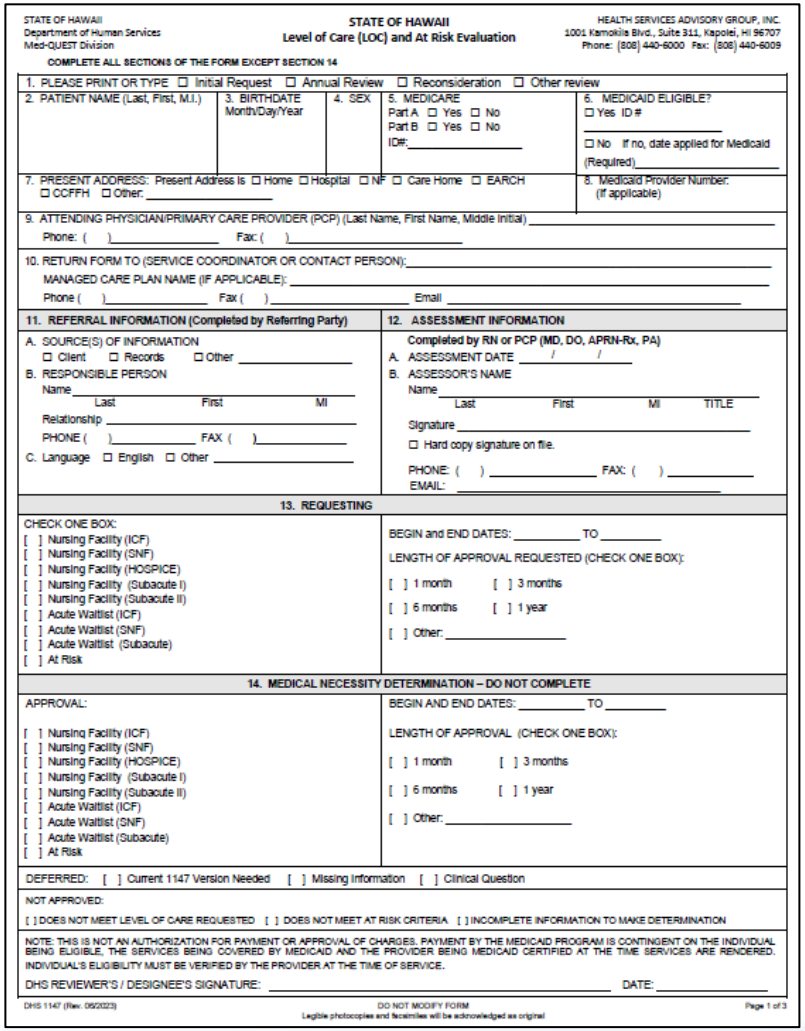
DHS Med-QUEST
Level of Care and At Risk Evaluation
1147 Form Training

Rev. 04.15.24

Agenda

1. Types of 1147 Forms
2. General information
3. Submittal process
4. Regulations– Long Term Institutional Services
5. Level of care definitions and criteria
   - Behavioral Health Parity
6. Functional status assessment
   - Skilled procedures, social situation

Types of 1147 Forms



STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ 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 If no, date applied for Medicaid (Required)_____

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 OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE):_____
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 or PCP (MD, DO, APRN-Rx, PA)
A. ASSESSMENT DATE ___/___/___
B. ASSESSOR'S NAME
Name_____
Last First MI TITLE
Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: _____

13. REQUESTING

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)
[ ] At Risk

BEGIN and END DATES: _____ TO _____
LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

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)
[ ] At Risk

BEGIN AND END DATES: _____ TO _____
LENGTH OF APPROVAL (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

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

NOT APPROVED:
[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

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: _____

DHS 1147 (Rev. 09/2023) DO NOT MODIFY FORM Page 1 of 3
Legible photocopies and facsimiles will be acknowledged as original

- 1147 - 3 pages (for Adults Only)
  - A comprehensive assessment of the individual
  - Initial entry into NF Level of Care (LOC) or At Risk
  - Annual Assessment
- 1147e - children, under the age of 21
- 1147a - short form for adults or children to extend or change in LOC

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COMPLETE ALL SECTIONS OF THE FORM

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 XVIII.

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 e. 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. (Examples required in section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

VII. FEEDING:
[0] a. Independent with or without an assistive device.
[1] b. Needs supervision or assistance with feeding.
[2] c. 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 physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bowel care.
[1] b. Continent with cues / requires reminders to perform bowel care.
[2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. 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.

Complete questions XIV to XVII for At Risk requests only:

XIV. HOUSECLEANING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely clean the home

XV. SHOPPING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely go shopping

XVI. LAUNDRY:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely do the laundry

XVII. MEAL PREPARATION:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely prepare a meal

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX. 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
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____
_____
_____
_____

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

XXI. 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
___	[ ]	[ ]	Nasopharyngeal 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.

XXII. 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: _____ Relationship: _____
Last First MI
Address: _____ Phone: (___) _____ Fax (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____
_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.
RN or PCP (MD, DO, APRN-Rx, PA) SIGNATURE: _____ **DATE:** ___/___/___
☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP.
RN or PCP (MD, DO, APRN-Rx, PA) Name (PRINT): _____

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1147 Forms – General Information

What is it?	1147 is the State's process to evaluate level of care.
What is the purpose?	Payment is needed from the QUEST Integration Health Plans Medicaid long term applicant
Who submits it?	Hospitals, NF, community providers, and health plans. 1147 assessment must be completed by a RN or PCP (MD, DO, APRN-Rx, PA)
What is required?	Must have Medicaid or Medicaid Pending
When is it not needed?	1147 is not needed for care home level of care or acute hospital stays

1147 Forms - Submittal Process

Hawaii Level of Care

Web Application

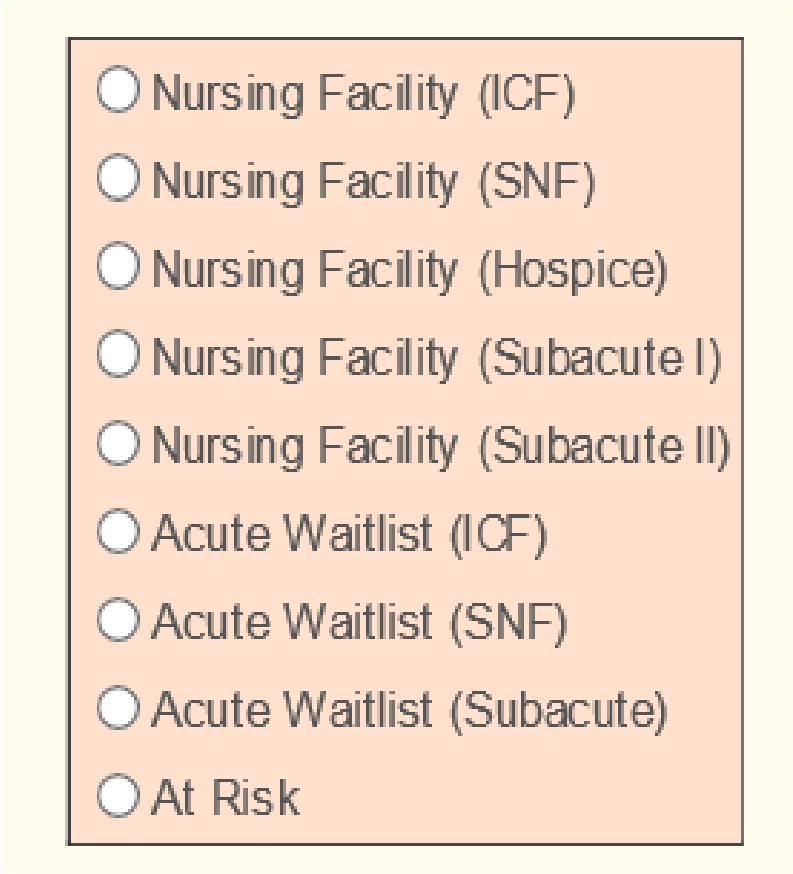
- Electronic submission of 1147 forms
- Able to track status and determination
- Must be a Medicaid provider
- Need to register for access and receive approval
- Non-HILOC users may mail or fax 1147 form

1147 Form Submittal Process

- **Assessment date:**
  - Day patient assessment was completed by a RN or PCP (MD, DO, APRN-Rx, PA)
  - Cannot be more than 60 days prior the end date of the previous 1147 approval 1147 approval
- **LOC start date:**
  - Must be on or after the assessment date (up to 60 days).
  - Cannot be before the assessment date.

1147 Form Submittal Process

Level of Care Request Types:



Length of approvals for end date:

- NF ICF: Up to 1 year, depending on situation
- NF SNF: 1-3 months, depending on skilled procedure
- Hospice: Up to 6 months
- NF Subacute: 1-3 months, up to 1 year depending on chronic conditions
- Acute Waitlist: Up to 1 month
- At Risk: Up to 1 year, depending on situation

1147 Form Submittal Process

Submitting 1147a (one page form)

- Use for adults or children to extend or change in LOC
- Requires previously approved 3-page 1147 (excluding At Risk approvals)
- Start date needs to be on or after the start date of previous 1147/1147a
- End date cannot be after the due date for an annual assessment
- Can be completed for acute waitlist, if a comprehensive reassessment 3-page 1147 is not warranted for continued stay or not an initial or an annual assessment

Types of 1147 Forms

1147a (short form cont.):

Example:

