**INSTRUCTIONS**

**Prior Authorization Form 1144**

## REQUEST FOR MEDICAL AUTHORIZATION

## I. General Instructions

A. Authorization Process

1) Forms must be legible, readable and complete.

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

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

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

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

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

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

B. Durable Medical Equipment

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

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

C. Home Health Services

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

D. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

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

## II. Content and Completion of Form 1144

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

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

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

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

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

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

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

E. Patient Information

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

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

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

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

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

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

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

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

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

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

F. Physician and Medical Information

All fields must be completed unless otherwise indicated.

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

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

a. For Vision Appliances:

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

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

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

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

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

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

e. Check attachment box when applicable.

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

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

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

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

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

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

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

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

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

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

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

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

G. Supplier Information

All requests for specialized goods or for services to be rendered by providers other than the requesting physician must be referred to the provider of the service for completion of the supplier information (e.g., requests for supplies, equipment, rehabilitation services,

appliances, etc.). Referral to rehabilitative therapist is not required if the therapy procedure code is known and entered on the form by the physician. All other services should be requested by the provider of the service.

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

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

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

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

H. Physician Section for Incontinence Supplies

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

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

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

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

5) Incontinence Supplies:

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

b. Period Requested: Enter the service period requested.

I. Physician Information

1) Physician's Signature: The physician completing the form must hand-sign the form. A rubber-stamped signature is not acceptable and will cause approval delays. A physician with the exception of vision appliances (which can be signed by an optometrist), podiatric services (which can be signed by the podiatrist), and

applicable dental services (which can be signed by a dentist) must sign all requests for authorization. Note the attestation clause when signing.

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

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

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

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

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

7) Fax #: Enter the fax number.

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

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

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

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

12) Date: Required. Indicate the date signed.

13) Telephone: Required. Enter the telephone number.

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

## III. Timeliness of Requests

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

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

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

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

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

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

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

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

## IV. Urgent Authorizations

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

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

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

D. Fax requirements and process:

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

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

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

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

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

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

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

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

E. Procedures for Conditional Authorizations:

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

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

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

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

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

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

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

## V. Authorization Inquiries

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

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

## VI. Exclusions to Authorization Requirement

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

## VII. Authorization Period

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

## VIII. Payment Requirements

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

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

## IX. Form Availability

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

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

or through the Med-QUEST website at:

www.medquest.us

or by writing to:

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