

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Liggett</i>	DATE <i>6-20-14</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <b>000417</b>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Mr. Heck</i> <i>Cleared 7/17/14, letter attached</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>7-1-14</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			



**RECEIVED**

JUN 20 2014

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

June 19, 2014

Dear Mr. Tony Keck:

Please see the enclosed letter from Eau Claire Cooperative Health Centers, one of the largest medical offices serving Medicaid patients. They will not complete any paperwork unless it is brought into their office by the patient. Other offices have the same policy. Therefore, I do not see how we can comply with the order that we must mail supply orders to physicians for them to complete. Thank you.

Sincerely,

A handwritten signature in black ink that reads "Bill Hayes". The signature is written in a cursive style with a large, stylized "B" and "H".

Bill Hayes  
All Medical, Inc.

## *Eau Claire Cooperative Health Centers, Inc.*

Bill  
Lynn  
ERIN  
miller

Sharon  
miller

STEVEN  
POTERK

Eau Claire Internal Medicine  
4605 Monticello Rd.  
Columbia, SC 29203  
Telephone: 803-754-0151  
Facsimile: 803-691-1778

May 25, 2014

To whom it may concern,

Our office receives numerous medical supply orders on behalf of patients. And, at times simultaneous orders for the same product but from different companies are received. Navigating this situation places an enormous burden on medical provider and staff time. And, this is a time where there is increased monitoring, attention, and scrutiny for waste, fraud, and abuse.

Due to this circumstance, all medical supply orders, including the attached, will be denied until they are brought in and accompanied by the patient for an established follow up office visit. At that time our medical team will consult with the patient and review the order, determine the medical necessity of the order, document in the progress note the medical conditions / facts that support the fulfillment of the order, and verify with the patient that they would like to receive the medical supply from the company attached to the order.

Thank you for your attention to this matter.

Kindly,

Medical Providers of Eau Claire Internal Medicine

---

May 23, 2014  
MB# 14-015

## MEDICAID BULLETIN

CLTC  
MC

**TO: Providers of Incontinence Supplies**

**SUBJECT: Incontinence Supplies Updates**

Effective July 1, 2014, incontinence supply providers will be responsible for obtaining the Physician Certification of Incontinence SCDHHS Form 168IS prior to delivering Incontinence supplies. This policy replaces the June 18, 2013, memo titled Changes in Incontinence Supplies Authorizations, section 2 Physician's Orders.

The Physician Certification of Incontinence SCDHHS Form 168IS is mandatory for all beneficiaries receiving incontinence supplies as a State Plan Home Health benefit. The form must be completed by the primary care physician both initially and at every certification period as selected by the primary care physician. The primary care physician information is gathered at intake once the referral is made to Community Long Term Care centralized intake.

- Beneficiaries enrolled in the Community Choices waiver, Head and Spinal Cord Injury waiver, Intellectual Disabilities and Related Disabilities waiver, HIV/AIDS waiver, Ventilator Dependent waiver, Medically Complex Children's waiver and Community Supports waiver must be re-certified to receive Incontinence supplies every 12 months.
- Non-waiver beneficiaries have certification periods of three months, six months, nine months or 12 months, and the certification period is determined by the primary care physician.

Medicaid prohibits incontinence supply providers from preparing the entire Physician Certification of Incontinence SCDHHS Form 168IS.

- Phoenix will auto-populate the following sections on the SCDHHS Form 168IS: physician address, beneficiary's name, social security number and DOB. The incontinence supply provider will be able to print the DHHS form 168IS from Phoenix.



Nikki Haley GOVERNOR

Anthony Keck DIRECTOR

P.O. Box 8206 • Columbia, SC 29202

www.scdhhs.gov

## PHYSICIAN CERTIFICATION OF INCONTINENCE

TO: \_\_\_\_\_ FROM: \_\_\_\_\_  
(Name of Physician)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(City, State) (ZIP)

BENEFICIARY'S NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB \_\_\_\_\_

Please complete the areas below and return to the "FROM" address above. This beneficiary is requesting incontinence supplies (includes diapers/briefs/pull-ups, wipes, and/or underpads) through the Medicaid Home Health benefit. In order to qualify the beneficiary must have one of the following conditions. Please check any that apply. The form must be fully completed.

☐

Incontinent of bladder

☐

Incontinent of bowel

Certifications for waiver beneficiaries are effective for 1 year from the date the physician signs the initial certification.

