Clinical Policy: Incontinence and Ostomy Supplies

Reference Number: GA.CP.MP.07 Coding Implications
Last Review Date: 05/2020 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Incontinence describes any accidental or involuntary loss of urine from the bladder or feces from the bowel. To provide medical necessity guidelines for authorization of incontinence supplies which include the following: diapers/briefs/pull-ups/liners, underpads, disposable wipes and emollients for members under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program under 21 years of age. To provide medical necessity guidelines for authorization of urinary catheters and ostomy supplies for all members.

Policy/Criteria

I. Documentation needed for medical necessity review:
The following are required information for a complete medical necessity review:
A. A signed medical necessity letter or prescription from member's treating physician/nurse practitioner (NP)/physician assistant (PA) within the last 12 months.
B. Accurate diagnostic information pertaining to the underlying diagnosis/condition, as well as any other medical diagnoses/conditions, to include the member's overall health status.
C. Diagnosis/condition causing incontinence or increased urination/stooling.
D. Number of times per day the physician/NP/PA has ordered that the supply be used.
E. Quantity of disposable supplies requested per month.
F. Incontinence supplies, urinary catheters, ostomy and related supplies are not covered for convenience.
G. Maximum authorization up to 6 months at a time with updated clinical notes for continued medical necessity every 6 months.
H. Prior authorization may be considered with documentation of medical necessity if the Medicaid allowable (number allowed per month) is exceeded.

II. It is the policy of Peach State Health Plan (PSHP) that **incontinence supplies for members under 21 years** of age who qualified under the EPSDT program are **medically necessary** for the following indications:
A. Nocturnal enuresis (bedwetting) in children
1. Intermittent nocturnal incontinence with discrete episodes of urinary incontinence (during sleep) in children younger than 5 years of age is considered normal and incontinence supplies are considered not medically necessary.
2. For children 5 years old or older with nocturnal enuresis, incontinence supplies may be medically necessary:
a. Two diaper/briefs/pull-up/liner/underpad per day or 60 per month may be approved.
b. If the requested quantity for diapers/briefs/pull-ups/liners/underpads ***exceeds*** two per day or 60 per month, the ***Prior auth nurse will send the request for secondary Medical Director Review.***

B. Two years of age and under age 21 years old
   1. Incontinence supplies are covered for children ages 2 and under 21 years old who have an underlying medical condition that prevents control of the bowels or bladder.
   2. Children under the age of 2 years will be considered for coverage on a case-by-case basis.
   3. There must be documentation of the member's diagnosis which supports the medical necessity of all items requested.
   4. The member presents with a medical condition such as spinal cord injury, cerebral palsy, spina bifida, moderate to severe intellectual and developmental disabilities autism, celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis, among others.

III. Incontinence supplies for adults 21 years of age and older

1. Incontinence supplies, such as diapers, briefs, pull-ups, liners, underpads, and disposable wipes are NOT covered benefit for adults 21 years of age and older.
2. Urinary catheters or indwelling foley and supplies and ostomy supplies are covered as medically necessary for adults 21 years of age and older with a medical condition causing urine and/or bowel incontinence.
3. For medical necessity review, the requesting provider must include documentation as noted on Section I. Documentation needed for medical necessity review.

Coding Implications

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HCPCS Code	Description	Modifier	Rates ($)	Limits
A4310	INSERTION TRAY WITHOUT DRAINAGE BAG WITHOUT CATHETER		6.13	2 per month
A4311	INSERT TRAY WO DRAIN BAG W/INDWELL CATH LATEX		16.46	2 per month
A4312	INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE		13.56	2 per month
A4313	INSERT TRAY WO DRAIN BAG W/3 WAY INDWELL CATH		17.48	2 per month

