DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
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DSS
Strong Families - South Dakota's Foundation and Our Future

September 20, 2019

ATTENTION: Medicaid Providers

FROM: South Dakota Medicaid and Department of Human Services

RE: Incontinence Supplies Prior Authorization

Effective July 1, 2019 SD Medicaid will cover $1,345 per recipient per plan year (July 1- June 30) for incontinence supplies. Recipients may exceed this limit with prior authorization (PA) through the recipient's appropriate Level of Care program. The Family Support waiver has auto-authorized recipients with a Family Support Level of Care for an annual limit of $2,250.

Prior authorization
The recipient's provider will submit a PA when a recipient is close to reaching the limit for incontinence supplies during the plan year (July1 – June 30). Submitting a PA prior to the recipient reaching the limit may result in incorrect billing and/or claim denials. The PA must include the relevant CPT and the estimated monthly units. The Certificate of Medical Necessity (CMN) must be submitted with the PA. The provider can use the current CMN already on record for the recipient; a new CMN is not required. The CMN must be updated annually. The provider should also include any other supporting documentation detailing the reason the recipient needs incontinence supplies exceeding the annual limit. Physician documentation should support the needs of the recipient. For further guidance on documentation and billing requirements, refer to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Manual.

Submitting prior authorization requests
Prior authorization requests for incontinence supplies must be submitted via fax to the Division associated with the recipient's Level of Care. PA's submitted to the incorrect Division will be denied and will need to be resubmitted to the appropriate Division. **Recipient Level of Care can be verified using the South Dakota Medicaid Online Portal.**

Level of Care	Division	Fax Number
ADLS	Rehabilitation Services	605-773-5483
HOPE	Long Term Services and Supports	605-773-4085
Family Support 360	Developmental Disabilities	605-773-7562
CHOICES	Developmental Disabilities	605-773-7562
All Others	DSS	605-773-5246

Sincerely,

South Dakota Medicaid

Incontinence Prior Authorization Form

ADLS WAIVER – Fax to 605-773-5483

This form must be submitted with Medical records to support services. To find level of care please refer to the "Look-up Level of Care" guidance found on the DSS website.

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ◉ M ○ F
Last Name:	**First Name:**	
Level of Care:		
GENERAL INFORMATION		
Date service limit exceeded:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
PROVIDER INFORMATION		
Servicing Provider Name:		
Point of Contact Name and Title:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Address:		
Fax:	**Phone:**	
Referring Provider Name:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ◯ M ◉ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment.		
DME PROVIDER INFORMATION		
Provider Name:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
SUPPLIES INFORMATION		
Description and Function of Supplies: (including HCPCS)		
Estimated number of Units:	**Price per unit:**	
Manufacturer:		

This form meets the requirements for South Dakota Medicaid found in ARSD 67:16:29:04.02.

Incontinence Prior Authorization Form

CHOICES WAIVER – Fax to 605-773-7562

This form must be submitted with Medical records to support services. To find level of care please refer to the "Look-up Level of Care" guidance found on the DSS website.

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ◯ M ◯ F
Last Name:	**First Name:**	
Level of Care:		
GENERAL INFORMATION		
Date service limit exceeded:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
PROVIDER INFORMATION		
Servicing Provider Name:		
Point of Contact Name and Title:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Address:		
Fax:	**Phone:**	
Referring Provider Name:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ◯ M ◯ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment.		
DME PROVIDER INFORMATION		
Provider Name:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
SUPPLIES INFORMATION		
Description and Function of Supplies: (including HCPCS)		
Estimated number of Units:	**Price per unit:**	
Manufacturer:		

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Incontinence Prior Authorization Form

FAMILY SUPPORT WAIVER – Fax to 605-773-7562

This form must be submitted with Medical records to support services. To find level of care please refer to the "Look-up Level of Care" guidance found on the DSS website.

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ◯ M ◯ F
Last Name:	**First Name:**	
Level of Care:		
GENERAL INFORMATION		
Date service limit exceeded:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
PROVIDER INFORMATION		
Servicing Provider Name:		
Point of Contact Name and Title:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Address:		
Fax:	**Phone:**	
Referring Provider Name:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ◯ M ◯ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment.		
DME PROVIDER INFORMATION		
Provider Name:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
SUPPLIES INFORMATION		
Description and Function of Supplies: (including HCPCS)		
Estimated number of Units:	**Price per unit:**	
Manufacturer:		

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Incontinence Prior Authorization Form

HOPE WAIVER – Fax to 605-773-7562

This form must be submitted with Medical records to support services. To find level of care please refer to the "Look-up Level of Care" guidance found on the DSS website.

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ◯ M ◯ F
Last Name:	**First Name:**	
Level of Care:		
GENERAL INFORMATION		
Date service limit exceeded:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
PROVIDER INFORMATION		
Servicing Provider Name:		
Point of Contact Name and Title:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Address:		
Fax:	**Phone:**	
Referring Provider Name:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ◯ M ◯ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment.		
DME PROVIDER INFORMATION		
Provider Name:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
SUPPLIES INFORMATION		
Description and Function of Supplies: (including HCPCS)		
Estimated number of Units:	**Price per unit:**	
Manufacturer:		

This form meets the requirements for South Dakota Medicaid found in ARSD 67:16:29:04.02.