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, City, State, ZIP code				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
Address, City, State, ZIP code	
Telephone No.	Fax No.

SECTION 3

Name of provider of DME	NPI
Address, City, State, ZIP code	
Telephone No.	Fax No.

SECTION 4

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

SECTION 4A

Must be completed by prescribing provider.

Item Requested	Size	HCPCS Code	Modifier	Daily Units	No. of Monthly Refills	Length of Need
☐ 1A. Diaper: Standard absorbency product ☐ Reusable ☐ Disposable ☐ Adult ☐ Child						
☐ 1B. Diaper: Premium absorbency product ☐ Reusable ☐ Disposable ☐ Adult ☐ Child PROVIDER: When requesting a premium absorbency product, you must establish medical necessity in the document you submit.						
☐ 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 15.

7. Is this a **request to change the size** of absorbent products? . . . . . ☐ Yes ☐ No
   If yes, current PA no.: _____

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 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.

DME provider's signature (Wet and electronic signatures are acceptable. 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.)

For wet signature, print legal name of provider Date / /

SECTION 6
Section 6 must be completed by the member's prescribing provider or their staff. Complete all applicable questions and attach any pertinent information (such as lab tests, medical history and physical examination, or clinical notes). 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 could improve or eliminate incontinence if treated? (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 any treatments, their results, and the member's responsiveness.)

6. Has the prescribing provider determined that the product is necessary to manage observable symptoms of incontinence if the member or caregiver (family member or guardian) refuses to have a medical history taken, a physical exam conducted, and/or treatments accepted for incontinence? (Provide documentation that the member or caregiver has refused medical history, examination, and/or treatments "against medical advice.") . . . . . ☐ Yes ☐ No

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

7. Does the member have a condition that causes incontinence, and are they participating or have they 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:

Is the member unable to leave their bed? . . . . . ☐ 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 either reusable or disposable underpads/bedpads.

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

Answer Questions 11–14 (and 15 if applicable) if requesting a premium absorbent brief or diaper for a member.

11. Has the member tried to use a standard absorbent product offered by MassHealth to meet their incontinence needs before requesting a premium absorbent product? ☐ Yes ☐ No

12. Does the member report leakage when using a MassHealth standard absorbent product? ☐ Yes ☐ No

13. Does the member have a history of skin breakdown? ☐ Yes ☐ No

14. Does the member access the community regularly? ☐ Yes ☐ No

15. Are you requesting a quantity of absorbent products that exceeds 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, General Information, Section I for information about requesting more than the maximum allowable number of units.) ☐ Yes ☐ No
If so, you must submit clinical documentation to justify the medical need for the quantity ordered.

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 herein.

Prescribing provider's signature (Wet and electronic signatures are acceptable; signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable):

Check applicable credentials: ☐ MD ☐ NP ☐ PA ☐ CNS

For wet signature, print legal name of 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 DME provider or the prescribing provider.

Instructions for the Use of This Form	Providers of DME should use this form when obtaining a Prescription and Letter of Medical Necessity from the member's prescribing provider for absorbent products, 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 DME provider's office.
Section 1	Once the absorbent products have been delivered, enter the delivery date in the Date of Delivery field in the upper right corner of Section 1. This date 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 ID number, date of birth, gender, height, and weight, as well as the applicable ICD diagnosis code(s) with their descriptions.
Section 2	Enter the prescribing provider's name, NPI number, address, telephone number, and fax number.
Section 3	Enter the name of provider of DME, NPI number, address, telephone number, and fax number.
Section 4	Place a checkmark beside the item requested. Enter the size, HCPCS code(s), and modifier(s). MassHealth has adopted minimum standards and premium quality standards established by the National Association for Continence to meet our members' incontinence needs. The premium quality standards should be considered when medical necessity has been determined and less costly options—such as standard quality briefs and diapers—have been considered/trialed and ruled out.

Section 5	The DME provider must sign and enter the date the form was completed. By signing the form, the provider is making the certifications listed above the signature line. **The signature of anyone other than the DME provider, or a person legally authorized to sign on behalf of a legal entity (if the DME provider is a legal entity), is not acceptable.** Wet signatures and electronic signatures as defined below and in Durable Medical Equipment Provider Bulletin 31 are acceptable. MassHealth will accept provider signatures executed by an authorized signatory in any of the following formats: 1. Traditional "wet signature" (ink on paper) 2. Electronic signature that is either a. hand drawn with a mouse or finger on a touchscreen device; or b. an uploaded picture of the signatory's hand drawn signature. 3. Electronic signatures added with an appropriate digital tool, including, but not limited to a. Adobe Sign b. DocuSign If used, electronic signatures must be visible, must include the signatory's name and title, and must be accompanied by a signature date. One of the following notes must be included to indicate that the signatory's name, usually applied in typed format, was electronically signed: a. electronically signed by b. authenticated by c. approved by d. completed by e. finalized by f. signed by g. validated by h. sealed by
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, the total number of monthly refills, and the expected duration of use of absorbent products.
Section 6	The member's prescribing provider or their staff must answer Questions 1–6 and attach any applicable supporting documentation 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 any type of absorbent underpads/bedpads. Answer Question 10 if requesting either disposable or reusable underpad/bedpads. Answer Questions 11–14 if requesting a premium absorbent brief or diaper. Answer Question 15 if requesting quantities of absorbent products that exceed the limits in the MassHealth DME and Oxygen Payment and Coverage Guidelines Tool.
Section 7	The prescribing provider listed in Section 2 of this form must review all information on and attached to this form and must sign and date the form. By signing the form, the prescribing provider is making the certifications listed above the signature line. The prescribing provider must be the member's physician (MD), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). The prescribing provider must check the applicable credential(s). Wet signatures and electronic signatures as defined in Durable Medical Equipment Provider Bulletin 31 are acceptable. Please also refer to Section 5 above for information and requirements for wet and electronic signatures.

If you have any questions about how to complete this form, please contact the MassHealth Customer Service Center at 1-844-368-5184.

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