A4314	INSERT TRAY W/DRAIN BAG & INDWELL CATH LATEX		25.90	2 per month
A4315	INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE	U1 >2	17.94	2 per month
A4316	INSERT TRAY W/DRAIN BAG & 3/WAY INDWELL CATH		31.52	2 per month
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE	U1 >30	3.77	30 per month
A4322	IRRIGATION SYRINGE BULB/PISTON EACH		3.29	4 per month
A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION CHAMBER, ANY T		11.98	31 per month
A4327	FEMALE EXT URINARY COLLECT DEVICE; METAL CUP EACH		49.51	4 per month
A4328	FEMALE EXT URINARY COLLECT DEVICE POUCH EACH		11.36	4 per month
A4330	PERIANAL FECAL COLLECTION POUCH W/ADHESIVE EACH		7.94	As needed
A4331	EXT DRAIN TUBING W/CNCTR/ADPTR EACH		3.53	2 per month
A4332	LUBE IND STR PKT-URIN CATH INS EACH		0.13	50 per month
A4333	URIN CATH ANC DEV ADHES SKIN ATT EACH		2.45	2 per month
A4334	URIN CATH ANCHRG DEV LEG STRAP EACH		5.46	2 per month
A4335	INCONTINENCE SUPPLY MISC		3.09	2 per month
A4338	INDW CATH FOLEY 2 WAY ATEX W/COATING EACH		11.57	2 per month
A4340	INDWELLING CATHETER, SPECIALTY TYPE, (E.G. COUDE, MUSHROOM, WING, ETC.) EACH		23.97	2 per month
A4344	INDW CATH FOLEY 2 WAY SILICONE EACH		15.10	2 per month
A4346	INDW CATH FOLEY 3 WAY CONT IRRIGATION EACH		18.48	2 per month
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	U1 >120	1.62	120 per month
A4351	INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH	U1 >120	1.44	120 per month

A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH	U1 >120	5.05	120 per month
A4353	INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	U1 >120	5.60	120 per month
A4354	INSERTION TRYA WITH DRAINAGE BAG WITHOUT CATHETER		8.87	2 per month
A4355	IRRIG TUB SET CONT IRRIG VIA FOLEY EACH		9.02	2 per month
A4356	EXT URETHRAL CLAMP/COMPRESS DEVICE EACH		50.64	2 per month
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH		6.60	4 per month
A4358	URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH		5.19	2 per month
A4360	DISPOSABLE EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, WITH PAD AND/OR POUCH, EACH		0.41	30 per month
A4361	OSTOMY FACEPLATE, EACH		17.90	As needed
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH	U1 >30	2.35	30 per month
A4363	OSTOMY CLAMP, ANY TYPE, REPLACEMENT ONLY, EACH		2.24	As needed
A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PER OZ		1.99	2 per month
A4366	OSTOMY VENT, ANY TYPE, EACH		1.44	As needed
A4367	OSTOMY BELT, EACH		5.39	2 per month
A4368	OSTOMY FILTER ANY TYPE-EA		0.28	As needed
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC), PER OZ		1.94	2 per month
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ		2.92	10 per month
A4372	OST SKN BARR SOL 4X4 BUILT-IN CONVX		4.66	As needed
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITH BUILT-IN CONVEXITY, ANY SIZE, EACH	U1>30	5.78	30

A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC, EACH		19.07	As needed
A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER, EACH		52.82	As needed
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH		4.77	As needed
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER, EACH		34.12	As needed
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH		16.67	As needed
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER, EACH		41.43	As needed
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH		5.13	As needed
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER, EACH		27.32	As needed
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER EACH		31.29	As needed
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EACH		10.67	As needed
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH	U1 >30	4.08	30 per month
A4387	OST POUCH CLO W/BARR BUILT-IN CONVX		2.49	As needed
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, (1 PIECE), EACH	U1 >30	3.49	30 per month
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	U1 >30	4.98	30 per month
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	U1 >30	7.69	30 per month
A4391	OST POUCH URIN W/EXT WEAR BARR EACH		7.85	As needed
A4392	OSTOMY POUCH,URINARY,WITH STANDARD WEAR BARRIER ATTACHED WITH BUILT-IN CONVEXITY, EACH		9.08	As needed
A4393	OSTOMY POUCH, URINARY, WITH EXT.WEAR BARR.ATT. WITH BUILT-IN CONVEXITY, EACH		10.04	As needed
A4394	OSTOMY DEODERANT, W OR W/OUT LUBRICANT FOR USE IN OSTOMY POUCH,		2.87	As needed
A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH, SOLID, PER TABLET		0.05	As needed

