

# Review Request for Treatment for Urinary Incontinence and Urinary Retention



Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

**Provider Data Collection Tool Based on Medical Policy SURG.00010**

Policy Last Review Date: 02/25/2010	Policy Effective Date: 02/25/2010	Provider Tool Effective Date: 04/14/2010
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:
Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	
Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient
Service Requested (CPT if known):	<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

- Request is for treatment of urinary incontinence
  - Adult Member
  - Pediatric Member
  - Male Member
  - Female Member

**Please fill out the appropriate section below based on requested treatment modality:**

**Behavioral Training**

- Request is for Behavioral training (check all that apply):
  - Bladder training
  - Prompted voiding
  - Pelvic muscle exercise training
  - Vaginal weight training with specially designed weights (cones) in all cases
  - Other(s) (Please describe): \_\_\_\_\_

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**Periurethral Bulking Agents**

- Request is for injecting FDA-approved periurethral bulking agents (check all that apply):
  - Request is for cross linked collagen:
    - Five (5) or less injections a week or more apart
    - Initial treatment
    - Repeat treatment (check all that apply):
      - Member achieved continence after initial treatment
      - Member's incontinence has recurred after 10-19 months of achieving continence due to:
        - Collagen degradation
        - Other (please describe): \_\_\_\_\_

Request is for (check all that apply):

- Carbon coated beads
- Copolymer
- Calcium hydroxylapatite
- Polydimethylsiloxane
- Teflon
- Three (3) or less injections a week or more apart
- Initial treatment
- Repeat treatment
- Other (please describe): \_\_\_\_\_

Member meets the following criteria (check all that apply):

- Member has stress urinary incontinence (SUI)
- Member has intrinsic sphincter deficiency (ISD)
- Member has post-traumatic injury
- Member has post surgical injury
- Member has urethral hypermobility
- Member has an abdominal leak point less than 100 cm H<sub>2</sub>O
- Member has completed at least 12 consecutive months of conventional therapy (e.g., exercise and/ or pharmacotherapy):
  - Member's incontinence has improved
  - Member's incontinence has not improved
  - Other (please describe): \_\_\_\_\_

**Sacral Nerve Stimulator**

- Request is for placement of a sacral nerve stimulator for (check all that apply):
  - Urge incontinence due to (check all that apply):
    - Neurologic condition (e.g., detrusor hyperreflexia)
    - Other (please describe): \_\_\_\_\_
  - Urinary urgency/frequency
  - Non-obstructive urinary retention
  - Stress incontinence
    - Due to neurologic conditions (e.g. spinal cord injury, diabetic neuropathy, multiple sclerosis)
    - Other (please describe): \_\_\_\_\_
  - Chronic voiding dysfunction
    - Due to neurologic conditions (e.g. spinal cord injury, diabetic neuropathy, multiple sclerosis);
    - Other (please describe): \_\_\_\_\_
  - Non urinary indications (e.g. chronic pelvic pain, constipation, fecal incontinence)
  - Other (please describe): \_\_\_\_\_

- Implantation is temporary
  - Peripheral nerve evaluation test has been done:
    - Test results are positive
    - Test results are negative
  - Member meets the following criteria (check all that apply):
    - Member has experienced urge incontinence for a minimum of 12 months associated with:
      - Absence of neurologic condition
      - Significant disability (frequency and/or severity impacts ability to work or participate in activities outside of the home)
    - Member has experienced urinary retention for a minimum of 12 months associated with:
      - Absence of neurologic condition
      - Significant disability (frequency and/or severity impacts ability to work or participate in activities outside of the home)
    - Member is refractory to a minimum of 12 consecutive months of conservative treatments (e.g., exercise and / or pharmacotherapy)
    - Member is intolerant to a minimum of 12 consecutive months of conservative treatments (e.g., exercise and /or pharmacotherapy)
    - Member has failed a trial of 12 consecutive months of intermittent catheterizations
    - Member is intolerant to intermittent catheterizations after a trial of 12 consecutive months
    - Member is an appropriate surgical candidate for permanent implantation
    - Other (please describe): \_\_\_\_\_
- Implantation is permanent
  - Member has had a successful trial of temporary sacral nerve stimulator as defined by (check all that apply):
    - Urinary urge incontinence: At least 50% reduction in one of the following: daily incontinence episodes, severity of the episodes or the number of pads/diapers used per day.
    - Urinary urge/frequency: At least 50% reduction in one of the following: number of voids daily, volume per void and frequency per void.
    - Urinary retention: At least a 50% reduction in catheter volume/catheterization.
  - Member is an appropriate surgical candidate for permanent implantation.
  - Other (please describe): \_\_\_\_\_

**Surgery**

- Request is for Surgery
  - Member has incontinence
  - Member is not responsive to other therapy
  - Other (please describe): \_\_\_\_\_

**Artificial Urinary Sphincter**

- Request is for artificial urinary sphincter implantation as a treatment for:
  - Intrinsic Sphincter Deficiency (ISD)
    - Refractory
    - Non refractory
  - Stress Urinary Incontinence (SUI)
    - Refractory
    - Non-refractory
  - Other (please describe): \_\_\_\_\_

**Biofeedback**

- Request is for Biofeedback
  - Electrical
  - Computerized
  - With behavioral therapy
  - Other (please describe): \_\_\_\_\_

**Pelvic Floor Stimulation**

- Request is for Pelvic floor stimulation
  - Electrical innervations
  - Extracorporeal magnetic innervations
  - Other (please describe): \_\_\_\_\_

**Percutaneous tibial nerve stimulation (PTNS)**

- Request is for percutaneous tibial nerve stimulation for (check all that apply):
  - Overactive bladder symptoms (check all that apply):
    - Urinary urgency
    - Urinary frequency
    - Urge incontinence
  - Other (please describe): \_\_\_\_\_
    - Stress incontinence
    - Non-obstructive urinary retention
    - Interstitial cystitis
  - Other (please describe): \_\_\_\_\_

**Other Treatments**

- Request is for transvaginal radiofrequency bladder neck suspension as a treatment of:
  - Stress Urinary Incontinence
  - Other (please describe): \_\_\_\_\_
- Request is for transurethral radiofrequency energy collagen micro-remodeling as a treatment of:
  - Stress Urinary Incontinence
  - Other (please describe): \_\_\_\_\_

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative \_\_\_\_\_ Date \_\_\_\_\_  
Completing Form and Attestation (Please Print)\*

**\* The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**