State of New Mexico
Medical Assistance Program Manual
Supplement

DATE: MARCH 16, 2017 **NUMBER: 17-03**

TO: PROVIDER TYPES 201, 202, 203, 301, 302, 303

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

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

SUBJECT: MAD 616 FEE FOR SERVICE OUT-OF-STATE PRIOR AUTHORIZATON REQUEST FORM

The Medical Assistance Division has implemented a new prior authorization form and instructions for Fee For Service (FFS) providers who request Out-of-State services. The purpose of this supplement is to implement the new FFS Out-of-State Service Prior Authorization MAD 616 form. The attached form will need to be completed in its entirety and submitted to the Third Party Assessor (TPA) for FFS members who require Out-of-State services.

Covered Out-of-State services are defined in 8.302.4.12 of the New Mexico Administrative Code (NMAC) and include medical and transplant services that cannot be provided within the State of New Mexico. Prior Authorization requests are initiated by the recipient's attending physician.

The MAD 616 form captures all required fields needed in order for the TPA to complete their review and issue a prior authorization.

This form will be mandatory for FFS Out-Of-State services prior authorizations effective April 1, 2017.

This form will be available on the following websites:

Qualis Health:
www.qualishealth.org

Medicaid Portal:
https://nmmedicaid.acsinc.com/static/ProviderInformation.htm#FormsPubs.

Questions regarding this supplement should be directed to La Risa Rodges, TPA UR Staff Manager (505) 827-7221 or email LaRisa.Rodges@state.nm.us.

FEE FOR SERVICE
OUT OF STATE SERVICES
PRIOR AUTHORIZATION REQUEST

SEND PA REQUESTS TO:
STATE OF NEW MEXICO
THIRD PARTY ASSESSOR (TPA)

SECTION A- GENERAL PATIENT INFORMATION

REQUEST DATE			
PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	NM MEDICAID ID NUMBER	DATE OF BIRTH	SEX ☐ M ☐ F
PATIENT MAILING ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)			

SECTION B- TREATING PROVIDER INFORMATION (TO BE COMPLETED BY REFERRING PHYSICIAN/FACILITY)

REQUESTING PHYSICIAN (NAME, ADDRESS, STATE, ZIP CODE)	
REQUESTING PHYSICIAN (PHONE NUMBER AND FAX NUMBER)	NEW MEXICO MEDICAID PROVIDER ID **(REQUIRED)**

SECTION C- SERVICING PROVIDER INFORMATION (TO BE COMPLETED BY REFERRING PHYSICIAN/FACILITY)

OUT OF STATE SERVICING PROVIDER/FACILITY/AGENCY (NAME, ADDRESS, STATE, ZIP CODE)	
OUT OF STATE SERVICING PROVIDER (PHONE NUMBER AND FAX NUMBER)	NEW MEXICO MEDICAID PROVIDER ID **(REQUIRED)**

SECTION D- REQUEST FOR TREATMENT OR SERVICE (SPECIFY FREQUENCY AND DURATION OF OUT OF STATE TREATMENT)

DATES OF SERVICE	FROM / / TO / /	
☐ INPATIENT CODE ☐ OUTPATIENT CODE	ICD 10 PROCEDURE CODE	UNITS/NUMBER REQUESTED
☐ INPATIENT CODE ☐ OUTPATIENT CODE	ICD 10 PROCEDURE CODE	UNITS/NUMBER REQUESTED
☐ INPATIENT CODE ☐ OUTPATIENT CODE	ICD 10 PROCEDURE CODE	UNITS/NUMBER REQUESTED

SECTION E- DIAGNOSIS, HISTORY AND MEDICAL JUSTIFICATION FOR REQUEST (IF APPLICABLE, ATTACH A SEPARATE SHEET OR COPY OF OFFICE RECORD)

DIAGNOSIS CODE (S)	
SIGNED MEDICAL ORDERS AND CLINICAL DOCUMENTATION ARE REQUIRED	
NAME AND TITLE OF PERSON COMPLETING FORM	PHONE NUMBER

