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DEPUTY DIRECTOR

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 18, 2003

MEMORANDUM

ACS M03-10

TO: Medicaid Providers

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: CHANGES TO THE 1144 MEDICAL AUTHORIZATION FORM

The Med-QUEST Division (MQD) will be implementing the use of a revised 1144 Medical Authorization Form. The revised 1144 Form and instructions are attached.

In addition to the revised 1144 Form, we have implemented two (2) new authorization forms:

1. **The 1144A** for incontinence supplies; and

2. **The 1144E** for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) Medically Fragile Case Management, Skilled Nursing, and Personal Care.

We believe that the utilization of these distinct authorization forms will expedite the authorization process.

The significant changes in the revised 1144 Form are as follows:

- There is a section for physician/supplier comments.

- The Incontinence Supply Section is removed.

- The supplier must certify that the items and quantities are prescribed by the physician and will be provided by the supplier.

- A section has been added for the MQD to indicate its decision for the purpose of faxing the decision to the physician and supplier when complex services/supplies are requested or when the requests are urgent.

Effective with the implementation of this revised 1144 Form, the MQD will be utilizing national Medicaid level of care modifiers. These modifiers are U1 through U9, UA, UB, UC, and UD. These modifiers will be used by MQD to identify miscellaneous codes when more than one miscellaneous code is needed to identify covered services/supply. If you receive an approval letter with these modifiers, you must use these modifiers when you submit the claims. Failure to use the modifier(s) may result in denial of the claim or delay the adjudication of the claim.

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 crossed-walked local codes to national 2003 HCPCS codes. Of all the codes requiring authorization, the following table lists those local codes requiring authorization and their corresponding national codes. It does not include the local codes used for incontinence supplies and EPSDT Medically Fragile services.

Current Code	Replacement National Code	Description
W0125, W0126	G0210 - G0234, 78810	Positron Emission Tomography (PET)
W7980	C1775	Fluorodeoxyglocose f18 (FDG)
W0371,W0372	K0538, K0539	Wound Vacuum Therapy
W1402	E1390-32	Oxygen Concentrator provided in SNF or ICF
W4206*	A4206-22*	Insulin syringe for home use only, each
W4927**	A4930**	Sterile gloves per pair

* Requires authorization if more than $125.00 total is charged for diabetic supplies (glucose strips, lancets, insulin syringes) per month.

** Requires authorization if more than $50.00 is charged per month.

For requests for authorization of services/supplies for service dates on or after October 1, 2003, please use the national codes instead of the local codes.

To expedite authorization and payment of claims, please use this revised 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* by October, 2003.

If you have existing authorizations for local codes with expiration dates after October 1, 2003, you may submit copies of your approval letters and change the local code to the national code on the approval letter. If you do not have approval letters, you may submit a list of local codes and the authorization numbers. If you provide a list, you must do so in the required format (attached) and all requested information must be included. MQD will convert the current codes to national codes for approved dates of service on or after October 1, 2003 based on your instructions on your letters or list. You will receive revised authorization letters with the national codes.

The approval letters or list should be submitted to:

Department of Human Services
Med-QUEST Division
Medical Standards Branch
1144 Authorization Code Changes
P.O. Box 700190
Kapolei, Hawaii 96709-0190

NO CHANGES WILL BE MADE IF THESE ARE SENT TO MQD BY FAX OR E-MAIL.

For questions or clarifications pertaining to this memo only, please call 692-8105.

Attachments

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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

ACS USE ONLY

PA No.:_______________

Page number _______ of _______

☐ Urgent Request ☐ Extension Request ☐ New Request

REQUEST FOR MEDICAL AUTHORIZATION

Check only ONE – Different Types of Services Must Be Requested on Separate 1144 Forms.

☐ BH – Psych. Testing/ & Detox
☐ GT – Transportation
☐ LT – Long Term Care
☐ OS- Out of State Services
☐ DE – Dental
☐ HE- Home Health
☐ MD- Professional Services
☐ RE – Rehabilitation Services
☐ DM – Appl./DME/ Supplies
☐ LN – Sign Language Interpretation
☐ OP – Outpatient Facility
☐ SR – Hospice

****** This Form should NOT be used for: Incontinence Supplies, EPSDT Medically Fragile Services and Drugs. ******

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.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Identification Number:

Patient Name (Last, First, M.I.):

Gender [ ] M [ ] F

Date of Birth ____/____/____

Medicare Coverage? [ ] Yes [ ] No

Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No

Currently at: [ ] Home [ ] SNF/ICF/ICF-MR Facility [ ] Other: ______________________ name

Patient Mailing Address (St., Apt. No., City, Zip Code)

	Physician Section			Supplier Section (Circle Rent or Repair)			
	Service Description	Procedure Code	QTY	Purchase Price	Rent/ Repair	Period Requested From	To
1							
2							
3							
4							
5							

Physician Section

Diagnosis(es):

Justification:

Attachment: [ ] Yes [ ] No

Physician/ Supplier Comments

If applicable: Serial No.:
MSRP Attached: [ ] Yes [ ] No

I certify that the items and quantities above are prescribed by the physician indicated below and will be provided by the supplier.

