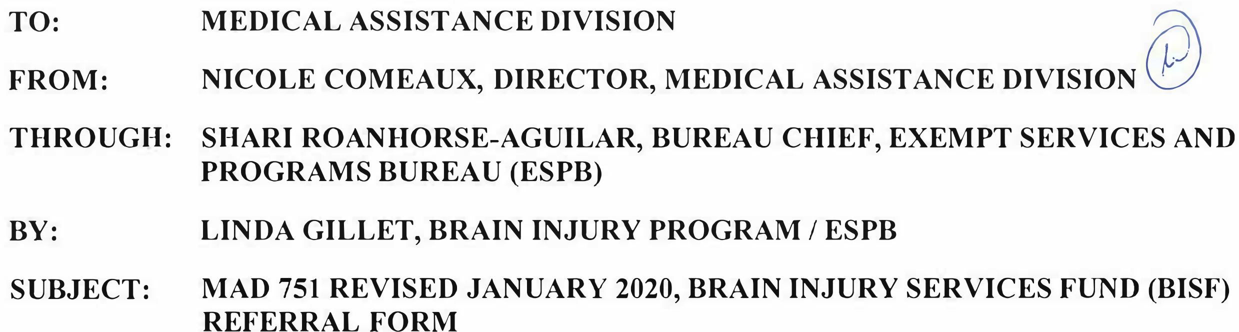
HUMAN SERVICES
DEPARTMENT

Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary Designate
Nicole Comeaux, J.D., M.P.H, Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 20-03
DATE: April 22, 2020



TO: **MEDICAL ASSISTANCE DIVISION**

FROM: **NICOLE COMEAUX, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

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

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

SUBJECT: **MAD 751 REVISED JANUARY 2020, BRAIN INJURY SERVICES FUND (BISF) REFERRAL FORM**

GENERAL INFORMATION

The MAD 751 is provided by the contracted Service Coordination Agency (SCA) of the Brain Injury Services Fund (BISF) for the purpose of requesting individual services to be paid through the contracted Fiscal Management Agency. The form was revised as follows:

- Form (page 1):
  - Replaced "Crisis Interim Services" with "Home and Community Based Services (HCBS);
  - Deleted "Renewal" and "Reactivation" as reasons to submit new referral;
  - Clarified language regarding other payer sources;
  - Clarified ILP Span and ILP Period and deleted "End Date" to correspond with semi-annual reviews; and
  - Under Section C, Notes:
    - Added language which allows an existing referral to be ongoing for an additional interim at the current frequency and cost, if there are no changes required in the service for up to one year.
    - Moved language regarding Homecare ADLs and IADLs, Assistive technology, and medications to the Instructions.
- Form (page 2):
  - Replaced "Crisis Interim Services" with "Home and Community Based Services (HCBS)" and
  - Deleted "Reactivation" and "Physician Order" paperwork requirements.
- Instructions (page 3-4):
  - Clarified language to correspond to changes noted on the form, as described above.

FILING INSTRUCTIONS

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

DELETE MAD 751 Issued June 2018
INSERT MAD 751 Revised January 2020

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

Attachment: MAD 751 Revised January 2020

MEDICAL ASSISTANCE DIVISION | PO BOX 2348 – SANTA FE, NM 87504 | PHONE: (505) 827-3100 FAX: (505) 827-3185

NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM

SERVICE COORDINATION REFERRAL FORM

BISF Home and Community Based Services (HCBS)

Initial: ☐ Change in Service: ☐ Approved Extension: ☐ Service Discontinued: ☐

A. PARTICIPANT INFORMATION: (Complete information required)

Social Security Number	Name Last	First		Initial
Address		City	State NM	Zip
Mailing Address (if different)		City	State NM	Zip
County	Region	Phone ( ) -		
Other Responsible Payer Sources (Federal/State program; insurance carrier; other; if none, write "none")				

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

1st Choice
2nd Choice
3rd Choice

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

Service or Item Description: (Select from drop-down menu)		Type of Request: ☐ Pay Provider or Vendor ☐ Reimburse Client
ILP Span Marking Initial/Changed Service: / / - / /	Begin Date: / /	ILP Period Marking Initial/Changed Service: Q1/Q2: ☐ Q3/Q4: ☐ Ext: ☐
Frequency: (e.g., 3x/month or 14 hours/week, etc.)	Duration: ☐per month ☐one-time	Total Cost: $
Notes/Special Instructions:		

Program Notes: A separate referral form is to be completed for each service and item requested, with exceptions as noted in the Instructions. The referral for this service, whether initial, changed, or under approved extension, is renewable at the designated frequency and cost, using the BISF Program's Recertification Process, as described in Standard Operating Procedures. It shall not expire until the end of a service year, or if there is a change in the service, or the service is being discontinued.

