



Medical Necessity Review Form for Support Surfaces

If you choose to submit this form with your request for prior authorization, the form must be completed by the prescriber and have a copy of the prescription attached. 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 name and ICD-9-CM code:			6. Secondary diagnosis name and ICD-9-CM code:		
Signs and symptoms (Use attachments as needed.)					
7. Wound type(s) <input type="checkbox"/> Stage 1 pressure ulcer <input type="checkbox"/> Stage 2 pressure ulcer <input type="checkbox"/> Stage 3 pressure ulcer <input type="checkbox"/> Stage 4 pressure ulcer <input type="checkbox"/> Other (describe): _____			8. Wound photo(s) <input type="checkbox"/> Photo attached <input type="checkbox"/> Patient refused photo <input type="checkbox"/> Diagram attached <input type="checkbox"/> 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 <input type="checkbox"/> Complete immobility <input type="checkbox"/> Limited mobility <input type="checkbox"/> Ambulates with _____ (#) assist <input type="checkbox"/> Transfers with _____ (#) assist <input type="checkbox"/> Chairbound <input type="checkbox"/> Other (describe): _____		11. Mental status <input type="checkbox"/> Alert <input type="checkbox"/> Comatose <input type="checkbox"/> Dementia <input type="checkbox"/> Depression or psychosis <input type="checkbox"/> Other (describe): _____		12. Comorbid condition(s) <input type="checkbox"/> Neurologic (describe): _____ <input type="checkbox"/> Degenerative (describe): _____ <input type="checkbox"/> Malnutrition <input type="checkbox"/> Contractures <input type="checkbox"/> Other (describe): _____	
Diagnostic evaluation (Use attachments as needed.)					
13. Nutritional status Height: _____ Weight: _____ IBW: _____ Enternal supplements: _____ TPN supplements: _____		14. Incontinence status <input type="checkbox"/> Bladder/urine <input type="checkbox"/> Bowel/stool <input type="checkbox"/> Catheter <input type="checkbox"/> Other (describe): _____		15. Drugs affecting wound healing <input type="checkbox"/> Oral (describe): _____ <input type="checkbox"/> Topical (describe): _____	
16. Wound care plan includes (Use attachments as needed.):					
<input type="checkbox"/> Nutritional intervention		<input type="checkbox"/> Wound treatments (describe): _____			
<input type="checkbox"/> Incontinence management		_____			
<input type="checkbox"/> Moisture management		_____			
<input type="checkbox"/> Pain management		<input type="checkbox"/> Other (describe): _____			
17. Outcome of treatment plan					
a. Over past month, the member's pressure ulcer(s) have:			<input type="checkbox"/> Improved	<input type="checkbox"/> Remained the same	<input type="checkbox"/> Worsened
b. Has a conservative treatment program been tried without success?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Does not apply
c. Was comprehensive assessment performed after failure of conservative treatment?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Does not apply
d. Is there a trained full-time caregiver to assist patient and manage all aspects involved with use of support surface?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Does not apply
18. Location where member will use item(s): <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other (specify): _____					
19. Duration of need (number of days): <input type="checkbox"/> Less than 30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 60-90 <input type="checkbox"/> Other: (specify): _____					

MNR-SS (04/06)

20. Type of support surface(s)	21. Description of equipment
<input type="checkbox"/> Mattress overlay system (powered)	
<input type="checkbox"/> Mattress overlay system, nonpowered	
<input type="checkbox"/> Pressure pads (gel or dry)	
<input type="checkbox"/> Air-fluidized bed	
<input type="checkbox"/> Air-flotation bed, powered	
<input type="checkbox"/> Semi-electric bed with mattress	
<input type="checkbox"/> Total electric bed with mattress	
<input type="checkbox"/> Other (specify):	
22. DME provider	
Company name:	MassHealth provider no. (if available):
Address:	Telephone no. (if available):
23. Prescriber	24. Person completing form on behalf of prescriber
Name:	Name:
Address:	Title:
Telephone no.:	Telephone no.:
MassHealth provider no.:	Organization:
Provider UPIN:	

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)

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-9-CM 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-9-CM 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.