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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

**In reply, please refer to:**

**In reply, please refer to:**

Governor's Referral No.:

September 15, 2003

MEMORANDUM

ACS M03-08

TO: Physicians and Providers of EPSDT Medically Fragile Case Management, Skilled Nursing and Personal Care Services

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: CHANGES IN CODING FOR EPSDT MEDICALLY FRAGILE CASE MANAGEMENT, SKILLED NURSING AND PERSONAL CARE SERVICES

The Health Insurance Portability and Accountability Act (HIPAA) requires that local codes be replaced by national HCFA Common Procedural Coding System (HCPCS) codes by October 16, 2003. The Hawaii Medicaid Program has reviewed 2003 HCPCS codes and crossed-walked the local codes currently being used for EPSDT Medically Fragile Case Management, Skilled Nursing and Personal Care Services to national HCPCS codes.

To efficiently convert to national HCPCS, the Med-QUEST Division (MQD) has created a new 1144E Form specifically for authorizing EPSDT Medically Fragile Case Management, Skilled Nursing and Personal Care services. This form identifies the national HCPCS codes for covered EPSDT Medically Fragile Case Management, Skilled Nursing, and Personal Care services that replace the current codes.

The 1144E Form and instructions are attached. To expedite authorization and payment of claims, please use this form for all services (both new services and renewals) that are to be provided beginning October 1, 2003. Additional copies will be available on MQD's website, *med-quest.us*.

Effective for authorizations received for service dates beginning October 1, 2003, ACS will replace the current codes with the national codes. Thus, your authorization letters will indicate the national codes even though your authorization request was submitted with the current codes.

For existing authorizations with expiration dates after October 1, 2003, MQD will convert the current codes to national codes for approved dates of service on or after October 1, 2003. You will receive revised authorization letters with the national codes.

For your convenience, the table below identifies the current codes, the replacement codes and their descriptions:

| Current Code | Replacement National Code | Description |
|---|---|---|
| W9880 | T1016-22 | Case Management, Inpatient hospital for Ventilator Dependent/Tracheostomized child prior to initial discharge to home/community. |
| W9881 | T1016-EP | Case Management for Ventilator Dependent/Tracheostomized child living in the home/community. |
| W9882 | T1016 | Case Management for Non-Ventilator Dependent/Non-Tracheostomized child with significant medical needs. |
| W9883 | T1016-52 | Maintenance Case Management for child with significant medical needs whose caregiver(s) are able to access services and supplies with little assistance from case managers. |
| W9884 | T1017-EP | Additional Case Management hours provided with T1016 and T1016-52 to address changing medical needs. |
| W0552 | *T1030 | Skilled Nursing Services in the home, by hourly basis. |
| W0572 | T1021 | Personal Care Services in the home, by hourly basis. |

* Authorization will be given for the code T1030 without a modifier. However, when submitting a claim, indicate the quantity of skilled nursing hours provided by the RN with the code T1030 and the quantity of skilled nursing hours provided by the LPN with the code T1030-52. The total hours provided by both the RN and LPN must not exceed the total quantity of hours approved for the billing period.

If the code you are using has a modifier (-22, -EP, -52), you must use the approved code and modifier when submitting claims.

For questions or clarifications pertaining to this memo only, please call 692-8112.

Attachments

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS
P.O. Box 2561
Honolulu, Hawaii 96804-2561

# REQUEST FOR MEDICAL AUTHORIZATION OF EPSDT MEDICALLY FRAGILE CASE MANAGEMENT, SKILLED NURSING AND PERSONAL CARE SERVICES

**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. Do not submit for patients in SNF/ICF/ICF-MR facility as payment is included in the facility's per diem.

**PLEASE PRINT INFORMATION CLEARLY**

| Medicaid I.D. No.: | Patient's Name: (Last, First, M.I.) | Date of Birth: | Gender: [ ] F [ ] M | Has Other Insurance: [ ] Yes _____ [ ] No (If yes, name of insurance co.) |
|---|---|---|---|---|
| | | | | |

| Present Address (Street, City and Zip Code): | [ ] Own Home/Family Home [ ] Other_____ |
|---|---|
| | |

**TO BE COMPLETED BY PHYSICIAN. FAILURE TO COMPLETE NUMBERS 1 – 7 WILL RESULT IN RETURN OF REQUEST.**

| | Yes | No | | List specific diagnosis(es): |
|---|---|---|---|---|
| 1) Ventilator dependent | | | If yes, indicate # of hours/day: | |
| 2) Tracheostomy; no ventilator | | | If yes, indicate frequency of suctioning: | |
| 3) Other | | | | |

| | Yes | No | | | Yes | No |
|---|---|---|---|---|---|---|
| 4) Requested service is Skilled Nursing | | | If yes, indicate # of hours/day: | 6) Requested service is Case Management | | |
| 5) Requested service is Personal Care | | | If yes, indicate # of hours/day: | 7) Required justification is attached | | |

***I certify that the above named patient is under my care and the services(s) requested are medically necessary and are NOT for respite (i.e., relieving caregiver(s) for rest or other activities).***

***Physician's Signature:*** _____ ***Date:*** _____

| Print Physician's/Provider's Name: | | Provider Number: |
|---|---|---|
| Contact Name: (If different from Physician) | Telephone Number: | Fax Number: |