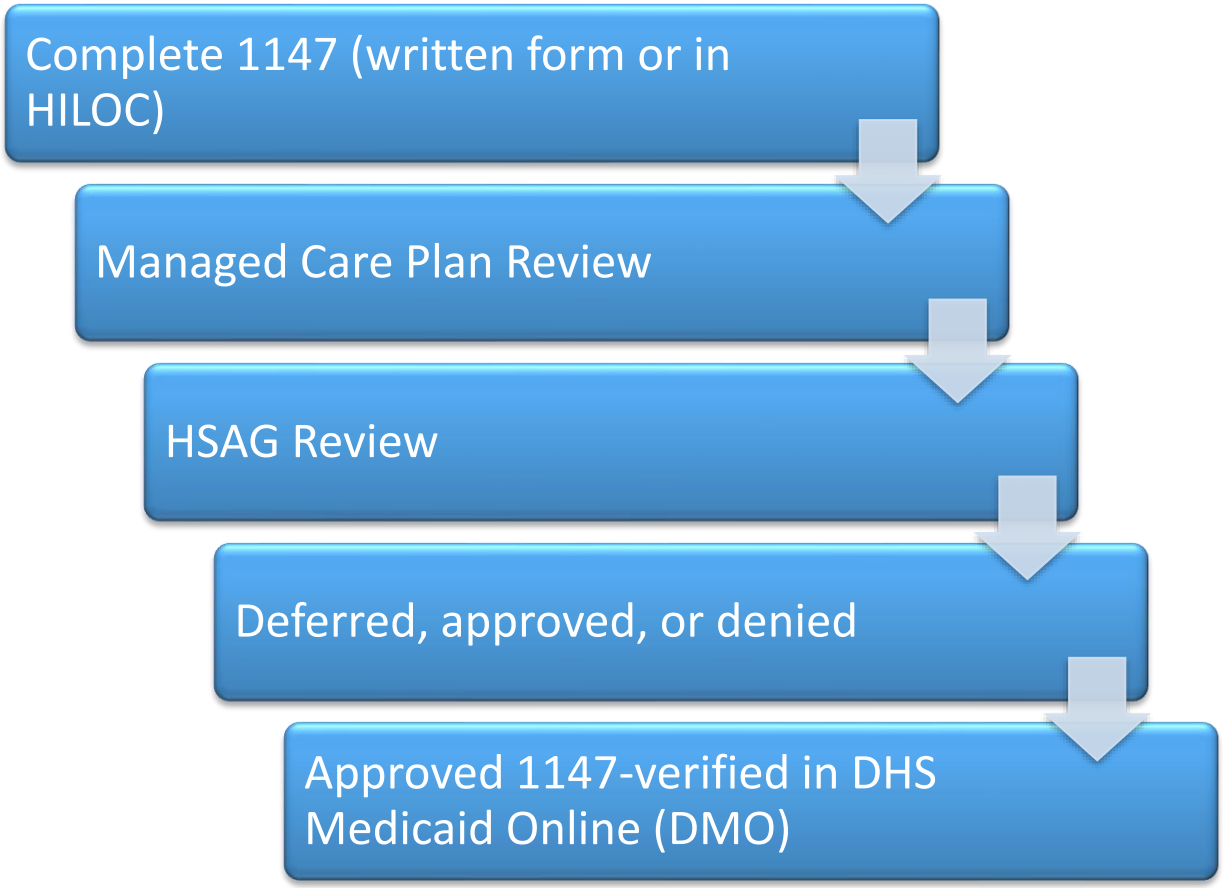
There is an approved 3-page 1147 for Acute Waitlist ICF 3/22/22 to 4/22/22

		Complete	4/20/2023	HMSA	Acute Waitlist (SNF)	3/27/2023	4/27/2023	Acute Waitlist (SNF)	3/27/2023	4/27/2023	
		Submitted	5/18/2023	HMSA	Acute Waitlist (SNF)	4/28/2023	5/1/2023	NONE			

- The patient requires continued Acute Waitlist at the same hospital and patient's medical condition and functional capabilities have not changed from the approved 3-page 1147 (regardless if the patient was discharged and re-admitted).
- The hospital may submit an **1147a** for one month (or less), 4/28/23-5/28/23, and may continue doing so until 4/22/22.

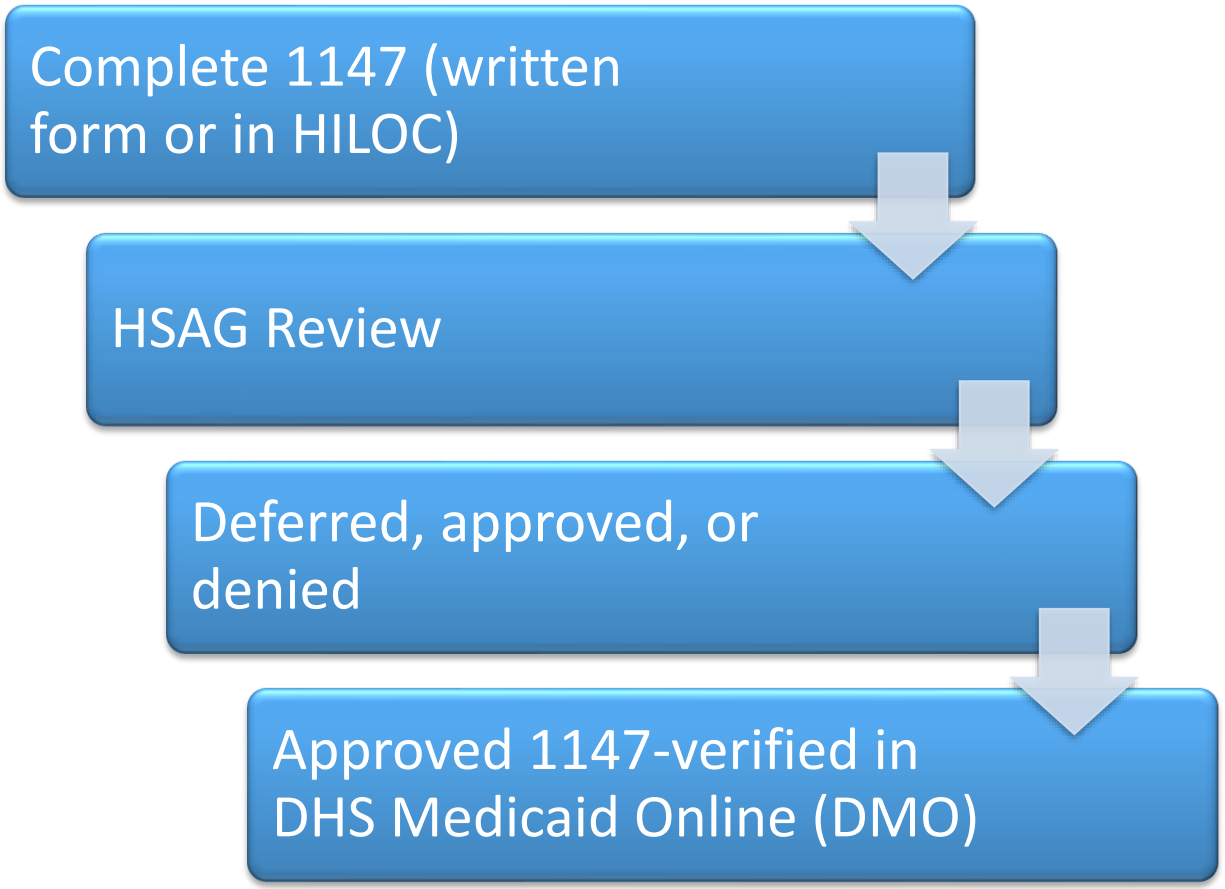
1147 Form Submittal Process

Process for Medicaid-Eligible individuals:



1147 Form Submittal Process

Process for Medicaid applicants individuals:



1147 Form Submittal Process

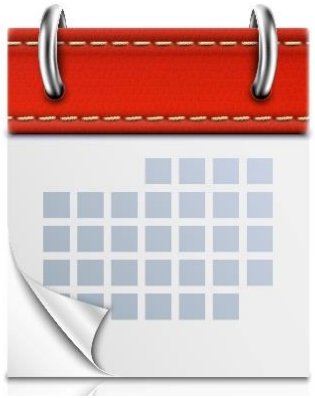
Reconsiderations:

- May ask for a reconsideration if an 1147 was not approved as meeting the level of care requested
  - Submit additional documentation to support level of care
  - Determination may not change, if this happens: Health plans communicates with provider, coordinates options, sends out denial letters, and provides appeal rights. For Medicaid applicants, the Med-QUEST Eligibility Branch sends out denial letters with appeal rights.

1147 Form Submittal Process

Retroactive Approvals:

- Twelve (12) months retroactive approvals
  - Exceptions will be given if more than 12 months
    - Medicaid eligibility issue
    - Medically necessary
    - Situation not the fault of provider and/or health plan



Regulations – Long Term Institutional Services

Long Term Institutional Services

Hawaii Administrative Rules (Section 17-1737-29):

Content of NF Services

a) Long-term institutional services shall be provided by free-standing or distinct part NFs that shall meet the eligibility requirements specified in chapters 17-1736 and 17-1739.

[1] Hawaii Administrative Rules Title 17, Department of Human Services Chapter 1737 (Sec. 17-1737-29)

See Attachment

Regulations – Long Term Institutional Services

Long Term Institutional Services (cont.)

Hawaii Administrative Rules (Section 17-1737-29):

Content of NF Services (cont.)

b) NFs shall provide:

1. Skilled nursing care and related services for resident who require medical or nursing care;
2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
3. On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them ONLY through institutional facilities, and is not primarily for the care and treatment of mental diseases[1]

[1] Hawaii Administrative Rules Title 17, Department of Human Services Chapter 1737 (Sec. 17-1737-29)

See Attachment

Regulations – Long Term Institutional Services

Long Term Institutional Services (cont.)

Hawaii Administrative Rules (Section 17-1737-29):

Content of NF Services (cont.)

c) NF services shall be provided either directly by or under the general supervision of licensed practical nurses or registered professional nurses.[1]

[1] Hawaii Administrative Rules Title 17, Department of Human Services Chapter 1737 (Sec. 17-1737-29)

See Attachment

Level of Care Definition & Criteria

Nursing Facility Intermediate Care Facility (NF ICF)

- The patient must require intermittent skilled nursing, daily skilled nursing assessment, and 24-hour supervision for the following:

  Unstable medical condition, i.e., fragile diabetic, COPD, or renal failure; wandering posing a safety concern day and night; behavioral needs

  – Oversight by RNs and/or LPNs
  – Requires significant assistance with activities of daily living (ADL)

Level of Care Definition & Criteria

Intermittent Skilled Nursing Services are, but not limited to:

- Changing of indwelling foley catheters
- Administering IM medications three times a week, routine oral, eye gtts, and ointments
- Assistance with ADLs
- Maintenance therapies, oxygen
- General maintenance care of colostomies or ileostomies
- Changes of dressing for non-infected post – operative wounds or for chronic conditions not involving sterile/complex dressing changes
- Prophylactic and palliative skin care
- General maintenance of treating incontinence, including use of incontinent appliances (all incontinent patient are not automatically ICF. Care Home residents may have daily incontinence, but should not require attention at night or be excessively incontinent)

Level of Care Definition & Criteria

Skilled Nursing Facility (SNF):

- Daily skilled nursing or restorative therapy:
- Examples:
  - Daily IV medications or IV fluids for hydration
  - Complex wound care
  - Respiratory treatment (suctioning or nebulizer) at least 4 times per day
  - PT/OT/SP

    Able to participate in therapy at least 45 minutes per day, 5 days per week, for at least one therapy type (not combined)

    Must provide 3 goals for at least one therapy type

Refer to LOC Criteria

Level of Care Definition & Criteria

Subacute I

- Mechanical ventilation 50% or more of the time

Subacute II

Pulmonary Care:

- Mechanical ventilation less than 50% of the time
- Trach care with frequent endotracheal suctioning (every 1-2 hrs.)
- Trach, bed-bound, and receiving hemodialysis
- Trach with suctioning at least once per shift (8 hours) and the patient is morbidly obese
- Trach with suctioning at least once per shift (8 hours) and the patient requires wound care for multiple Stage II or higher wounds
- Trach care with suctioning at least once per shift (8 hours) and total skilled nursing needs are at least 4 hours per day.

