



HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

DEPARTMENTAL MEMORANDUM

MAD-MR:

DATE:

TO: MEDICAL ASSISTANCE DIVISION

FROM: *NLS* NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: SHARI ROANHORSE-AGUILAR, BUREAU CHIEF, EXEMPT SERVICES AND PROGRAMS

BY: LINDA GILLET, BRAIN INJURY PROGRAM / ESPB

SUBJECT: BRAIN INJURY SERVICES FUND CRISIS INTERIM SERVICES REFERRAL FORM, MAD 751 ISSUED JUNE 2018

GENERAL INFORMATION

This form is for completion by contracted Service Coordination Agencies of the Brain Injury Services Fund for the purpose of requesting individual services to be paid through the contracted Fiscal Management Agency.

FILING INSTRUCTIONS

Please make the following replacements in the Medical Assistance Forms Manual:

INSERT MAD 751 Issued June 2018

Please address any questions concerning these guidelines to Lindab.gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 751 BISF CIS Referral Issued June 2018

NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM



SERVICE COORDINATION REFERRAL FORM - CRISIS INTERIM SERVICES

Initial: Renewal: Change in Service: Approved Extension: Reactivation: Service Discontinued:

A. PARTICIPANT INFORMATION: (Complete information required)

Social Security Number	Name Last	First	Initial
Address		City	State NM
Mailing Address (if different)		City	State NM
County	Region	Phone () -	
Other Payer Sources (insurance carrier; coverage; copay; if none, write "none")			

B. REQUESTED SERVICE PROVIDER OR VENDOR (Enter Name/Company, Address, Telephone, Contact Person)

1 st Choice
2 nd Choice
3 rd Choice

C. SERVICE/ITEM REQUESTED: (Use Notes Section for additional details)

Service or Item Description: (Select from drop-down menu)		Type of Request: <input type="checkbox"/> Pay Provider or Vendor <input type="checkbox"/> Reimburse Client	
ILP Span: / / - / /	Begin Date: / /	End Date: / /	ILP Quarter: (Check "Ext" if beyond one service year) Q1: <input type="checkbox"/> Q2: <input type="checkbox"/> Q3: <input type="checkbox"/> Q4: <input type="checkbox"/> Ext: <input type="checkbox"/>
Frequency: (e.g., 3x/month or 14 hours/week, etc.)	Duration: <input type="checkbox"/> per month <input type="checkbox"/> one-time		Total Cost: \$

Notes/Special Instructions:

Notes may include alternate providers of a service. For Homecare, ADLs and IADLs must be specified. A separate referral form is to be completed for each service and item requested. Exceptions: Multiple medications may be listed on one form; likewise, special equipment ordered with accessories. (See additional information in the Form Instructions.)

D. SERVICE COORDINATOR ELECTRONIC VERIFICATION:

Name	Agency/Region
Phone () -	Email

I, the undersigned Service Coordinator, have determined that the above named participant has no available resources and currently has no other means of paying for the unique goods or services requested on this form.

	/ /
BISF Service Coordinator Electronic Signature (See Form instructions for eSignature terms)	Date

E. FISCAL INTERMEDIARY AGENCY (FIA) AUTHORIZATION STATUS: (To be completed by FIA only)

Organization/Authorizing Individual: _____ Date Received: / /

Phone () - _____ Email _____

Request for Information (RFI):

Date: / /

The FIA has noted issues that prevent the processing of the referral submission, as indicated below. (Check all that apply in table below and provide details of missing, incomplete or incorrect information under Comments):

Referral Documentation:	Missing	Incomplete	Inaccurate
<input type="checkbox"/> MAD 751 CIS Referral form	☐	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Issues with Supporting Documentation (check appropriate boxes for each issue)			
Copy of HSD BI Program Manager's approval of extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of HSD BI Program Manager's approval of reactivation (only if reactivated within 6 months of inactivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactivation Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denial of Service Documentation (written; verbal, to be included in Section C "Notes")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Order for the specified therapy (new, upon expiration, or upon HSD BIPM approval of extension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment Verification Form for applicable physician services (new or upon HSD BIPM approval of extension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New/Updated ILP - signed by participant and SC, services listed (including Homecare ADLs), accurate costs, dates and frequencies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Application Pages (1 – 3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Program Release of Information – signed and dated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Signed Release of Liability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Comments:

Status of Requested Service/Item:

Vendor Declined

Reason/Notes:

Authorized

Date of Authorization: / /

Other notes:

Pending Authorization

Reason:

Final Date of Authorization: / / (to be completed and sent to SCA with update)

Other notes upon authorization:

Denied

Date of Denial: / /

Reason for Denial:

Enter Name of Organization and Certify:

(Organization Name) certifies the above noted status for the requested service/item.