**To be completed by Case Management Supplier**

**Medicaid Only A=Approved P=Pended D=Denied R=Revoked**

| Code | Item | Qty./Mo. | Period Requested | ty./Mo. | Auth. | Period Approved | Comments |
|---|---|---|---|---|---|---|---|
| T1016-22 | Case Management for Tracheostomized and/or Ventilator dependent child (following initial discharge to home/community). | | From: To: | | | From: To: | |
| T1016-EP | Case Management for Tracheostomized and/or Ventilator dependent child living in home/community. | | From: To: | | | From: To: | |
| T1016 | Case Management for Non-Ventilator/Non-Tracheostomized child with significant medical needs. | | From: To: | | | From: To: | |
| T1016-52 | Maintenance Case Management for child with significant medical needs whose caregiver(s) are able to access services and supplies with little assistance from case managers. | | From: To: | | | From: To: | |
| T1017-EP | Additional Case Management hours provided with T1060 and T1060-52 to address changing medical needs. | | From: To: | | | From: To: | |

**To be completed by Skilled Nursing/Personal Care Supplier/Agency**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| T1030* | Skilled Nursing services in the home; by hourly basis. | | From: To: | | | From: To: | |
| T1021 | Personal Care Services in the home; by hourly basis. | | From: To: | | | From: To: | |

*** When submitting a claim, indicate the service hours provided by the RN with the code T1030; indicate the service hours provided by the LPN with the code T1030-52.**

***1) I certify that the services requested above have been prescribed by the physician named above and will be provided by me/my agency.***

***2) I also certify that I have verified that if the above named patient has a primary insurer other than Medicaid (name)_____, the primary insurer***

***[ ] will not cover the services above [ ] will cover the services above.***

***Signature of Supplier/Agency:*** _____ ***Date:*** _____

| Print Supplier's Name/Mailing Address: | | Supplier Number: |
|---|---|---|
| Contact Name: | Telephone Number: | Fax Number: |

DHS 1144E (Rev. 08/03)

# INSTRUCTIONS
# DHS 1144E
# REQUEST FOR MEDICAL AUTHORIZATION OF EPSDT MEDICALLY FRAGILE CASE MANAGEMENT, SKILLED NURSING AND PERSONAL CARE SERVICES

**I.** **Purpose:** The DHS 1144E Form is used to obtain medical authorization of case management, hourly skilled nursing and personal care services for Medicaid recipients under age 21 years who are medically fragile. EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. EPSDT is the Medicaid program for Medicaid recipients under age 21 years.

***II.*** **General Instructions:** Type or print legibly. ***An incomplete form will be returned to the provider.***

**A.** **Recipient Information:** *This section is to be completed by the provider.*

1. Enter Medicaid ID number, Patient's Name, Date of Birth (mm/dd/yy), and Gender.
2. Check type of Present Address, and provide Patient's Mailing Address.
3. If the recipient has other health care insurer(s) for medical care, check "yes" and name the insurer.

**B.** **Physician Information**: *This section is to be completed by the physician.* The form will be returned if numbers 1-7 are not checked and/or if the physician's signature and physician's printed name are not provided.

1. Check "Yes" or "No" for Ventilator Dependent and Tracheostomy. If Ventilator dependent, state the number of hours per day the recipient uses the ventilator. If tracheostomy without ventilator, state the number of times per day suctioning is required. If "Other" is checked, list the specific diagnosis(ses) and the reason the recipient qualifies as being medically fragile. If insufficient space, attach a separate page.
2. Check "Yes" or "No" for the services requested and the number of hours per day requested for hourly skilled nursing and personal care. Attach a completed/signed/dated EPSDT Home Skilled Nursing Scoring Tool if skilled nursing services are requested.
3. Check "Yes" or "No" in the appropriate box to indicate for medically fragile case management. Attach a completed/signed/dated EPSDT Medically Fragile Case Management Scoring Tool.

The services requested on a single form must be provided by a single agency. Therefore, if skilled nursing and personal care are provided by the same agency, they may be requested on the same form. However, if case management is provided by another agency, a separate form must be completed.

4. The physician who is requesting services must verify that recipient is under his/her care and that the requested services are medically necessary and are NOT for respite. The physician must sign and date the form.
5. Print legibly or stamp Physician/Provider Name and Provider Number.
6. Provide Contact Name (if different from physician), Telephone Number, and Fax Number where the Medicaid Consultant can contact Provider if additional information is needed to process the request.

**C. Supplier Information:**

This section is to be completed by the EPSDT Medically Fragile Case Management Supplier.

1. Circle the appropriate code(s) and complete the quantity per month. The quantity should be one (1) except for T1017-EP. Enter the period requested.

This section is to be completed by the Skilled Nursing/Personal Care Supplier/Agency.

1. Circle applicable code(s) and enter the quantity in hours requested per month and the period requested.

*Both Medically Fragile Case Management Supplier and Skilled Nursing/Personal Care Supplier/Agency.*

1. Certify 1 and 2 by signing and dating. If the recipient has primary insurer other than Medicaid, please verify with the insurer whether the services requested will be covered.
2. Print legibly or stamp Supplier Name and Supplier Number. The supplier name and supplier Medicaid I.D. number should match the name and number registered with the Med-QUEST Division.
3. Provide Contact Name (if different from supplier), Telephone Number, and Fax Number where the Medicaid Consultant can contact Supplier if additional information is needed to process the request.

**D. Medicaid Only:** *This section is to be completed by the Medicaid Consultant.*

1. Consultant will indicate the Quantity/Month approved.
2. Consultant will assign a Code for each item; such as: A – Approved, P – Pend, D – Denied, or R – Revoked.
3. Consultant will enter Period Approved.
4. Consultant will write comment(s), as needed.

**E.** Upon receipt of this 1144E Form, ACS will assign a prior authorization number.