MEDICAID BULLETIN

TO: Providers Indicated

SUBJECT: Physician Certification of Incontinence

In §6407 of the Affordable Care Act (Pub.L. 111-148) Congress added some conditions on the coverage of Durable Medical Equipment (DME). The Centers for Medicare and Medicaid Services (CMS) has proposed implementing changes to the DME regulations which also clarify the federal agency’s position as to the availability of incontinence and other supplies and equipment under the Medicaid State Plan Home Health benefit. See 76 FR 41032–41039 (July 12, 2011).

In anticipation of these changes, the South Carolina Department of Health and Human Services is issuing this Bulletin which sets forth the interim policy for obtaining physician certification of incontinence supplies as a State Plan Service under the Home Health regulations at 42 CFR §440.70. An order must be obtained from the primary physician that the beneficiary is incontinent using the Physician Certification of Incontinence DHHS Form 168IS, which is attached.

The Physician Certification of Incontinence DHHS Form 168IS is mandatory for all beneficiaries receiving incontinence supplies as a State Plan Home Health benefit with the following effective dates:

- January 1, 2013 for beneficiaries in the Medically Complex Children’s (MCC) waiver, Ventilator Dependent waiver and Community Support (CS) waiver.
- July 1, 2013 for non-waiver, fee for service beneficiaries.

The Physician Certification of Incontinence DHHS Form 168IS must be completed by the primary physician initially and every 12 months at a minimum.

Please visit www.scdhhs.gov for additional information on the Medicaid State Plan Home Health incontinence policy. Thank you for your continued support of the South Carolina Medicaid program.

/s/

Fraud & Abuse Hotline 1-888-364-3224
PHYSICIAN CERTIFICATION OF INCONTINENCE

TO: _________________________________  FROM _________________________________

(Name of Physician)  

(Address)  

(City, State) (ZIP)

BENEFICIARY’S NAME: ____________________________________________________________

SOCIAL SECURITY #: ___________________________  DOB ____________________________

Please complete the areas below and return to the “FROM” address above. This beneficiary is requesting incontinence supplies (includes diapers/briefs/pull-ups, wipes, and/or underpads) through the Medicaid Home Health benefit. In order to qualify the beneficiary must have one of the following conditions. Please check any that apply. The form must be fully completed.

☐ Incontinent of bladder
☐ Incontinent of bowel

How long is this condition likely to continue? ________________________________

What is the related diagnosis? ________________________________________________

Comments: __________________________________________________________________

Please indicate one of the following:

☐ Incontinence Supplies are NOT medically necessary.
☐ Incontinence Supplies are MEDICALLY NECESSARY for this Medicaid beneficiary.

Physician’s Signature: ___________________________  Date: __________________________