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GOVERNOR

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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

November 22, 2006

MEMORANDUM ACS M06-19

TO: Physicians, Nursing Facilities, Hospitals, Case Managers and EPSDT Providers

FROM: Wesley Mun, Acting Med-QUEST Division Administrator

SUBJECT: DHS 1147E (July, 2006) LEVEL OF CARE AND SERVICE AUTHORIZATION REQUESTS

The Department of Human Services (DHS), Med-QUEST Division (MQD) distributed ACS memo M06-04 dated February 14, 2006 with information of the adoption of the DHS 1147e – "Children/Youth EPSDT/Medicaid Waiver Level of Care/Services Determination" form.

Effective December 1, 2006 the following changes apply:

- Only the attached DHS 1147e (July, 2006) will be accepted when requesting or changing existing authorized services for long-term care, medically fragile case management, skilled nursing, personal care, hospice care in the nursing home, and Medicaid medically fragile waiver services. All other forms of the DHS 1147e shall no longer be used and will be returned to the sender/requestor without any determination.

- Send facsimile of DHS 1147e to:

  Health Services Advisory Group (HSAG)

  Oahu facsimile number: (808) 440-6009
  Neighbor island facsimile number: 1-877-211-5570

- Send DHS 1147e by postal mail to:

  Health Services Advisory Group (HSAG)
  1440 Kapiolani Boulevard, Suite 1110
  Honolulu, Hawaii 96814-3600

The attached DHS 1147e (July, 2006) will be available in PDF format in which many fields can be inputted using a computer.

Should you have any questions, please contact Ms. Cynthia Nishimura at (808) 692-8112

Attachments

Department of Human Services
Med-QUEST Division/Medical Standards Branch

STATE OF HAWAII
Children/Youth EPSDT Level of Care (LOC)
Services Request/Authorization

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

Please Print or Type ☐ Initial Request ☐ 6-Month Review ☐ Annual Review ☐ Other Review

1. NAME (Last, First, Middle Initial)	2. MEDICAID ID NO.	3. BIRTHDATE Month/Day/Year	4. SEX	5. OTHER INSURANCE ☐ Yes Insurer _____ ☐ No

6. PRESENT ADDRESS (Specify Facility Name When Applicable) Address is ☐Home ☐Hospital ☐NF ☐Foster Home ☐Other _____ | 7. PROVIDER I.D. NO.

8. ATTENDING PHYSICIAN (PRINT Last, First, M.I.)	9. PROVIDER NO.	10. CONTACT PERSON (Last Name, First Name, AND Title)/DATE

11. RETURN FORM TO: _____ VIA [ ] FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)

Phone ( ) _____ Fax ( ) _____ (Mail) _____

12. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ CLIENT ☐ RECORDS ☐ OTHER _____

B. ☐ PARENT/LEGAL GUARDIAN
Name _____
Last First MI
Relationship _____
Phone ( ) _____ Fax ( ) _____

C. Language ☐ English ☐ Other _____

13. ASSESSMENT INFORMATION (Completed by RN or Physician)

A. LAST ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI
Title: _____
Signature: _____
Phone: ( ) _____ Fax: ( ) _____

14. REQUESTING (Check all that apply)

[ ] Initial Level of Care Determination (LOC) [ ] Re-eval LOC Provider: _____ TO/FROM: _____

[ ] Nursing Facility (NF) (complete page 2) Provider: _____ TO/FROM: _____

[ ] Hospice in NF (complete page 2 and attach hospice election form) Provider: _____ TO/FROM: _____

[ ] EPSDT Case Management (complete pages 2, 3). Attach service plan ONLY if service plan is new or has changed. Code: T1016-_____. Agency: _____ TO/FROM: _____

[ ] Skilled Nursing (complete pages 2, 3). Agency(ies): _____ _____ Hrs/Mo TO/FROM: _____

