox"/> SUBACUTE <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPICE <input type="checkbox"/> ACUTE WAITLISTED SNF from _____ to _____ <input type="checkbox"/> ACUTE WAITLISTED ICF from _____ to _____ <input type="checkbox"/> ACUTE WAITLISTED SUB-ACUTE from _____ to _____ Next Review in <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Annual (specify mm/yy) _____ <input type="checkbox"/> Other _____ NEXT 1147/1147a due on (date) _____ II. <input type="checkbox"/> DEFERRED III. <input type="checkbox"/> 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 _____					
<b>13. DISPOSITION</b>					
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Home and Community-Based Services       <input type="checkbox"/> Nursing Home Without Walls (NHWW)       <input type="checkbox"/> Residential Alternatives Community Care Program (RACCP)                       <input type="checkbox"/> Level 1 _____ <input type="checkbox"/> Level 2 _____       <input type="checkbox"/> HIV Community Care Program (HCCP)       <input type="checkbox"/> PACE Program</div><div><input type="checkbox"/> Nursing Facility       <input type="checkbox"/> Hospice       <input type="checkbox"/> Own Home       <input type="checkbox"/> Extended Care ARCH       <input type="checkbox"/> Other _____</div></div> Comments _____  Signature _____ Date _____					

**APPLICANT/CLIENT BACKGROUND INFORMATION** (Please print or Type)

<b>1. NAME</b> (PRINT Last, First, MI)	<b>2. BIRTHDATE</b>	
<b>3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS</b>		
<b>I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):</b>		
PRIMARY: _____		
SECONDARY: _____		
<b>II. COMATOSE</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," go to <b>XIV.</b>		
<b>III. VISION/HEARING/SPEECH</b>		
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech		
[1] b. Individual has impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech		
[2] c. Individual has complete absence of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech		
<b>IV. COMMUNICATION</b>		
[0] a. Adequately communicates needs/wants.		
[1] b. Has difficulty communicating needs/wants.		
[2] c. Unable to communicate needs/wants.		
<b>V. MENTAL BEHAVIOR</b> (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 <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both, or in danger of self-inflicted harm or self-neglect.		
<b>VI. FEEDING/MEAL PREPARATION</b>		
[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.		
<b>VII. TRANSFERRING</b>		
[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.		
<b>VIII. MOBILITY/AMBULATION</b> (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.		
<b>IX. BOWEL FUNCTION/CONTINENCE</b>		
[0] a. Continent.		
[1] b. Continent with cues.		
[2] c. Incontinent (at least once daily).		
[3] d. Incontinent (more than once daily, # of times _____).		
<b>X. BLADDER FUNCTION/CONTINENCE</b>		
[0] a. Continent.		
[1] b. Continent with cues.		
[2] c. Incontinent (at least once daily).		
[3] d. Incontinent (more than once daily, # of times _____).		
<b>XI. BATHING</b>		
[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).		
<b>XII. DRESSING AND PERSONAL GROOMING</b>		
[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.		
<b>XIII. TOTAL POINTS</b>		
Total Points Indicated _____		
<b>XIV. MEDICATIONS/TREATMENTS</b>	Requires Supervision	PRNs Only Actual
(List all Significant Medications, Dosage, Frequency and mode/ Freq.		
Attach Treatment sheet if more space is needed.)		
_____	and/or monitoring	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
<b>XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS</b>		
_____		
_____		
_____		
_____		
_____		

<b>1. NAME</b> (PRINT Last, First, MI)			<b>2. BIRTHDATE</b>	
<b>XVI. SKILLED PROCEDURES</b> D=Indicate number of times per day     (Check L or N if appropriate)     L=Less than once per day     N=Not applicable/Never				
<b>D(#)</b>	<b>L</b>	<b>N</b>	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) Specify number of hours per day. _____	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy – Specify agent & frequency. _____	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Stage III and above.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Less than Stage III; Wound care – Specify nature of ulcer/wound and care prescribed.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters – Specify agent.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications – Specify agent. _____	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications – Explain.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on renal dialysis, chemotherapy, radiation therapy, with orthopedic traction. Circle problem(s) and describe.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment. Describe.	
_____				
_____	<input type="checkbox"/>	<input type="checkbox"/>	Other – Specify condition and describe nursing intervention.	
_____				
<input type="checkbox"/> Yes    Therapeutic Diet – Describe.				
_____				
<input type="checkbox"/> Yes    Restorative Therapy: PT/OT/Speech – Circle therapy and submit/attach evaluation and treatment plan.				
_____				
<b>XVII. SOCIAL SITUATION</b>				
A. Caregiving support system is willing to provide/continue to provide care with assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No				
State assistance needed by Caregiver _____				
If YES, complete B & C.    If NO, go to D.				
B. Name _____ Relationship _____				
Address _____ Last, First, MI				
_____ Phone _____				
_____ Fax _____				
C. Person currently has a home and can return home <input type="checkbox"/> Yes <input type="checkbox"/> No    Residential setting can be considered as an alternative to facility. <input type="checkbox"/> Yes <input type="checkbox"/> No				
D. Patient is appropriate for <input type="checkbox"/> Care Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospice Residence				
Check all appropriate site(s) <input type="checkbox"/> Foster Care <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____				
_____				
<b>XVIII. RECOMMENDATIONS/DISCHARGE PLANS</b>				
A. Requested LOC _____				
B. Requested Effective Date of Medicaid Coverage. _____				
C. Effective Date of LOC _____				
D. Hospice Elected <input type="checkbox"/> Yes <input type="checkbox"/> No				
E. Appropriate for HCBS <input type="checkbox"/> Yes <input type="checkbox"/> No				
_____				
<b>XIX. PHYSICIAN'S SIGNATURE</b> _____ <b>DATE</b> _____				
Physician's Name _____ Please Print				
<b>Comments</b> _____				
_____				
_____				

