INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION

SECTION A: Incontinence Provider Information

1. Contact Person	2. Contact Telephone Number	3. Contact Fax Number

SECTION B: Patient Information

4. Patient Name– Last, First, Middle (as appears on card)

5. Medi-Cal ID Number	6. Gender	7. Date of Birth (mm/dd/yy)	8. Age
	Male ☐ Female ☐		

9. Type of Residence
☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N ☐ Other _____

SECTION C: Documentation Supporting Medical Necessity

Note: If necessary, include supporting documentation on an attachment

10. Does the patient **meet the Code 1 Restriction**? Yes ☐ No ☐
If yes, indicate the primary and secondary diagnosis name and ICD-10-CM codes.

_____

_____

_____

If no, provide clinical evidence and describe in detail the medical conditions and/or extenuating circumstances to support the medical necessity.

_____

_____

_____

_____

11. Have any **previous treatments** (for example, drug therapy, behavioral techniques, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? Yes ☐ No ☐
If yes, describe treatment(s), treatment results, and patient's responsiveness.

_____

_____

_____

_____

If no, explain reasons why other treatments are not appropriate to decrease or eliminate incontinence.

_____

_____

_____

_____

SECTION C: Documentation Supporting Medical Necessity (Continued)

12. Is this patient **prescribed multiple absorbent product types** to be used during the same time period? Yes ☐ No ☐
If yes, explain in detail the need for multiple varieties of supplies.

13. Does this request include a billing code that **requires prior authorization?** Yes ☐ No ☐
If yes, list billing code(s) and supporting documentation of medical need.

14. Does the patient require a quantity that **exceeds the quantity limits** for any of the supplies needed? Yes ☐ No ☐
If yes, list billing code(s), provide clinical evidence and describe in detail the acute medical condition and/or extenuating circumstances for increased need for additional quantities.

15. Does the patient require supplies (except creams and washes) that **exceed the $165 per month allowable**? Yes ☐ No ☐
If yes, provide a detailed explanation to support the need for supplies exceeding $165 per month.

16. Does this request have an attachment for additional supporting documentation? Yes ☐ No ☐

NOTE: Medical justification must be complete and thorough to process this request. If necessary, provide the supporting documentation and any additional information on an attachment.

SECTION D: List All Prescribed Product Types (For example, briefs, protective underwear, etc.)

17. Complete the table below for the supplies prescribed. Enter the last date of service (DOS) if previously billed.

Billing Code	Product Type	Last DOS	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units

18. This prescription is valid for _____ months. **NOTE:** The maximum allowed is 12 months. The physician's signature date below must be within 12 months of the date of service on the claim.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

By my signature below, I verify that I have physically examined the patient within the last 12 months and certify to the best of my knowledge that the information contained in this form is true, accurate and complete. I have prescribed the items on this form and will maintain a copy of this prescription in the beneficiary's medical record to meet Medi-Cal documentation requirements.

19. Physician's Name	20. Physician's National Provider Identifier
21. Physician's Business Address (number, street) City	ZIP Code
22. Physician Telephone Number	23. Physician's Signature / 24. Date

Code I restriciton - Incontinence supplies are reimbursable only for use in chronic pathologic conditions causing the recipient's incontinence.

Secondary Dx - F98.0, F98.1, R15.2, R15.9, R30.1, R32, R39.2, R39.81-R39.9, N39.3, N39.41-N39.46 N39.490-N39.492, N39.498

FAX TO: 888-518-7568

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION INSTRUCTIONS

SUBMISSION REQUIREMENTS: This form must accompany each Treatment Authorization Request (TAR) and must contain <u>all</u> supplies needed for the time period, not just supplies needing a TAR.

SECTION A: Incontinence Provider Information

1. Enter the name of the individual to contact for TAR questions.
2. Enter the phone number where the contact person can be reached.
3. Enter the fax number to receive information.

SECTION B: Patient Information

4. Enter the patient's last name, first name and middle initial.
5. Enter the Medi-Cal Identification Number.
6. Check the appropriate box.
7. Enter the complete date as 2-digit month, 2-digit day, and 2-digit year.
8. Enter the patient's current age.
9. Check the appropriate box.

SECTION C: Documentation Supporting Medical Necessity

10. – 15. An answer to each question is required. Depending on the response further explanation to support medical justification is required and if needed may be included on an attachment.
    NOTE: Medical justification must be complete and thorough in order to process the request.
16. Indicate if an attachment is included with this form.

SECTION D: List All Prescribed Product Types

17. This table must include **<u>all</u> supplies prescribed** for this patient's use during the number of months covered by this prescription.
    - Billing Code - Enter the HCPCS billing code for each supply item. Refer to the *List of Incontinence Medical Supplies Billing Codes*
    - Product Type – For each billing code enter the corresponding product type name (for example, cream, wash, disposable brief, protective underwear, pad, liner and underpad). Do not list brand name.
    - Last DOS – Enter the last date of service if product type was previously billed.
    - Daily Usage – Enter the estimated number of units the patient will use daily
    - Monthly Usage – Enter the estimated number of units the patient will use monthly.
    - Monthly Cost – Enter the estimated monthly cost for this supply, including markup and sales tax (unit cost multiplied by the monthly usage plus markup and sales tax)
    - Total units – Enter the total number of units for each supply item prescribed (monthly usage multiplied by the total number of months covered by this prescription).
18. Enter the number of months covered by this prescription. The maximum allowed is twelve (12) months.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

NOTE: This section must be completed by the attending physician. The physician's personal signature in ink and date of signature is required. Signatures stamped, printed or initials are not acceptable.