_____ _____ Hrs/Mo TO/FROM: _____

[ ] Home and Community-Based Services (HCBS) (complete pages 2, 3)
( ) Medically Fragile Community Care (MFCC) ( ) Nursing Home without Walls (NHWW) ( ) HIV Community Care (HCC)
HCBS Option Counseling provided: ☐ Yes ☐ No
If NO: explain: _____

If YES, by whom: Name _____ Title: _____

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

LEVEL OF CARE APPROVAL:
[ ] Acute Waitlist [ ] Subacute I [ ] Subacute II [ ] SNF [ ] ICF [ ] Hospice

16. SERVICE AUTHORIZATION

SERVICE	HOURS	CODE	PROVIDER NAME	PROVIDER #	EFFECTIVE DATES (TO/FROM)
[ ] Facility					
[ ] EPSDT Case Mgmt		T1016			
[ ] EPSDT Skilled Nursing		T1030			
[ ] EPSDT Skilled Nursing		T1030			
[ ] EPSDT Personal Care		T1021			

[ ] DEFERRED: [ ] New form 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: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

HEALTH SERVICES ADVISORY GROUP
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 Name, First Name, Middle Initial)

2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):

PRIMARY: _____

_____

_____

_____

ACTIVE: _____

_____

_____

_____

_____

B. MEDICATIONS/TREATMENTS:

List all Significant Medications, Dosage and Frequency
(As an option, attach treatment sheet with same information)

	PRN Only	Actual Freq
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____
_____	[ ]	_____

C. ACTIVITIES OF DAILY LIVING: Identify only assistance required due to developmental delays:

☐ Feeding ☐ Transferring ☐ Mobility/Ambulation

☐ Toileting ☐ Bathing ☐ Dressing/Grooming

Provide comments or explanation on page 3.

D. NON-VENT/NON-TRACH CASE MANAGEMENT:
☐ Yes ☐ No
Provide comments or explanation on Page 3.

E. CARE PLAN

☐ No Changes ☐ Changes (plan attached)

	4. Nursing Intervention	Frequency/Complexity	Points
☐	Ventilator	Continuous	50
☐		Intermittent	30
☐	Tracheostomy		30
☐	Oxygen therapy	Continuous	20
☐		Intermittent	10
☐	Nebulized Medications	TID or less	10
☐		>TID	20
☐	Vascular access catheter		40
☐	Parenteral nutrition	Continuous	40
☐		Intermittent	30
☐	Gastrostomy/jejunostomy nasogastric tube	Gravity feedings	20
☐		Pump feedings	30
☐	Ileostomy/colostomy		10
☐	Urinary bladder catheterization	Intermittent or continuous	10
☐	Orthopedic appliance	Splint/cast	5
☐		Complex (describe)	10
☐	Isolation/reverse isolation		30
☐	Enteral Medications	8 doses/day or less	05
☐		>8 doses/day	10
☐	IM/SQ medications	4 doses/day or less	10
☐		>4 doses/day	15
☐	IV medications	4 doses/day or less	15
☐		>4 doses/day	20
☐	Oral medications	Less than 12 doses/day	2
☐		12 or more doses/day	5
☐	Monitor (Apnea, Pulse Oximeter, C-R)		20
☐	Special Skin Care (Burn, decubiti)	Localized	5
☐		Extensive (describe)	10
☐	Wound Care (describe)		10
☐	Restorative therapy (PT, OT, Speech)		5
☐	Initial Discharge from hospital		50
☐	Readmission for exacerbation of existing medical condition or new diagnosis		40
☐	Acute, episodic illness requiring physician or emergency room visits		20
☐	Other specialized nurse interventions (explain on page 3)		____
☐	Comatose (Rancho Los Amigos Scale of I. No Response or II. Generalized Response.		30
		Total Nursing Points	

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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

APPLICANT/CLIENT INFORMATION (Please Type or Print)