Level of Care Definition & Criteria

Subacute II

Other:

- Continuous cardiac monitoring
- Patients with complex drains or tubes, including Ommaya reservoir, fecal re-implantation, Aspira chest tube, and drains requiring monitoring and draining (i.e., JP drains)
- Other patients will be approved on a case-by-case basis provided they need at least 4 hours of skilled nursing care daily

Refer to LOC Criteria

Level of Care Definition & Criteria

Acute Waitlist (AW):

- Patient is in the hospital (acute care bed) waitlisted for either discharge to home or placement in an alternative care environment (i.e., care home, foster home)
- Care can only be provided inpatient
  - **AW ICF:**

    Receiving intermittent skilled nursing, 24-hr supervision, significant assistance with ADLs
  - **AW SNF:**

    Receiving skilled nursing or skilled restorative rehabilitative therapy
  - **AW Subacute:**

    Refer to previous slide and LOC Criteria

Level of Care Definition & Criteria

At-Risk:

- Individual is in a home, shelter, or group home and has a MCP
- The individual does not meet NF ICF LOC and is at-risk of deteriorating to an institutional LOC if certain long-term services and support are not provided.

MCP: Managed care plan (QUEST Integration health plan)

Level of Care Definition & Criteria

At Risk (cont.):

- Individual may be eligible to receive home and community-based services (HCBS):
  - Home-delivered meals
  - Personal Emergency Response System (PERS)
  - Personal assistance (levels I and II)
  - Adult day care
  - Adult day health
  - Skilled nursing services
- Must document how patient would benefit from HCBS

Level of Care Definition & Criteria

Nursing Facility Hospice

- Requires **hospice election** form signed and dated by the patient or the patient's legal representative.
  - If the patient is not able to sign, please indicate the reason.
- Requires a copy of the **certification of terminal illness (COTI):**
  - Signed and dated by two physicians.
  - Stated that the patient is terminally ill and prognosis is for a life expectancy of 6 months or less.
- Must meet nursing facility ICF level of care
- Must provide the name of the Medicaid certified NF

Level of Care Criteria

HSAG HEALTH SERVICES ADVISORY GROUP

State of Hawaii LOC Criteria
Revised March 8, 2024

Criteria for LOC Decisions

The following examples of clinical indications for the different levels of care are listed; the patient's overall medical status and functional limitations should be considered when determining the appropriate level of care.

CLINICAL INDICATIONS FOR LEVEL OF CARE

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Ostomy care	Initial teaching of ostomy care; operative admission; irrigation initiated.	Appropriate for complications and total skilled nursing care are at least 4 hours per day.	Uncomplicated ostomy care does not qualify.	Maintenance care.
IV Therapy	Adjunct therapy.	IV Therapy (continuous): Administration of therapeutic agents or hydration thru a peripheral or central line or both and total skilled nursing care are at least 4 hours per day. IV Therapy (intermittent): Administration of therapeutic agents at least once a shift (8 hours). Therapeutic agents include antibiotics, non-vesicant oncology chemotherapy, and analgesics and total skilled nursing care are at least 4 hours per day.	IV is intermittent and given for hydration to restore fluid and electrolyte balance (potassium, vitamins, etc.) IV administration of therapeutic agents, including antibiotics, non-vesicant oncology chemotherapy, and analgesics at least once a day.	Not appropriate.
Total Parenteral Nutrition (TPN)	Initial administration; adjunct therapy.	Requires at least 4 hours of skilled nursing care per day.	Intermittent or continuous.	Not appropriate.
Chemotherapy	24 hr infusion or observation.	Infusion more than 4 hours, RN supervision for 4 hours per day.	Short term infusion less than 4 hours or PO, RN supervision.	Not appropriate.
Radiation therapy	Initial treatments (daily for 1 week) in debilitated patients.	Daily treatments in patients and total skilled nursing care are at least 4 hours per day.	Daily treatments in patients requiring RN supervision.	Occasionally appropriate.

See Attachment

HSAG HEALTH SERVICES ADVISORY GROUP

Level of Care Criteria

Level of care review process:

- Clinical status of the patient and the intensity and severity:
  - Diagnoses
  - Physical and cognitive impairments
  - Care needs: Ostomy care, decubitus & wound care, tube feedings, bladder catheterization, pulmonary care, rehabilitative therapy, medications, insulin, vital signs, renal dialysis, isolation, traction, etc.
- Functional status, ADL assistance, and the intensity and severity

Level of Care Criteria

Level of care review process (cont.)

- Social Situation:
  - Does the patient have a home, can return home, can community setting be considered?
  - Has a caregiver who is willing to provide/continue care?
  - What assistance does the caregiver need?
- Other: Age, placement history, behavioral needs, etc.

Level of Care Criteria

Infant/Child level of care criteria:

- Medically fragile
- Unstable medical condition
- Requires intensive skilled procedures
- Refer to LOC criteria and Kapiolani Medical Center LOC protocol

Adult Residential Care Homes (ARCH) Department of Health

Adult Residential Care Homes/Department of Health

(Not Medicaid)

- There is a difference between Medicaid NF ICF and care home level
  - 1147 is not required for care home
  - Patient does not meet NF ICF level of care
  - Generally custodial care but includes individuals with medical needs
  - Care home level does not qualify for Medicaid coverage
- Examples:
  - Needs assistance with ADLs during the day and evening, but not at night
  - Needs supervision less than 24 hours
  - Wanders during the day and evening, not at night

Adult Residential Care Homes (ARCH)
Department of Health

- Examples (cont.):
  - Stable medical conditions: Diabetics on routine insulin, kidney disease, COPD, etc.
  - Stable equipment usage: CPAP, BiPAPs, ostomies, wheelchairs, oxygen, nebulizer treatments, etc.
  - Self preserving, can exit a home with minimal assistance in an event of a fire

COPD= Chronic Obstructive Pulmonary Disease
CPAP= Continuous positive airway pressure therapy
BiPAPs= Bilevel Positive Airway Pressure

Behavioral Health Parity

Behavioral health conditions are included in the 1147 assessments:

- LOC determinations are not based solely on medical or mental health diagnosis
- 1147 form assesses behaviors:
  - Mental Status/Behavior (section VI): Aggressive and/or abusive, wandering, in danger of self-inflicted harm or self-neglect
  - Behavioral problems related to neurological impairment (section XXI)

Functional Status Assessment Skilled Procedures and Social Situation

Functional Status Assessment Instructions & Examples

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/speech 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 some help of another because of communication impairment.
2	Requires complete assistance in areas of communication.	Unable to communicate without help of another person.

- Seven pages functional status assessment description and examples

See Attachment

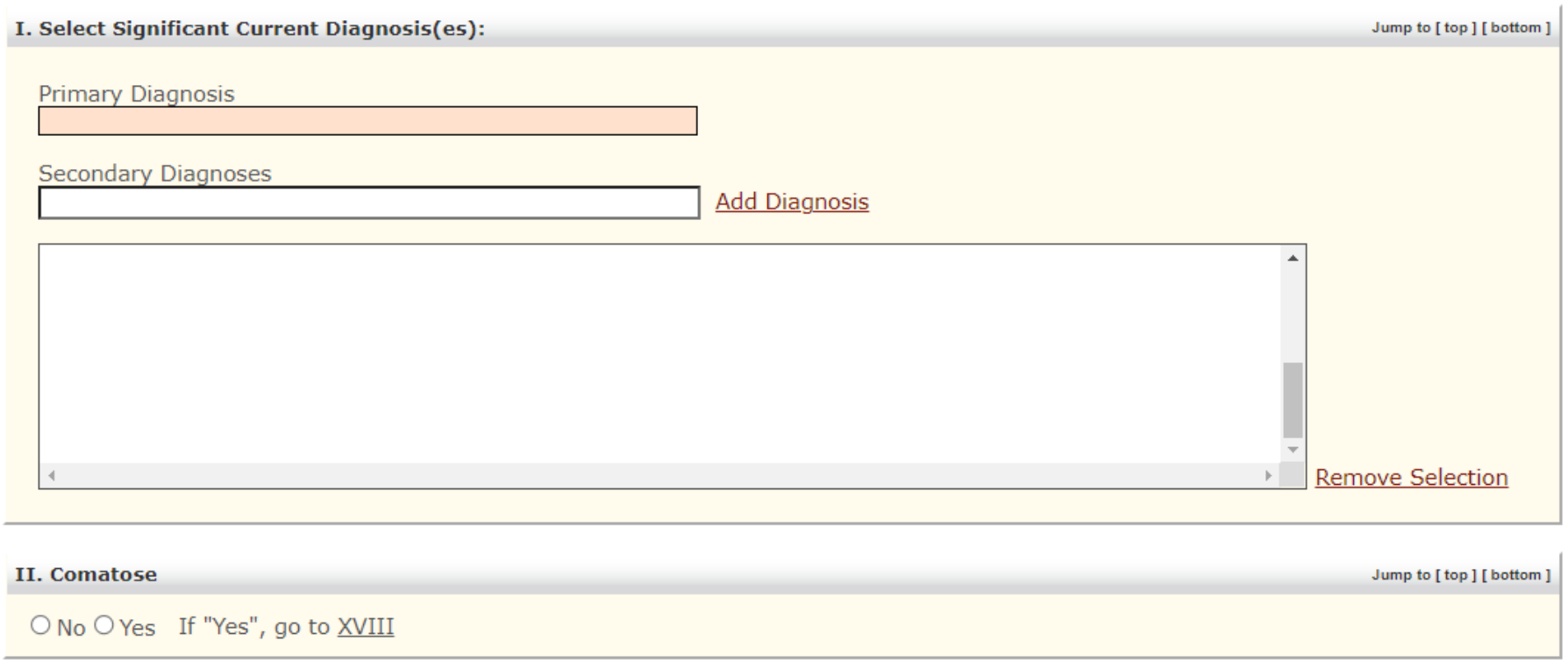
Functional Status Assessment Instructions & Examples

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 / self-propels wheelchair.	May use cane, crutches, walker or wheelchair and does not require assistance of another person. Able to self-propel wheelchair; may need assistance at tight corners or spaces.
1	Ambulates with/without device / stand-by assist / unsteady / risk for falls.	Can walk/be mobile but requires stand-by assistance or a person to be close by for safety and/or is unsteady and risk for falls.
2	Able to walk/be mobile with minimal assistance.	Can walk/be mobile, but requires the presence of another person for minimal assistance. Individual is able to assume most of his/her body weight. The helper supports by touching/steadying and providing at least 25 percent of the work during ambulation.
3	Able to walk/be mobile with one-person hands-on/moderate assistance.	Can walk/be mobile but requires another person for physical assistance. Individual is able to assume part of his/her body weight. The helper lifts, holds, and provides support to trunk or limbs during ambulation, providing at least 50 percent of the work.
4	Able to walk/be mobile with more than one-person hands-on assistance.	Can walk/be mobile, but requires more than one person for physical assistance. Individual is able to assume little of his/her weight. Helpers lift, hold, and provide support to trunk or limbs during ambulation, providing maximum assistance of at least 75 percent of the work.
5	Unable to walk / immobile.	Unable to walk/be mobile.

