MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR **SUPPORT SURFACES**

Print Reset

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

All sections of this form must be completed by the prescriber and submitted with the MassHealth Prior Authorization Request. Providers should submit this form in place of the MassHealth General Prescription Form when requesting prior authorization for support surfaces. Please refer to the instructions for completing this form provided at the end of this document. Please print or type all sections.

1. Member Name
2. Member's MassHealth ID no. | 3. Member's DOB
4. Member's address
5. Primary diagnosis | 6. Secondary diagnosis

Signs and symptoms (Use attachments as needed.)

7. Wound type(s)
☐ Stage 1 pressure ulcer ☐ Stage 2 pressure ulcer ☐ Stage 3 pressure ulcer ☐ Stage 4 pressure ulcer
☐ Other (describe) _____

8. Wound photo(s)
☐ Photo attached ☐ Patient refused photo ☐ Diagram attached
☐ Other (specify) _____

9. Wound description	Wound #1	Wound #2	Wound #3	Wound #4
Wound stage(s)				
Location				
Length (cm)				
Width (cm)				
Depth (cm)				
Color				
Drainage				
Tunneling				
Undermining:				

Risk factors (Use attachments as needed.)

10. Functional status
☐ Complete immobility ☐ Limited mobility ☐ Ambulates with ____ (#) assist ☐ Transfers with ____ (#) assist
☐ Chairbound ☐ Other (describe) _____

11. Mental status
☐ Alert ☐ Comatose ☐ Dementia ☐ Depression or psychosis
☐ Other (describe) _____

12. Comorbid condition(s)
☐ Neurologic (describe) _____ ☐ Degenerative (describe) _____ ☐ Malnutrition ☐ Depression or psychosis
☐ Other (describe) _____

Diagnostic evaluation (Use attachments as needed.)

13. Nutritional status
Height _____ Weight _____ IBW _____
Enternal supplements _____ TPN supplements _____

14. Incontinence status
☐ Bladder/urine ☐ Bowel/stool ☐ Catheter
☐ Other (describe) _____

15. Drugs affecting wound healing
☐ Oral (describe) _____ ☐ Topical (describe) _____

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16. Wound care plan includes (Use attachments as needed.)

☐ Nutritional intervention ☐ Incontinence management ☐ Moisture management ☐ Pain management
☐ Wound treatments (describe) _____
☐ Other (describe) _____

17. Outcome of treatment plan

a. Over past month, the member's pressure ulcer(s) have	☐ Improved	☐ Remained the same	☐ Worsened
b. Has a conservative treatment program been tried without success?	☐ Yes	☐ No	☐ Does not apply
c. Was comprehensive assessment performed after failure of conservative treatment?	☐ Yes	☐ No	☐ Does not apply
d. Is there a trained full-time caregiver to assist patient and manage all aspects involved with use of support surface?	☐ Yes	☐ No	☐ Does not apply

18. Location where member will use item(s)

☐ Home ☐ Work ☐ Other (specify) _____

19. Duration of need (number of days)

☐ Less than 30 ☐ 30-60 ☐ 60-90 ☐ Other (specify) _____

20. Type of support surface(s)

☐ Mattress overlay system (powered) ☐ Mattress overlay system, nonpowered ☐ Pressure pads (gel or dry)
☐ Air-fluidized bed ☐ Air-flotation bed, powered ☐ Semi-electric bed with mattress ☐ Total electric bed with mattress
☐ Other (specify) _____

21. Description of equipment

_____
_____
_____
_____
_____

22. DME provider

Company name _____ Address _____
MassHealth provider no. (if available) _____ Telephone no. (if available) _____

23. Prescriber

Name _____ Address _____
Telephone no. _____ MassHealth Provider no. _____
Provider UPIN _____

24. Person completing form on behalf of prescriber

Name _____ Title _____
Telephone no. _____ Organization _____

25. Attestation

I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

_____ _____
Prescriber's attestation (signature) Date (mm/dd/yy)

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Instructions: Complete all applicable fields on the form. Print or type all sections.

