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MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR **ABSORBENT PRODUCTS**

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Sections 1, 2, 3, and 4 may be completed by the provider of DME or the prescribing provider. Section 5 must be completed by the provider of DME. Sections 4A, 6, and 7 must be filled out by the prescribing provider.

SECTION 1

Member Name			Date of Delivery / /	
Address			Telephone No.	
City			State	Zip
MassHealth ID No.	Date of Birth / /	Gender	Height	Weight
Primary ICD-9 Code	Description			
Secondary ICD-9 Code	Description			

SECTION 2

Prescribing Provider's Name		NPI
Address		
Telephone No.	Fax No.	

SECTION 3

Name of provider of DME		NPI
Address		
Telephone No.	Fax No.	

SECTION 4

Place checkmark beside item requested and enter the appropriate size, HCPCS code, and modifier.

SECTION 4 A

Must be completed by prescribing provider

Item Requested	Size	HCPCS Code	Modifier	Daily Units	No. of Monthly Refills	Length of need
☐ 1. Diaper: ☐ Reusable ☐ Disposable ☐ Adult ☐ Child						
☐ 2. Pull-up/Pull-on: ☐ Reusable ☐ Disposable ☐ Adult ☐ Child						
☐ 3. Insert/liner						
☐ 4. Disposable underpad/bedpad:						
☐ 5. Reusable underpad/bedpad:						

6. Is this a **request to exceed the quantity limits** for any absorbent product? . . . . . ☐ Yes ☐ No

   If yes, current prior-authorization (PA) no.: _____

   If yes, documentation must be submitted in accordance with Section 6, Question 11.

7. Is this a **request to change the size** of absorbent products? . . . . . ☐ Yes ☐ No

   If yes, current PA no.: _____

continued on back ➔

Member Name: _____

SECTION 5
Provider of DME Attestation, Signature, and Date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and it is true, accurate and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material contained herein.

Signature of provider of DME (Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of provider — Date

Printed legal name of individual signing (if the provider is a legal entity)

SECTION 6
Section 6 must be completed by the member's prescribing provider or his or her staff. Complete all applicable questions and attach any pertinent information (i.e., lab tests, medical history and physical examination, clinical notes, etc.). Please check all boxes that apply for each question.

Answer Questions 1 – 6 for all requests for absorbent products.

1. Member presents:
   - ☐ Stress incontinence
   - ☐ Urge incontinence
   - ☐ Mixed incontinence
   - ☐ Overflow incontinence
   - ☐ Total/functional incontinence
   - ☐ Indeterminable incontinence
   - ☐ Fecal incontinence
   - ☐ Other (specify) _____

2. Has a focused medical history and targeted physical exam been performed to detect factors contributing to incontinence, that, if treated, could improve or eliminate incontinence? (See *MassHealth Guidelines for Medical Necessity Determination for Absorbent Products* for specific contributing factors.). . . . . ☐ Yes ☐ No
   (If yes, attach medical history and physical exam).

3. Risk factors identified for developing incontinence:
   - ☐ Urological disorder
   - ☐ Impaired cognitive function
   - ☐ Neurological disorder
   - ☐ Impaired mobility
   - ☐ Other (specify) _____

4. The following tests/exams have been conducted:
   (Please attach results.)
   - ☐ Urinalysis/culture sensitivity
   - ☐ Urological test/consultation
   - ☐ Rectal examination
   - ☐ Pelvic examination (women)
   - ☐ Developmental assessment and prognosis (children)

5. Have treatments (for example, behavioral techniques, pharmacologic therapy, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? . . . . . ☐ Yes ☐ No
   (If yes, attach clinical evidence of such treatment(s), treatment results, and member's responsiveness.)

6. Is it the prescribing provider's determination that the product is necessary to manage observable symptoms of incontinence in circumstances where the member or caregiver (family member or guardian) refuses to have a medical history taken, physical exam conducted, and/or treatments accepted for incontinence? (Documentation that the member or caregiver refused medical history, examination and/or treatments "against medical advice" must be provided.) . . . . . ☐ Yes ☐ No

Answer Question 7 if requesting pull-up/pull-on absorbent briefs.

7. Does the member have a condition that causes incontinence and is he or she participating in or has participated in a toilet-training program? . . . . . ☐ Yes ☐ No

If it is impractical for the member to participate in a toilet-training program, list reason(s) here:

Does the member have the cognitive and physical ability to pull up and take off briefs on his or her own? . . . . . ☐ Yes ☐ No

Is the member bed-ridden? . . . . . ☐ Yes ☐ No

Member Name:

Answer Question 8 if requesting absorbent liners/inserts.

