Medical Policy

Northwood

Incontinent Supplies (NH Medicaid Members Only)

Description

Incontinent supplies are items used to assist individuals with the inability to control excretory functions.

Policy

Incontinent supplies are authorized for members age **3 years and older** meeting coverage criteria below. Refer to policy guidelines for coverage criteria and length of authorizations.

Policy Guidelines

Coverage criteria:

NOTE: Urinary stress incontinence alone is not a covered condition unless caused by one of the conditions 1., 2., or 3 listed below.

A. Incontinence supplies will be authorized for one year if the recipient's type of incontinence is:

1. Secondary to a disease process or injury to the bladder which results in irreversible loss of control of the urinary bladder and/or rectal sphincter;

2. Secondary to an injury to the brain or spinal cord; or

3. Attributed to a profound cognitive disability, such as severe mental retardation or dementia, that results in an inability to achieve continence through bladder training;

B. For 6 months if the recipient's type of incontinence is:

1. Secondary to a surgical procedure, such as prostatectomy, resulting in temporary urinary incontinence; or

2. Secondary to an injury to the bladder and/or urinary sphincter, including nerve injury and detrusor muscle instability, resulting in temporary urinary incontinence.

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Quantity Limits:

Disposable under pads	3/day up to 93 per month (not to exceed 144 per month)
Incontinence briefs	6/day up to 186 per month (not to exceed 216 per month)
Pull-ups	6/day up to 186 per month (not to exceed 216 per month)
Diapers	6/day up to 186 per month (not to exceed 216 per month)
Pads and liners	3/day up to 93 per month (not to exceed 144 per month)

Documentation:

- Prior authorization is required for usage over the established quantities.

Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit

determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

References

1. New Hampshire Medicaid. Part He-W 571 DURABLE MEDICAL EQUIPMENT, PROSTHETIC AND ORTHOTIC DEVICES, AND MEDICAL SUPPLIES.

Applicable URAC Standard

Core 8	Staff operational tools and support.

Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:	Effective Date:
A	4-9-12	Policy specific for NH Medicaid using NH Medicaid guidelines	Susan Glomb	Dr. B. Almasri		
01	11-29-12	Annual Review – No changes	Susan Glomb	Dr. B. Almasri	Nov 12	
02	10-14-13	Updated policy to state that Urinary Stress incontinence alone is not a	Susan Glomb	Dr. B. Almasri		

		covered condition unless accompanied by a secondary condition noted in the coverage criteria 1-3.				
03	12-09-13	Policy updated to include quantity limits for Pads/Liners. Not to exceed 144 per month.	Susan Glomb	Dr. B. Almasri		
04	12-30-13	Annual review. No further changes.	Susan Glomb	Dr. B. Almasri		
05	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
06	11-16-15	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2015	
07	12-01-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016	
08	12-15-17	Annual Review. No Changes.	Lisa Wojno	Dr. Cheryl Lerchin	December 2017	
09	11-30-18	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2018	
10	4-12-19	Added to policy the requirement of age 3 years and older to qualify.	Carol Dimech	Dr. C. Lerchin	April 2019	

11	12-09-19	Annual review. No additional changes – see entry above.	Carol Dimech	Dr. C. Lerchin	December 9, 2019	December 9, 2019
12	12-02-20	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	December 2020	December 2020