A4396	OSTOMY BELT W/PERISTOMAL HERNIA SUPPORT		44.93	1 per month
A4397	IRRIGATION SUPPLY; SLEEVE, EACH		3.53	5 per month
A4398	OSTOMY IRRIGATION SUPPLY BAG-EACH		14.06	As needed
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, WITH OR WITHOUT BRUSH		11.82	1 per month
A4400	OSTOMY IRRIGATION SET		33.23	2 per year
A4402	LUBRICANT, PER OUNCE		1.09	4 per month
A4404	OSTOMY RING, EACH		1.35	15 per month
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED, PASTE, PER OUNCE		2.72	10 per month
A4406	OSTOMY SKIN BARRIER, PECTIN-BASED, PASTE, PER OUNCE		4.59	4 per month
A4407	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4X4 INCHES OR SMALLER, EACH	U1 >30	7.01	30 per month
A4408	OST SKN BARRIER W/CONVXITY > 4X4 IN		10.95	As needed
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4X4 INCHES OR SMALLER, EACH	U1 >30	4.98	30 per month
A4410	OST SKN BARR EXT W/O CONVX >4X4 IN		10.04	As needed
A4411	OSTOMY SKIN BARRIER SOLID 4X4 OR EQUIV EXTEND WEAR W BUILT-IN CONVEX		5.66	As needed
A4412	OSTOMY POUCH DRAINABLE HIGH OUTPUT FOR USE ON A BARRIER W FLANGE		3.00	As needed
A4413	OST POUCH DRNABL BARRIER FLNGE/FLTR		6.11	As needed
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), WITHOUT BUILT-IN CONVEXITY, 4X4 INCHES OR SMALLER, EACH	U1 >30	3.94	30 per month
A4415	OSTOMY SKN BARRIER W/O CONVX >4X4 IN		6.65	As needed
A4416	OSTOMY POUCH, CLOSED, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH		3.06	As needed
A4417	OSTOMY POUCH, CLOSED, WITH BARRIER, WITH BUILT-IN CONVEXITY, W FILTER (1 P), EACH		4.13	As needed

A4418	OSTOMY PCH, CLSD W/OUT BARRIER ATT, WITH FILTER (ONE PIECE), EACH		2.02	As needed
A4419	OSTOMY PCH, CLSD/USE ON BARR W NON-LOCKING FLNG, W FILTER (2PIECE), EACH		1.93	As needed
A4420	OSTOMY PCH, CLSD/USE ON BARR WITH LOCKING FLANGE (2 PIECE), EACH		2.41	As needed
A4421	OSTOMY SUPPLY MISC		23.00	As needed
A4422	OSTOMY ABSORBENT MATERIAL THICKN LIQUID STOMAL OUTPUT		0.13	As needed
A4423	OSTOMY PCH, CLSD/USE ON BARR W LOCKING FLNG, W FILTER (2PIECE), EACH		2.07	As needed
A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED, WITH FILTER (1 PIECE), EACH	U1 >30	3.80	30 per month
A4425	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	U1 >30	2.86	30 per month
A4426	OSTOMY POUCH, DRNB/USE ON BARR WITH LOCKING FLANGE (2 PIECE SYS), EACH		3.03	As needed
A4427	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH LOCKING FLANGE, WITH FILTER (2 PIECE SYSTEM), EACH	U1>30	2.56	30
A4428	OSTOMY PCH, URNY/W EXTND WEAR BARR ATT/W FAUCET-TYPE TAP WITH VALVE (1PC)		7.23	As needed
A4429	OSTOMY PCH/URNY/W BAR ATTD/W BUILT-IN CONV/W FCET-TYPE TAP WITH VALVE (1PC)		9.16	As needed
A4430	OSTOMY PCH URNY/EXT WEAR BAR ATT/BUILT-IN CONV/W FCT-TYP TAP WITH VALVE (1PC)		9.45	As needed
A4431	OSTOMY PCH/URNY/BARR ATT/FCT-TYPE TAP/VALVE (1PC)		6.9	As needed
A4432	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH NON-LOCKING FLANGE, WITH FAUCET-TYPE TAP WITH VALVE (2 PIECE), EACH	U1 >30	2.87	30 per month
A4433	OSTOMY PCH/URNY/USE ON BARR/LOCKING FLNG (2PC)		3.71	As needed
A4434	OSTOMY PCH/URNY/USE ON BARR/LOCKING FLNG/FCT - TYPE TAP/VALVE (2PC)		4.17	As needed
A4435	1 PIECE OSTOMY PCH DRAIN HGH OUTPUT		6.41	As needed
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES		0.09	300 per month
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES		0.28	200 per month