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 Name / Authorizing Individual:

Date Received: / /

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
☐ MAD 751 HCBS Referral form	X	☐	☐
☐ Issues with Supporting Documentation (check appropriate boxes for each issue)			
Copy of HSD BI Program Manager's approval of extension	☐	☐	☐
Reactivation Form	☐	☐	☐
Denial of Service Documentation (written; verbal, to be included in Section C "Notes")	☐	☐	☐
Treatment Verification Form for applicable physician services (new or upon HSD BIPM approval of extension)	☐	☐	☐
New/Updated ILP - signed by participant and SC, services listed (including Homecare ADLs), accurate costs, dates and frequencies)	☐	☐	☐
Application Pages (1 – 3)	☐	☐	☐
New Program Release of Information – signed and dated	☐	☐	☐
New Signed Release of Liability	☐	☐	☐
Other (specify):	☐	☐	☐

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 BISF HCBS
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 responsible payer source and submitted to the BISF-contracted Fiscal Intermediary Agency (FIA). The form will only be filled out and submitted to the BISF FIA when payment for a service by the BISF Program is being requested to cover an assessed need, which is corroborated on a related Independent Living Plan (ILP). The form will be accompanied by the MAD 767 Document Cover Sheet and any supporting documentation noted on the Cover Sheet. The MAD 751 will be certified by the BISF FIA for date of receipt and status of the authorization. The referral, whether initial, changed, or under approved extension, is renewable at the designated frequency and cost, using the BISF Program's Recertification Process, as described in Standard Operating Procedures, and shall not expire until the end of a service year, or if there is a change in the service or the service is discontinued. BISF Contractors are referred to Standard Operating Procedure BISF 18-1 or subsequent updates for additional procedural details.

INSTRUCTIONS:

1) Service Coordinators will indicate at the top of the referral whether it is for "Initial/Updated" set-up of a service; "Change in Service" (e.g., frequency or identified provider); "Approved Extension" (beyond one service year); 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 semi-annual ILP span of the current quarter, as noted on the semi-annual ILP.
    d. Enter the "Begin Date" for the requested service; this will mark the start of the initial or changed service or the date for any mid-cycle change in the referral. Enter the "ILP Semi-Annual Period" (Q1/Q2 or Q3/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.
    e. 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 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 or special equipment that involve a one-time cost for a device must be referred separately from requests for ongoing purchase of consumables that are

replaced periodically. Special equipment ordered with accessories may also be listed on one form as a one-time cost.

f. Enter "Duration" as "per month" or "one-time".

g. 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 4.4 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.

h. "Notes" Section:

   i. Requests for medication reimbursements must list the specific BISF formulary approved medications for which reimbursement is requested. Multiple medications may be listed on one form as a recurring cost.

   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 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 FIA or HSD.

ROUTING:

The form will be completed by the SCA and submitted to BISF FIA. 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 FIA with accompanying ILPs, and will be referred back to as necessary.

FORM RETENTION:

Permanent

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SERVICE COORDINATION REFERRAL FORM

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Initial: ☐ Change in Service: ☐ Approved Extension: ☐ Service Discontinued: ☐

A. PARTICIPANT INFORMATION: (Complete information required)				
Social Security Number	Name Last	First		Initial
Address	City		State NM	Zip
Mailing Address (if different)	City		State NM	Zip
County	Region	Phone ( ) -		
Other Responsible Payer Sources (Federal/State program; insurance carrier; other; if none, write "none")				

B. REQUESTED SERVICE PROVIDER OR VENDOR (Enter Name/Company, Address, Telephone, Contact Person)
1st Choice
2nd Choice
3rd Choice

C. SERVICE/ITEM REQUESTED: (Use Notes Section for additional details)		
Service or Item Description: (Select from drop-down menu)		Type of Request: ☐ Pay Provider or Vendor ☐ Reimburse Client
ILP Span Marking Initial/Changed Service: / / - / /	Begin Date: / /	ILP Period Marking Initial/Changed Service: Q1/Q2: ☐ Q3/Q4: ☐ Ext: ☐
Frequency: (e.g., 3x/month or 14 hours/week, etc.)	Duration: ☐per month ☐one-time	Total Cost: $
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Reason/Notes:

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