See Attachment

1147 Form Page 2: Functional Status Related to Health Conditions



III. Vision / Hearing/ Speech

☐ Vision ☐ Hearing ☐ Speech

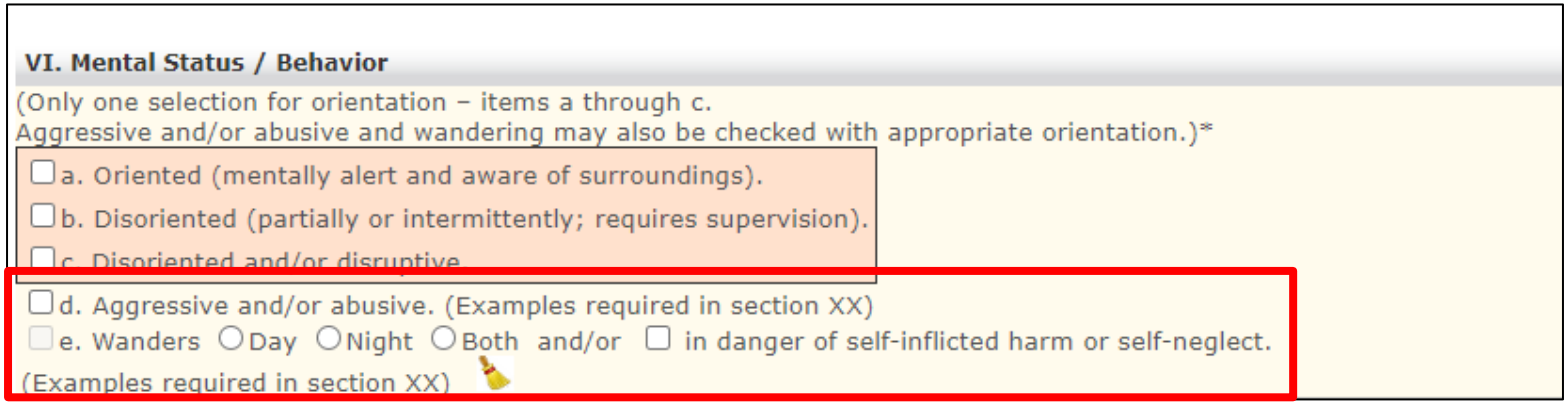
- ○ a. Individual has normal or minimal impairment (with/without corrective device)
- ○ b. Individual has impairment (with/without corrective device)
- ○ c. Individual has complete absence of hearing/vision/speech

IV. Communication

- ○ a. Adequately communicates needs/wants
- ○ b. Has difficulty communicating needs/wants
- ○ c. Unable to communicate needs/wants

V. Memory

- ○ a. Normal or minimal impairment of memory
- ○ b. Problem with long-term or short-term memory.
- ○ c. Individual has a problem with both long-term and short-term memory



VI. Mental Status/Behavior

Aggressive and/or abusive

- Should be recurrent episodes (1–3 times a day), requiring intensive supervision **and** physical/mechanical/medication interventions to manage behaviors

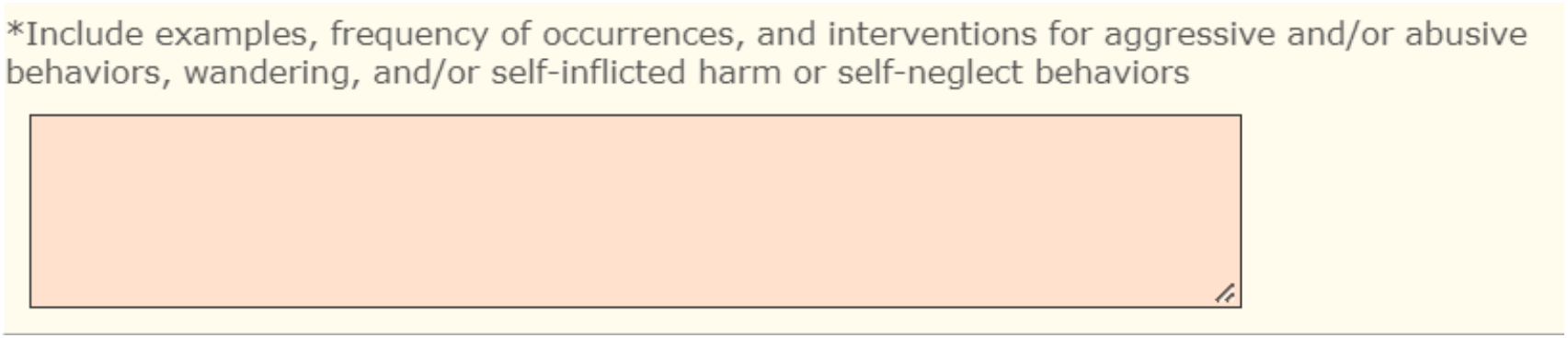
Wanders Day, Night, or Both (day and night):

- Should be occurring at least daily and causing a safety concern requiring intensive supervision. Provide a wandering log.

In danger of self-inflicted harm or self-neglect:

- Should be examples that are beyond what is already captured in the functional assessment (i.e., "not able to do ADLs" is already reflected in assessment).

VI. Mental Status/Behavior (cont.)



Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors

VII. Feeding

- ○ a. Independent with or without an assistive device.
- ○ b. Needs supervision or assistance with feeding.
- ○ c. Is spoon / syringe / tube fed, does not participate.

VIII. Transferring

- ○ a. Independent with or without a device.
- ○ b. Transfers with minimal /stand-by help of another person.
- ○ c. Transfers with physical / moderate assistance of another person.
- ○ d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. Mobility / Ambulation

(Check a maximum of 2 for items b through e.
If an individual is either independently mobile or unable to walk, no other selections can be made.)

- ☐ a. Independently mobile with or without device / self-propels wheelchair.
- ☐ b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
- ☐ c. Able to walk/be mobile with minimal assistance.
- ☐ d. Able to walk/be mobile with one-person hands-on/moderate assistance.
- ☐ e. Able to walk/be mobile with more than one-person hands-on assistance.
- ☐ f. Unable to walk / immobile.

X. Bowel Function / Continence

- ○ a. Continent / able to independently perform bowel care.
- ○ b. Continent with cues / requires reminders to perform bowel care.
- ○ c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
- ○ d. Incontinent (more than once daily) / dependent for all bowel care.

XI. Bladder Function / Continence

- ○ a. Continent / able to independently perform bladder care.
- ○ b. Continent with cues / requires reminders to perform bladder care.
- ○ c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
- ○ d. Incontinent (more than once daily) / dependent for all bladder care.

XII. Bathing

- ○ a. Independent bathing.
- ○ b. Unable to safely bathe without minimal assistance and supervision.
- ○ c. Unable to safely bathe without moderate assistance
- ○ d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath)

XIII. Dressing and Personal Grooming

- ○ a. Appropriate and independent dressing, undressing and grooming.
- ○ b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
- ○ c. Physical assistance needed on a regular basis.
- ○ d. Requires total help in dressing, undressing, and grooming.

Bladder Function/Continence: Observation of activity is daily.

Score	Status	Description
0	Continent / able to independently perform bladder care.	Individual is able to perform bladder care/needs, including changing incontinence briefs, cleaning self, urostomy or indwelling catheter care (i.e. emptying bag, changing bag, stoma care, cleaning skin around catheter site) without the assistance of another person. May need assistance with changing the urostomy or indwelling catheter bag, which is not done daily.
1	Continent with cues / requires reminders to perform bladder care.	Individual only requires cues/reminders to perform bladder care/needs, including changing incontinence brief, cleaning self, urostomy or indwelling catheter care (i.e. emptying bag, changing bag, stoma care, cleaning skin around catheter site).
2	Incontinent (at least once daily) / requires help with bladder care on a regular basis.	Occasional or stress incontinence requires toileting or reminders by another person; needs help to clean self on a regular basis to maintain bladder cleanliness. Individual is able to empty urostomy and indwelling catheter bag but needs help with stoma care or cleaning skin around catheter.
3	Incontinent (more than once daily) / dependent for all bladder care.	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bladder care, including emptying of urostomy and indwelling catheter and stoma care or cleaning skin around catheter.

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

Score	Status	Description
0	Independent bathing	Individual is able to bathe full body and hair independently. May require someone to prepare bathroom and/or help get in and out of the bathtub or shower. May need cueing or reminders to bathe. May need supervision for safety.
1	Unable to safely bathe without minimal assistance and supervision.	Needs supervision while bathing to ensure safety and minimal assistance to maintain cleanliness. Helper needs to bathe partial body (i.e. back, hair, and/or feet).
2	Unable to safely bathe without moderate assistance.	Needs supervision while bathing to ensure safety and needs moderate assistance to maintain cleanliness. Helper needs to bathe most of the body and individual can only wash face and front part of the upper body.
3	Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).	Totally dependent for bathing because of physical or mental disability. Individual is not able to wash any parts of body.

Additional Questions for At-Risk

Complete questions XIV to XVII for At Risk only:

XIV. House Cleaning

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely clean the home.

XV. Shopping

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely go shopping.

XVI. Laundry

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely do the laundry.

XVII. Meal Preparation

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely prepare a meal.

