**DEPARTMENT OF VERMONT HEALTH ACCESS**

**VERMONT MEDICAID MEDICAL NECESSITY FORM (MNF)**

**ORTHOTICS, PROSTHETICS, MEDICAL SUPPLIES & EQUIPMENT**

All claims for supplies and equipment require a written order. Orders must be signed by a physician, physician assistant, or nurse practitioner. All home health plans of care require a physician signature. Copies of the order must be kept in the patient record by both the ordering provider and Durable Medical Equipment (DME) supplier. It is the responsibility of the ordering provider to complete or review this Medical Necessity Form (MNF) and provide adequate documentation supporting the medical need for the items listed. The ordering provider must provide this documentation either for the Medicaid beneficiary to take to the DME supplier of choice, or directly to the DME supplier. The DME supplier must be enrolled in Vermont Medicaid. The ordering provider must document a description of the device and/or its HCPCs code. If the ordering provider does not provide the HCPCs code, the DME supplier must provide the HCPCs code for all prior authorizations and on all claims, on this form or on other documentation submitted to the DVHA and DXC. The codes submitted to DVHA and DXC must match the description documented by the ordering provider.

All orders must adhere to state and federal rules and regulations. Vermont Medicaid Rules can be found online at <http://humanservices.vermont.gov/on-line-rules>.

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|  **Section A: (must be completed or reviewed and signed by ordering provider)**1. **Beneficiary’s name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicaid ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Diagnoses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Place of service:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the beneficiary living in a skilled nursing facility? Yes [ ]  No[ ]

Is the request part of a home health plan of care? Yes [ ]  No[ ]

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| **4. HCPCs Code** | **Description** | **Modifier** | **Medical Necessity of Item** | **Expected Length of Need (months)** | **# Per Month** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ |
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The HCPCS code(s) may be provided by the supplying provider when the ordering provider has included a clear description of the required item(s).

I CERTIFY THAT THE ITEM(S) PRESCRIBED ABOVE IS(ARE) A MEDICALLY NECESSARY PART OF THE COURSE OF TREATMENT AND NOT FOR CONVENIENCE, COMFORT, OR PRECAUTIONARY PURPOSES

**5. Ordering provider’s name & address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Ordering provider’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**7. Ordering provider’s Medicaid provider #:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

See back of form for DME information and instructions

**Section B FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES** (completed by the DME supplier)

**8. Date supplies/original equipment first dispensed**: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**9. Name of DME employee completing above information**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10**.**Signature of DME employee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Medicaid DME provider #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Claims:** All DME requires an MNF to be submitted with the claim, with the exception of certain items that are identified in the Provider Manual, available at: [www.vtmedicaid.com](http://www.vtmedicaid.com). For exceptions, an MNF must be kept on file by the DME supplier.

**Prior Authorization:** The DME supplier must include a copy of an MNF with every Prior Authorization request.

Fax the MNF and any other supporting documents to the DVHA **at** **(802) 879-5963.** Use of this DVHA Medical Necessity Form is recommended for all prior authorization requests to ensure timely processing.

Medicaid may request a copy of the medical record upon audit.

**\*INSTRUCTIONS FOR SECTIONS A & B\***

**Section A** must be completed or reviewed, signed, and dated by the ordering physician/physician assistant/nurse practitioner.

**Section B** must be completed by the DME supplier when equipment and/or supplies are ordered.

1. Beneficiary’s first & last name, and Medicaid ID number.
2. List all relevant diagnoses, including status diagnoses such as colostomy, tracheostomy. If this is an initial order or there have been significant clinical changes, attach documentation reflecting the provider’s treatment plan. All DME ordered within a home health plan of care require a physician signature.
3. The place of service in which the item will be used. If it is to be used in a facility, document the facility name and address. A place of service code may be used.
4. List for each item being ordered: HCPCS code (optional for ordering provider, but then must appear on other documentation submitted to DVHA for PA and to DXC for billing), medical necessity rationale, expected length of need (will be interpreted as months unless stated otherwise), and the number of items needed (for example: 2 bottles of sterile saline per month). NOTE: If the quantity ordered is more than the number allowed (based on customary usage and as listed in the DVHA DME Restriction list, available at: http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines), an explanation from the physician is required.
5. The ordering provider’s name and address.
6. The ordering provider’s signature must be that of the ordering provider and attests to the validity of the information given. The date of this signature is also required.
7. Medicaid provider number and phone number.
8. To be completed by the DME supplier: the date that the base device was first provided. If there is no base device (for example, incontinence products), document the date the supply was first provided.
9. The name of the DME employee completing the form.
10. DME employee’s signature and phone number.
11. DME Medicaid provider number.