A4554	DISPOSABLE UNDERPADS ALL SIZES (CHUX)		0.43	120 per month
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, CEMENT OR OTHER ADHESIVE), PER OUNCE		1.14	2 per month
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH		0.21	30 per month
A4927	GLOVES NON-STERILE PER 100		7.97	1 per month
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTACHED (1 PIECE), EACH	U1 >30	1.66	60 per month
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER ATTACHED (1 PIECE), EACH	U1 >30	1.19	60 per month
A5053	OSTOMY POUCH CLOS; USE FACEPLATE EACH		1.65	As needed
A5054	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH	U1 >30	1.43	30 per month
A5055	STOMA CAP		1.15	30 per month
A5056	1 PIECE OSTOMY POUCH W FILTER		5.18	As needed
A5057	1 PIECE OSTOCMY POUCH W BUILT-IN CONVEXITY		10.66	As needed
A5061	OSTOMY POUCH, DRAINABLE; WITH BARRIER ATTACHED, (1 PIECE), EACH	U1 >30	2.82	30 per month
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER ATTACHED (1 PIECE), EACH	U1 >30	1.78	30 per month
A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARRIER WITH FLANGE (2 PIECE SYSTEM), EACH	U1 >30	2.16	30 per month
A5071	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED (1 PIECE), EACH	U1 >30	4.81	30 per month
A5072	OSTOMY POUCH URIN; W/O BARR ATTCH EACH		3.92	As needed
A5073	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WITH FLANGE (2 PIECE), EACH	U1 >30	2.54	30 per month
A5081	CONTINENT DEVICE PLUG CONTINENT STOMA		3.12	As needed
A5082	CONTINENT DEVICE CATH CONTINENT STOMA		13.2	As needed
A5083	STOMA ABSORPTIVE COVER		0.71	As needed
A5093	OSTOMY ACCESSORY CONVEX INSERT		2.17	As needed
A5102	BEDSIDE DRAINAGE BOTTLE W/WO TUBING, RIGID OR EXPANDABLE, EACH		25.06	2 per month

A5105	URINARY SUSPENSORY		45.25	4 per year
A5112	URINARY LEG BAG		38.42	2 per month
A5113	LEG STRAP LATEX REPLCE ONLY PER SET		5.23	2 per month
A5114	LEG STRAP FOAM/FABRIC REPLAC ONLY PER SET		8.45	2 per month
A5120	SKIN BARRIER, WIPES OR SWABS, EACH		0.18	100 per month
A5121	SKIN BARRIER SOLID 6X6/EQUIVALENT EACH		7.03	As needed
A5122	SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT, EACH		10.28	20 per month
A5126	ADHESIVE DISC/FOAM PAD		1.46	As needed
A5131	APPLIANCE CLEAN (INCONTINENCE/OSTOMY) PER 16 OZ		17.6	1 per month
A5200	PERCUT CATH/TUBE ANCHOR DEV ADHES SKIN ATT		12.55	2 per month
E0275	BED PAN STANDARD METAL/PLASTIC	NU	17.00	2 per year
E0275	BED PAN STANDARD METAL/PLASTIC	RR	1.78	2 per year
E0275	BED PAN STANDARD METAL/PLASTIC	UE	12.74	2 per year
E0276	BED PAN, FRACTURE, METAL OR PLASTIC		10.64	1 per 6 months
E0325	URINAL MALE JUG TYPE ANY MATERIAL	NU	9.55	2 per year
E0325	URINAL MALE JUG TYPE ANY MATERIAL	RR	1.43	
E0325	URINAL MALE JUG TYPE ANY MATERIAL	UE	6.31	
E0326	URINAL FEMALE JUG TYPE ANY MATERIAL	NU	10.23	2 per year
E0326	URINAL FEMALE JUG TYPE ANY MATERIAL	RR	1.12	
E0326	URINAL FEMALE JUG TYPE ANY MATERIAL	UE	7.67	
T4521	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH		0.60	250 per month
T4522	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH		0.60	250 per month
T4523	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH		0.80	250 per month
T4524	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH		0.90	250 per month
T4525	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH		0.60	250 per month

T4526	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH		0.60	250 per month
T4527	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH		0.80	250 per month
T4528	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH		0.90	250 per month
T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH		0.60	250 per month
T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH		0.60	250 per month
T4531	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH		0.80	250 per month
T4532	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH		0.90	250 per month
T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH		0.34	250 per month
T4534	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH		0.60	250 per month
T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH		0.50	31 per month
T4541	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH		0.50	50 per month
T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH		0.94	240 per month
T4544	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, ABOVE EXTRA LARGE, EACH		0.94	250 per month