- THIS AUTHORIZATION MUST BE ATTACHED WHEN FILING A CLAIM OR AUTHORIZATION NUMBER IS TO BE INSERTED IN THE APPROPRIATE BLOCK ON THE CLAIM FORM.
- THIS AUTHORIZATION IS SUBJECT TO THE PATIENT'S ELIGIBILITY FOR NEW MEXICO MEDICAID SERVICES AT THE TIME THE SERVICE IS RENDERED. THE PROVIDER SHALL VERIFY THE PATIENT'S ELIGIBILITY BEFORE RENDING SERVICE(S). IF THE PATIENT'S HEALTH CARE IS PROVIDED UNDER A MEDICAID MANAGED CARE ORGANIZATION (MCO), THE PROVIDER SHOULD NOT USE THIS FORM AND SHOULD CONTACT THE MCO DIRECTLY.
- THE PATIENT'S ELIGIBILITY MAY TERMINATE WITHOUT NOTIFICATION TO THE PROVIDER. TRANSFER OF THE PATIENT TO A NURSING HOME OR OTHER INSTITUTIONAL SETTING MAY CHANGE THE BENEFITS AVAILABLE TO THE PATIENT. THE PROVIDER MUST VERIFY THE STATUS OF THE APPROVAL WHEN SUCH A TRANSFER OCCURS.
- PAYMENT IS CONTINGENT ON PAYMENT LEVELS IN EFFECT ON THE DATE OF SERVICE. APPROVAL DOES NOT GUARANTEE PAYMENT LEVELS THAT MAY BE QUOTED AS PART OF THE APPROVAL REQUEST.
- AUTHORIZED SERVICES AND GOODS MUST BE PROVIDED ONLY WITHIN APPROVED DATES.

SECTION F- STATE OF NEW MEXICO THIRD PARTY ASSESSOR USE ONLY

DATE REVIEWED	☐ APPROVED ☐ DENIED	REVIEWER NAME	SERVICE AUTHORIZED FROM ____________ TO ____________	AUTHORIZATION NUMBER

Instructions for Medical Assistance Division (MAD) FFS OOS PA Request (MAD 616) Form

PURPOSE: The Out of State (OOS) Service Prior Authorization form (MAD 616) is used in the Medicaid Fee for Service (FFS) program to assess and issue prior authorizations (PA) for all out of state service requests for patients who are covered under the Fee for Service program. If the patient's health care is provided under a Medicaid Managed Care Organization (MCO), the provider should not use this form and should contact the MCO directly.

The completed form and any supplemental documentation is evaluated by the State of New Mexico Third Party Assessor (TPA) to determine if the patient meets the State's criteria for OOS services.

The requesting physician should complete this form and return it to the TPA for a prior authorization.

INSTRUCTIONS:

A – General Patient Information: This section must contain complete patient identifying and contact information. Date of submitted request, client name, Medicaid ID number, date of birth and gender must be clearly documented, in addition to the patient's mailing address.

B – Treating Provider Information: This section is to be completed by the referring physician/facility. This section must contain the requesting (referring) physician name address state and zip code. Enter the phone number and fax number in addition to the New Mexico Provider ID number. All fields in section B are mandatory.

C –Servicing Provider Information: This section is to be completed by the referring physician/facility. The Servicing provider (who the patient is being referred to) needs to be clearly documented along with the address, state, zip, phone and fax numbers and New Mexico Provider ID number. Please note that NM Medicaid Provider ID is a required field.

D –Request for Treatment or Service: Enter the dates of requested date of service. Identify each ICD 10 procedure code by marking inpatient or outpatient code. Enter the procedure code and number of units requested. Please note that the TPA cannot convert days into units, the requester should enter the number of units and attach medical orders and all pertinent clinical documentation.

E – Diagnosis, History and Medical Justification for Request: All diagnosis codes must be documented. The requestor should attach medical orders and all pertinent clinical documentation. Please print the name and title of the person completing the Out of State Service Request form and include a contact phone number. The TPA will reach out to this contact person if there are any missing documents or if more information is needed.

F- Third Party Assessor Use Only: The TPA will complete this section. The review date, outcome, TPA name, date authorized and authorization number fields will be completed by the TPA.