Certificate of Medical Necessity for Incontinence Supplies, Page 1 of 3

MEMBER INFORMATION	PROVIDER INFORMATION
Member Name: ______________________ *(Last, First, MI)*	Ordering Provider's Name: ______________________
Alaska Medicaid Member ID: ______________________	Provider Medicaid ID or NPI: ______________________
Date of Birth *(MM/DD/YY)*: ____________ Age:_____ Sex:______	Phone Number: ______________________ Ext. ________________

SECTION C - REQUESTED SERVICES OR ITEMS	Conduent Use Only
Supplier Name: ______________________	Approved: As requested Modified request
Address: ______________________	Denied:
Provider Medicaid ID: ______________________	Service Authorization No: ______________________
Requester Name: ______________________	Start Date: __________ End Date: ____________
Phone Number: ______________________Ext. ________________	Comments:
Fax Number: ______________________Ext. ________________	Authorizing Agent Signature/Date:
Dates of Need – Start Date: _______________ **End Date:** _________________	______________________

	Procedure Code	Mod	Description	Qty	Charges	Authorized		Approved Quantity	Approved Amount
						Yes	No		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

SECTION D - SUPPLIER ATTESTATION, SIGNATURE, AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering physician/physician assistant/nurse practitioner specified in this form, and that these exact services or items listed in this form will be supplied to the specified member. A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

____ ______________________

Signature of Supplier Date

Service authorization approval does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

MEMBER INFORMATION	PROVIDER INFORMATION
Member Name: ______________________ *(Last, First, MI)* Alaska Medicaid Member ID: ______________ Date of Birth *(MM/DD/YY)*: ______ Age: ____ Sex: ____ *Height: ____ *(inches)* *Weight: ______ *(pounds)* Date of last visit related to incontinence: __________	Ordering Provider's Name: ______________ Provider Medicaid ID or NPI: ______________ Phone Number: ____________ Ext. ______ Prescription Start Date: ________

SECTION A - CLINICAL INFORMATION *(This section **MUST** be completed by the attending physician, physician assistant, or nurse practitioner.)*

	Diagnosis Code	Diagnosis Description
ICD-10		
	Include ALL diagnoses to include the type of incontinence and the cause of the incontinence at a minimum.	

Estimated Length of Need *(# of Months)*: _______ *(99 = Lifetime)*

SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN

Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification.

(This section may only be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.)

Questions 1-7 below must be completed.

1. Is the individual at least three years of age and under 10 years of age and do medical records document that the recipient has not responded to, would not benefit from, or has failed bowel or bladder training? ☐ Yes ☐ No ☐ N/A
2. What is the individual's frequency of incontinence?
3. Provide a description of the individual's ability to manage incontinence independently or with assistance.
4. What is the individual's prognosis for controlling incontinence?
5. What is the individual's level of skin integrity and vulnerability to skin breakdown?
6. Is the individual prescribed diuretics or other medications that increase output? ☐ Yes ☐ No
7. Does the individual have any allergies to known product materials? ☐ Yes ☐ No

Provide additional medical justification, as it pertains to the member's specific diagnoses, indicating the medical necessity of the requested items. Attach any supporting documentation as needed. If requests are made for greater than current maximum quantities of items, additional medical justification **MUST** be submitted with this form to justify the need for greater than maximum quantities. Please see quantities listed on page 2 of the Certificate of Medical Necessity for Incontinence Supplies Instructions.

MEMBER INFORMATION	**PROVIDER INFORMATION**
Member Name: ______________________________ *(Last, First, MI)*	Ordering Provider's Name: ______________________________
Alaska Medicaid Member ID: ______________________	Provider Medicaid ID or NPI: ______________________
Date of Birth *(MM/DD/YY)*: __________ Age:_____ Sex:______	Phone Number: ____________________ Ext. ____________

PLAN: *The plan should list each service or item specifically needed for the treatment of the member. Attach additional treatment information.* ***If "Other Qty" is completed****, you must provide* ***additional medical justification*** *for the higher quantity requested.*

** ***Please see current max quantity limits under the Certificate of Medical Necessity for Incontinence Supplies Instructions, page 2. For quantities requested under 'Other Qty' sections below, additional medical justification MUST be submitted with this form to justify the need for greater than maximum quantities.***

Daily Usage Supplies *(mark appropriate quantity)*:

Item	Quantity	Other
Disposable Brief / Undergarment	1 2 3 4 5 6	Other Qty ____
Insert Pads *(used in briefs)*	1 2 3 4 5 6	Other Qty ____
Disposable Bed Pads	1 2 3 4	Other Qty ____

Quarterly Usage Supplies *(mark appropriate quantity)*:

Item	Quantity
Reusable Bed Pads w/ or w/o Flaps	1 2 3 4

Monthly Usage Supplies *(mark appropriate quantity)*:

Item	Quantity	Other
Gloves *(per month)*	100 200 300 400	Other Qty _____
Disposable Wipes *(each)*	100 200 300 400 500	Other Qty _____
Disposable Wash Cloths *(each)*	100 200 300 400 500	Other Qty _____

*May be based on recipient preference of up to 1000 wipes or 1000 wash cloths without requiring an updated prescription/CMN form.

Note to Supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity selected, round to the nearest size packaging to avoid breaking open a package.

Monthly Skincare Supplies *(mark appropriate quantity)*: 1 Unit = One container *(bottle, tube, etc.)* regardless of size or volume.

These supplies are for incontinence treatment only and not for treatment of other areas of the body.

Current utilization requirements limit the following supplies to no more than 2 bottles, containers, etc. of any one product per month or combination of products. Requests for more than a total 2 products per month, regardless of the type of product or combination of products, will not be approved.

