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HENRY OLIVA
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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

February 8, 2006

MEMORANDUM ACS M06-02

TO: Medicaid Acute Care Hospitals, Nursing Facilities and Hospice, Physicians, Medicaid Waiver Providers

FROM: Angie Payne, Acting Med-QUEST Division Administrator

SUBJECT: FILL-IN REVISED 1147 FORMS AND CHANGES TO THE 1147c FORM

The Med-QUEST Division (MQD) has made minor changes to its revised 1147, 1147a, and 1147c forms. The revised forms are attached. The MQD is also pleased to announce the availability of fill-in revised 1147 forms (1147, 1147a, and 1147c). The fill-in forms will enable the user to fill in the appropriate areas of the 1147s on a computerized form. The revised forms, fill-in forms and instructions can be downloaded from MQD's website at *www.med-QUEST.us* and by clicking on Provider Resources, Frequently Used Forms.

The revised 1147 and 1147a contains minor typographical/numerical corrections. However, for data analysis/extraction purposes, the 1147c form had to be revised to allow for only one discipline to complete a form, i.e., if a resident's plan of care includes daily restorative treatments with physical therapy and occupational therapy, then two forms will need to be completed (one for physical therapy and one for occupational therapy). The 1147c form has also been revised to include MQD's new contractor (Health Services Advisory Group – HSAG) demographic information.

As a reminder, to expedite the processing of authorizations, effective January 1, 2006, the MQD will ONLY accept the new forms (contained in ACS MO5-08) or these revised forms.

Attachments

STATE OF HAWAII
Department of Human Services
Med-QUEST Division (MSB)

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or Type ☐ Initial Request ☐ Annual Review ☐ Other review

1. PATIENT NAME (Last, First, M.I.)	2. BIRTHDATE Month/Day/Year	3. SEX	4. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:____	5. MEDICAID ELIGIBLE? ☐ Yes ID # ____ ☐ No Date Applied ____

6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ Other ____

7. PROVIDER I.D. NO.

8. ATTENDING PHYSICIAN (Last Name, First Name, Middle Initial)
Phone: ( )____ Fax: ( )____

9. CONTACT PERSON (Last Name, First Name, AND Title)
Phone: ( )____ Fax: ( )____

10. RETURN FORM TO: ____ [ ] VIA FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)
Phone ( )____ Fax ( ) ____ Mail ____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other ____
B. RESPONSIBLE PERSON
Name ____
Last First MI
Relationship ____
PHONE ( )_ FAX ( ) ____
C. Language ☐ English ☐ Other ____

12. ASSESSMENT INFORMATION (Completed by RN or Physician)

A. ASSESSMENT DATE ___/___/___
B. ASSESSOR'S NAME
Name ____
Last First MI
Title ____
Signature ____
PHONE: ( ) ____ FAX: ( ) ____

13. REQUESTING (Check all that apply)

Expected Placement Date: ____
☐ Nursing Facility (NF) ☐ Subacute I ☐ Subacute II ☐ SNF ☐ ICF ☐ Acute Waitlist ☐ Subacute ☐ SNF ☐ ICF ☐ Hospice – NF
☐ Home & Community Based Services (HCBS) ☐ NHWW ☐ RACCP 1 ☐ RACCP 2 ☐ HCCP ☐ PACE Program
HCBS Option Counseling provided: ☐ Yes ☐ No
If NO: explain: ____
If YES, by whom: Name ____ Title: ____
Independent Living (IL) service/material provided: ☐ Yes ☐ No

14. MEDICAL NECESSITY / LEVEL OF CARE ACTION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:
[ ] Subacute Level I [ ] Subacute Level II
[ ] SNF [ ] ICF
[ ] Acute Waitlisted Subacute [ ] Acute Waitlisted SNF
[ ] Acute Waitlisted ICF [ ] Hospice - NF

EFFECTIVE DATE:____
LENGTH OF APPROVAL:
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other – Specify:____ to____

SETTING APPROVAL:
[ ] Home and Community-Based Services
☐ Nursing Home Without Walls (NHWW)
☐ Residential Alternatives Community Care Program (RACCP)
Level I ____ Level 2 ____
☐ HIV Community Care Program (HCCP)
☐ PACE Program

[ ] Nursing Facility
[ ] Hospice - NF
[ ] Home
[ ] Extended Care ARCH
[ ] Other ____

Comments: ____

[ ] DEFERRED: [ ] New 1147 Needed. [ ] Other. Reason: ____

[ ] DENIED

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: ____

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

STATE OF HAWAII
Department of Human Services
Med-QUEST Division (MSB)

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: ______________________________

____

SECONDARY: ______________________________

____

____

____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XIV.**

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

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

V. MEMORY:
[0] a. Normal or minimal impairment of memory
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (refer to instructions)
[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive.
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, or in danger of self-inflicted harm or self-neglect.

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

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

IX. MOBILITY / AMBULATION: (refer to instructions)
[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.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times ________________).

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times ________________).

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

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

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: __________

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:
Attach additional sheet if more space is needed.