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

5. **FAMILY/SOCIAL CONSIDERATIONS:**		**Points**
☐	Homeless, or at risk for displacement, or no suitable home	20
☐	Non-English speaking	10
☐	Limited communication skills (less than 5th grade level)	15
☐	Limited/lack of family support system	15
☐	Remote location (neighbor island, or >10 miles from primary care site)	10
☐	No automobile	5
☐	Extenuating family/social circumstances (explain below)	15
	Subtotal	
	Total points (nursing points + family considerations)	

6. SCHOOL ATTENDANCE INFORMATION:

1. Child attends school? ☐Yes ☐No Type: ☐Private ☐Public ☐Home Schooled ☐Home/Hospital
2. If "Yes", number of hours per day:____ Days per week:____
3. Months per year, including Winter and Spring vacation:____
4. Child's transportation to/from school provided by the Department of Education? ☐Yes ☐No

7. COMMENTS AND EXPLANATIONS FOR MEDICAL CONDITION, FUNCTIONAL STATUS OR SKILLED NURSING:

8. COMMENTS ON FAMILY SITUATIONS:

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____/____/____

Physician's Name: _____
(Please Print)

INSTRUCTIONS
DHS 1147e
(07/06)

CHILDREN/YOUTH
EPSDT SERVICES REQUEST AND AUTHORIZATION
LEVEL OF CARE (LOC)/SERVICES DETERMINATION

Top of Form: Initial Request, 6-Month Review, Annual Review, Other Review: Check the most appropriate box for the level of care (LOC)/service request. Note: Check only one box per request.

For all initial requests, check the "Initial Request" box. Once a level of care is determined and/or services are authorized, new forms shall be submitted based on the appropriate review period. Services will be authorized consistent with the review period. At a minimum, each medically fragile client will be reviewed and services authorized every 6 months. For these clients, check the "6-month review" box. Check the "annual review" box for other clients who are in nursing homes, in the community at ICF level of care or in Medicaid waiver programs such as Nursing Home Without Walls (NHWW), or HIV Community Care (HCC). If the review is being requested either by the Department of Human Services or its agent, or if the review is being requested due to medical and/or level of care changes, select "Other Review."

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

2. ***Medicaid I.D. Number***: Enter Medicaid I.D. number of the patient assigned by the Department of Human Services. If the I.D. number is unknown, use one of the verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write in "pending" and the application date.

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

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

5. ***Other Insurance***: Identify whether the patient has other insurance. If so, check "yes" and identify insurer and policy number if available. If patient has no other insurance, check "no." Do not leave blank. Check one box.

6. ***Present Address/Facility***: Identify facility name if patient is residing in a facility. If patient is at another location, enter street address, city and zip code. Check the appropriate box that identifies the patient's residence. Do not leave blank. Check one box.

7. ***Provider I.D. Number***: Enter the Medicaid I.D. number of the provider (hospital, nursing home or physician) responsible for the child's care.

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

9. ***Provider I.D. Number***: Enter the Medicaid I.D. number of the attending physician. It may be the same as the provider number in box 7 if the patient is residing in the community and NOT in a facility.

10. ***Contact Person***: Enter the name, title and phone number of the person able to provide additional information about the patient. In most cases, it will be the case manager for the patient. In other cases, it may be the primary contact in the hospital or nursing home.

11. ***Return Form***: Indicate how the form should be returned (i.e., fax or mail) and to whose attention (name of hospital, nursing home, or case management agency). The form will NOT be mailed with a cover sheet so the information must be accurate. The contact information in box 10 will be used to identify the specific individual within the case management agency, hospital or nursing home that will be receiving the completed form.

12. ***Referral Information***: Complete all sections.

    A. **Source(s) of Information**: Identify the information available on the patient.

    B. **Parent/Guardian**: Provide the name, relationship, phone and fax numbers of the parent/guardian who will be making decisions for the patient.

