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 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

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.

Signature of provider of DME (Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.):

Printed legal name of provider:	Date / /
Printed legal name of individual signing (if the provider is a legal entity)	

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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 contained herein.

Note: Signature and date stamps or the signature of anyone other than the prescribing provider are not acceptable.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.):

Check applicable credentials: ☐ MD ☐ NP ☐ PA

Printed name of prescribing 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.

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 on this form must match the date on the delivery slip required under 130 CMR 409.000 and 450.000. 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 provider of DME, 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	Providers of DME must sign the form and enter the date the form was completed. By signing the form, the provider is certifying the information above the signature line. **Note: 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 (if provider of DME is a legal entity), are not acceptable.**
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). **This section must be completed, 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 certifying the information 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), or physician assistant (PA). The prescribing provider must check the applicable credential(s).**

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