MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR AMBULATORY INFUSION PUMPS (Insulin Pumps) and CONTINUOUS GLUCLOSE MONITORS (CGMs)

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

Sections 1, 2, 3, 4, 5, and 6 must be completed by the provider of durable medical equipment and supplies (DME).
Section 7 must be completed by the prescribing provider or their employee. Section 8 must be completed by the prescribing provider.

SECTION 1

Member Name			Date of Delivery	
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 Insulin Pumps and CGMs Only. Please enter the appropriate HCPCS code, modifier, and description of equipment.

(This section is used only for HCPCS E0784 and A9278)

Description of Item(s) Being Requested	HCPCS Code	Modifier

SECTION 5 Insulin Pumps and CGM Supplies Only. Please enter the appropriate HCPCS code, modifier, and description of the supplies.

(This section is used only for HCPCS E1399U3, E1399U4, A9274, A9276, A9277)

Description of Item(s) Being Requested	HCPCS Code	Modifier

SECTION 6 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 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..... Date .....

Member Name _____

SECTION 7

Section 7 (1) or (2) and questions 3-13 must be completed in their entirety by the member's prescribing provider or the provider's staff. Please attach any pertinent information (for example, lab tests, medical history and physical examination, or clinical notes, etc.).

(1) Ambulatory Infusion Pumps (Insulin Pumps)

Length of Need for Insulin Pump .....
Quantity Monthly (Catheters) ..... Quantity Monthly (Cartridges).....
OmniPods Quantity Monthly..... V-Go Quantity Monthly ..... Refills .....

(2) Continuous Glucose Monitors (CGMs)

Length of Need for CGM Only .....
Quantity Monthly (Transmitters)..... Refills ..... (**note:** *refill should equal length requested date range*)
Quantity Monthly (Sensors)..... Refills .....

(3) What co-morbidities are present?

☐ Retinopathy..... ☐ Nephropathy.....
☐ Neuropathy ..... ☐ Other .....

(4) What was the date of the member's most recent HbA1c? ..... What was the value? .....
Other relevant tests (specify) .....

(5) How many injections of insulin does the member self-administer a day?

☐ One to three times a day ☐ Three to six times a day ☐ Six to nine times a day ☐ 10 or more times a day
☐ Other (specify) .....

(6) Does the member frequently adjust their insulin dosage? ☐ Yes ☐ No
Please explain how often the dosage is adjusted.....
How long has the member been adjusting their dosage of insulin? .....

(7) Does the member have a history of recurring hypoglycemia? ☐ Yes ☐ No
How often? .....

(8) Does the member have wide fluctuations in blood glucose before mealtime? ☐ Yes ☐ No
Please list the three most recent ranges before mealtime
From ..... to ..... mg/dL From..... to ..... mg/dL From..... to ..... mg/dL

(9) Does the member have dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL? ☐ Yes ☐ No
How often in the last 30 days?

(10) Does the member have a history of severe glycemic excursions? ☐ Yes ☐ No
If yes, please explain .....

(11) Does the member have a history of prior treatment with MDIs (multiple daily injections) that have been tried and not been effective in managing blood sugars or medical symptoms? ☐ Yes ☐ No
If yes, please explain .....

(12) Is the member motivated to maintain optimal control of their diabetes? ☐ Yes ☐ No

(13) Member has been hospitalized or required paramedical treatment for low blood sugar in the last six months ☐ Yes ☐ No

Member Name _____

SECTION 8
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.

....
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

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

Clear Print

Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Insulin Pumps and CGMs

Sections 1, 2, 3, 4, 5, and 6 must be completed by the provider of DME. Section 7 must be completed by the prescribing provider or their employee. Section 8 must be completed by 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 Insulin Pumps, and CGMs as an attachment to a prior authorization (PA) request for insulin pumps and CGMs and supplies. 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 Diabetes Management Devices: Continuous Glucose Monitoring Systems and Insulin Pumps* for further information about required clinical documentation and information that must be submitted for PA requests for insulin pumps and CGMs. 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 insulin pumps or CGMs at the top of the form. The date of delivery on this form must match the date on the delivery slip. Enter the member's name, MassHealth member ID, address (including apartment number if applicable) telephone, date of birth, gender, height, weight, and applicable ICD diagnosis code(s) with their descriptions.
Section 2	Enter the prescribing provider's name, NPI, address, telephone, and fax number.
Section 3	Enter name of provider of DME, NPI, address, telephone, and fax number.
Section 4	Enter the description of the insulin pump or CGM being requested, please use the correct HCPCS code(s) below: **E0784:** External ambulatory infusion pump, insulin **A9278:** Receiver (monitor), external for use with interstitial continuous glucose monitoring system Please do not list insulin pump or CGM supplies in Section 4, but separately complete Section 5 for that purpose.
Section 5	Enter the description of the insulin pump and CGM supplies being requested, if any, along with the correct HCPCS code(s) and modifiers below: **E1399U3:** Supplies for maintenance of insulin infusion pump, catheter each, (used for MassHealth members instead of A4224) **E1399U4:** Supplies for external insulin infusion pump, syringe type cartridge, sterile each (used for MassHealth members instead of A4225) **A9274:** External ambulatory insulin delivery system, disposable, each includes all supplies and accessories **A9276:** Sensor, invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system. **A9277:** Transmitter, external for use with interstitial continuous glucose monitoring system.

Section 6

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), are not acceptable. Wet signatures or electronic signatures as defined below and in 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 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 an appropriate digital tool including, but not limited to:
   a. Adobe Sign
   b. DocuSign

If 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

Section 7 must be completed by the prescribing provider or their employee.

Section 7

The member's prescribing provider or their staff must complete section 7 in its entirety. Please include the number of equipment/supplies ordered, length of need, and medical justification for the requested product(s). Additional supporting documentation must be attached.

Section 7 (1)

	Infusion Pump catheters	**Infusion Pump cartridges**
Quantity monthly, if changing every 3 days.	10	10
Quantity monthly, if changing every 2 days.	15	15

Section 7 (2)

	Transmitters	**Sensors**	**Refills**
Dexcom quantity monthly	1 every 3 months	3 per month	12 months
Medtronic quantity monthly	1 every 12 months	5 per month	12 months
Libre quantity monthly	N/A	2 per month	12 months

Section 8 must be completed by the prescribing provider.

Section 8

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 Provider Bulletin 31 are acceptable. Please also refer to Section 6 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** (toll free).