    C. **Language**: Check the box of the primary language spoken by this individual. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

13. ***Assessment Information***: Complete all sections.

    A. **Assessment Date**: Date the most current assessment was completed.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN) or physician must perform the assessment. Enter the name, title, and telephone and fax numbers of the assessor. Have assessor sign the form.

14. ***Requesting***: Check all of the services that are being requested. Referrals to the Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form. If requesting EPSDT Case Management or EPSDT skilled nursing hours, the requester may identify the code, provider, skilled nursing hours being requested, and the period of time (to and from dates). This does not guarantee that the requested service will be authorized.

    If HCBS is being offered, indicate whether counseling was provided and by whom. Provide an explanation if the person did not receive information and/or counseling.

    If EPSDT case management is being requested for the first time, the service plan must be submitted once it is completed. If EPSDT case management is being requested to be continued, the service plan must be attached to the form.

15. ***Medical Necessity/Level of Care Action***: To be completed by DHS or Designee. Leave Blank. DO NOT COMPLETE. A copy of the completed form will be sent (via mail or fax as identified in box 11).

16. **Service Authorization**: The requester may complete the provider name and provider number for EPSDT case management, skilled nursing and personal care. Be sure to enter the correct provider number(s) for the services. DO NOT COMPLETE the rest of this area. It will be completed by DHS or Designee. A copy of the completed form will be sent (via mail or fax as identified in box 11).

PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

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

2. ***Birthdate***: Self-explanatory

3. ***Functional Status Related to Health Conditions***: Complete all sections.

   A. **List significant current diagnosis(es)**: List the main diagnosis(ses) or medical conditions related to the person's need for long-term care or community-based services.

   B. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (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. As an option to completing this section, the most current prescription listing can be attached. If using this option, please indicate "attached" in this area.

   C. **Activities of Daily Living**: Check all of the areas that the individual requires assistance on a regular basis, considering developmental age. If the client is a newborn, he/she is not expected to toilet, feed, transfer and dress him/herself. Therefore, these areas would NOT be checked. However, in the case of a 3-year old, the developmentally appropriate child would be expected to walk, toilet and feed himself. If the child requires assistance in those areas, the appropriate boxes should be checked. Use space on page 3, section 7 to identify how much assistance (minimal or total) is required.

   D. **Non-Vent, Non-Trach Case Management**: Indicate whether an individual who is not vent or trach dependent can benefit from case management. Provide an explanation on page 3.

   E. **Care Plan Change**: Indicate whether a new care plan has been developed for the patient. If so, attach the most current care plan. This assumes the most recent previous care plan has been provided to the Department.

4. **Nursing Interventions**: Check the nursing intervention(s) that apply. Hospital admissions for minor procedures such as elective admissions, assessments, or adjustments are not provided any nursing points. Only readmissions for exacerbation of existing medical condition or new diagnosis should be noted on the form. Total the number of points based on the nursing interventions. Comatose patients (meeting Levels I or II of the Rancho Los Amigos Scale) are assigned 30 points.

5. **Other Considerations**: Check all circumstances that apply to the child's family. Total the number of points for family circumstances and add to the nursing interventions to get total points.

6. **School Attendance Information**: Complete the information on the child's attendance at school. Put N/A if child is not attending school or is too young to attend school. If attending school, identify the type of school attending. Private and public schools refer to schools managed by private entities or the Department of Education. Home schooled refers to the parents' choice to school the child at home without DOE or private teachers. Home/hospital refers to schooling provided by the DOE either in the home or hospital environment.

7. **Comments and Explanations for Medical Condition, Functional Status or Skilled Nursing**: Provide any additional information, comments or explanation of the child's functional assessment, nursing intervention requirements.

8. **Comments on Family/Social Situation**: Provide any additional information, comments or explanations of the child's family social situation that will impact the health of the child.

Physician's Signature: Self-explanatory.
Date: Date that physician signs the form.
Physician's Name: Self-explanatory.