LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 9, 2009

ACS M09-26

TO: All Medicaid Providers, QUEST, and QUEST Expanded Access (QExA) Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH

SUBJECT: CLARIFICATION ON THE 1147 FUNCTIONAL POINTS INSTRUCTION

The Med-QUEST Division has provided expanded written clarification on the 1147 functional point assessment section (page 2) on the Nursing Facility Level of Care Evaluation (Enclosed). The clarification enhances the understanding of matching the actual observed and/or documented functional status of an individual with the established point system.

If there are any questions regarding this clarification, please call Ms. Kathleen Ishihara, Nurse Consultant, at (808) 692-8159.

Enclosure

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:______	6. MEDICAID ELIGIBLE? ☐ Yes ID # ______ ☐ No Date Applied ______

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: ______

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)
______
Phone : ( )______ Fax: ( )______

10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): ______
MANAGED CARE PLAN NAME (IF APPLICABLE): ______
[ ] VIA FAX (Print Fax Number Below)
Phone ( )______ Fax ( ) ______ Email ( ) ______

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, Physician, PCP)

A. ASSESSMENT DATE ___/___/___

B. ASSESSOR'S NAME
Name ______
Last First MI
Title ______
Signature ______
☐ Hard copy signature on file.
PHONE: ( ) ______ FAX: ( ) ______
EMAIL: ( ) ______

13. REQUESTING LEVEL OF CARE

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: ______ TO ______

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: ______

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

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN AND END DATES: ______ TO ______
LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: ______

Comments: ______

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

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: ______

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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: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.)
[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: (Check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.)
[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:

____

____

____

____

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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} ________
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. ________
___	[ ]	[ ]	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
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	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

☐ Yes ☐ No The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. SOCIAL SITUATION:

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

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.

PHYSICIAN'S SIGNATURE/PCP: ________

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP. **DATE:** ____/____/____

Physician's/PCP Name (PRINT): ________

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Functional Status related to Health Conditions:

Sections III – XII are scored. These sections primarily provide information about the resident's functional status as related to his/her health conditions. A critical component to assist with planning the best environment for a person with medical and/or physical disabilities is an assessment of these areas. In general, residents will meet the medical necessity criteria for long term care services with a total score of 15 or more points in these areas.

The following provides a description of each item per category.

Score	Status	Description
30	Comatose	Unable to be aroused by external stimuli.

Vision / Hearing / Speech:

Score	Status	Description
0	Has normal or minimally impaired vision / hearing/ speech with or without a device.	May wear a hearing aid, glasses, or may have minimal speech impairment.
1	Needs some assistance with hearing, being able to see, and being able to speak.	Requires some help of another because of vision/ hearing/vision impairment.
2	Has absence of hearing, vision, and/or speech.	Requires help of another, resident is deaf, is legally blind, and / or has complete absence of speech.

Communication:

Score	Status	Description
0	Adequately communicates needs / wants with or without the assistance of communication enhancing devices or techniques (i.e. sign board; sign language)	May wear glasses or hearing aids, and/or use communication devices, but impairment does not restrict self-care of communication.
1	Needs some assistance to communicate needs / wants.	Requires help of another because of communication impairment.
2	Requires complete assistance in areas of communication.	Unable to communicate without help of another person.

Memory

Score	Status	Description
0	Normal or minimal impairment of memory	Able to recall recent and long term situations with cueing.
1	Problem with long term or short term memory	Unable to recall long term situations or unable to recall recent situations.
2	Individual has problem with both long term and short term memory	Unable to recall long term and recent situation.

Mental / Behavior (circle all that apply). Make only one selection for orientation – score 0 through 2). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation:

Score	Status	Description
0	Oriented (mentally alert and aware of surroundings)	Oriented to person, place, time; understands and if needed, can direct needs that must be met to maintain self-care. Does not exhibit behavior that is disruptive, aggressive or dangerous to self/others.
1	Disoriented (partially or intermittently)	Intermittently confused and/or agitated. Behavior is sporadic with an unpredictable pattern. Need occasional reminders as to person, place, or time. May have difficulty understanding needs that must be met but will cooperate when given direction or explanation. No major safety concerns.
2	Disoriented and /or disruptive	Recurrent episodes (1-3 times per day) of being confused, forgetful, agitated, disruptive or aggressive (either physically or verbally). Needs special tolerance/management and assistance with reorientation. Has difficulty understanding needs that must be met but will cooperate when given direction or explanation. Past history or present problem of substance abuse, including alcohol or prescription drugs, alone or combined. No major safety concerns.
3	Aggressive, abusive or disruptive	Recurrent episodes (1-3 times per day). Requires intensive supervision and physical/mechanical/ medication intervention because of behavior. **Caregiver judgment is required to determine appropriate intervention, based on MD order (e.g. when to apply restraints).** Episodes documented daily with MD intervention(s) documented monthly.
4	Ambulatory Wanderers and/or in danger of self-inflicted harm or self-neglect.	Recurrent episodes (1-3 times per day). Serious safety concerns because of forgetfulness and/or wandering. Causes harm to self because of physical or mental condition i.e. repetively hits self. Judgment is poor and requires environmental/ physical/mechanical/medication intervention. **Needs constant caregiver protection and intensive supervision because of unsafe or inappropriate behavior.** Episodes documented daily with MD intervention(s) documented quarterly. Non Ambulatory wanderers will be given consideration if the individual has documented elopement(s) off caregiver's site within one year from assessment date.

Scenarios for aggressive, abusive or disruptive

Requirement: Recurrent episodes (1-3 times per day). Requires intensive supervision and physical/mechanical/medication intervention because of behavior. Caregiver judgment is required to determine appropriate intervention, based on MD order (e.g. when to apply restraints). Episodes documented daily with MD intervention(s) documented monthly.