## 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 INFORMATION CONCERNING 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.



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: \_\_\_\_\_

☐ Subacute Level I      ☐ SNF      ☐ ICF

☐ Subacute Level II      ☐ Acute Waitlisted ICF      ☐ Acute Waitlisted Subacute

☐ Acute Waitlisted SNF      ☐ Hospice

LOC BEING REQUESTED – Effective Date: \_\_\_\_\_

☐ Subacute Level I      ☐ SNF      ☐ ICF

☐ Subacute Level II      ☐ Acute Waitlisted ICF      ☐ Acute Waitlisted Subacute

☐ 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: \_\_\_\_\_

DHS 1147a (Rev. 10/02)

Do Not Modify Form - Legible photocopies and facsimiles will be acknowledged as original

**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) *Self-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:** *Self-explanatory*

**STATE OF HAWAII**  
**Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) Report**

<b>Name:</b>	<b>Birthdate:</b>	<b>Date:</b>
--------------	-------------------	--------------

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 \_\_\_\_\_

<b>Print Name and Title</b>	<b>Signature</b>	<b>Date</b>
-----------------------------	------------------	-------------

<b>Disposition:</b>	<b>To be completed by Med-QUEST division staff or designee</b>
---------------------	--

Restorative    ☐ PT    ☐ OT    ☐ ST    ☐ Approved    Effective dates: from \_\_\_\_\_ to \_\_\_\_\_

☐ Not approved

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.



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

### I. BIOGRAPHICAL (Please Type)

PATIENT (SURNAME, FIRST NAME, MIDDLE INITIAL)	DHS IC 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" (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.

	YES	NO	CURRENT	GOAL		YES	NO	CURRENT	GOAL
<b>BEHAVIOR</b>					<b>FEEDING</b>				
SEXUALLY/SOCIALLY APPROPRIATE	[ ]	[ ]	[ ]	[ ]	FEEDS SELF USING UTENSILS	[ ]	[ ]	[ ]	[ ]
SELF ABUSIVE	[ ]	[ ]	[ ]	[ ]	ASSISTS IN MEAL PREPARATION	[ ]	[ ]	[ ]	[ ]
AGGRESSIVE	[ ]	[ ]	[ ]	[ ]	FEEDS SELF WITH ADAPTIVE DEVICE	[ ]	[ ]	[ ]	[ ]
HEALTH, SAFETY, AND/OR COMMUNITY RISK	[ ]	[ ]	[ ]	[ ]	SPOON/SYRINGE FED (DOES NOT PARTICIPATE)	[ ]	[ ]	[ ]	[ ]
<b>COMMUNICATION</b>					<b>BOWEL AND BLADDER FUNCTION</b>				
ADEQUATELY COMMUNICATES NEEDS/WANTS	[ ]	[ ]	[ ]	[ ]	CONTINENT	[ ]	[ ]	[ ]	[ ]
UNDERSTANDS SIMPLE INSTRUCTIONS	[ ]	[ ]	[ ]	[ ]	PERFORMS STEPS IN BLADDER ELIMINATION	[ ]	[ ]	[ ]	[ ]
USES OTHER COMMUNICATION TECHNIQUE/DEVICE	[ ]	[ ]	[ ]	[ ]	PERFORMS STEPS IN BOWEL ELIMINATION	[ ]	[ ]	[ ]	[ ]
<b>TRANSFER</b>					<b>PERSONAL HYGIENE</b>				
TRANSFERS FROM BED	[ ]	[ ]	[ ]	[ ]	BATHES SELF (ALL NECESSARY STEPS)	[ ]	[ ]	[ ]	[ ]
TRANSFERS FROM CHAIR/TOILET	[ ]	[ ]	[ ]	[ ]	GROOMS SELF (COMBS HAIR, ETC.)	[ ]	[ ]	[ ]	[ ]
DOES NOT TRANSFER OR IS BEDFAST	[ ]	[ ]	[ ]	[ ]					
<b>MOBILITY</b>					<b>COGNITIVE/SOCIAL SKILLS</b>				
MOVES ABOUT THE COMMUNITY	[ ]	[ ]	[ ]	[ ]	MAKES OWN CHOICES	[ ]	[ ]	[ ]	[ ]
AMBULATES	[ ]	[ ]	[ ]	[ ]	MANAGES MONEY	[ ]	[ ]	[ ]	[ ]
WALKS WITH DEVICE	[ ]	[ ]	[ ]	[ ]	DOES HOUSEHOLD CHORES	[ ]	[ ]	[ ]	[ ]
DOES NOT WALK	[ ]	[ ]	[ ]	[ ]	DOES SHOPPING	[ ]	[ ]	[ ]	[ ]
MOVES ABOUT IN A WHEELCHAIR	[ ]	[ ]	[ ]	[ ]	CHOOSSES/INITIATES LEISURE ACTIVITY	[ ]	[ ]	[ ]	[ ]
					AWARE OF GENDER SIMILARITIES/DIFFERENCES	[ ]	[ ]	[ ]	[ ]
					ACCESSES COMMUNITY RESOURCES	[ ]	[ ]	[ ]	[ ]
					SOCIALLY INTERACTS WITH OTHERS	[ ]	[ ]	[ ]	[ ]
<b>DRESSING</b>									
PUTS ON ALL ITEMS OF CLOTHING	[ ]	[ ]	[ ]	[ ]					
REMOVES ALL ITEMS OF CLOTHING	[ ]	[ ]	[ ]	[ ]					