Physician/Provider Signature: Date:

Print Physician/ Provider Name: Provider Number:

Print Contact Name: (if different from Physician) Telephone Number: Fax Number:

I certify that the items and quantities above are prescribed by the physician indicated above and will be provided by the supplier.

Supplier Signature: Date:

Print Supplier/ Company Name: Supplier Number:

Print Contact Name: Telephone Number: Fax Number:

To be completed by Medicaid (A= Approved P= Pended D= Denied R= Revoked)

Code Line	Modifier(s)	QTY	Auth. Code	Approved Period From	To	Consultant Comments:
1						
2						
3						
4						
5						

INSTRUCTIONS
DHS 1144
REQUEST FOR MEDICAL AUTHORIZATION

I. **Purpose:** The DHS 1144 Form is used to obtain medical authorization of medical services/equipment/items. It should not be used for obtaining any of the following services/equipment/items: (1) Drugs; (2) EPSDT medically fragile case management, skilled nursing and/or personal care; and (3) Incontinence supplies.

II. Prior Authorization (PA) No.: On receipt of this 1144 Form, ACS will assign an authorization number. DO NOT WRITE ANTHING HERE.

III. Each 1144 has 5 lines for requestors to describe and code the services/items being requested. Thus, if more than 5 lines are needed to identify the services/items requested, the requestor MUST indicate the page number of each sheet and the total number of sheets per request.

IV. Check "Urgent" if applicable. Requests are considered URGENT only if the patient has an urgent need for the service/equipment/item. The "Urgent" box MUST NEVER be checked if the physician/supplier is late in submitting the request, has submitted the request before, but has not received a response, or wants the request authorized quickly. Certain equipment for discharge from the hospital are not considered urgent because they have a 30 day conditional approval. (See the Medicaid Provider Manual) Check "Extension Request" if an initial request for the same service/item was requested and the current request is for continuation of the service/item. Check "New Request" if this is the first time an authorization is requested for the service/item.

V. Check only one of the 12 blocks that apply to the type of service being requested. Each type of service must be requested on a separate 1144 Form.

VI. **General Instructions:** Type or print legibly. ***An incomplete form will be returned to the provider and delay the authorization process.***

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

1. Enter Medicaid I.D. Number, Patient's Name, Gender, and Date of Birth (mm/dd/yy).

2. Check the appropriate box "Yes" or "No" about Medicare coverage and/or Medicare Home Health Benefits.

3. Check type of Present Address, and provide Patient's Mailing Address. If "Other" is checked, provide the name--example: Jane Doe, Care Home.

B. **Physician Section**: *This section is to be completed by the physician.*

1. Describe the service(s) being requested, indicate the appropriate CPT/HCPCS code and the quantity requested.

2. Provide the justification for the medical need of the service/item for the specific patient. Indicate "Yes" or "No" if you are attaching additional justification or documents justifying the medical need to the 1144 Form.

3. Sign the form and provide a date. Your signature certifies that the patient is under your care and that the service(s) requested are medically necessary for the patient. Your signature on this 1144 Form carries the same medical/legal responsibility as that on a prescription.

4. Print legibly or stamp Physician/Provider Name and Provider Number. Provide Contact Name (if different from physician), Telephone Number, and Fax Number where the Medicaid Consultant can contact the Provider if additional information is needed to process the request.

C. Supplier Section: *This section is to be completed by the Supplier.*

1. Indicate the purchase price (your charge for the equipment/supply/item). Circle rent or repair as appropriate (Purchase price, rent/repair should be left blank on requests for professional services). Indicate the period requested.

2. Print legibly or stamp Supplier Name and Supplier Number.

3. The supplier may make comments in the section "Physician/Supplier Comments."

4. If applicable--indicate the serial number. This is required for FINAL approval of wheelchairs, hearing aids, and hospital beds. Please supply it if you have it for other kinds of equipment. Indicate "Yes" or "No" for MSRP attached. (This serial number and the MSRP attachment should be left blank on requests for professional services).

5. The Supplier or its authorized representative must sign and date the form. The supplier signature certifies that the items and quantities requested were prescribed by the physician indicated on the form and will be provided by the supplier.

6. Print legibly or stamp the supplier/company name (do not enter the name of the person signing the form if it is not the same as the supplier/company name that corresponds to the Supplier Provider Number) and Supplier Provider Number.

7. Print Contact Name, Telephone Number, and Fax Number where the Medicaid Consultant can contact the Supplier if additional information is needed to process the request. Enter the Quantity/Month for the items being requested.

D. To be completed by Medicaid: *This section is to be completed by the Medicaid Consultant.* It will only be returned to the physician and supplier if the request is urgent or if the request is complex.

1. Consultant will indicate the modifier (if appropriate) for each code line and the quantity approved.

2. Consultant will assign a Code for each item; such as: A – Approved, P – Pend, or D – Denied, R – Revoked.

3. Consultant will enter Period Approved.

4. Consultant will write comment (s), as needed.

Please change the local codes that were previously authorized to the national codes.

Provider/Agency Name: ______________________ **Medicaid I.D. No.:** ____________________

Signature of provider/agency authorized to request this change: ______________________________

Date: ______________________

Authorization No.	Recipient Name	Recipient I.D. No.	Local Code	National Code	Approved Dates