MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Review Form for Foot Orthoses, Footwear, and Modifications

Use this form for non-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: _____
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 No.: _____
Address: _____
Telephone No.: _____ Fax No.: _____

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

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

Section 4 (*must be completed by the provider or the prescriber*) (*Invoice required for all 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*)

Medical justification for requested products: _____

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 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: _____

Check applicable credential: ☐ MD ☐ NP ☐ DO ☐ DPM ☐ PA **Date:** _____

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

Instructions for Completing the MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Review Form for Foot Orthoses, Footwear, and Modifications

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 when submitting a prior authorization (PA) request for non-diabetic or, if no PA is required, when submitting a claim to MassHealth. Providers may consult the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool to determine which service codes require this form. 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 ICD codes with their descriptions. The provider must include their assessment of the foot disorder/deformity for the items being dispensed.

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

Section 3 Enter the orthotics or prosthetics provider's name, NPI, address, telephone, and fax number.

Section 4 Enter the appropriate service code (HCPCS), modifier, description of product, manufacturer, and model number of item being dispensed. Check Y or N to indicate whether an invoice is attached. (An invoice is required for all IC items.) A provider signature is required along with the signature and date.

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

Section 5 The member's treating prescriber or his/her staff must complete the medical justification for the requested product. This section must be filled in.

Section 6 The member's 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 indicates 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 for Foot Orthoses, Footwear, and Modifications in the patient's medical record. The form must be signed by the member's physician (MD), nurse practitioner (NP), doctor of osteopathy (DO), podiatrist (DPM), or physician assistant (PA).

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