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

January 21, 2005

MEMORANDUM ACS M05-02

TO: Providers of Incontinence Products

FROM: Steven S. Kawada, Med-QUEST Division Assistant Administrator

SUBJECT: CHANGES IN THE CODING OF INCONTINENCE PRODUCTS EFFECTIVE JANUARY 1, 2005

The Centers for Medicare and Medicaid Services (CMS) decided that HCFA Common Procedural Coding System (HCPCS) ***deleted*** codes cannot be used past the last effective date of the code. The last effective date for use of the "A" codes for diapers and underpads was December 31, 2004. Thus, effective January 1, 2005, the "A" codes for diapers and underpads can no longer be used in requests for prior authorization or in claims submittal. The code A4927 and A4927 modifier 22 can still be used.

The following table details the coding changes:

Code before 01/01/05	Code after 01/01/05	Description
A4521	T4521	Diapers, Adult Small/All Children's
A4522	T4522	Diapers, Adult, Medium/Large
A4524	T4524	Diapers, Adult, Extra Large
A4554	T4541	Underpads, Large
A4927, A4927-22	NO CHANGE	Gloves

If you have received prior authorization on the "A" diaper/underpad codes or the "T" diaper/underpad codes and provided the supplies on or after January 1, 2005, you must submit the claims with the "T" code. If you are experiencing difficulty in receiving payment for the "T" codes, please contact the ACS Call Center at 955-5570. They will help you resolve the problems.

Attached is an update of the 1144A. The only changes in the form are the changes in the table above. The form is also available on the Hawaii Medicaid website, www.med-quest.us.

Attachments

AN EQUAL OPPORTUNITY AGENCY

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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

REQUEST FOR MEDICAL AUTHORIZATION OF INCONTINENCE SUPPLIES

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 per diem.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Identification Number:	Patient's Name (Last, First, M.I.)	Date of Birth:	Gender: [ ] F [ ] M

Present Address: [ ] Own Home/Family Home [ ] Care Home (CH) ____________ (Name of CH) [ ] Foster Home (FH) ____________ (Name of FH)
[ ] Medicaid Waiver Program [ ] Other ____________

Patient's Mailing Address:
(Street, City and Zip Code)

TO BE COMPLETED BY PHYSICIAN. FAILURE TO COMPLETE NUMBERS 1 – 5 WILL RESULT IN RETURN OF REQUEST. SUBMIT JUSTIFICATION FROM PHYSICIAN FOR QUANTITIES EXCEEDING 200 DIAPERS, 50 UNDERPADS AND 100 GLOVES.

1) Incontinence is secondary to:
[List specific diagnosis(es)]

2) Recipient requires diapers:	3) Recipient requires underpads:	4) Caregiver requires gloves:	5) Required justification attached:
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
If Yes, number used per month ______.	If Yes, number used per month ______.	If Yes, number used per month ______.	If Yes, number of pages_____.
		Note: For Non-Latex Gloves submit medical justification.	

I certify that the above named patient is under my care and requires the number of incontinence supplies I have prescribed. Physician's Signature: ____________ ***Date:*** ________

Physician/Provider Name:		Provider Number:
Contact Name: (If different from Physician)	Telephone Number:	Fax Number:

To be completed by Supplier.

Supplier Name:		Supplier Number:
Contact Name: (If different from Supplier))	Telephone Number:	Fax Number:
Supplier's Signature:		Date:

To be completed by Supplier.				**To be Completed by Medicaid (A=Approved P=Pended D=Denied)**				
Code	Item	Qty./Mo.	Period Requested	Qty./Mo.	Auth. #1	Auth. #2	Period Approved	Comments
T4521	Diapers, Adult Small/All Children's		From: To:				From: To:	
T4522	Diapers, Adult Medium/Large							
T4524	Diapers, Adult Extra Large							
T4541	Underpads, Large							
A4927	Gloves, Latex (each)							
A4927 -22	Gloves, Non-Latex (each)							

To be completed by Medicaid.

	Additional Comments:
#1 Consultant/Reviewer Initial: Date:	
#2 Consultant/Reviewer Initial: Date:	

INSTRUCTIONS

DHS 1144A

REQUEST FOR MEDICAL AUTHORIZATION OF INCONTINENCE SUPPLIES

I. **Purpose:** The DHS 1144A form is used to obtain medical authorization of incontinence supplies, which are necessary for the care of Medicaid patients with bowel and bladder incontinence.

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

A. Patient Information: *This section is to be completed by the Physician/Provider.*

1. Enter Medicaid Identification Number, Patient's Name, Date of Birth (mm/dd/yy), and Gender.
2. Check type of Present Address, and provide Patient's Mailing Address.

B. Physician/Provider Information: *This section is to be completed by the Physician/Provider.*

1. List specific diagnosis(es) causing the incontinence (e.g., neurogenic bowel and bladder secondary to spinal cord injury/stroke/multiple sclerosis; severe dementia/mental retardation, etc.).
2. Check Yes or No in the appropriate box to indicate whether the patient requires diapers. If Yes, enter the number of diapers used per month.
3. Check Yes or No in the appropriate box to indicate whether the patient requires underpads. If Yes, enter the number of underpads used per month.
4. Check Yes or No in the appropriate box to indicate whether caregiver requires gloves. If Yes, enter the number of gloves (**each**, not pairs) used per month.
5. Check Yes or No in the appropriate box to indicate whether additional justification is attached.
6. The Physician/Provider who is requesting incontinence supplies and certifying that the patient is under his/her care must sign and date the form.
7. Print legibly or stamp Physician/Provider Name and Provider Number.
8. Provide Contact Name (if different from Physician/Provider), Telephone Number, and Fax Number where the Medicaid Consultant can contact the Physician/Provider if additional information is needed to process the request.

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

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

2. Provide Contact Name (if different from supplier), Telephone Number, and Fax Number where the Medicaid Consultant can contact the Supplier if additional information is needed to process the request.

3. The Supplier or its authorized representative must sign and date the form.

4. Enter the Quantity/Month for the items being requested.

5. Enter Period Requested for supplies. If the supply was provided prior to approval, indicate the date provided, in the Comments section. Provide justification for the late submission of the 1144A.

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

1. Consultant will indicate the Quantity/Month for incontinent supplies that are approved.

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

3. Consultant will enter Period Approved for supplies.

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

5. Consultant will provide Initial and Date for 1st review; and 2nd review, if applicable.

6. Additional Comments Section may be used for additional remarks.

E. On receipt of this 1144A form, the Affiliated Computer Services (ACS), the Medicaid Fiscal Agent, will assign a prior authorization (PA) number.