____

____

____

____

____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division (MSB)

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XVII. SKILLED PROCEDURES: D = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

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

☐ Yes ☐ No Therapeutic Diet (Describe) ___

☐ Yes ☐ No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan: ☐ PT ☐ OT ☐ Speech

XVIII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No Residential setting can be considered as an alternative to facility? ☐ Yes ☐ No

B. If person has a home, caregiving support system is willing to provide/continue care. ☐ Yes ☐ No
Caregiver requires assistance? ☐ Yes ☐ No
Assistance required by Caregiver: ___

C. Caregiver name:

Name: ___ (Last, First, MI) Relationship: ___

Address: ___ Phone: ( ) ___ Fax ( ) ___

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

___

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

PHYSICIAN'S SIGNATURE: ___ **DATE:** ___ / ___ / ___

Physician's Name (PRINT): ___

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

STATE OF HAWAII
Department of Human Services
Med-QUEST Division (MSB)

STATE OF HAWAII
Level of Care (LOC) Reevaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or Type

1. PATIENT NAME (Last, First, M.I.)	2. MEDICAID ID NO.	3. BIRTHDATE Month/Day/Year	4. SEX	5. ADMIT DATE Month/Day/Year

6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ Other ______
7. PROVIDER I.D. NO.

8. ATTENDING PHYSICIAN (PRINT Last Name, First Name, M.I.)
Phone ( )______ Fax ( ) ______

9. CONTACT PERSON (Last Name, First Name, AND Title)
Phone ( )______ Fax ( ) ______

10. RETURN FORM TO: ______ VIA [ ] FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)
Phone ( )______ Fax ( )______ (Mail) ______

11. REASON(S) FOR LOC RE-EVALUATION (Check all that apply)

[ ] Admission/Readmission after acute hospitalization to: Date: ______
( ) NF(name) ______
( ) Home & Community-based Services (HCBS) Program:
( ) Nursing Home Without Walls (NHWW)
( ) PACE Program
( ) Residential Alternatives Community Care Program (RACCP)
( ) HIV Community Care Program (HCCP)
( ) Other (name) ______
Case Management Agency: ______
[ ] Transfer from NF to NF (name) ______ Date: ______
[ ] Change in LOC
[ ] Extension of Acute Waitlist NF status (date of initial determination) ______ (period requested) From: ______ To ______
[ ] At home, ☐ waitlisted for NF or ☐ waitlisted for HCBS program
[ ] In NF, and discharge options offered. Complete disposition below:
[ ] Disposition (check all that apply):
( ) Returned Home ( ) Extended Care ARCH ( ) Hospice - NF ( ) Other: ______
( ) Placed in HCBS Waiver Program ( ) NHWW ( ) RACCP 1 ( ) RACCP 2 ( ) HCCP ( ) PACE
( ) Inappropriate for HCBS ( ) No waiver "slot" available ( ) No willing provider ( ) No willing caregiver

12. APPROVED LOC ON MOST CURRENT FORM (Date) ______

[ ] Subacute Level 1 [ ] Subacute Level II
[ ] SNF [ ] ICF
[ ]Acute Waitlist Subacute [ ] Acute Waitlist SNF
[ ]Acute Waitlist ICF [ ] Hospice - NF

13. LOC BEING REQUESTED (Effective Date) ______

Anticipated time: From ______ to ______
[ ] Subacute Level I [ ] Subacute Level II [ ] SNF [ ] ICF
[ ] Acute Waitlist [ ] Subacute [ ] SNF [ ] ICF
[ ] Hospice - NF

14. CURRENT STATUS (Check all that apply)

[ ] No change in diagnoses (Specify Primary Diagnoses) ______
[ ] Additional Diagnoses (list diagnoses) ______
[ ] Functional Capabilities ( ) No Change ( ) Change(s) {Specify} ______
[ ] Nursing needs ( ) No Change ( ) Change(s) {Specify} ______
[ ] Change in LOC ( ) No Change ( ) Change(s) {Specify} ______
DOCUMENT NEED AT REQUESTED LOC: ______

PHYSICIAN'S SIGNATURE: ______ **DATE:** ______
Physician's Name (PRINT): ______

15. MEDICAL NECESSITY/LEVEL OF CARE ACTION – DO NOT COMPLETE

APPROVED FOR:
[ ] Subacute Level I [ ] Subacute Level II [ ] SNF [ ] ICF
[ ] Acute Waitlist Subacute [ ] Acute Waitlist SNF [ ] Acute Waitlist ICF
[ ] Hospice - NF

EFFECTIVE DATE: ______
LENGTH OF APPROVAL
[ ] 1 year [ ] 6 months
[ ] Other – Specify: ______To ______

DEFERRED: [ ] New 1147 Needed. [ ] Other. Reason: ______

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: ______ DATE: ______

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

STATE OF HAWAII
Department of Human Services
Med-QUEST Division (MSB)

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

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or Type

PATIENT NAME (Last, First, M.I.):	BIRTHDATE:	RECIPIENT I.D. NO

Restorative Therapy being considered: *(select one discipline per form)* ☐ PT ☐ OT ☐ ST

Primary diagnosis or medical condition for which the therapy is to be provided:

____

____

List applicable secondary diagnosis(ses):

____

____

List the 3 main goals of therapy:

1.
2.
3.

Anticipated period of time therapy is to be provided: *(check one)*

( ) 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 restorative therapy. *Dates:* from ____________ to ____________

( ) The patient is covered by Medicare and 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 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 45 minutes per session. (*explain*): ______________________

____

Additional justification for restorative therapy: ____

____

Recommended effective dates of restorative therapy: From ___________ To ___________

____ ____________________

Signature Date

Name and Title (PRINT): ____

DISPOSITION – DO NOT COMPLETE

Therapy	Approved?		Effective Dates (TO/FROM)
☐ PT ☐ OT ☐Speech	[ ] Yes	[ ] No	

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 performed by a facility's therapist(s) when restorative therapy services are being considered. Report one discipline per form.

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