

Clinical Policy: Incontinence Supplies

Reference Number: TX.CP.MP.508

Last Review Date: 11/19

[Coding Implications](#)

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Description

This policy outlines medical necessity criteria for the authorization of incontinence supplies, which includes: diapers/briefs/pull-ups/liners, wipes, under pads, and emollients. Incontinence describes any accidental or involuntary loss of urine from the bladder or feces from the bowel.

This policy applies to the following products: STAR, STAR Health, STAR Kids, STAR+PLUS, MMP, and CHIP.

Policy/Criteria

I. It is the policy of Superior HealthPlan that incontinence supplies are **medically necessary** when all the following criteria are met:

A. **Documentation Requirements for All Ages**

1. Diagnosis/condition causing incontinence; and
2. Quantity of incontinence supplies requested per month:
 - a. The following procedure codes must be used when billing for diapers, briefs, and liners and are limited to a combined total of 240 per month:
 - i. T4521 T4522 T4523 T4524 T4525 T4526 T4527 T4528 T4529 T4530 T4531 T4532 T4533 T4534 T4535 T4543 T4544
 - b. Procedure code A4335 is limited to two (2) per month and A4554 is limited to 120 per month.
 - c. A request over the limit will require a medical director review.

B. **Birth up to Four Years of Age:**

A medical condition resulting in an increased urine or stool output beyond the typical output for this age group. Examples of such conditions include, but are not limited to celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

Note: Lack of bladder or bowel control is considered developmentally normal for members who are three years of age or younger.

C. **Four Years of Age and Older:**

For members who are four years of age and older, incontinence supplies in the presence of a medical condition that results in an impairment of control of urination and/or stooling.

D. **Nocturnal Enuresis in Children Five and Older:**

1. For members who are five years of age and older diagnosed with nocturnal enuresis, incontinence supplies are limited to 30 under pads per month.

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2. Diapers and wipes are considered **not medically necessary**.
3. Intermittent nocturnal incontinence with discrete episodes of urinary incontinence (during sleep) in children up to age five, as this is considered normal and incontinence supplies are considered **not medically necessary**.

E. Supplies for Adults, 21 and Older:

Absorbent products are considered medically necessary for members diagnosed with incontinence and meet any of the following conditions:

- a. Persistent incontinence despite all appropriate treatments;
- b. Inability to participate in behavioral programs for management of incontinence, due to illness or disability;
- c. Presence of an incontinence disorder that cannot be helped by medications or other therapeutic interventions;
- d. Presence of an incontinence disorder that cannot be corrected by surgery;
- e. Waiting while definitive treatment has a chance to work; or
- f. Prior to surgery.

F. Other Information:

1. Reusable diapers, briefs, pull-ons, liners, wipes, and underpads are not covered benefits.
2. Diaper wipes and emollients may be considered for members who are receiving disposable diapers, briefs, or pull-ups.
3. Gloves used to change diapers, briefs, and/or pull-ons are allowed if member has skin breakdown or documented disease that may be transmitted through urine or feces.

Background

Nocturnal Enuresis:

- Nocturnal enuresis has a high rate of spontaneous resolution. Management of nocturnal enuresis may involve one or a combination of interventions, including:
 - a. Education, reassurance, motivational therapy (examples: sticker or star chart)
 - b. Enuresis alarms
 - c. Desmopressin

Definitions:

- **Pre-treatment Evaluation** – the evaluation of children with enuresis is discussed separately. It is particularly important to look for causes of nocturnal enuresis that may require additional evaluation and treatment (e.g., diabetes mellitus, obstructive sleep apnea, encopresis or constipation, bowel and bladder dysfunction, etc.). It is difficult to successfully treat enuresis if coexistent constipation is not addressed. When evaluating for constipation, it may be helpful to ask about soiling in addition to the usual questions about bowel habits.
- **Absorbent Products** – for purposes of prior authorization, absorbent products are defined as disposable under pads, diapers, briefs, pull-ons, and liners.

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Coding Implications

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CPT® Codes	Description
A4335	Incontinence supply; miscellaneous
A4554	Disposable underpads, all sizes
A4927	Gloves, nonsterile, per 100
T4521	Adult sized disposable incontinence product, brief/diaper, small, each
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each
T4233	Youth sized disposable incontinence product, brief/diaper, each
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each
T4543	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

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Reviews, Revisions, and Approvals	Date	Approval Date
Updated prior authorization protocol and work process. Updated Medicaid allowable list to only include codes requiring authorization. Removed Specific Guidelines since these do not require prior authorization. Added Service Coordination protocol. Updated signatories.	04/14	04/14
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Indicated that HCPC and Diagnosis table is not an inclusive list. Added disclaimer regarding no PA required if DME provider is a SHP preferred DME supplier	04/15	04/15
Removed work process document imbedded in attachment section. Remove work processes from policy. Removed Section B: Diagnosis Requiring Additional Clinical. Added nocturnal enuresis can be normal up to age five and that under pads will be a benefit for members age five and older with nocturnal enuresis. Updated signatories. Grammatical edits. Added absorbent products to definitions.	02/16	02/16
Removed MRSA and CHIP RSA from product type. Added STAR Kids to Product type. Removed member's height, weight, and waist size as requirement for medical necessity review and prior authorization protocol.	12/16	12/16
Grammatical edits. Updated references and signatories.	02/17	02/17
Minor edits. Removed the verbiage "number of times per day the physician has ordered the supplies be used". Removed type/treatment management table from policy.	05/17	05/17
Updated references and signatories. Deleted revision history prior to 2014.	02/18	02/18
Removed description of incontinent supplies and moved to definitions. Removed HCPCS/Medicaid allowable chart. Changed medical necessity review section/title to documentation requirements. Removed benefit limitations. Updated supplies for adults. Grammatical edits. Updated signatories and references.	01/19	01/19
Updated to new template from TX.UM.10.28 (TX.CP.MP.508 nomenclature implementation 11/11/19). Heading 'Birth thru Three Years of Age' changed to 'Birth up to Four Years of Age'. Nocturnal enuresis management information moved to background section. Specified adults as 21 years of age and older. Added section for indications when incontinence supplies are considered not medical necessary. Incontinence supply definition added to description. Updated ICD-10 Code chart. Reviewed against TMPPM October 2019. Updated references.	11/19	11/19

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References

1. 2019 Texas Medicaid Provider Procedures Manual: Incontinence Supplies
2. Management of nocturnal enuresis in children - Wolters Kluwer Health - 20.7 - C20.16 - 6/2012
3. Urinary Incontinence Treatment & Management – Medscape Reference – Sandip P Vasavada, MD, Maude E Carmel, MD, FRCSC, Raymond Rackley, MD, Edward David Kim, MD, FACS, Peter MC DeBlieux, MD, Farzeen Firoozi, MD, Michael S Inber, MD, Shunaha Kim-Fine, MD, Christopher J Klingele, MD, MS, Nur-Ain Nadir, MD, Mark Jeffery Noble, MD, Oflufunmilayo Ogundele, MD, Erik D Schraga, MD, Mark A Silverberg, MD, MMB, FACEP, Richard H Sinert, DO, Kris Strohbehn, MD, Francisco Talavera, PharmD, PhD, Martha K Terris, MD, FACS – 04/05/2012

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

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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.

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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.

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