New Mexico Medicaid Checklist
Fee-for-Service (FFS) Prior Authorization

Request Types and Forms

Prior authorization forms are available on the NM Medicaid Portal:
https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm

The following forms are required for each request:

- New Mexico Uniform Prior Authorization Request Form (see page 2 for checklist)
  - DME
  - Therapies
  - Hearing aids
  - Vision
  - Nutritional supplements
  - Wound care
  - Outpatient surgery
  - Prosthetics and orthotics
  - Home health care
- MAD 302: Eye Services Prior Approval Request — Contact Lenses (see page 3 for checklist)
- No MAD form required for Vision/Eyeglasses – High power lenses & Polycarbonate lenses (add page #)
- MAD 331: Title XIX Request for Prior Approval — Inpatient Rehabilitation Services (see page 5 for checklist)

New Mexico Uniform Prior Authorization Form

Provider to submit NM Uniform Prior Authorization form and supporting documentation.

☐ NM Uniform Prior Authorization form with the following sections completed:

1. Priority and Frequency — only one may be selected
   - Standard
     Indicate the service scheduled date in this section.
   - Urgent/Expedited
     Provider to certify that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.
   - Frequency: Initial or Extension
     If the request is an extension to the previous authorization, the existing prior authorization number must be provided.

2. Enrollee Information
   - Enrollee name
   - Enrollee date of birth
   - Subscriber/Member ID # (Medicaid ID Number)
   - Enrollee street address
   - City
   - State
   - Zip code

3. Provider Information — Provider must indicate if the request is for the ordering provider, rendering provider or both and complete the following sections:
   - Provider name
   - Provider type/specialty
   - Administrative contact
   - NPI #
     The NM Provider ID is also required in this section.
   - DEA # (not applicable)
     Leave this field blank as it pertains to pharmacy reviews only. Pharmacy requests are not reviewed by Comagine Health.
   - Clinic/facility name
   - Clinic/pharmacy/facility street address
   - City, State, Zip code
   - Phone number and extension
   - Facsimile/Email

4. Requested medical or behavioral health course of treatment/procedure/device information
   - Service description
   - Setting/CMS POS Code: Outpatient, Inpatient, Home, Office or Other
   - Please specify if other

5. HCPCS/CPT/ICD-10 Codes **– Please ensure all submitted codes are active – if inactive codes are submitted this will result in claims not being paid or a denial.**
   - Latest ICD-10 Code
   - HCPCS/CPT/CDT Code
   - Medical Reason

6. Frequency/Quantity/Repetition Request
   - Does this service involve multiple treatments?
     If this question is marked "No," the rest of Section 6 is not required.
   - Type of Service
   - Name of therapy/agency
   - Units/Volume/Visits requested
     Units must be converted prior to submission.
   - Frequency/length of time needed

7. Not required. This section is used for prescription drugs only.

8. Attestation
   Requester's signature and date must be completed (MD, DO, NP, PA).

9. Supporting medical documentation:
   - ☐ Home Health Requests: Provide Discharge Summary with Plan of Care signed and dated by provider; please request in Rev Codes.
   - ☐ Physical Therapy Requests:
     - ☐ Include the initial signed provider order or new order for continuing treatment.
     - ☐ Provide the Plan of Care Evaluation to include treatment goals and home exercise plan for both initials and continued therapies.
     - ☐ Include number of weeks for treatment requested.

MAD 302: Eye Services Prior Approval Request — Contact Lenses

Provider to submit MAD 302 form and clinical notes.

☐ Clinical notes must be included with submission.

☐ MAD 302 form with the following sections completed:

- Patient Information
  - Name
  - ID Number
  - Medicaid ID Number or SSN
  - Sex
  - Date of Birth
  - Street Address
  - City
  - State
  - Zip Code
- Provider
- Ordering Physician's Name, Address, Zip Code
- Use Snellen Notation
  - Prior Rx Date
    - Distance — R and L eye
    - Near or Add — R and L eye
  - VA with Old Rx
    - Distance — R and L eye
    - Near or Add — R and L eye
  - VA No Rx
    - Distance — R and L eye
    - Near or Add — R and L eye
  - New Rx Date
    - Distance — R and L eye
    - Near or Add — R and L eye
  - Corrected VA
    - Distance — R and L eye
    - Near or Add — R and L eye
- Comments/Justifications
- Date of Exam
- Provider Name
- Provider Signature

Eye Services Prior Approval Request — High Power Lenses and Polycarbonate Lenses

The following information must be included with CHPP submission:

- Contact Name
- Contact Phone Number
- Recipient's Information
  - Name
  - ID Number
  - Date of Birth (must be 21 or older)
  - Date of Prescription (must be written within one year of submission)
  - Provider ID
  - Procedure Codes

    Note: Check to see if prior authorization is required for each code before submitting request. Call Customer Service to check if a PA is needed.
  - Number of units requested for each procedure code requested
  - Recipient's prescription on business letterhead
  - Clinical notes or justification must be included with exception submissions for less than 36 months for replacement lenses

MAD 331: Title XIX Request for Prior Approval — Inpatient Rehabilitation Services

Provider to submit MAD 331 form and supporting documentation.

☐ MAD 331 form with the following sections completed:

- Patient's Name
- Medicaid ID
- Date of Birth
- Sex
- Diagnosis
- Admitting Facility Name/Address/Zip Code
- NM Medicaid Provider ID Number
- NPI Number
- Taxonomy Number
- Date of Onset of Disability (if known)
- Has this patient been treated at this facility before?
- Name of Referring Physician
- Assessment of Patient's Disabilities
  Indicate or provide documentation. If providing documentation, enter "See Attached" in this section.
- Description of Comprehensive Rehabilitation Plan
  Indicate or provide documentation. If providing documentation, enter "See Attached" in this section.
- Goals of Therapy
  Indicate or provide documentation. If providing documentation, enter "See Attached" in this section.
- Number of days of Inpatient Rehabilitation Request
- Indicate if request is for evaluation only
- Physician Signature

☐ History and Physical (medical admissions record)

☐ Pre-admission summary

☐ Progress notes — To/From dates required

☐ Discharge summary from hospital

- ☐ Social services assessment
- ☐ Discharge planning
- ☐ PT/OT/ST evaluations with recommendations and goals
  - ☐ All therapies must have documentation of the patient response and participation.
  - ☐ PT: Include patient response or participation. Document that the patient was a full participant in the therapy offered in the hospital.
- ☐ Respiratory therapy orders and interventions
  - ☐ Respiratory status (chest PT, O2, hi flow, NIPPV, etc.)

Requesting provider/facility to submit additional information/documentation as applicable:

- ☐ Schedule of outside appointments
- ☐ Ventilator settings (if any)
- ☐ Neuro status (Glasgow scale, seizures, etc.)
- ☐ Mental status (sitter, chemical/physical restraints, etc.)
- ☐ Lab values
- ☐ Diagnostics (imaging, etc.)
- ☐ Vital signs (current day of admit or w/in previous 24 hours)
- ☐ Nutrition (related labs, weight loss, other factors (fistula, etc.))
- ☐ Wounds (if any)
  - ☐ Measurements
  - ☐ Wound care orders
  - ☐ Adjunctive wound therapies
- ☐ Infection (if any)
  - ☐ Type of infection
  - ☐ Treatment date
  - ☐ Treatment started
  - ☐ Treatment