# MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Review Form for Therapeutic Shoes, Inserts, and Modifications

*Use this form for diabetics.*

## Section 1 *(must be completed by the provider or the prescriber)* **Date of Delivery:** _____

Member's Name: _____ MassHealth ID No.: _____
Address: _____ Telephone No.: _____
Date of Birth: _____ Gender: ☐ M ☐ F Height: _____ Weight: _____

*At least one of the ICD codes listed below must clearly indicate one of the conditions listed in Section 5.*

Primary ICD Code: _____ Description: _____
Secondary ICD Code: _____ Description: _____
Provider's Assessment: _____

## Section 2 *(must be completed by the provider or the prescriber)*

Prescriber's Name: _____ NPI: _____
Address: _____
Telephone No.: _____ Fax: _____

## Section 3 *(must be completed by the provider or the prescriber)*

Provider's Name: _____ NPI: _____
Address: _____
Telephone No.: _____ Fax: _____

## Section 4 *(must be completed by the provider or the prescriber) (Invoice required for all Individual Consideration (IC) items)*

| HCPCS | Modifier | Description of Product | Manufacturer | Model No. | Invoice? |
|---|---|---|---|---|---|
| | | | | | ☐ Y ☐ N |
| | | | | | ☐ Y ☐ N |
| | | | | | ☐ Y ☐ N |
| | | | | | ☐ Y ☐ N |
| | | | | | ☐ Y ☐ N |

Provider's Signature: _____ Date: _____

## Section 5 *(Must be completed by the member's treating prescriber or his/her staff)*

ICD codes must clearly indicate one of the conditions listed below (please indicate which foot). Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

1. Patient has diabetes mellitus (ICD diagnosis codes E08.00 through E13.9); AND
2. Patient has one or more of the following conditions. (Please check one or more of the following.)

☐ a. Previous amputation of the other foot, or part of either foot
☐ b. History of previous foot ulceration of either foot
☐ c. History of pre-ulcerative calluses of either foot
☐ d. Peripheral neuropathy with evidence of callus formation of either foot
☐ e. Foot deformity of either foot (must clearly indicate the foot deformity)
☐ f. Poor circulation in either foot

## Section 6 *(Must be signed by the member's treating prescriber)*

### Prescriber's Attestation and Signature/Date

I certify that I am the treating prescriber for this patient, and that I am treating this patient for diabetes mellitus and associated foot problems. I have reviewed and confirm that the summary of the assessment and diagnosis above in Section 1 is accurate. I attest that the products listed on this form are appropriate to meet my patient's medical needs. I certify, to the best of my knowledge, that the medical necessity information on this form is true, accurate, and complete. 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. I attest my patient's medical record has adequate documentation to corroborate all information on this prescription and that this documentation will be retained in my patient's medical record and, in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth members corresponding to, or documenting the services claimed, in accordance with M.G.L. c. 118E, §38, and 130 CMR 450.205.

**Prescriber's Signature:** _____ **Date:** _____
Check applicable credential: ☐ MD ☐ DO **(Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.)**



Clear Print

(over ►)

# Instructions for Completing the MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Review Form for Therapeutic Shoes, Inserts, and Modifications for Diabetics

**Sections 1, 2, 3, and 4 must be completed by the provider or the prescriber.**

**Instructions** This form was created to include all the elements contained in 130 CMR 442.409 and 428.409 (Prescription Requirements) in the orthotics and prosthetics regulations, and will also meet the requirements found in 130 CMR 442.423 and 428.423 (Recordkeeping Requirements). Providers are required to use this form for any service code listed in the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool that indicates a shoe form is required. This revised form serves as both the prescription and letter of medical necessity and must be maintained in the member's medical record at the treating prescriber's office and at the provider's office.

**Section 1** Enter the member's name, MassHealth member ID, address (including apartment number if applicable), telephone, date of birth, gender, height, weight, and applicable diabetic ICD diagnosis code(s) with their descriptions. If the ICD codes listed in Section 1 do not indicate a diagnosis of diabetes mellitus, MassHealth will deny the claim or the PA. The provider must include his/her assessment of the foot deformity for the items being dispensed.

**Section 2** Enter the member's treating prescriber's name, NPI, address, telephone, and fax number.

**Section 3** Enter the orthotic and prosthetic provider's name, NPI, address, telephone, and fax number.

**Section 4** Enter the HCPCS, modifiers, description of products, manufacturer, model number of items being dispensed. Check Y or N to indicate whether an invoice is attached. (An invoice is required for all items requiring individual consideration (IC).) A provider signature is required along with the signature date.

**Section 5 and 6 must be completed by the treating prescriber or his/her staff.**

**Section 5** The member's treating prescriber (physician (MD) or doctor of osteopathy (DO)) must confirm that he/she is treating the member for one of or more of the ICD diagnosis codes listed in Sections 1 and 5 on the form (E08.00 through E13.9). The prescriber (or his/her staff) must circle one or more of the conditions listed in Section 5.

**Section 6** The treating prescriber listed in Section 2 of this form is required to review all the information completed in Sections 1, 2, 3, and 4 by the provider for medical necessity. The prescriber's signature signifies that all information contained on the form is accurate to the best of his or her knowledge and agrees that the products identified on the form are medically necessary for the member. The prescriber must maintain a copy of the MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Review Form in the member's medical record. **Only the member's physician (MD) or Doctor of Osteopathy (DO) may sign Section 6 of this form**.

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