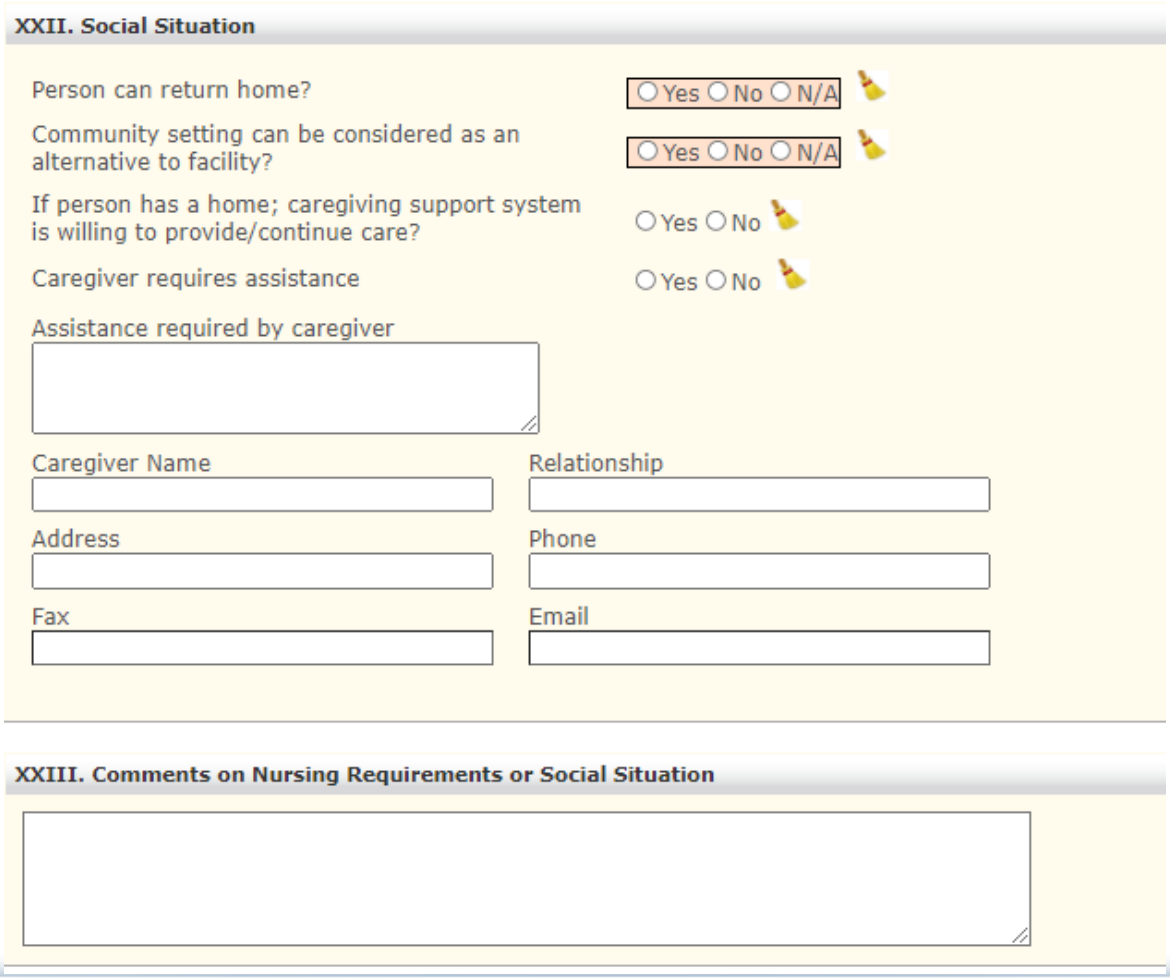
Skilled Procedures

1147 form Page 3: Skilled Procedures:

- Tracheostomy care/suctioning in ventilator or
- non-ventilator dependent person
- Nasopharyngeal suctioning in persons with no tracheostomy
- Total parenteral nutrition (TPN)
- Maintenance of peripheral/central IV lines
- IV therapy
- Decubitus ulcers
- Wound care
- Instillation of medications via indwelling urinary catheters
- Intermittent urinary catheterization
- IM/SQ medications
- Difficulty with administration of oral medications
- Swallowing difficulties and/or choking.
- Stable Gastrostomy/Nasogastric/ Jejunostomy tube feedings; enteral pump
- Initial phase of oxygen therapy
- Nebulizer treatment
- Renal dialysis, chemotherapy, radiation therapy, orthopedic traction
- Behavioral problems related to neurological impairment
- Therapeutic diet
- Restorative therapy

Social Situation

1147 Form Page 3 (cont.)- Social Situation



HSAG Contacts

Health Services Advisory Group (HSAG)
Desire Mizuno, Nurse Reviewer/Manager: dmizuno@hsag.com
Susan Mora, Project Coordinator (user accounts): smora@hsag.com
Website: www.hsag.com/myhawaiieqro

Technical Assistance:
HILOC: HILOCSupport@hsag.com
HSAG Hawaii Office: 808.941.1444
(office hours 7:45 A.M. – 4:30 P.M. HST)
HSAG Help Desk (after hours):
1.866.316.6974

DHS Med-QUEST
Kathy Ishihara, Nurse Consultant: kishihara@dhs.hawaii.gov
Phone: 808.900.8664

Managed Care Plans Contacts:
Available in HILOC Resources & Instructions and website, www.hsag.com/myhawaiieqro

Questions?

HSAG HEALTH SERVICES ADVISORY GROUP

Thank you!

Documents attached:

1. DHS Med-QUEST 1147 forms
2. Level of Care Criteria
3. Functional Status Assessment Instructions & Examples
4. Hawaii Administrative Rules 17-1737

Documents also available:

HILOC Resources and Instructions and

HSAG website: https://www.hsag.com/en/myhawaiieqro/loc-forms/

Hawaii Administrative Rules 17-1737 link:

https://humanservices.hawaii.gov/wp-content/uploads/2013/10/HAR-17-1737-Scope-Contents-of-the-fee-for-service-medical-assistant-program.pdf

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

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

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

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 OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE): _____
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 or PCP (MD, DO, APRN-Rx, PA)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI TITLE

Signature _____
☐ Hard copy signature on file.

PHONE: ( ) _____ FAX: ( ) _____
EMAIL: _____

13. REQUESTING

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)
[ ] At Risk

BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

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)
[ ] At Risk

BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

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

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

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

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

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 **XVIII.**

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. (Examples required in section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

VII. FEEDING:
[0] a. Independent with or without an assistive device.
[1] b. Needs supervision or assistance with feeding.
[2] c. 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 physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bowel care.
[1] b. Continent with cues / requires reminders to perform bowel care.
[2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. 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.

Complete questions XIV to XVII for At Risk requests only:

XIV. HOUSECLEANING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely clean the home

XV. SHOPPING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely go shopping

XVI. LAUNDRY:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely do the laundry

XVII. MEAL PREPARATION:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely prepare a meal

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX 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
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____

_____

_____

_____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

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

XXI. 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
___	[ ]	[ ]	Nasopharyngeal 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.

XXII. 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: _____ Relationship: _____
Last First MI
Address: _____ Phone: (___) _____ Fax (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.
RN or PCP (MD, DO, APRN-Rx, PA) SIGNATURE: _____ **DATE:** ___/___/___
☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP.
RN or PCP (MD, DO, APRN-Rx, PA) Name (PRINT): _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Re-Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or Type

1. PATIENT NAME (Last, First, M.I.)	2. BIRTHDATE Month/Day/Year	3. SEX	4. MEDICAID ID NUMBER

5. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other _____

6. Medicaid Provider Number: (If applicable)

7. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)

_____

Phone ( )_____ Fax ( ) _____

8. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

VIA [ ] FAX (Print Fax Number Below)
Phone ( )_____ Fax ( )_____ Email ( ) _____

9. REASON(S) FOR LOC RE-EVALUATION

[ ] Change in LOC
[ ] Extension of Current LOC
[ ] At home and waitlisted for Long Term Care Services: ☐ NF or ☐ Home and Community Based Services
[ ] No longer meeting LOC (NOT in acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute waitlisted ICF or SNF or Subacute) as of date: _____. Fill out #10, then do not proceed.

10. APPROVED LOC ON MOST CURRENT FORM (Date Span) From: _____ TO _____	**11. LOC BEING REQUESTED LOC BEGIN and END DATES: _____ TO _____**
[ ] Nursing Facility (ICF)	[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)	[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)	[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)	[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)	[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)	[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)	[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)	[ ] Acute Waitlist (Subacute)

12. CURRENT STATUS

Specify Current Primary Diagnosis _____

[ ] Additional Diagnoses (list diagnoses) _____

[ ] Functional Capabilities ( ) No Change ( ) Change(s) {Specify} _____

[ ] Nursing needs ( ) No Change ( ) Change(s) {Specify} _____

DOCUMENT NEED AT REQUESTED LOC: _____

_____

RN or PCP (MD, DO, APRN-Rx, PA) SIGNATURE: _____ **DATE:** _____

☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP

RN or PCP (MD, DO, APRN-Rx, PA) Name (PRINT): _____

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

LEVEL OF CARE APPROVAL:	LOC BEGIN AND END DATES: _____ TO _____
[ ] Nursing Facility (ICF)	LENGTH OF APPROVAL (CHECK ONE BOX):
[ ] Nursing Facility (SNF)	[ ] 1 month [ ] 3 months
[ ] Nursing Facility (HOSPICE)	[ ] 6 months [ ] 1 year
[ ] Nursing Facility (Subacute I)	[ ] Other: _____
[ ] Nursing Facility (Subacute II)	
[ ] Acute Waitlist (ICF)	
[ ] Acute Waitlist (SNF)	
[ ] Acute Waitlist (Subacute)	

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

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

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

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

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. Private/Other Insurance ☐ Yes ☐ No Ins. Co.:_____ ID#: _____	6. MEDICAID ELIGIBLE? ☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS (Specify Facility Name When Applicable) 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 OR 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. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY:
Name _____
Last First MI
Relationship _____
PHONE ( ) _____ FAX ( ) _____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION

Complete by RN or PCP (MD, DO, APRN-Rx, PA)

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

[ ] 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

[ ] Other: _____

Comments: _____

DEFERRED: [ ] Current 1147e 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: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

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:

SECONDARY:

B. MEDICATION/TREATMENTS (Attach additional sheet if necessary)
List all Significant Medications, Dosage and Frequency

1.
2.
3.
4.
5.
6.

