Combined MassHealth Managed Care Organization (MCO)
Medical Necessity Review Form
For Enteral Nutrition Products (Special Formula)

You must 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.***

All sections must be completed.

1. Member's name:	**2. Member's ID no:**
3. Member's DOB (Age): ☐ Weeks of gestation for premature infants (if applicable):	**4. Member/family's primary language:**
5. Member's address and telephone no: **Telephone No:** _____	**6. Member's current location:** ☐ Home ☐ Hospital ☐ NICU ☐ Other (specify): _____ **Telephone No:** _____
7. Primary diagnosis name and ICD-9-CM code:	**8. Secondary diagnosis name and ICD-9-CM code:**
9. Anthropometric measures (Complete all items.) ☐ Height: _____ ☐ Weight: _____ ☐ Growth percentile (child only): _____ ☐ Body mass index (BMI): _____ ☐ Basal metabolic rate (BMR): _____ ☐ Ideal body weight: _____	**10. Laboratory tests** (Attach results) ☐ Type of blood tests (specify): _____ ☐ Type of urine tests (specify): _____ ☐ Allergy testing (specify): _____ ☐ Other tests (specify): _____
11. Risk factors (Use attachments as needed.) ☐ Anatomic structure of gastrointestinal tract ☐ Neurological disorder (specify): _____ ☐ Inborn errors of metabolism (specify): _____ ☐ Malabsorption syndrome (specify type): _____ ☐ Treatment with anti-nutrient or catabolic properties ☐ Increased metabolic or caloric need ☐ Other (Specify): _____	**12. Route of treatment** ☐ Mouth (oral) only ☐ Nasogastric (NG-tube) ☐ Gastric (G-tube) ☐ Jejunal (J-tube) ☐ Other (specify): _____
13. Treatment regimen initiated (Attach explanation.) ☐ Past (Note: specific dates of duration of usage and signs and symptoms of complications of any prior used formulas) ☐ Current (last six months) ☐ None	**14. Expected treatment outcome** (Attach explanation.) ☐ Expected to improve within 3 months ☐ Expected to improve within 6 months ☐ Expected to improve within 12 months ☐ Not expected to improve
15. Location where member will use items: ☐ Home ☐ Work ☐ Hospital ☐ Other (specify): _____	**16. *Expedited service authorization request *(Must attach detailed explanation.)*** Could seriously jeopardize the member's: ☐ Life or health ☐ Ability to attain, maintain, or regain maximum function ☐ Other (Specify): _____ **MCO Plan to provide notice to provider no later than 3 business days after receipt of request.*
17. Duration of need (number of months): Start and End Dates	**18. No. of refills:**

19. Enteral formula and supplies (include HCPCS codes)	**20. Volume/fluid oz. and Calories per Day (list all)**	**21. Quantity per month (Total Units Requested per HCPCS code)**
a.	a. Volume/fluid oz. per day -	
b.	b. Calories per day -	
c.	c. Calories per fluid oz. -	

22. Type of formula requested: ☐ **P = powder** ☐ **R = ready-to-use** ☐ **C = concentrate**

23. DME provider	
Company name:	NPI provider ID no. (if available):
Address:	Telephone no. (if available): Fax no. (if available):
24. Prescriber	**25. Person completing form on behalf of prescriber**
Name:	Name:
Address:	Title:
Telephone no.: Fax no.:	Telephone no.: Fax no.:
NPI provider ID no.:	Organization:

26. 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 attestation (signature) **Date** (mm/dd/yy)

This form must be completed by the prescriber. Please check off the member's MCO Plan and fax or submit this completed and signed form according to the MCO's special instructions below.

☐ **Boston Medical Center HealthNet Plan (BMCHP) -**
Special Instructions: Choose a vendor from the attached list and fax the completed form directly to the vendor. The vendor will then obtain prior authorization. This list and the Special Formula/Enteral Nutrition form can also be found at: http://www.bmchp.org/pages/providers/provider_home.aspx (click on Authorization Forms, Enteral Nutrition Request Form)

- For all oral enterals, contact Northwood for prior-authorization, Tel # 1-866-802-6471, Fax # 1-877-552-6551.
- For tube fed enterals:
  - Home Infusion providers contact BMCHP for prior authorization. Tel # 1-888-566-0008, Option 3
  - DME providers contact Northwood for prior authorization: Tel # 1-866-802-6471, Fax # 1-877-552-6551

☐ **CeltiCare Health** – Contact Department: Prior Authorization Tel# 855-678-6975 Fax #: 866-614-1950
Special Instructions: Prior authorization is required for certain covered Enteral Formulas and Low Protein Foods products over $500. Please check the CeltiCare Health web based Pre Authorization tool to determine if the specific CPT code requires prior authorization at: **http://www.celticarehealthplan.com/for-providers/pre-auth-needed/medicaid-pre-auth-needed/.** If prior authorization is required send completed form via fax or web to CeltiCare. If prior authorization is not required, fax the completed form directly to the contracted DME/medical supplier.

☐ **Fallon Health (FCHP) -** Contact : Prior Authorization Department
Tel #: 508-368-9138/Fax #: 508-368-9700 or urgent Fax request 508-368-9133.
Special Instructions: Please provide notes of past one year of office visits, yearly check ups, testing results and growth charts. For a list of contracted medical suppliers visit the Physician and Provider section at www.fchp.org.