8. Does the member report light or infrequent incontinence? ☐ Yes ☐ No

Answer Question 9 if requesting any type of absorbent underpads/bedpads.

9. Is the member using absorbent products and does the member report leakage? ☐ Yes ☐ No

Does the member report leakage when there is an indwelling catheter? ☐ Yes ☐ No

Is the member able to reposition independently? ☐ Yes ☐ No

Answer Question 10 if requesting both reusable and disposable underpads/bedpads.

10. Does the member report high volume of urine or fecal leakage ☐ Yes ☐ No

Please provide additional documentation if requesting a number of units that exceed the maximum allowable.

11. Clinical documentation must be submitted to justify the medical need for a quantity of absorbent product that is above the allowable limit set forth in the *MassHealth DME and Oxygen Payment and Coverage Guidelines Tool*. Refer to *MassHealth Guidelines for Medical Necessity Determination for Absorbent Products*, Clinical Coverage, Section II.A.12, for criteria justifying a number of units that exceed the maximum allowable.

SECTION 7
Prescribing Provider's Attestation, Signature, and Date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in Section 2 of this form. Any attached statement on my letterhead or assessment on this form has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.):

Check applicable credentials: ☐ MD ☐ NP ☐ PA

Printed name of prescribing provider: Date / /

Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Absorbent Products

Sections 1, 2, 3, and 4 may be completed by the provider of DME or the prescribing provider.

Instructions for the Use of this Form	Providers of DME are instructed to use this form when obtaining a Prescription and Letter of Medical Necessity from the member's prescribing provider for absorbent products, and as an attachment to a prior-authorization (PA) request for absorbent products. Providers of DME are responsible for ensuring compliance with applicable MassHealth regulations and guidelines when using this form. MassHealth reserves the right not to accept the form if it is completed improperly, or if the provider has failed to meet applicable MassHealth regulations, requirements, and guidelines, including without limitation medical necessity requirements. Please refer to the *MassHealth Guidelines for Medical Necessity Determination for Absorbent Products* for further information about required clinical documentation and information that must be submitted for PA requests for absorbent products. A copy of this completed form (including all attachments and supporting documentation) must be maintained in the member's medical record at the prescribing provider's office and at the provider of DME's office.
Section 1	Enter the date of delivery of the absorbent products at the top of the form. The date of delivery on this form must match the date on the delivery slip required under 130 CMR 409.419. Enter the member's name, address (including apartment number, if applicable), telephone number, MassHealth member ID number, date of birth, gender, height, weight, and applicable ICD-9 diagnosis code(s) with their descriptions. Once the delivery has been made, enter the date of the delivery in the date of delivery field in the upper right corner of Section 1.
Section 2	Enter the prescribing provider's name, NPI, address, and telephone and fax numbers.
Section 3	Enter the name of provider of DME, NPI, address, and telephone and fax numbers.
Section 4	Place a checkmark beside the item requested. Enter the size, HCPCS code(s), and modifier(s).
Section 5	The provider of DME must sign and enter the date the form was completed in Section 5. By signing the form, the provider is making the certifications contained above the signature line. **Note: Signature and date stamps, or the signature of anyone other than the DME provider or a person legally authorized to sign on behalf of a legal entity (if the provider of DME is a legal entity), are not acceptable.**
Sections 4A, 6, and 7 must be completed by the prescribing provider	
Section 4A	The prescribing provider must enter the total number of monthly units, monthly refills, and expected duration of use of absorbent products by the member.
Section 6	The member's prescribing provider or his or her staff must answer questions 1-6 if requesting any type of absorbent product. Answer question 7 if requesting pull-up or pull-on absorbent briefs. Answer question 8 if requesting absorbent inserts or liners. Answer question 9 if requesting disposable or reusable absorbent underpads/bedpads. Answer question 10 if requesting disposable and reusable underpad/bedpads to be used in conjunction with each other. Answer question 11 if requesting quantities of absorbent products that exceed the limits in the *MassHealth DME and Oxygen Payment and Coverage Guidelines Tool*. **Section 6 must be filled in, and applicable supporting documentation must be attached.**
Section 7	The member's prescribing provider listed in Section 2 of this form is required to review all information completed on and attached to this form, and must sign and date the form. By signing the form, the prescribing provider is making the certifications contained above the signature line. **The form must be signed by the member's prescribing provider, who must be either the member's physician (MD), nurse practitioner (NP), or physician assistant (PA). The prescribing provider must check the applicable credential(s). Note: Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.**

If you have any questions about how to complete this form, please contact MassHealth Customer Service at **1-800-841-2900**.