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

☐ Feeding ☐ Transferring ☐ Mobility/Ambulation

☐ Toileting ☐ Bathing ☐ Dressing/Grooming

D. FAMILY/SOCIAL CONSIDERATIONS

1. Child can return home ☐ Yes ☐ No ☐NA
2. Community setting can be considered as an alternative to facility?
   ☐ Yes ☐ No ☐NA
3. If child has a home, caregiving support system is willing to provide/continue care? ☐ Yes ☐ No
   a. Assistance required by Caregiver:_____
   _____
   b. Caregiver Name/relationship: _____/_____
   Address: _____ Phone: _____
   Fax: _____ Email address: _____

E. Additional information concerning functional status and justification for LOC, i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision etc:

_____
_____
_____
_____
_____
_____

4. Nursing Intervention	**Frequency/Complexity**
☐ Ventilator	Continuous
☐	Intermittent, specify time on ventilator:
☐ Tracheostomy	
☐ Oxygen therapy	Continuous
☐	Intermittent
☐ Nebulized Medications	TID or less
☐	>TID
☐ Vascular access catheter	
☐ Parenteral nutrition	Continuous
☐	Intermittent
☐ Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings
☐	Pump feedings
☐ Ileostomy/colostomy	
☐ Urinary bladder catheterization	Intermittent or continuous
☐ Orthopedic appliance	Splint/cast (each)
☐	Complex (describe)
☐ Isolation/reverse isolation	
☐ Enteral Medications	8 doses/day or less
☐	>8 doses/day
☐ IM/SQ medications	4 doses/day or less
☐	>4 doses/day
☐ IV medications	4 doses/day or less
☐	>4 doses/day
☐ Oral medications	Less than 12 doses/day
☐	12 or more doses/day
☐ Monitor (Apnea, Pulse Oximeter, C-R)	
☐ Special Skin Care (Burn, decubiti)	Localized
☐	Extensive (describe)
☐ Wound Care (describe):	
☐ Restorative therapy (PT, OT, Speech – include treatment plan)	
☐ Initial discharge from hospital	
☐ Readmission for exacerbation of existing medical condition or new diagnosis	
☐ Acute, episodic illness requiring physician or emergency room visits	
☐ Other specialized nurse interventions (explain):	
☐ Comatose	

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.

RN, PCP (MD, DO, APRN-Rx, PA) Signature:_____ RN, PCP (MD, DO, APRN-Rx, PA) Name (Print):_____

☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP Date: _____

Criteria for LOC Decisions

The following examples of clinical indications for the different levels of care are listed; the patient's overall medical status and functional limitations should be considered when determining the appropriate level of care.

CLINICAL INDICATIONS FOR LEVEL OF CARE

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Ostomy care	Initial teaching of ostomy care; operative admission; irrigation initiated.	Appropriate for complications and total skilled nursing care are at least 4 hours per day.	Uncomplicated ostomy care does not qualify.	Maintenance care.
IV Therapy	Adjunct therapy.	IV Therapy (continuous): Administration of therapeutic agents or hydration thru a peripheral or central line or both and total skilled nursing care are at least 4 hours per day. IV Therapy (intermittent): Administration of therapeutic agents at least once a shift (8 hours). Therapeutic agents include antibiotics, non-vesicant oncology chemotherapy, and analgesics and total skilled nursing care are at least 4 hours per day.	IV is intermittent and given for hydration to restore fluid and electrolyte balance (potassium, vitamins, etc.) IV administration of therapeutic agents, including antibiotics, non-vesicant oncology chemotherapy, and analgesics at least once a day.	Not appropriate.
Total Parenteral Nutrition (TPN)	Initial administration; adjunct therapy.	Requires at least 4 hours of skilled nursing care per day.	Intermittent or continuous.	Not appropriate.
Chemotherapy	24 hr infusion or observation.	Infusion more than 4 hours, RN supervision for 4 hours per day.	Short term infusion less than 4 hours or PO, RN supervision.	Not appropriate.
Radiation therapy	Initial treatments (daily for 1 week) in debilitated patients.	Daily treatments in patients and total skilled nursing care are at least 4 hours per day.	Daily treatments in patients requiring RN supervision.	Occasionally appropriate.
Decubitus care/Wound care	For Graft or Surgical debridement; Aggressive therapy both surgical and intravenous antibiotics.	1) Complex skilled wound care, such as debridement, packing, medicated irrigation with or without whirlpool treatment, with 2) Aseptic dressing changes, skilled management of extensive (Stage III) decubitus ulcers, or wound infection, and total skilled nursing care are at least 4 hours per day. 3) Multiple stage 2 or higher wounds, has a tracheostomy, and requires suctioning at least once per shift (8 hrs).	Complex wound care involving daily skilled nursing assessment and daily complex intervention(s) such as wound debridement, soaks, irrigation, whirlpool, packing, and/or complex dressing changes requiring sterile (aseptic) technique. Wound vacuum therapy that requires dressing changes and skilled nursing assessment every 1-3 days and daily monitoring for signs and symptoms of complications.	Wound care that is not complex, such as dressing changes requiring CLEAN technique, wet to dry dressings, dry dressings, occlusive dressings.
TUBE FEEDING				

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Enteral feedings with J-tube or NG tube for nutritional needs, hydration and/or medication administration.	Initial acute care and initial teaching.	Requires at least 4 hours of skilled nursing care per day.	1) Appropriate if the patient is on continuous pump feeds or there is a history of aspiration pneumonia in past 12 months or history of multiple episodes of aspiration pneumonia while on NG tube feedings or if patient requires specific skilled nursing services to prevent aspiration. Also appropriate for new NG feeders, until stabilized. 2) Appropriate if the patient is on continuous pump feeds or there is a history of aspiration pneumonia in past 12 months or history of multiple episodes of aspiration pneumonia while on GT tube feedings or if patient requires specific skilled nursing services to prevent aspiration. Also appropriate for new GT feeders, until stabilized.	Appropriate for patients with no history of aspiration pneumonia on NG/GT feedings and patients who are stable on chronic, bolus feedings (pump or gravity) on stable schedule. Appropriate for patients who are able to self-administer and capable of learning and performing aspiration precautions.
Intermittent Bladder Catheterization (E*x., neurogenic bladder, urinary retention).*	Adjunct to care.	Requires at least 4 hours of skilled nursing care per day.	Appropriate if required at least once each shift; patient unable to do own catheterization; catheterization required to be done by a professional nurse.	Appropriate when done by patient or when a professional nurse does not need to perform this service.
Mechanical Ventilation	Acute care requiring daily M.D. monitoring and R.N. care.	1) Continuous (Level I) 2) Less than 50% per day (Level II) and in combination with trach care, suctioning, and inhalation treatment with or without oxygen at least once per shift (8 hours).	Not appropriate	Not appropriate
PULMONARY CARE 1) Tracheostomy Care	1) Newly created; adjunct to care.	1) Trach care with suctioning at least every 1 to 2 hours. 2) Trach, bed-bound, and receiving hemodialysis. 3) Trach with suctioning at least once per shift (8 hours) and the patient is morbidly obese. 4) Trach with suctioning at least once per shift (8 hours) and the patient requires wound care for multiple Stage II or higher wounds. 5) Trach care with suctioning at least once per shift (8 hours) and total skilled	1) Requires suctioning at least four (4) times during a 24-hr. period not purely routine and skilled nursing assessment at least once per shift (8 hours). *	1) Maintenance with prn suctioning or self suctioning.

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
		nursing care are at least 4 hours per day.		
2) Nasopharyngeal suction	2) Adjunct to care.	2) Requires suctioning at least every 1 to 2 hours and total skilled nursing care are at least 4 hours per day.	2) Requires suctioning at least four (4) times during a 24 hr period and skilled nursing assessment at least once a shift (8 hours). *	2) Suctioning less than once a shift or prn with/without skilled nursing assessment each shift.
3) Respiratory Treatment/Inhaled Updraft Medications	3) Initiation of treatment, esp. during acute exacerbations: medically unstable.	3) Medically justified as needed more than once per shift, pt. incapable of correct self-administration; pulmonary patient who requires skilled assessment more than once per shift and total skilled nursing care are at least 4 hours per day.	3) Medically justified as needed at least four (4) times during a 24 hr period, pt. incapable of correct self-administration and requires skilled nursing assessment at least once per shift (8 hours). * *Patients require one type of the above respiratory services or a combination of services four (4) or more times during a 24-hour period (example: nasopharyngeal suctioning BID and nebulized treatment BID).	3) Updraft/bronchodilators via nebulizer less than once a shift or prn with/without skilled nursing assessment each shift.
Rehabilitation Therapy Services (Physical Therapy, Speech Therapy; for occupational therapy see below).	Initial treatment(s) following surgery or neurological impairment (generally 1 week or less).	Not applicable.	DAILY planned, progressive program with documented short and long term attainable goals require services of therapist to increase functional ability; must be a restorative program. Patient must be participating in PT and/or ST at least 45 minutes per day, 5 days per week. Participation minutes cannot be combined across therapies.	Maintenance, non-restorative nonprogressive program to prevent loss of function.
Occupational Therapy (OT).	Adjunct therapy.	Not applicable.	May qualify if this is the only restorative service and it is done daily. Patient must be participating in OT at least 45 minutes per day, 5 days per week. Participation minutes cannot be combined across therapies.	Appropriate for recreational OT and/or fabrication or modification of maintenance splints for contractures.
ADL Ability (Activities of Daily Living).	Not applicable.	Not applicable.	No applicable.	Basis of placement between ICF and lower levels of care; ICF care covers incontinent and totally dependent patients, or patients who need significant assistance with ADLs.
Medication (Also, see *insulin*).	Not appropriate, if P.O. meds are the only treatment or skilled care need.	Requires total skilled nursing care at least 4 hours per day.	Monitoring and adjusting meds, including oral types. IV administration of therapeutic agents, including antibiotics, non-vesicant oncology chemotherapy, and analgesics at least once a day (including IV pumps and PCA pumps). IM and SQ may be appropriate depending on frequency and acuity of patient.	Regimen of P.O. medications, regimen of maintenance P.O. medication , IM, or SQ oral; IM or SQ may be appropriate depending on frequency.

