MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR **GAIT TRAINERS**

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

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 6 and 7 must be filled out 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	NPI
Address	
Telephone	Fax

SECTION 4

Description of Item(s) Being Requested	HCPCS Code	Modifier
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

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 refer to the 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 Date

Reset form

Member Name _____

SECTION 6

Section 6 must be completed 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).

1. Is the member able to stand upright with assistance and have some lower-extremity and trunk strength? ..... Yes ☐ No ☑
2. Is the member unable to ambulate due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities? ..... Yes ☐ No ☑
3. Does the member have lower-extremity contractures that preclude ambulation? ..... Yes ☐ No ☑
4. Does the member have adequate range of motion (ROM) to support mobility? ..... Yes ☐ No ☑
5. Is the alignment of the member's lower extremity such that the foot and ankle can tolerate a standing position as well as independent reciprocal movement? ..... Yes ☐ No ☑
6. Does the member have complete paralysis of the hips and legs? ..... Yes ☐ No ☑
7. Does the member have improvement in mobility, weight bearing, ambulation, function, or physiologic symptoms, or has the member maintained status with the use of the selected gait trainer (for example, used in inpatient or outpatient setting) and is able to follow a home therapy program incorporating the use of the gait trainer? ..... Yes ☑ No ☐
8. Does the member have a home therapy plan outlining the use of the requested gait trainer and affirming that there is a caretaker who can appropriately supervise the use of the gait trainer? ..... Yes ☑ No ☐
9. Does the member have the cognitive ability to functionally ambulate with the support of a gait trainer? ..... Yes ☐ No ☑

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.
Refer to the 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

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

Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Gait Trainers

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 6 and 7 must be filled out 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 gait trainers, and as an attachment to a prior authorization (PA) request for gait trainers. 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 Gait Trainers for further information about required clinical documentation and information that must be submitted for PA requests for gait trainers. 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 that the items were dispensed to the member. (To be completed once the service has been provided.) 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, 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 numbers.
Section 3	Enter the name of DME provider, NPI, address, telephone, and fax numbers.
Section 4	Enter the HCPCS code(s), the modifier(s), and a description of the gait trainer.
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 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 is 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
Sections 6 and 7 must be completed by the prescribing provider.	
Section 6	The member's prescribing provider or the provider's staff must complete the medical justification for the requested product(s). Complete this section and attach applicable supporting documentation.

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 above and 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 LTSS Provider Service Center at **(844) 368-5184.**