Certifications for non-waiver beneficiaries are effective for the timeframe indicated below as certified by the physician signing the certification:

☐

3 months

☐

6 months

☐

9 months

☐

12 months

What is the diagnosis related to incontinence?

\_\_\_\_\_

Does this beneficiary use any appliances (e.g. catheter, ostomy) to prevent incontinence? If so, please list

\_\_\_\_\_

Comments: \_\_\_\_\_

Please indicate **one** of the following:

☐Incontinence Supplies are **NOT** medically necessary.☐Incontinence Supplies are **MEDICALLY NECESSARY** for this Medicaid beneficiary.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Nurse Practitioner or Physician Assistant signatures are not acceptable)





P.O. Box 1296  
Columbia, S.C. 29202

COLUMBIA,  
SC 29202  
19 JUN '14  
PM 4:41

**RECEIVED**

JUN 20 2014

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Anthony Keck, Director  
P.O. Box 8206  
Columbia, SC 29202



29202820606

Close Log 417 ✓

SOUTH CAROLINA

Healthy Connections  
MEDICAID



Nikki Haley GOVERNOR

Anthony Keck DIRECTOR

P.O. Box 8206 > Columbia, SC 29202

www.scdhhs.gov

July 17, 2014

Mr. Bill Hayes  
All Medical  
2011 Hampton Street  
Po Box 1296  
Columbia, South Carolina 29202

Dear Mr. Bill Hayes:

Thank you for your letter regarding the Physician Certification of Incontinence Form 168IS.

The Physician Certification of Incontinence Form 168IS must be completed as a condition of the medical necessary criteria for incontinence supplies under the Medicaid State Plan Home Health benefit. The Medicaid Bulletin, *Incontinence Supplies Updates*, dated May 23, 2014 states that the incontinence supply provider must send the form to the primary care physician to complete.

There are several methods by which the Form 168IS can be sent to the primary care physician to complete. Prior to the May 23, 2014 bulletin, the practice has been to mail the Form 168IS to the primary care physician. However, this is a practice not a requirement.

Some incontinence providers have asked if the Form 168IS can be faxed. If the physician's office accepts documents by fax then yes you can fax. Please check with the primary care physician's office prior to faxing.

The Form 168IS can be brought in and accompanied by the patient for an established office visit if that is required by the primary care physician's office. This would have to be coordinated and communicated between the patient, incontinence provider and primary care physician's office.

Thank you for your continued support in the South Carolina Healthy Connections Medicaid program.

Sincerely,

*Nicole Mitchell-Threatt*

Nicole Mitchell-Threatt  
Program Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
<i>Liggett / Nicole</i>	<i>6-20-14</i>

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APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. <i>Nicole can sign. Letter is ok. BCL</i>			
2.			
3.			
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OFFICE OF THE DIRECTOR

June 19, 2014

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Sincerely,

A handwritten signature in cursive script that reads "Bill Hayes".

Bill Hayes  
All Medical, Inc.

## ***Eau Claire Cooperative Health Centers, Inc.***

Bill  
Lynn  
Erin  
M. 1020

Sharon  
M. 122

STEVEN  
POTERICK

Eau Claire Internal Medicine  
4605 Monticello Rd.  
Columbia, SC 29203  
Telephone: 803-754-0151  
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Nikki Haley GOVERNOR

Anthony Keck DIRECTOR

P.O. Box 8206 &gt; Columbia, SC 29202

www.scdhhs.gov

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TO: \_\_\_\_\_ FROM: \_\_\_\_\_  
 (Name of Physician) \_\_\_\_\_  
 (Address) \_\_\_\_\_  
 (City, State) \_\_\_\_\_ (ZIP) \_\_\_\_\_

BENEFICIARY'S NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_

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12 months

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 \_\_\_\_\_Does this beneficiary use any appliances (e.g. catheter, ostomy) to prevent incontinence? If so, please list  
 \_\_\_\_\_

Comments: \_\_\_\_\_

Please indicate **one** of the following:☐Incontinence Supplies are **NOT** medically necessary.☐Incontinence Supplies are **MEDICALLY NECESSARY** for this Medicaid beneficiary.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Nurse Practitioner or Physician Assistant signatures are not acceptable)





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Columbia, S.C. 29202

COLUMBIA,  
SC 29202  
19 JUN '14  
PM 4:11

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JUN 20 2014

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Anthony Keck, Director  
P.O. Box 8206  
Columbia, SC 29202



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