State of Hawaii LOC Criteria

Revised March 8, 2024

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Insulin.	Initiating administration; uncontrolled status adjunct to treatment.	Diabetes is unstable and patient requires blood glucose monitoring and/or sliding scale insulin (SSI) and total skilled nursing care are at least 4 hours per day.	Qualifies if diabetes is unstable due to an acute illness in which the short term use of blood glucose monitoring and/or sliding scale insulin (SSI) is needed or the longer term use of blood glucose monitoring and/or SSI if diabetes is relatively unstable AND the physician is adjusting insulin.	Routine administration of one or more doses of insulin per day and/or chronic use of blood sugar monitoring and/or SSI if blood sugars are relatively stable and routine insulin dose is not being frequently adjusted by the physician.
Vital Signs.	As required to evaluate total clinical picture and prompt physician directed intervention.	Vital signs requires a R.N. to complete and requires total skilled nursing care at least 4 hours per day.	For increased medical monitoring of an acute illness or exacerbation of chronic illness requiring skilled nursing observation at least once a shift, ordered by a physician as part of an active treatment plan for at least 72 hours and ONLY with active physician involvement to avoid acute hospitalization in patients whose level of care is normally ICF and who will return to ICF within 24 hours after increased medical monitoring and active physician involvement ceases.	Routine assessment, no anticipated interventions.
Heat Treatment.	Adjunct care.	Part of active treatment plan, requires skilled observation and evaluation by R.N. and total skilled nursing care are at least 4 hours per day.	Part of active treatment plan, requires skilled observation and evaluation by R.N.	For comfort and palliation, maintenance.
Medical Gases (Oxygen).	Adjunct care.	Initial phases involving, O_2 bronchodilators, etc. and total skilled nursing care are at least 4 hours per day.	Initial phases involving titration of O_2 Approvable up to 3 days with documentation of physician orders to titrate.	After initial phase and teaching of the patient to institute O_2 therapy, maintenance O_2 and self-administered O_2 are appropriate (stable patients may qualify for care home residency or residency in foster care homes).
Renal Dialysis (Hemodialysis and peritoneal dialysis performed at Dialysis Facilities).	Appropriate for acute medical problems and complications.	1) Appropriate for complications which require skilled nursing services and total skilled nursing care are at least 4 hours per day. 2) Receiving hemodialysis, has a tracheostomy, AND is bed-bound.	Appropriate for complications which require skilled nursing services and when skilled nursing assessment and monitoring services pre and post dialysis are being provided by the facility.	Appropriate for stable dialysis patients (stable dialysis patients may qualify for care home residency or residency in foster care homes) and when skilled nursing assessment and monitoring services pre and post dialysis are not needed or not being provided by the facility.
Neurological impairments (i.e., Alzheimer's, traumatic or infectious brain injuries, frequent recurrent TIAs, recent CVAs).	Acute illness or exacerbation.	Requires nursing assessments and interventions for behavior management and total skilled nursing care are at least 4 hours per day.	Appropriate if skilled nursing assessment is required at least once a shift to assess need for medications, adjust dosages, etc.; ONLY if PASARR requirements are met.	Neurologically stable or in good control, requiring significant assistance with ADLs; ONLY if PASARR requirements are met; (may qualify for care home residency).
Isolation	Acute care requiring daily M.D. monitoring and R.N. care.	Patient is in contact, droplet, or airborne isolation, which is medically necessary, and requires total skilled nursing care at least 4 hours per day.	Patient is in contact, droplet, or airborne isolation, which is medically necessary, and requires total skilled nursing less than 4 hours per day.	Not appropriate.
Traction	Acute care requiring daily M.D. monitoring and R.N. care.	Requires total skilled nursing care at least 4 hours per day.	Requires total skilled nursing less than 4 hours per day.	Not appropriate.
Telemetry	Acute care requiring daily M.D. monitoring and R.N. care.	Continuous cardiac monitoring.	Not appropriate	Not appropriate.

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Complex Drains and/or Tubes	Acute care requiring daily M.D. monitoring and R.N. care.	Patients with complex drains or tubes, including Ommaya reservoir, fecal re-implantation, Aspira chest tube, and drains requiring monitoring and draining (i.e., JP drains).		

* Subacute LOC reserved for inpatient facilities. For pediatrics (0-20 years old), refer to Subacute Criteria-Hawaii Administrative Rule and DHS Med-QUEST Memo (QI-2114).
** ICF LOC: Additional requirements include significant assistance with activities of daily living (ADL) and 24-hour supervision.

Subacute Criteria -Hawaii Administrative Rules and DHS Med-QUEST Memo (QI-2114):
Revised March 8, 2024

Exclusions: Medically unstable patients requiring acute care, SNF/ICF designations, newborns/premature infants for sucking reflex training, monitoring of weight and oral feeding to gain sufficient weight for discharge to home setting, children/newborns/infants under the care of CPS awaiting placement, patients in terminal phase of disease who request or whose legal guardians have requested in writing the desire not to be resuscitated and no subacute services have been or will be rendered.

Newborns or Premature Infants (under age one, who have been inpatient in the acute hospital for at least a week and cannot be discharged, requires following services)

Level I	**Intensity**
Level II	**Intensity**
Bradycardia, Apnea which are resolved by manual stimulation	Continuous monitoring for whom discharge from a facility is medically inappropriate.
Nasogastric tube (NGT), Gastrostomy feedings (GT)	

Pediatrics (No longer require inpatient care. Must be at baseline status, not at risk for rapid deterioration)

Level I	**Intensity**
Ventilator Dependent	
Level II	**Intensity**
Tracheostomy care with skilled interventions, i.e., suctioning (Sx.) greater than once per shift (8 hours)	Weekly medical interventions and monitoring, and 24 hours a day skilled nursing.
IV Therapy (Continuous) for administration of therapeutic agents or hydration	Requires chronic care, medical interventions, monitoring at least weekly, and skilled nursing at least once per shift (8 hours).
IV Therapy / TPN Intermittent for administration of therapeutic agents	At least once per shift (8 hours) thru a peripheral or central line (antibiotics, non-vesicant oncology chemotherapy, and analgesics.
Two or more of the following services: • Tracheostomy care with Sx., not more than once per shift (8 hours), and does not require continuous monitoring; • Debridement, packing, medicated irrigation, aseptic dressing changes, extensive care of decubiti (stage III) or wound Infection and drains; • Nutritionally compromised, eating disorders at high risk of medical complications if managed in an outpatient setting;	

Level II	Intensity
• At least daily inhalation therapy by skilled staff; or • Multiple (two or more modalities) rehabilitative services with short- and long-term attainable goals.	

Level-of-Care Protocols – Kapiolani Medical Center for Women and Children (KMCWC)

Revised 4/30/09

Pediatric Acute Level of Care:

This level of care is for patients who are significantly medically unstable. Parameters include:

1. Any of the following that require frequent/constant monitoring and adjustments of treatments and/or aggressive intervention/treatment:

   Hemodynamic instability, acute intubation/mechanical ventilation, respiratory insufficiency, pulmonary instability, unstable airway, electrolyte instability requiring acute interventions, unstable blood counts, surgery and immediate post operative period, IV antibiotic therapy, IV chemotherapy, or other IV medications that require monitoring/titration during the acute phase of the illness (not applicable to patients who are medically stable, afebrile and continue to require IV therapy) photo therapy for jaundice during the acute phase of illness, Heliox/Nitric Oxide therapy.

2. Any combination of treatments that require increased nursing surveillance/monitoring and/or intervention, indicating an unstable medical condition.

3. Narcotic weaning (includes methadone wean)—IF CONDITIONS 1 AND 2 ARE MET. If the patient is stable and the weaning is slow, over the course of month, this is subacute or SNF.

Sub-Acute Level of Care:

1. Patients who have reached a baseline status in their care and who are not at risk for rapid deterioration, but however continue to require frequent nursing evaluation interventions and/or treatment.

2. TPN that is anticipated to provide the bulk of the nutrition for an extended period of time. TPN is never SNF for newborns and infants.

3. Patients with stable vital signs receiving wound vacuum dressing and/or IV antibiotics greater than 30 days for newborn and infants. This situation is SNF for adults.

Unit Specific Level of Care Criteria

PICU

Acute Level of Care:

1. Any of the following that require frequent/constant monitoring and adjustments of treatments and/or aggressive intervention/treatment:

   Hemodynamic instability, acute intubation/mechanical ventilation, respiratory insufficiency, pulmonary instability, unstable airway, electrolyte instability requiring acute interventions,

unstable blood counts, surgery and immediate post operative period, IV antibiotic therapy, IV chemotherapy, or other IV medications that require monitoring/titration during the acute phase of the illness (not applicable to patients who are medically stable, afebrile and continue to require IV therapy), photo therapy for jaundice during the acute phase of illness, Helix/Nitric Oxide therapy.

2. Any combination of treatments that require increased nursing surveillance/monitoring and/or intervention, indicating an unstable medical condition.

3. Narcotic weaning (including Methadone wean) in a child WHO HAS MET REQUIREMENTS 1 AND 2.

Sub-Acute Level of Care:

1. Continuous Positive Air Pressure (CPAP) weans are sub-acute, once the child has moved past the initial phase of transitioning to CPAP sprints, is stable on those sprints, and does not appear to be at risk for rapid deterioration.

2. Treatment of tracheitis with either oral or one IV antibiotic, unless the nursing intervention is significantly increased due to increased suctioning, increased respiratory treatment, etc.

3. TPN that is anticipated to provide the bulk of the nutrition for an extended period of time is never SNF for children who are NOT maintained on TPN in the home/community setting.

4. Patients with stable vital signs and wound vac treatment with significant drainage and/or more than two antibiotics given IV in dosages and length of time in keeping with the manufacturer's recommendations.

NICU

Acute Level of Care:

1. Aggressive therapies such as IV antibiotic, surgery, mechanical ventilation, CPAP, level IV medications for sedation and/or paralyzing.

2. Aggressive ventilator weaning.

3. Aggressive CPAP weaning.

4. TPN in the medically unstable baby.

5. Medically necessary monitoring and/or interventions at least every 2 hrs.

6. More than 10 apnea events per 24 hours and/or apnea events that require vigorous stimulation (oxygen and positive pressure breast through a bag/mask).

7. High Flow Nasal Cannula (HFNC) with aggressive weaving, similar to CPAP.

8. Isolette care for babies less than 35 weeks that are thermodynamically unstable.

Sub-Acute Level of Care:

1. Unsuccessful wean where baby's respiratory condition has obviously reached a plateau, a maintenance level without significant fluctuations.

2. Baby has tracheotomy and will require long wean off ventilator and/or CPAP (oxygen level is <40%).

3. Babies that are transitioning from Nasal Gastric (NG) feeds to nipple feeds with nursing and/or OT/PT intervention required for active training of the baby to nipple feed.

4. TPN that is anticipated to provide the bulk of the nutrition for an extended period of time. TPN is never SNF if children are NOT maintained on TPN in the home/community setting.

5. Between 5 to 10 apnea events per 24 hours and/or apnea events that require moderate stimulation (shake or increase oxygen).

6. Isolette care for babies that have other medical issues, such a nasal cannula, apnea that may need supplemental oxygen or manual stimulation, but who are otherwise relatively stable.

SNF Level of Care:

1. O^2 maintenance without additional respiratory support and not aggressively weaning.

2. NG/GT feeds without plan for weaning or active change in feeds.

3. Nipple feeds with NG feeds that will continue after discharge (baby will go home on NG/nipple feeds).

4. Less than 5 apnea events per 24 hours and/or apnea events that require mild stimulation (very little tactile stimulation) or are self resolved.

5. Baby ready for discharge and who has a need for parent training of use and care of medical supplies and/or equipment.

6. Baby's awaiting community placement (i.e., CPS, foster care, nursing home) that have need for skilled nursing services and/or medical supplies/equipment.