### VI. MEDICAL/HEALTH PROCEDURES

(Use "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): _____		

### VII. MEDICATIONS

	Supervision Required		Administration on More Than One Shift	
	YES	NO	YES	NO
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]

### VIII. THERAPEUTIC

YES NO

### IX. HABILITATION

Client needs active treatment 24-hours per day and facility services required. [ ] [ ]

Client does not need active treatment and waiver HCB services required. [ ] [ ]

Is the placement facility the least restrictive alternative environment available. [ ] [ ]

Placement Desired: DD Domiciliary [ ] Adult Foster Home [ ] Own Home [ ] Other [ ]

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

ICF-MR/Waiver Program: [ ] ICF-MR/Facility [ ] Other [ ]

	Physician	Evaluation Date	R.N.	Evaluation Date
Psychologist	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____
QMRP	_____	_____	_____	_____

### XI. MEDICALLY APPROVED: ICF-MR/Waiver Program [ ] ICF-MR/Facility [ ] Deferred [ ] Denied [ ]

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

Reviewing 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**

**I. BIOGRAPHICAL:**

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.

PATIENT EVALUATION FOR RE-ADMISSION TO ICF-MR

Section I: To Be Completed By Attending Physician

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

ACUTE FACILITY TO WHICH ADMITTED:

Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Discharge Date: \_\_\_\_\_

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

With Changes: \_\_\_\_\_

Without Changes: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Section II: To Be Completed By DHS Staff

DHS Decision:

Approved \_\_\_\_\_

Denied \_\_\_\_\_

Deferred \_\_\_\_\_

Effective Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Med-QUEST Consultant

\_\_\_\_\_  
Date

DHS 1150A (Rev. 01/96)

## **INSTRUCTIONS DHS 1150A**

### **PATIENT EVALUATION FOR RE-ADMISSION TO ICF-MR**

#### **PURPOSE**

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

#### **GENERAL INSTRUCTIONS**

1. Section I shall be completed by the attending physician of the ICF-MR facility to which the client is returning and submitted to DHS, Med-QUEST.
  - a. Enter surname, first name and middle initial of client.
  - b. Enter birth month, day, and year of client.
  - c. ACUTE FACILITY TO WHICH ADMITTED: Enter acute hospitalization data as follows:
    - Enter name of acute care facility client admitted to.
    - Enter date client admitted.
    - Enter significant diagnosis related to the need for acute care admission.
    - Enter date client discharged from the acute care facility.
  - d. Enter supportive comments relative to client's medical disposition indicating whether the client is able to continue with previous ICF-MR programming, with or without changes.
  - e. Enter physician's full signature, acronym and date form is completed.
2. Section II shall be completed by DHS Med-QUEST consultant staff.



**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)**

\_\_\_\_\_  
(Last Name, First Name)

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_ M \_\_\_\_ F

\_\_\_\_\_  
(Medical ID #)

Diagnosis : \_\_\_\_\_ DSM-IV  
Code: \_\_\_\_ . \_\_\_\_

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):

<u>NAME OF MEDICATION</u>	<u>DOSAGE/FREQUENCY</u>	<u>DATE USED:</u>
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

Have symptoms of Tardive Dyskinesia ever been present? \_\_\_\_ Yes \_\_\_\_ No

Psychiatric hospitalizations within the past five years:

<u>HOSPITAL</u>	<u>LOCATION</u>	<u>DATE</u>	
_____	_____	_____	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

<u>TOPIC</u>	<u>DESCRIPTION</u>	<u>RATING</u>
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 of 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 DIVISION (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) or HSOD**

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 existing 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.

<b>EMERGENCY INTERPRETER REFERRAL</b>
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| <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul> |
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