_____ / /

BISF Fiscal Intermediary Agency Electronic Signature (See Form instructions for eSignature terms)

Date



Brain Injury Services Fund (BISF) Service Coordination Referral Form for Crisis Interim Services (CIS) Form Instructions

PURPOSE: The MAD 751 is for use by contracted Service Coordination Agencies and the Fiscal Intermediary Agency of the Brain Injury Services Fund (BISF) Program. It is to be completed by Service Coordinators to refer only those services which cannot be paid by any other payer source, and submitted to the BISF-contracted provider of Crisis Interim Services (CIS) Fiscal Intermediary Agency (FIA). The form will only be filled out and submitted to the contracted CIS-FIA when payment for a service by the BISF Program is being requested to cover an assessed need, which is corroborated on a current Independent Living Plan (ILP). The form will be accompanied by the MAD 767 Cover Sheet and any supporting documentation noted on the Cover Sheet. The MAD 751 will be certified by the CIS-FIA for date of receipt and status of the authorization. BISF Providers are referred to Standard Operating Procedure BISF 18-1 for additional procedural details.

INSTRUCTIONS:

- 1) Service Coordinators will indicate at the top of the referral whether it is for “Initial” set-up of a service; “Renewal” of service for another 90 days; “Change in Service” (e.g., frequency or identified provider); “Approved Extension” (beyond one service year); participant “Reactivation”; or when notifying of “Service Discontinued”.
- 2) The Service Coordinator will complete sections A – D, completing all fields.
- 3) Section A captures general participant information and identification of any other payer sources.
- 4) Section B allows for the indication of alternate providers and will be completed in order of participant preference.
- 5) Section C is to be completed with as much detail as possible and includes a “Notes” section.
 - a. Select applicable Service from the drop-down menu. If the service is not listed, but has been approved by the BISF Program, enter “Other”, provide description in the “Notes” section, and attach supporting documentation.
 - b. Specify the “Type of Request” for payment. Check “Reimburse Client” for direct reimbursement to the participant for copays, mileage or medications.
 - c. Enter the complete 90-day ILP span of the current quarter, as noted on the 90-day ILP.
 - d. Enter the “Begin Date” and “End Date” for the requested service; this will represent either the full span of the 90-day ILP or the dates for any mid-cycle change in the referral (less than 90 days). In no instance shall an “End Date” be entered for one year out from the start date.
 - e. Enter the “ILP Quarter” (Q1-Q4) in which services are to be delivered. Services approved for extension beyond one service year will be noted by also checking “Ext”. The HSD BISF Program Approval for Continued Services must be attached to any service referral indicating extension of services beyond one service year.
 - f. Enter the “Frequency” of a referred service to determine Total Cost.
 - i. Referrals which list “as needed” or “PRN” will not be accepted by the CIS-FIA. Referrals for such services may be submitted only when the need for the service is imminent, and must be entered as a “one-time” cost.

- ii. Requests for Assistive Technology that involve a one-time cost for a device must be referred separately from requests for ongoing purchase of consumables that are replaced periodically.
- g. Enter "Duration" as "per month" or "one-time".
- h. Enter "Total Cost" based on assessed Frequency and Duration and as derived from BISF Program Rate Sheets.
 - i. For services required month to month, "Total Cost" will require a monthly dollar value and a checkmark to the box marked "per month". Monthly costs will be assessed on the average of 4.33 weeks per month, as applicable to the service.
 - ii. For services, having a one-time cost, "Total Cost" will require that the dollar cost be entered and a checkmark to the box marked "one-time".
 - iii. The cost estimate will include sales tax, as represented on the BISF Program Rate Sheet, as part of the total cost of services. Sales tax does not need to be added when estimating the cost of reimbursements for mileage, medications, or physician services; nor is sales tax added when estimating the patient responsibility of fee for service (copays and coinsurance costs), when a participant has insurance that covers a referred service.
- e. "Notes" Section:
 - i. Requests for medication reimbursements must list the specific BISF formulary approved medications for which reimbursement is requested.
 - ii. Requests for Homecare must identify the specific ADLs and IADLs, for which a participant has been assessed by the SCA as having a need.
 - iii. Requests for transportation mileage reimbursement must include names of medical/therapy offices, starting and destination addresses and round trip miles.
 - iv. Other notes may be added by the SCA, as needed.
- 6) Section D requires the dated Service Coordinator signature, which may be handwritten or electronic, prior to submission.
- 7) Section E will be completed by the CIS-FIA to note accurate status of the referral with dates entered, where noted.
 - a. For "Vendor Declined", "Pending Authorization", and "Denied", reasons will be provided.
 - b. The Request for Information (RFI) section will be completed in the event that additional information is required, prior to processing of the referral, to specify paperwork that is missing, incomplete or inaccurate. The Comments section will include details about what is missing, incomplete or inaccurate.
- 8) Electronic Signatures in Section D and E. The SCA and FIA consent and agree that the respective use and submission of the electronic form constitutes the SC's and FIA's signature, acceptance and agreement as if actually signed by them in writing. Further, the SC/SCA and FIA agree that no certification authority or other third party verification is necessary to validate the electronic signature; and that the lack of such certification or third party verification will not in any way affect the enforceability of the signature or resulting contract between the SCA and the CIS-FIA or HSD.

ROUTING:

The form will be completed by the SCA and submitted to CIS-FIA contractor.

The original referral, as well as any updated referrals, will be filed in the participant's master case record by both the SCA and the CIS-FIA with accompanying ILPs, and will be referred back to as necessary.

FORM RETENTION:

Permanent