Choose only ONE (1) Option below

- ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream
- **OR** ☐ 2 bottles Moisture barrier lotion/ointment/gel/cream
- **OR** ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Protectant Powder
- **OR** ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Skin Cleanser
- **OR** ☐ 1 bottle Protectant Powder AND 1 bottle Skin Cleanser
- **OR** ☐ 1 bottle Protectant Powder
- **OR** ☐ 2 bottles Protectant Powder
- **OR** ☐ 1 bottle Skin Cleanser
- **OR** ☐ 2 bottles Skin Cleanser

ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER

A physician, physician assistant, or nurse practitioner who attests to the medical necessity and quantity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws, and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

I hereby certify that I am the ordering physician, physician assistant, or nurse practitioner identified in this form.

____ ____________________

Signature of Physician / Physician Assistant / Nurse Practitioner Date

Service authorization approval does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

Certificate of Medical Necessity for Incontinence Supplies Instructions

Submission Requirements: This Certificate of Medical Necessity (CMN) for Incontinence Supplies must be completed to request services and must bear the signatures of the professionals who, by signing the form, attest that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements. **Submit all CMN requests directly to Conduent, the fiscal agent**, by fax at 907.644.8131 or by mail at Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808.

Submitted by: Enter the name of the individual submitting the CMN.

Date: Enter the date the CMN is completed.

Member Information *This information is auto-filled on the 2nd page.*

Member Name: Enter the member's last name, first name, and middle initial.

Alaska Medicaid Member ID: Enter the Alaska Medicaid Member ID number.

Date of Birth: Enter the member's date of birth using the calendar feature or a MM/DD/YY format.

Age: Enter the age of the member.

Sex: Select the gender of the member.

***Height:** Enter the member's height in inches.

***Weight:** Enter the member's weight in pounds.

***Note:** Certain services/items cannot be approved without height and weight.*

Date of Last Visit: Enter the date of the member's last visit using the calendar feature or a MM/DD/YY format.

Provider Information *This information is auto-filled on the 2nd page.*

Ordering Provider's Name: Enter the ordering provider's last name, first name, and middle initial.

Provider Medicaid ID or NPI: Enter the ordering provider's Medicaid ID or NPI number.

Phone Number & Ext.: Enter the ordering provider's contact phone number and extension.

Prescription Start Date: Enter the requested prescription start date using the calendar feature or a MM/DD/YY format.

Retrospective Review?: Check 'Yes' or 'No'.

Section A – Clinical Information

***Note:** This section **must** be completed by the attending physician, physician assistant, or nurse practitioner.*

Diagnosis Code (ICD-10): Enter the primary ICD-10 diagnosis code, at a minimum, for the requested services.

Diagnosis Description (ICD-10): Enter the corresponding description for each ICD-10 diagnosis code entered.

Estimated Length of Need: Enter the number of months the requested services or items will be needed. Enter '99' in this field if the services or items requested are needed on a continuous basis for the member's lifetime.

***Note:** Entering a lifetime span does not guarantee payment to the provider for these services or items for the member's lifetime. Medical justification must support the request and the member must meet eligibility requirements for the duration of the authorization. Additionally, lifetime requests are subject to a periodic recertification to ensure medical necessity.*

Section B – Clinical Assessment of Need for Prescribed Services or Item(s) and Plan

***Note:** This section may be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.*

Clinical Assessment of Need for Prescribed Service(s) or Item(s): Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. The member's specific medical condition causing the incontinence must be included in the justification. Medical justification must be complete and thorough in order to process the request. Attach additional supporting documentation as needed for further justification.

Plan: The plan should list each item specifically needed, based on a daily or monthly usage, for the treatment of the member. Attach a detailed treatment plan or other pertinent information as needed.

Attestation, Signature, and Date of Physician/Physician Assistant/Nurse Practitioner: Enter signature of the physician/physician assistant/nurse practitioner submitting the CMN request and date signed. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

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Section C – Requested Services or Items

Provider Name: Enter the supplying provider's last name, first name, and middle initial.

Address: Enter the address of the supplying provider.

Provider Medicaid ID or NPI: Enter the supplying provider's Medicaid ID or NPI number.

Requester Name: Enter the name of the requesting individual.

Phone Number & Ext.: Enter the supplying provider's contact phone number and extension.

Fax Number & Ext.: Enter the supplying provider's fax number and extension, if applicable.

Dates of Need – Start Date / End Date: Enter the start date and end date of the authorization.

Procedure/Drug Code: Enter the procedure/drug code for the service or item requested.

MOD: Enter any applicable modifier codes for the requested service or item.

Description: Enter the description of the requested service or item.

Qty: Enter the quantity of the service to be performed or item to be dispensed.

Charges: Enter the total estimated charges for the requested service or item.

Section D – Supplier Attestation, Signature, and Date: Enter signature and title of the supplying professional submitting the CMN request. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

Certificate of Medical Necessity for Incontinence Supplies Amendments

Any changes to an approved CMN or requests for additional services or items must be requested through the Conduent Service Authorization department. All changes to any field(s) on the approved form must be initialed and dated by the original prescribing medical provider. Additionally, supporting medical documentation justifying medical necessity must accompany any requests for additional services or items.

Maximum Quantities for Incontinence Supplies as of 01/01/2020:

Item	Quantity	Period
ADULT SIZE BRIEF	180	Per Month
ADULT SIZE PULL-ON	180	Per Month
PED SIZE BRIEF/DIAPER	180	Per Month
PED SIZE PULL-ON	180	Per Month
YOUTH SIZE BRIEF/DIAPER	180	Per Month
YOUTH SIZE PULL-ON	180	Per Month
DISPOSABLE LINER/SHIELD/PAD	200	Per Month
DISPOSABLE UNDERPAD	120	Per Month
REUSABLE UNDERPAD	4	Per 3 Months