Item 1	Member's Name	Enter the member's name as it appears on the MassHealth card.
Item 2	Member's MassHealth ID no.	Enter the member's MassHealth identification number, which appears beside the member's name on the MassHealth card.
Item 3	Member's DOB	Enter the member's date of birth in month/day/year order.
Item 4	Member's address	Enter the member's permanent legal address (street address, town, and zip code).
Item 5	Primary diagnosis	Enter the primary diagnosis name and ICD code that correspond to the condition for which the support surface is being requested.
Item 6	Secondary diagnosis	Enter the secondary diagnosis names and ICD codes (up to 3 codes) that correspond to other medical conditions associated with the need for the requested support surface. Enter "N/A" if not applicable.
Item 7	Wound type(s)	Place a checkmark beside all wound types that apply. If checking "Other," specify the type not listed (for example, non-healing wound) in the space provided. Use attachments as needed.
Item 8	Wound photo(s)	Place a checkmark beside all types of documentation provided. If checking "Other," specify the type of documentation in the space provided. Attach the applicable documentation for each item checked.
Item 9	Wound description	For each wound, enter in the spaces provided, the wound stage, location, size (length, width, depth), color, drainage, tunneling, and undermining. Use attachments as needed.
Item 10	Functional status	Place a checkmark beside all statuses that apply. If checking "Other," specify the status not listed in the space provided. Attach clinical information about all items checked.
Item 11	Mental status	Place a checkmark beside all statuses that apply. If checking "Other," specify the condition not listed in the space provided. Attach clinical information as needed.
Item 12	Comorbid condition(s)	Place a checkmark beside all conditions that apply. When indicated, specify the conditions in the space provided. Attach clinical information about all items checked.
Item 13	Nutritional status	Enter member's height in inches, weight in pounds, ideal body weight (IBW) in pounds, and type of enteral and parenteral supplements used. Attach clinical information as needed.
Item 14	Incontinence status	Place a checkmark beside all that apply. If checking "Other," specify the status not listed in the space provided.
Item 15	Drugs affecting wound healing	Place a checkmark beside all that apply. Describe the types of oral or topical medications affecting wound healing in the space provided.
Item 16	Wound care plan includes	Place a checkmark beside all that apply. If checking "Wound treatments," describe the treatments used (for example, calcium alginates or hydrogel). If checking "Other," describe the treatments not listed.
Item 17	Outcome of treatment plan	Place a checkmark beside the appropriate response for each question asked.
Item 18	Location where member will use item(s)	Place a checkmark beside all locations that apply to use of the product requested. If checking "Other," specify the location (for example, skilled nursing facility, end stage renal disease facility) in the space provided.
Item 19	Duration of need (number of days)	Enter total number of days that prescriber expects the member to require use of the items requested. If "other" is checked fill in blank.
Item 20	Type of support surface	Place a checkmark beside all requested items. If checking "Other," specify the type of support surface not listed in the space provided.
Item 21	Description of equipment	Enter a description of the item(s) requested (for example, accessories, supplies, or options).
Item 22	DME provider	Enter the company name and address of the provider who will supply the support surface(s) being requested. If available, also provide the DME provider's telephone number and MassHealth provider number.
Item 23	Prescriber	Enter the physician's/clinician's name, address, and telephone number where he or she can be contacted if more information is needed. Include the prescriber's MassHealth provider number, or if the prescriber is not a MassHealth provider, enter the prescriber's unique physician identification number (UPIN).
Item 24	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse or wound-care specialist) or a physician employee answers any of the items listed he or she must print his or her name, professional title, and name of employer (organization) where indicated.
Item 25	Attestation	The prescriber must attest that the clinical information provided on the form is accurate and complete to the best of the prescriber's knowledge by signing this field.

Note: Prior-authorization requests with incomplete medical necessity documentation may be returned for more information or denied. Please refer to the MassHealth Guidelines for Medical Necessity Determination for Support Surfaces for further information about submitting required clinical documentation.