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 completed by the prescribing provider.

SECTION 1

Member Name			Date of Delivery	
Address			Telephone	
MassHealth ID	Date of Birth	Gender	Height	Weight
Primary ICD Code	Description			
Secondary ICD Code	Description			

SECTION 2

Prescribing Provider's Name	NPI
Address	
Telephone	Fax

SECTION 3

Name of Provider of DME DELIGHT MEDICALS INC	NPI 1164736146
Address 1032 EASTERN AVE MALDEN MA 02148	
Telephone 781-435-0570	Fax 781-357-1922

SECTION 4

Place checkmark beside item requested and enter the appropriate size, HCPCS code, and modifier. See Section 4 of instruction page for daily allowable units for each product.

SECTION 4A

(Must be completed by prescribing provider)

Item Requested	Size	HCPCS Code	Modifier	Daily Units	No. of Refills	Length of need
1. Brief/Diaper: ☐ Reusable ☐ Disposable ☐ Adult ☐ Child ☐ Brief/Diaper: Standard performance product ☐ Brief/Diaper: Premium performance product **PROVIDER: Medical necessity must be established in the documentation submitted when requesting a premium performance brief/diaper. See Section 6.11.**						
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) number: .....
   If yes, documentation must be submitted in accordance with Section 6, Question 11.

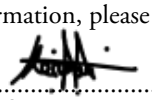
Reset form

Member Name _____

7. Is this a request to change the size of absorbent products? ☐ Yes ☐ No
   If yes, current prior authorization (PA) number: .....

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 contained herein.
For more information, please refer to Durable Medical Equipment Bulletin 31 and instructions for Section 5.



....
DME Provider's Signature Date

(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 DELIGHT MEDICALS ..... 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 (e.g., 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
- ☐ 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:
- ☐ Genito urological or gynecological disorders
- ☐ Lower gastrointestinal tract disorder
- ☐ Impaired cognitive function
- ☐ Neurological disorder
- ☐ Impaired mobility
- ☐ Increasing age
- ☐ Obesity
- ☐ 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 to manage symptoms of incontinence been tried and failed or been partially successful? (For example, behavioral techniques, pharmacologic therapy, and/or surgical intervention)

☐ 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?

☐ Yes ☐ No

(Documentation that the member or caregiver refused medical history, examination and/or treatments "against medical advice" must be provided.)

Member Name

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 in or have participated in toilet-training? ☐ Yes ☐ No

If it is impractical for the member to participate in toilet-training, list reason(s) here. ☐ Yes ☐ No

Is the member bedridden? ☐ Yes ☐ No

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.

Answer Question 11 if requesting premium performance absorbent products (brief/diaper) products for your member.

11. Has member attempted to utilize or ruled out standard performance brief/diapers and reports frequent urine or fecal leakage that causes unsanitary conditions? ☐ Yes ☐ No

Has member had to double up on products, such as using standard performance brief/diaper and a liner/insert in attempts to achieve appropriate coverage? ☐ Yes ☐ No

Does member access the community frequently, requiring a premium performance brief that allows for multiple wettings? ☐ Yes ☐ No

Is the member at risk for or have a history of skin breakdown? ☐ Yes ☐ No

12. 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 and listed below in Section 4 of the instruction page. Refer to MassHealth Guidelines for Medical Necessity Determination for Absorbent Products, Clinical Coverage, Section II.A., 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 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.
For more information, refer to Durable Medical Equipment Bulletin 31 and instructions for Section 7.

Prescribing provider's signature ..... Date .....

(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

If 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 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.

Instructions for using 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 in Section 1 at the top of page one of this form must match the date of initial delivery on the delivery slip in accordance with 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 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 number, address, telephone, and fax numbers.
Section 3	Enter the DME provider's name, NPI number, address, telephone, and fax numbers.
Section 4	Place a checkmark beside the item requested. Enter the size, HCPCS code(s), and modifier(s). MassHealth has adopted minimum quality requirements for standard performance absorbent products (briefs/diapers) in 2018 and has implemented minimum quality requirements for premium performance products (briefs/diapers) in 2021 based on those of the National Association for Continence (NAFC). Premium performance absorbent products (brief/diaper) should be considered when medical necessity has been determined and less costly options, standard performance products (briefs/diapers), have been ruled out. Absorbents' Allowable Units: **Briefs/Diapers:** • allowable units: 8 per day or 248 per month (standard performance) • allowable units: 6 per day or 180 per month (premium performance) • allowable units: 5 per 3 months (reusable) **Protective underwear/Pull-on products:** • allowable units: 8 per day or 248 per month (disposable) • allowable units: 5 per 3 months (reusable) **Inserts/liners:** • allowable units: 8 per day or 248 per month **Underpad/bedpad/mattress protector:** • allowable units: 8 per day or 248 per month (disposable) • allowable units: 2 per month (reusable)

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. **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) is not acceptable. Wet signatures or electronic signatures as defined below and in Durable Medical Equipment 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 using a mouse or finger if working from a touch screen device b. An uploaded picture of the signatory's hand-drawn signature 3. Electronic signatures affixed using a digital tool such as, but not limited to: a. Adobe Sign b. DocuSign If the provider using an electronic signature, the signature must be visible, include the signatory's name and title, and must be accompanied by a signature date. One of the following notations must be included to indicate that the signatory's name, typically applied in typed format, was electronically signed. • Electronically signed by • Authenticated by • Approved by • Completed by • Finalized by • Signed by • Validated by • 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, monthly refills, and expected duration of use of absorbent products by the member.
Section 6	The member's prescribing provider or their 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 an premium performance absorbent brief/diaper. Answer question 12 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 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), clinical nurse specialist (CNS), or physician assistant (PA). **The prescribing provider must check the applicable credential(s). Wet signatures or electronic signatures as defined in Durable Medical Equipment 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 **(844) 368-5184.**