HUMAN SERVICES
DEPARTMENT

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

DEPARTMENTAL MEMORANDUM
MAD-MR: 18-15
DATE: 9/7/2018

TO: **MEDICAL ASSISTANCE DIVISION**

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

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

BY: **LINDA GILLET, BRAIN INJURY PROGRAM / ESPB**

SUBJECT: **BRAIN INJURY SERVICES FUND (BISF) PHYSICIAN'S ORDER, MAD 404 REVISED AUGUST 2018**

GENERAL INFORMATION

The MAD 404 is provided by the contracted Service Coordination Agency (SCA) of the Brain Injury Services Fund (BISF) to a Program participant's medical provider for the purpose of ordering a service/item that is deemed medically necessary to treat their patient's brain injury. The form was revised to include the following:

- Clear separation of the section to be completed by the medical provider from the introductory description about the BISF and the purpose of the form;
- Replacement of "ICD-9" with "ICD-10";
- Physician can specify a recommended frequency for the service/item or indicate that frequency will be determined by the provider of the service;
- A note at the bottom of the form specifies that a separate form is needed for each service/item and includes information about the form's expiration date; and
- Inclusion of a formal instructions page.

FILING INSTRUCTIONS

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

INSERT MAD 404 Revised August 2018
DELETE MAD 404 Issued 10-06-14

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

Attachment: MAD 404 Revised August 2018

HUMAN SERVICES DEPARTMENT

NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
Medical Assistance Division

PHYSICIAN'S ORDER FORM - CRISIS INTERIM SERVICES

FAX TO: Goodwill Industries of New Mexico • 505-884-3157
For Questions: Goodwill Industries of New Mexico • 505-881-6401 (Brain Injury Program)

Dear Attending Medical Provider,

Your patient, _____ DOB _____
may be eligible to receive assistance from the New Mexico Brain Injury Service's Fund (BISF) Program to pay for the following service/item: _____

In order for the BISF to cover this service/item, a statement is required from a licensed physician or other qualified medical professional, indicating that the service/item is necessary for the treatment of Brain Injury or symptoms resulting from a Brain Injury. (Brain Injury is defined as traumatic or other acquired brain injury, per approved program ICD-10 Codes.) Your statement confirms that the service/item is being ordered to address unmet rehabilitation needs that may be covered by the Program. If the need for the service/item meets these criteria, please complete and sign the following.

Physician's Order

For the patient named above, I am ordering _____ for the treatment of Brain Injury or symptoms resulting from Brain Injury. This service/item is needed in order to address my patient's unmet rehabilitation needs or otherwise address an immediate and imminent risk to my patient's health and safety. This service/item is being requested through the BISF, using available budget, due to the patient's lack of health insurance coverage or ability to pay.

☐ I am recommending a need for this service/item at the following frequency: _____
☐ I am recommending that frequency of the service/item be determined by the qualified provider, following their evaluation.

_____
Printed Name of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Address of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Phone Number of Physician, Physician Assistant, or Certified Nurse Practitioner

_____ _____
Signature of Physician, Physician Assistant, or Certified Nurse Practitioner Date

Please note: A separate Physician's Order Form is required for each service/item. The BISF Program cannot accept this form if more than one service/item appears on the lines above. In the event that multiple services/items are being referred for payment through BISF Crisis Interim Services, the physician may list these on his / her own letterhead or prescription form, clearly specifying the relationship between the services/items and the Brain Injury. If the physician does not specify an earlier expiration date, this order will automatically expire one year from the patient's program start date, program reentry date, or program-approved service extension date.

HUMAN SERVICES DEPARTMENT

NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM

PHYSICIAN'S ORDER FORM - CRISIS INTERIM SERVICES

Form Instructions

PURPOSE: The MAD 404 is a Physician's Order (PO) that is to be completed by a participant's medical provider for the purpose of ordering a service/item that is medically necessary to treat their patient's brain injury. The order may be fulfilled, only in the event that the participant lacks the needed health insurance coverage for the service and the BISF Program has available budget to cover related costs at the recommended frequency. The top portion is to be completed by the contracted Service Coordination Agency (SCA) of the Brain Injury Services Fund (BISF) Program; it introduces the Program and explains the purpose of the form. The portion of the form inside the box, representing the actual "Order", is to be completed by the participant's Medical Doctor/Physician, Physician's Assistant, or Certified Nurse Practitioner. BISF Program providers are directed to BISF SOP 18-1 Revised for information on completing related referrals.

INSTRUCTIONS:

The Service Coordinator (SC) will complete the top portion of the MAD 404 by entering the program participant's name, date of birth (DOB), and the service/item that is requested.

The portion of the MAD 404 inside the box is to be completed by the participant's Attending Physician, Physician's Assistant, or Certified Nurse Practitioner. The licensed Medical Professional will:

1) Enter the name of the service/item being ordered.
2) Check the appropriate box that specifies
    a. the recommended frequency of the service/item or
    b. that frequency will be determined by the provider of the service/item, following their evaluation.
3) Enter the attending medical professional's printed name, address and phone number.
4) Sign in ink and date. The BISF Program cannot accept an electronic signature.
5) Fax the form to the number provided for the SCA at the top of the form.

ROUTING:

The SCA will complete the top of the MAD 404 and send it to the Attending Physician's office. Following completion of the actual order by a licensed medical professional, the Physician's office will fax page 1 of the form to the office of the SCA. The SCA will submit POs for services requested as part of any service extension beyond one year to the HSD BISF Program Manager. As authorized, the SCA will submit the MAD 404 and any related referral documentation to the contracted Crisis Interim Services Fiscal Intermediary Agency (CIA-FIA) for fulfillment of the order. The MAD 404 Physician's Order will be retained by the SCA and CIS-FIA as part of the participant's file.

FORM RETENTION:

Permanent

Effective 07/01/2014

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
Exempt Services & Programs Bureau
Medical Assistance Division / Human Services Department
Phone: 1-505-827-7218

PHYSICIAN'S ORDER FORM - CRISIS INTERIM SERVICES

HelpNet LLC • PO Box 159 • Espanola, NM 87532 • Phone: 505-753-5794

Dear Attending Physician,

Your patient, _____ DOB _____ , may be eligible to receive funding from the New Mexico Brain Injury Services Fund (BISF) Program for the following item/service*.

_____

Before this fund can cover this item/service, a statement is required from a physician or other qualified medical professional, indicating that it is being ordered for treatment of Brain Injury or symptoms resulting from a Brain Injury (defined as traumatic or other acquired brain injury, per approved program ICD-9 Codes), and is being ordered to address immediate and imminent risk to the patient's health and safety. If you care to provide such a statement, please complete and sign the following.

Physician's Order

I confirm that I have ordered _____ for my patient, named above, for treatment of Brain Injury or symptoms resulting from Brain Injury, and that what I have ordered addresses immediate and imminent risk to my patient's health and safety.

_____
Printed Name of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Address of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Phone Number of Physician, Physician Assistant, or Certified Nurse Practitioner

_____ _____
Signature of Physician, Physician Assistant, or Certified Nurse Practitioner Date

MAD 404 Issued 10/06/14