MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR HOSPITAL BEDS

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 (shaded below), 6, and 7 must be completed by the prescribing provider. Failure to complete all sections may result in a denial.

SECTION 1

Date of Delivery	Member Name			
Address			Telephone No.	
MassHealth ID No.	Date of Birth	Gender	Height	Weight
Primary ICD Code	Description			
Secondary ICD Code	Description			

SECTION 2

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

SECTION 3

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

SECTION 4

Place checkmark beside item requested and enter the appropriate HCPCS code, modifier, and description of equipment.

SECTION 4A

Item Requested	HCPCS Code	Modifier	Description of Equipment	Duration of Need (months)
☐ 1. Fixed height hospital bed				
☐ 2. Variable height hospital bed				
☐ 3. Semi-electric hospital bed				
☐ 4. Total electric hospital bed				
☐ 5. Heavy duty, extra wide hospital bed (with weight capacity greater than 350 pounds, but less than or equal to 600 pounds)				
☐ 6. Extra heavy duty, extra wide hospital bed (with weight capacity greater than 600 pounds)				
☐ 7. Manual, pediatric hospital bed Is a safety enclosure required? ☐ yes ☐ no				
☐ 8. Electric or semi-electric pediatric hospital bed Is a safety enclosure required? ☐ yes ☐ no				
☐ 9. Pediatric crib Is a safety enclosure required? ☐ yes ☐ no				

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 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 fact contained herein.

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

_____Date:_____

Printed legal name of provider:

_____

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

_____

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Member Name: _____

SECTION 6

Section 6 must be completed by the member's prescribing provider or his or her staff. Complete all applicable items. If you answer "yes" to any question in this section, you must provide an appropriate explanation. Also provide clinical documentation (e.g., lab tests, medical history and physical examination, clinical notes, etc.) supporting medical necessity.

Answer Questions 1-4 if requesting any type of hospital bed. The member must meet one or more of the following four criteria (questions 1-4), below.

1. Does the member have a medical condition that requires positioning of the body in ways not feasible with an ordinary bed? ☐yes ☐no

   If yes, please explain and attach any supporting clinical documentation. Provide justification of the need for a hospital bed for positioning and the degree of elevation that is required. Include member's functional status (e.g., bed mobility, transfers, ambulation, etc.).

2. Does the member have a medical condition that requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain? ☐yes ☐no

   If yes, please explain and attach any supporting clinical documentation. Provide justification of the need for a hospital bed and describe the type of positioning that is required to alleviate pain.

3. Does the member have a medical condition that requires the head of the bed to be elevated more than 30 degrees most of the time? ☐yes ☐no

   a. If yes, please explain and attach any supporting clinical documentation. Explain the need for elevation that is greater than 30 degrees.

   b. Please describe any attempts at using pillows or wedges and the results of those attempts.

4. Does the member have a medical condition that requires traction or other equipment, which can only be attached to a hospital bed? ☐yes ☐no

   If yes, please explain and attach any supporting clinical documentation. Specify the equipment to be used, what the equipment is to be used for, and for how long.

Answer Question 5 if requesting a variable-height hospital bed or a total electric hospital bed.

5. Does the member's medical condition require a bed height different from a fixed-height hospital bed to permit transfers to a chair, wheelchair, or standing position? ☐yes ☐no

   If yes, please explain and attach any supporting clinical documentation.

Answer Question 6 if requesting a semi-electric or total electric hospital bed.

6. Does the member have a medical condition that requires frequent and/or immediate changes in body position? ☐yes ☐no

   a. If yes, please explain and attach any supporting clinical documentation. Provide a description of the medical condition(s) requiring frequent and/or immediate changes in body position.

   b. Please submit clinical documentation to include the member's level of function (e.g., bed mobility, transfers, ambulation, etc.) and note if the member is cognitively capable of operating the controls, including use of adaptive equipment to operate the bed. Specify the adaptive equipment needed to operate the bed, if any.

Answer Question 7 if requesting a total electric hospital bed.

7. Is the total electric hospital bed the least costly medically appropriate alternative for the member's care? ☐yes ☐no

   If yes, please explain and attach supporting clinical documentation.

Answer Question 8 if requesting a heavy duty, extra wide hospital bed.

8. Is the member's weight more than 350 pounds, but does not exceed 600 pounds? ☐yes ☐no

   If yes, the member's prescribing provider must enter the member's current weight in this section: _____

Answer Question 9 if requesting an extra heavy duty, extra wide hospital bed.

9. Does the member's weight exceed 600 pounds? ☐yes ☐no

   If yes, the member's prescribing provider must enter the member's current weight in this section: _____

Answer Questions 10-12 if requesting an enclosed pediatric hospital bed or crib.

10. Does the member have a medical condition that puts the member at risk for falling out of or seriously injuring him/herself while in an ordinary bed or standard hospital bed? ☐yes ☐no

    a. If yes, please explain and attach supporting clinical documentation. Provide justification of need for a safety enclosure.

    b. Please describe any attempts to use side rail padding and the results of those attempts.

11. Does the member have a history of behavior involving unsafe mobility that puts the member at risk for serious injury while in an ordinary bed or standard hospital bed? ☐yes ☐no

    If yes, please explain and attach supporting clinical documentation, including history of behavior involving unsafe mobility and history of injuries or risk that have occurred up to this request.

12. Were less costly alternatives (e.g., wearing a protective helmet) tried and unsuccessful or contraindicated? ☐yes ☐no

    If yes, please explain and attach supporting clinical documentation.

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 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 fact contained herein.

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

_____ Date: _____

Check applicable credentials: ☐MD ☐NP ☐PA

Printed name of prescribing provider: _____

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Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Hospital Beds

Sections 1, 2, 3, and 4 must 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 completed by 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 hospital beds, and as an attachment to a prior authorization (PA) request for hospital beds. 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 Hospital Beds* for further information about required clinical documentation and information that must be submitted for PA requests for hospital beds. 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 hospital bed. The date of delivery on this form must match the date on the delivery slip required under 130 CMR 409.419. Please note that the effective start date for prior authorization cannot be before the date the form was completed by the prescribing provider (Section 7), regardless of the date of the delivery. Enter the member's name, address (including apartment number if applicable), telephone, MassHealth member ID, date of birth, gender, height, weight, and applicable ICD diagnosis code with their descriptions.
Section 2	Enter the prescribing provider's name, NPI, address, telephone, and fax number
Section 3	Enter the name of provider of DME, NPI, address, telephone, and fax number.
Section 4	Place a checkmark beside the item requested. Enter the HCPCS code(s), modifier(s), and description of equipment.
Section 5	The provider of DME must sign and enter the date the form was completed. By signing the form, the provider is making the certifications contained above the signature line. Signature and date stamps, the signature of anyone other than the provider of DME 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 months that he/she expects the member is expected to require use of the item requested
Section 6	The member's prescribing provider or the provider's staff must answer questions 1-4 of Section 6 if requesting any type of hospital bed. In addition, if you are requesting a • variable height hospital bed, question 5 must be answered; • semi-electric hospital bed, question 6 must be answered; • total electric hospital bed, questions 5-7 must be answered; • heavy duty, extra wide hospital bed, question 8 must be answered; • extra heavy duty, extra wide hospital bed, question 9 must be answered; • enclosed pediatric hospital bed or crib, questions 10-12 must be answered. Section 6 must be completed and applicable supporting documentation must be attached.
Section 7	The member's prescribing provider listed in Section 2 of this form must 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). 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.