Scenario #1: Recipient can ambulate and is physically aggressive, abusive and/or disruptive to others during all hours of the day. Caregiver is constantly at the side of the recipient when he/she is ambulating to ensure that the recipient does not harm others. Restraints may be needed to ensure safety of others.

Scenario #2: Recipient pushes his wheelchair into others, throws objects in order to hit others, throws human waste at others during all hours of the day. Caregiver has to provide constant supervision ensuring the safety of others. Restraints may be needed to ensure safety of others.

Scenarios for wanders and/or in danger of self-inflicted harm or self-neglect

Requirement: Recurrent episodes (1-3 times per day). Serious safety concerns because of forgetfulness and/or wandering. Causes harm to self because of physical or mental condition i.e. repetively hits self. Judgment is poor and requires environmental/physical/ mechanical/medication intervention. Recipient requires constant caregiver protection and intensive supervision because of unsafe or inappropriate behavior. Episodes documented daily with MD intervention(s) documented quarterly.

Scenario #1: Recipient wanders either during the day, evening, and/or night. There is a risk for serious safety concerns due to the recipient wandering off a caregiver's location/site. Constant caregiver protection needed to ensure safety of the recipient.

Scenario #2: Recipient ambulates and will drink and/or eat inappropriate items, i.e. Drano, gasoline, small jacks, marbles, etc. all hours of the day. Caregiver must consistently provide supervision to ensure that the recipient does not ingest any harmful items. Constant caregiver protection needed to ensure safety of the recipient.

Scenario #3: Recipient constantly hurts self by punching his/her head. Recipient requires a helmet and mitten for self protection, but constantly takes the helmet and mitten off. Caregiver must constantly tend to recipient all hours of the day to ensure that the recipient does not hurt himself/herself. Constant caregiver protection needed to ensure safety of the recipient.

Feeding / Meal Preparation. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independent with or without an assistive device.	Independently feeds self. Needs no intervention.
1	Feeds self; needs assistance with meal preparation.	Unable to prepare meals because of physical or mental impairment.
2	Needs supervision or assistance to assure nutritional needs are met.	Unable to plan and prepare meals. May need constant encouragement and prompting to eat.
4	Is spoon/syringe/tube fed and does not participate.	Cannot or will not feed self. Requires constant attention and hand feeding by assistant. Tube feeding prepared and administered by another person.

Transferring (How a person moves between surfaces – to/from: bed, chair, wheelchair, car, standing position, excludes to and from bath). Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independently able to transfer with or without a device.	Does not require assistance of another person.
2	Transfers with minimal / stand by help of another person.	Able to transfer with minimal or stand by assistance due to occasional loss of balance on transferring.
3	Transfer with supervision and physical assistance of another person.	Requires the presence of another when transferring because of e.g. unsteadiness and/or weakness.
4	Does not assist in transfer or is bedfast.	Completely dependent due to physical or mental condition. Frequent transfer and/or positioning. May require 2-person transfer of lifting equipment because of person's size or disability.

Mobility / Ambulation. Check a maximum of 2 for score 1 through 4. If an individual is either mobile or unable to walk, no other selections can be made. Activity observed and documented to occur at least daily:

Score	Status	Description
0	Independently mobile with or without device.	May use cane, crutches, walker or wheelchair and does not require assistance of another person.
1	Ambulates with or without device but unsteady / subject to falls.	Can walk/be mobile, but requires stand by assistance.
2	Able to walk/be mobile with minimal assistance.	Can walk/be mobile, but requires the presence of another person for minimal assistance.
3	Able to walk/be mobile with one assist.	Requires assistance in mobility and requires another person for physical assistance.
4	Able to walk/be mobile with more than one assist.	Requires assistance in mobility and requires more than one person physically for assistance to walk/be mobile.
5	Unable to walk.	Unable to walk/be mobile.

Bowel Function / Continence:

Score	Status	Description
0	Continent	Resident is able to perform bowel care/needs, including colostomy without the assistance of another person.
1	Continent with cues	Resident only requires cues / reminders to perform bowel care/needs.
2	Incontinent (at least once daily).	Occasional incontinence requires toileting or reminders by another; needs help to clean self. Requires the help of another on a regular basis to maintain bowel cleanliness.
3	Incontinent (more than once daily, # of times_____.	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bowel care.

Bladder Function / Continence:

Score	Status	Description
0	Continent	Resident is able to perform bladder care/ needs including ileostomy or indwelling catheter car without the assistance of another person.
1	Continent with cues.	Resident only requires cues / reminders to perform bladder care/needs.
2	Incontinent (at least once daily).	Occasional or stress incontinence requires toileting or reminders by another; needs help to clean self. Requires the help of another on a regular basis to maintain bladder cleanliness.
3	Incontinent (more than once daily, # of times ____)	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bladder care.

Bathing. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independent bathing	May require someone to prepare bathroom.
1	Unable to safely bathe without minimal assistance and supervision.	Needs supervision while bathing to ensure safety. Needs assistance to maintain cleanliness.
3	Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).	Totally dependent for bathing because of physical or mental disability.

Dressing and Personal Grooming. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Appropriate and independent dressing, undressing, and grooming.	Can perform dressing and personal grooming activities with little or no assistance.
1	Can groom/dress self with cueing (can dress, but unable to choose or lay out clothes).	Can dress, but unable to choose or lay out clothes or manipulate fasteners. Can brush teeth, wash face, comb/brush hair with some assistance.
2	Physical assistance needed on a regular basis.	Always requires help in most areas of dressing and grooming. Can do small tasks alone.
3	Requires total help in dressing, undressing, and grooming.	Cannot dress or undress or groom without help or another.