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	11/2015	11/2015
Changed DESCRIPTION to: Incontinence describes any accidental or involuntary loss of urine from the bladder or feces from the bowel. Under Criteria for Medical Necessity added; Incontinence supplies are not covered for convenience. Changed aged to BIRTH THROUGH 3 YEARS OF AGE. Changed age to Under FOUR YEARS OLD AND OLDER and added sentences per the EPSDT DCH Manual: Incontinence supplies are covered for children ages 4 through 21 years who have an underlying medical condition that prevents control of the bowels or bladder. There must be documentation of the patient's diagnosis which supports the medical necessity of all items requested. Added HCPCS T4541 $0.79 240 per month to the fee schedule since is on the Medicaid PSHP configuration fee schedule. Updated References.	5/2016	5/2016
Updated References. Updated Appendix A. PSHP Incontinence Supplies Fee Schedule Covered and Codes and Limits.	5/2017	5/2017
Updated References. Minor reformatting throughout for ease of reading. Added One diaper/briefs/pull-up/liner/underpad added before underpad under 1) Nocturnal Enuresis in Children section. Removed word severe from autism under 3) FOUR YEARS OLD AND OLDER section. Updated Appendix A. PSHP Incontinence Supplies Fee Schedule Covered and Codes and Limits.	5/2018	5/2018
Converted to new Centene Corporation clinical policy template with minor reformatting throughout. References reviewed and updated. Added Descriptions to the HCPCS codes. Updated the HCPCS codes per the Georgia Medicaid fee schedule. Under 4) Incontinence in Adults 21 years of age and older, removed "Urinary Incontinence is any involuntary leakage of urine, almost always caused by an underlying, treatable medical condition. Removed the table of Type of Incontinence and Treatment Management. Under **1. Documentation needed for medical necessity review:** Change Maximum authorization up to 6 months at a time with updated clinical notes for continued medical necessity every 6 months. Added **III. Incontinence supplies for adults 21 years of age and older**, 1. Incontinence supplies, such as diapers, briefs, pull-ups, liners, underpads, and disposable wipes are NOT covered benefit for adults 21 years of age and older. 2. Urinary catheters or indwelling foley and supplies and ostomy supplies are covered as medically necessary for adults 21 years of age and older with a medical condition causing urine and/or bowel incontinence. 3. For medical necessity review, the requesting provider must include documentation as noted on Section I. Documentation needed for medical necessity review.	4/2019	5/2019
Changed policy title from "Medical Necessity for Authorizing Incontinence Supplies" to "Incontinence and Ostomy Supplies".	05/2020	05/2020

Reference number changed from GA.MP.07 to GA.CP.MP.07 per the Centene State-Specific Clinical Policy Process: CP.CPC.04. Description: added "To provide medical necessity guidelines for authorization of urinary catheters and ostomy supplies for all members." I. F. Added "urinary catheters, ostomy and related supplies". Deleted Section II. B. Birth through 3 years of age 1. Incontinence supplies, such as diapers, briefs, pull-ups, liners, underpads, and disposable wipes, may be considered medically necessary if the member presented with a medical condition(s) that results in an increased urine or stool output beyond the typical output for this age group, such as neurogenic bladder or bowel from spina bifida, celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis, among others. New Section II. B. Changed Four years of age and under age 21 to "Two years of age and under age 21 years old". On section II. B. 1. Changed age from 4 to 2 and under 21 years old. Added 2. Children under the age of 2 years will be considered for coverage on a case-by-case basis. Changes made per the EPSDT Services Manual, GA DCH, Division of Medicaid. Updated References.		
Policy/Criteria II. A. 2. Nocturnal enuresis (bedwetting) in children change from one to two per day or 60 per month. a."Two diaper/briefs/pull-up/liner/underpad per day or 60 per month may be approved." b. "If the requested quantity for diapers/briefs/pull-ups/liners/underpads ***exceeds*** two per day or 60 per month, the ***Prior auth nurse will send the request for secondary Medical Director Review."***	08/2020	08/2020
Updated ostomy skin barrier, with flange, HCPCS: A4373 and ostomy pouch drainable HCPCS: A4427 limits to 30/month for each, added State modifier for overutilization: U1>30, and adjusted rates for purchase price per the GA Medicaid DME Services Fee Schedule.	10/2020	10/2020

References

1. Part II Policies and Procedures for Durable Medical Equipment Services. Georgia Department of Community Health. Revised: 10/15; 04/16; 04/17; 04/18; 01/19; 04/19; 04/2020.
2. Part II Policies and Procedures for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services. Georgia Department of Community Health, Division of Medicaid. Revised: 04/16; 04/17; 04/18; 01/19; 04/19; 04/2020.
3. Georgia Medicaid DME Services Fee Schedule. Revised 01/19; 04/19; 04/2020.
4. McInerny TK, Adam HM, Campbell DE, Dewitt TG, Foy JM, Kamat DM, eds. American Academy of Pediatrics Textbook of Pediatric Care. Elk Grove Village, IL: American Academy of Pediatrics; 2017.
5. McInerny TK, Adam HM, Campbell DE, Kamat DM, Kelleher KJ, eds. American Academy of Pediatrics Textbook of Pediatric Care. Elk Grove Village, IL: American Academy of Pediatrics; 2009.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.