☐ **Health New England (HNE) -** Contact Person/Department: Health Services Department.
Tel #: 413-787-4000 x5027/Fax #: 413-233-2700.
Special Instructions: Please provide notes of past one year of office visits, yearly checkups, testing results and growth charts. The completed form is to be faxed to the contracted DME/medical supplier.

☐ **Neighborhood Health Plan (NHP) –** Contact Department: DME-Nutritional Authorizations Team – Department: Clinical Operations. Tel #: 1-855-444-4647 (toll free) - Fax #: 617-586-1700.
Special Instructions: The DME provider is to submit the request to NHP via electronic submission on Health Trio and upload the form to NHPnet. Home Infusion Therapy and enteral feedings will each require a separate submission.

☐ **Tufts Health Plan -** Contact Person/Department: Medical Management Team
Tel #: 888-257-1985/Fax #: 781-393-2601
Special Instructions: Send the completed form to the contracted DME/medical supplier. If the diagnosis is

failure to thrive (FTT), submit a growth chart in addition to the form. For a list of our DME vendors, visit our website at www.tuftshealthplan.com.

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

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 MCO Plan card.
Item 2	Member's MCO ID no.	Enter the member's MCO Plan identification number, which appears beside the member's name on the MCO card.
Item 3	Member's DOB/Age	Enter the member's date of birth in month/day/year order and age. Also include weeks of gestation for premies if applicable.
Item 4	Member/family's primary language	Enter the member/family's primary language. (If other than English this will flag the possible need for translator and/or interpreter services).
Item 5	Member's address	Enter the member's permanent legal address (street address, town, and zip code) including telephone where can be reached.
Item 6	Member's current location	Place a checkmark beside the member's current location (include telephone number). *Note: if NICU (Neonatal Intensive Care Unit) is checked off, the MCO and/or its designated DME or Pharmacy Vendor will flag the PA, process and track it expeditiously in order to ensure that the member's nutritional needs will be met as soon as the member is ready to be discharged to the community.*
Item 7	Primary diagnosis	Enter the primary diagnosis name and ICD-9-CM code that corresponds to the nutritional disorder for which the enteral product is being requested. Include evidence based clinical data regarding disease processes (i.e. not just GERD – all the clinical data that confirms that diagnosis).
Item 8	Secondary diagnosis	Enter the secondary diagnosis name and ICD-9-CM codes (up to three codes) that further describe medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable. Include evidence based clinical data regarding disease processes (i.e. not just GERD – all the clinical data that confirms that diagnosis).
Item 9	Anthropometric measures	Complete all items associated with signs and symptoms of nutritional risk. Enter the member's height in inches, weight in pounds, body mass index, basal metabolic rate, and ideal body weight. Enter the growth percentile for children, and attach a growth chart.
Item 10	Laboratory tests	Place a check mark beside all diagnostic laboratory tests that apply, and specify the type of tests (for example, serum albumin, hematocrit, and enzyme profiles) in the space provided. Attach the results for each test.
Item 11	Risk factors	Place a check mark beside all risk factors that may affect treatment of nutritional risk. When indicated, specify the risk factors in the risk space provided. Attach clinical information for items checked.
Item 12	Route of treatment	Place a check mark beside the primary method that enteral products will be administered. If checking "Other", specify the method (for example, gravity, pump, or syringe) in the space provided.
Item 13	Treatment regimen initiated	Place a checkmark beside treatments that have been tried to manage nutritional risk. Attach an explanation on other nutritional support products used and responsiveness to such treatments.
Item 14	Expected treatment outcome	Place a checkmark beside the item that describes the prognosis for improvement with enteral treatment. Attach an explanation.
Item 15	Location where member will use items	Place a checkmark beside all locations that apply to use of this product. If checking "Other", specify the location where the product will be used (for example, skilled nursing facility or end stage renal disease facility) in the space provided.
Item 16	Expedited service authorization request	Place a checkmark beside the reason for requesting an expedited service authorization request. Must attach a detailed explanation for any reason checked.
Item 17	Duration of need	Enter the total number of months that the prescriber expects the member to require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use. Enter Start and End Dates if known.
Item 18	No. of refills	Enter the number of monthly refills for this prescription.
Item 19	Enteral formula and supplies	Print the name of the enteral formula being requested and, if applicable, the supplies (for example, syringes or pump) required to administer the formula. Include HCPCS codes.
Item 20	Volume/fluid oz. per day and Calories per day	Enter the volume/fluid oz. per day of reconstituted formula being recommended for the member; and enter the calories per day (i.e. 1 unit = 100 calories)
Item 21	Quantity per month/Total Units Requested per HCPCS code.	Enter the quantity of enteral products requested per month for items listed (for example, 30 8-oz. cans).
Item 22	Type of formula requested	Place a checkmark beside the type of formula requested.
Item 23	DME provider	Enter the company name and address of the provider who will supply the enteral product(s) being requested. If available, also provide the DME provider's telephone and fax numbers and provider National Provider Identifier (NPI) number.

Item 24	Prescriber	Enter the physician's/clinician's name, address, telephone and fax numbers where he or she can be contacted if more information is needed. Include the prescriber's MCO Plan provider's NPI number, or if the prescriber is not an MCO Plan provider, enter the prescriber's NPI number.
Item 25	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse, dietician, physical therapist, or nursing facility staff) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title, and name of employer (organization) where indicated.
Item 26	Attestation	The prescriber must attest that the clinical information provided on this form is accurate and complete to the best of the prescriber's knowledge by signing this field.