

# Medicaid State Plan Incontinence Supplies (Under 21)

Incontinence Supplies are available to Medicaid eligible children under age 21 who meet established medical necessity criteria.

Providers: Incontinence supplies must be provided by licensed vendors enrolled with SCDHHS as an Incontinence Supply provider.

**Covered Supplies:** Medicaid state plan offers the following incontinence supplies based on medical necessity:

- ❖ One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
- ❖ One (1) case of incontinence pads/liners [1 case = 130 pads]
- ❖ One (1) case of underpads
- ❖ One (1) box of wipes
- ❖ One (1) box of gloves

**Note:** Requests for additional supplies will be considered on a case by case basis **and** if medical necessity is justified.

**Criteria:** The following criteria must be met for children to receive incontinence supplies:

1. The child must be between ages 4 - 20.
2. The child's inability to control bowel or bladder function must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS)**.
3. The Service Coordinator must conduct an assessment to determine the frequency and amount of supplies authorized.

**Arranging for the Service:** Once the child's need has been identified and documented in the plan and in the participant's record, you will determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS)**. This form is to be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

**Occasionally Incontinent =**

- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

**Frequently Incontinent =**

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.
- Bowel—Approximately between 2 to 3 times a week.

**Totally Incontinent =**

- No control of bladder or bowel

**NOTE:** If the child has an ostomy or catheter for urinary control **and** an ostomy for bowel control, **only underpads may be authorized.**

**NOTE: If the individual has an appliance for bowel or bladder control, diapers may be authorized based on the frequency of incontinence.**

When conducting the assessment, you should determine the number of diapers used on average/per day to calculate the number of cases of diapers and other supplies needed per month. This should be thoroughly recorded in service notes to justify the need.

Once a frequency and amount has been determined, the individual must make a choice of provider and you must complete an **Authorization for Incontinence Supplies (Form IS-3)** and send it to the provider. A copy of the authorization must remain in the individual's file. **FOR INDIVIDUALS UNDER AGE 21, DO NOT ADD INCONTINENCE SUPPLIES TO THE BUDGET.**

**Note:** An authorization for wipes is based on the presence of an incontinence need only; therefore, an individual **must also be receiving** diapers and/or underpads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.

**Monitoring Services:** Because Incontinence Supplies for children is not a waiver service, you need only monitor as part of the routine Plan Review”.

SAMPLE

## SCDDSN RECONSIDERATION PROCESS

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability-Related Disabilities (ID-RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver, and the Pervasive Developmental Disorder (PDD) Waiver. If a Waiver participant disagrees with a decision made and/or action taken by SCDDSN, reconsideration and reversal of the adverse decision/action may be requested.

**The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.**

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

**State Director  
SC Department of Disabilities and Special Needs  
P.O. Box 4706  
Columbia, SC 29240**

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

**Note:** In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

## SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS).

The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at [www.scdhhs.gov/appeals](http://www.scdhhs.gov/appeals).  
**OR**

The appeal request may be mailed to:

**SC Department of Health and Human Services  
Division of Appeals and Hearings  
P.O. Box 8206  
Columbia, SC 29202-8206**

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30<sup>th</sup>) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
AUTHORIZATION FOR SERVICES  
SC MEDICAID STATE PLAN INCONTINENCE SUPPLIES**

**BILL TO S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES (include Prior Authorization # below)**

**TO:** \_\_\_\_\_  
Provider Name

**Participant's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **(Must be under 21 years of age)**

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Medicaid #:** \_\_\_\_\_

**Prior Authorization #** \_\_\_\_\_

**NOTE:** The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the ID/RD Waiver. Our information indicates this person has:

Medicaid only       3<sup>rd</sup> Party liability (private insurance)       Medicare

**You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for these services.**

**Diapers /each** **Start Date:** \_\_\_\_\_  
**Number of diapers:** \_\_\_\_\_ **Frequency:**  Monthly  Bi-Monthly  Quarterly  
**Size:**  Adult Small (T4521)  Adult Medium (T4522)  Adult Large (T4523)  
 Adult X-Large (T4524)  Adult Bariatric (T4543)  
 Child Small/Medium (T4529)  Child Large (T4530)  Youth (T4533)

**Briefs (Protective Underwear) /each** **Start Date:** \_\_\_\_\_  
**Number of Briefs:** \_\_\_\_\_ **Frequency:**  Monthly  Bi-Monthly  Quarterly  
**Size:**  Adult Brief /Ex. Lrg (T4528)  Adult Brief / Lrg (T4527)  Adult Brief /Med. (T4526)  
 Adult Brief /Sm. (T4525)  Youth Brief (T4534)  Child Brief Small (T4531)  
 Child Brief Large (T4532)

**Incontinence Pads (Liners)/each (T4535)** **Start Date:** \_\_\_\_\_  
**Number of Pads:** \_\_\_\_\_ **Frequency:**  Monthly  Bi-Monthly  Quarterly

**Under Pads/case (A4554)** **Start Date:** \_\_\_\_\_  
**Number of Cases:** \_\_\_\_\_ **Frequency:**  Monthly  Bi-Monthly  Quarterly

**Wipes (T5999)** **Start Date:** \_\_\_\_\_  
**Number of Boxes:** \_\_\_\_\_ **Frequency:**  Monthly  Bi-Monthly  Quarterly

**Gloves (A4927)** **Start Date:** \_\_\_\_\_

Service Coordination Provider: \_\_\_\_\_ Service Coordinator Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Authorizing Services

\_\_\_\_\_  
Date