



Urological

Documentation Requirements

All Insurances

- ★ Urological Supplies Prescription
- ★ Medical records (see below for criteria)

Medical Record Requirements

- ★ Face to face visit with treating practitioner documenting patient's urinary incontinence or retention
 - For Medicaid, this visit must take place within 6 months of the order.
 - Patient must have a permanent impairment documented. Medical records must support that the condition is of a long and indefinite duration (ordinarily at least 3 months).
 - Frequency of use for catheters must be documented. Ranges (i.e. 1-2 times per day) are not acceptable.
- ★ For Coude Tip Catheters
 - Records must support why a straight tip catheter will not work. An example would be the inability to pass a straight tip catheter due to an enlarged prostate.
- ★ For Sterile Catheter Kits – must meet one of the following:
 - Patient is immunosuppressed,
 - Patient has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,
 - Patient is a spinal cord injured female with neurogenic bladder who is pregnant,
 - Patient has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization and sterile lubricant, twice within the 12-month prior to the initiation of sterile intermittent catheter kits.
 - Documented UTIs must have medical records supporting:
 - Urine culture with greater than 10,000 colony forming units of a urinary pathogen AND one of the following: Fever (100.4 F); Systemic leukocytosis; change in urinary urgency, frequency, or incontinence; appearance of new or increase in autonomic dysreflexia; physical signs of prostatitis, epididymitis, orchitis; increased muscle spasms, pyuria.
- ★ Irrigation of an indwelling catheter is rarely covered. If your patient may need irrigation, please call our office to discuss the documentation requirements.