7. Isolette care where baby requires temperature regulation but has no other medical issues and baby is greater than or equal to 35 weeks adjusted gestational age.

DHS 1147 Form - Functional Status related to Health Conditions:

Sections III – XII are scored. These sections primarily provide information about the individual'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.

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	Individual has impairment with vision/hearing/speech with/without corrective device.	Requires some help of another because of vision/hearing/speech impairment.
2	Individual has complete absence or hearing, vision, and/or speech.	Requires help of another, individual is deaf, is legally blind, and/or has complete absence of speech.

Communication:

Score	Status	Description
0	Adequately communicates needs/wants.	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	Has difficulty communicating needs/wants.	Needs some assistance to communicate needs and wants. Requires some help of another because of communication impairment.
2	Unable to communicate needs/wants.	Unable to communicate without help of another person. Requires complete assistance in areas of communication.

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 problems 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, wandering, and/or in danger of self-inflicted harm or self-neglect 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; requires supervision).	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	Wanders day, night, or both 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. repetitively 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 individuals who wandered in the past 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. restively hits self. Judgment is poor and requires environmental/physical/mechanical/medication intervention. Recipient requires constant caregiver protection and intensive supervision because of unsafe of 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. 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	Needs supervision or assistance with feeding	Unable to plan and prepare meals. May need constant encouragement and prompting to eat.
2	Is spoon/syringe/tube fed, 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	Independent with or without a device.	Independently able to transfer with or without a device. Does not require assistance of another person.
2	Transfers with minimal/stand by help or another person.	Able to transfer with minimal or stand by assistance due to occasional loss of balance on transferring. Individual is able to assume most of his/her body weight. The helper supports by touching/steadying and providing at least 25 percent of the work during transfers.
3	Transfer with physical/moderate assistance of another person.	Requires the presence of another and physical, moderate assistance when transferring because of unsteadiness and/or weakness. Individual is able to assume part of his/her body weight. The helper lifts, holds, and provides support during transfers, providing at least 50 percent of the work during transfers.

4	Does not assist in transfer / requires maximum assist / or is bedfast.	Completely dependent due to physical or mental condition. Frequent transfer and/or positioning. May require 2-person transfer or lifting equipment because of person's size or disability. Individual is able to assume little to none of his/her weight. Helper(s) lift, hold, provides maximum assistance of at least 75 percent of the work during transfers.

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 / self-propels wheelchair.	May use cane, crutches, walker or wheelchair and does not require assistance of another person. Able to self-propel wheelchair; may need assistance at tight corners or spaces.
1	Ambulates with/without device / stand-by assist / unsteady / risk for falls.	Can walk/be mobile but requires stand-by assistance or a person to be close by for safety and/or is unsteady and risk for falls.
2	Able to walk/be mobile with minimal assistance.	Can walk/be mobile, but requires the presence of another person for minimal assistance. Individual is able to assume most of his/her body weight. The helper supports by touching/steadying and providing at least 25 percent of the work during ambulation.
3	Able to walk/be mobile with one-person hands-on/moderate assistance.	Can walk/be mobile but requires another person for physical assistance. Individual is able to assume part of his/her body weight. The helper lifts, holds, and provides support to trunk or limbs during ambulation, providing at least 50 percent of the work.
4	Able to walk/be mobile with more than one-person hands-on assistance.	Can walk/be mobile, but requires <u>more</u> than one person for physical assistance. Individual is able to assume little of his/her weight. Helpers lift, hold, and provide support to trunk or limbs during ambulation, providing maximum assistance of at least 75 percent of the work.
5	Unable to walk / immobile.	Unable to walk/be mobile.

Bowel Function/Continence: Observation of activity is daily.

Score	Status	Description
0	Continent / able to independently perform bowel care.	Individual is able to perform bowel care/needs, including ileostomy/colostomy (i.e. emptying bag and stoma care) without the assistance of

		another person. May need assistance with changing the ileostomy/colostomy bag, which is not done daily.
1	Continent with cues / requires reminders to perform bowel care.	Individual only requires cues/reminders to perform bowel care/needs, including ileostomy/colostomy (i.e. emptying bag and stoma care).
2	Incontinent (at least once daily) / requires help with bowel care on a regular basis	Occasional incontinence requires toileting or reminders by another person and needs help to clean self on a regular basis to maintain bowel cleanliness. Individual is able to empty ileostomy or colostomy bag but needs help with stoma care.
3	Incontinent (more than once daily) / dependent for all bowel care.	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bowel care, including emptying ileostomy/colostomy bag, changing bag, and stoma care.

Bladder Function/Continence: Observation of activity is daily.

Score	Status	Description
0	Continent / able to independently perform bladder care.	Individual is able to perform bladder care/needs, including changing incontinence briefs, cleaning self, urostomy or indwelling catheter care (i.e. emptying bag, changing bag, stoma care, cleaning skin around catheter site) without the assistance of another person. May need assistance with changing the urostomy or indwelling catheter bag, which is not done daily.
1	Continent with cues / requires reminders to perform bladder care.	Individual only requires cues/reminders to perform bladder care/needs, including changing incontinence brief, cleaning self, urostomy or indwelling catheter care (i.e. emptying bag, changing bag, stoma care, cleaning skin around catheter site).
2	Incontinent (at least once daily) / requires help with bladder care on a regular basis.	Occasional or stress incontinence requires toileting or reminders by another person; needs help to clean self on a regular basis to maintain bladder cleanliness. Individual is able to empty urostomy and indwelling catheter bag but needs help with stoma care or cleaning skin around catheter.

3	Incontinent (more than once daily) / dependent for all bladder care.	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bladder care, including emptying of urostomy and indwelling catheter and stoma care or cleaning skin around catheter.

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

Score	Status	Description
0	Independent bathing	Individual is able to bathe full body and hair independently. May require someone to prepare bathroom and/or help get in and out of the bathtub or shower. May need cueing or reminders to bathe. May need supervision for safety.
1	Unable to safely bathe without minimal assistance and supervision.	Needs supervision while bathing to ensure safety and minimal assistance to maintain cleanliness. Helper needs to bathe partial body (i.e. back, hair, and/or feet).
2	Unable to safely bathe without moderate assistance.	Needs supervision while bathing to ensure safety and needs moderate assistance to maintain cleanliness. Helper needs to bathe most of the body and individual can only wash face and front part of the upper body.
3	Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).	Totally dependent for bathing because of physical or mental disability. Individual is not able to wash any parts of body.

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 manipulated 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.

Complete for At-Risk only:
Housecleaning:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
2	Needs Assistance	Member able to complete some tasks with some assistance, includes oversight/cueing.
3	Unable to safely clean the home	Member unable to complete task on own and needs assistance to complete task.

Shopping:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
2	Needs Assistance	Member able to complete but needs assistance to complete task.
3	Unable to safely go shopping	Member unable to complete task on own and needs assistance to complete task.

Laundry:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
1	Needs Assistance	Member able to complete but needs assistance to complete task.
2	Unable to safely do the laundry	Member unable to complete task on own and needs assistance to complete task.

Meal Preparation:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
1	Needs Assistance	Member able to complete but needs assistance to complete task.
2	Unable to safely prepare a meal	Member unable to complete task on own and needs assistance to complete task.

(1) Residential treatment centers;
(2) Skilled nursing facilities;
(3) Intermediate care facilities;
(4) Consortiums; and
(5) Home visits to a residence, care home, boarding home, or other living arrangement, except in an emergency situation.
[Eff 02/16/02] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §456.3)

§§17-1737-23 to 17-1737-25 (Reserved).

SUBCHAPTER 4

LONG TERM INSTITUTIONAL SERVICES

§17-1737-26 Scope and purpose. (a) This subchapter governs the standard for payment which providers of long-term institutional services shall meet to qualify for medical payments for services provided to medicaid recipients.

(b) This subchapter shall ensure provision of effective and appropriate long-term institutional services and the on-going evaluation of the quality, appropriateness and timeliness of such services to medicaid recipients. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10; Pub. L. No. 100-203) (Imp: 42 C.F.R. §§440.40, 440.150, 440.260, 483.1)

§17-1737-27 REPEALED. [R 09/30/13]

§17-1737-28 Eligibility requirements. (a) The individual applicant shall meet the basic eligibility requirements of the medicaid program in order to qualify for medicaid assistance.

(b) Long-term institutional services shall be available to recipients who have been approved by the department to receive these services.
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 442.1) (Imp: 42 C.F.R. §§431.10, 442.1)

§17-1737-29 Content of NF services. (a) Long-term institutional services shall be provided by free-standing or distinct part NFs that shall meet the eligibility requirements specified in chapters 17-1736 and 17-1739.

(b) NFs shall provide:

(1) Skilled nursing care and related services for residents who require medical or nursing care;

(2) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(3) On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases.

(c) NF services shall be provided either directly by or under the general supervision of licensed practical nurses or registered professional nurses.

(d) NF services shall include, but shall not be limited to:

(1) Room and board;

(2) Administration of medication and treatment;

(3) Development, management, and evaluation of the written resident care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the resident's care needs, promote recovery, and ensure the resident's health and safety;

(4) Observation and assessment of the resident's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the resident's need for possible medical intervention, modification of treatment, or both, to stabilize the resident's condition;

(5) Health education services provided by skilled technical or professional personnel to teach the recipient self care, such as gait training and self administration of medications;

(6) Provision of therapeutic diet and dietary supplement as ordered by the attending physician;

(7) Laundry service, including items of recipient's washable personal clothing;

(8) Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicator, tongue depressor, cotton ball, gauze, adhesive tape, band aids, incontinent pad, V-pad, thermometer, blood pressure apparatus, plastic or rubber sheet, enema equipment, and douche equipment;

(9) Durable medical equipment and supplies used by residents but which are reusable, such as ice bag, hot water bottle, urinal, bedpan, commode, cane, crutch, walker, wheelchair, and siderail and traction equipment;

(10) Activities of the resident's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well-being;

(11) Social services provided by qualified personnel;

(12) A review of the drug regimen of each resident at least once a month by a licensed pharmacist, as required for a nursing facility to participate in Medicaid;

(13) Nonrestorative or nonrehabilitative therapy, or both, provided by nursing staff; and

(14) Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. Other services that may be needed, such as transportation to realize the provision of services ordered by the attending physician, shall also be arranged through contractual agreements. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the NF and the person or entity that contracts to provide the service.

(15) Feeding assistance performed by a feeding assistant, nurse aide, or nurse. The feeding assistant must work under the supervision of a registered nurse or licensed practical nurse who is licensed to practice in Hawaii. [Eff 08/01/94; am 02/10/97; am 05/05/05; am 05/24/07] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 483.1) (Imp: 42 C.F.R.