ADVANCED MEDICAL SOLUTIONS
"Your Complete Home Medical Equipment Company"
517-548-1443 OPTION 5 FAX: 517-548-1585

Clear Form

Urology Detailed Written Order Prior to Delivery

Referral Source: _____

Patient Name: _____

Account #: _____ Patient DOB: _____

Gender: ☐ Male ☐ Female

Order Date: _____

☐ ***Chart Notes Attached***
(Chart notes must include the need for the supplies ordered)

☐ ***Face Sheet/Demographics Faxed***

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

DIAGNOSIS (Check appropriate diagnosis below)		**DURATION OF NEED**: _____months (1-99 months; 99=Lifetime)
☐	R33.9 – Urinary Retention	Latex Allergy: ☐ Yes ☐ No
☐	R32 – Urinary Incontinence	UTI History: ☐ Yes ☐ No (Please fax a copy of lab work and/or supporting documentation with this form).
☐	Other Primary Diagnosis: _____	
☐	Secondary Diagnosis: _____	

CATHETER PRODUCT TYPES (HCPCS)		**FRENCH SIZE**
☐	Straight Catheter (A4351)	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ Other: _____
☐	Catheter Kit (A4353) w/ Insertion Supplies	
☐	Coude Catheter (A4352)	

FREQUENCY			
☐	2 per day/60 per month/180 per 3 months	☐	5 per day/150 per month/450 per 3 months
☐	3 per day/90 per month/270 per 3 months	☐	6 per day/180 per month/540 per 3 months
☐	4 per day/120 per month/360 per 3 months	☐	Other _____ per day _____ per month _____ per 3 months

OTHER PRODUCT TYPES, SIZES and QUANTITIES	
☐	Lubricant Packets 3gm (A4332) Quantity (# of packets) _____ per month
☐	Male External Catheters (A4349) Length: _____ ☐ 35 per month/105 per 3 months ☐ Other ____ per day _____ per 3 months
☐	Leg Bags (A4358) ☐ 500ml ☐ 1000ml ☐ 2 per month/6 per 3 months ☐ Other_____ per day _____per 3 months
☐	Drainage Bags (A4357) ☐ 2000ml ☐ Other: _____ ☐ 2 per month/6 per 3 months ☐ Other____ per day ____ per 3 months
☐	Other: _____ ☐ Quantity Per Month: _____

PRESCRIBING PHYSICIAN INFORMATION

Name & Credentials _____

Telephone _____

Signature _____

(Stamped signature not accepted)

NPI # _____

Fax _____

Signature Date _____

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

INTERMITTENT CATHETERIZATION

Intermittent catheterization is covered when basic coverage criteria are met and the beneficiary or caregiver can perform the procedure.

For each episode of covered catheterization, Medicare will cover:

A. One catheter (A4351, A4352) and an individual packet of lubricant (A4332); or
B. One sterile intermittent catheter kit (A4353) if additional coverage criteria (see below) are met.

Intermittent catheterization using a sterile intermittent catheter kit (A4353) is covered when the beneficiary requires catheterization and the beneficiary meets one of the following criteria (1-5):

1. The beneficiary resides in a nursing facility,
2. The beneficiary is immunosuppressed, for example (not all-inclusive):
   - on a regimen of immunosuppressive drugs post-transplant,
   - on cancer chemotherapy,
   - state such as chronic oral corticosteroid use
   - has AIDS,
   - has a drug-induced
3. The beneficiary has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,
4. The beneficiary is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only),
5. The beneficiary has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant A4332, twice within the 12-month prior to the initiation of sterile intermittent catheter kits.

A beneficiary would be considered to have a urinary tract infection if they have a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of one or more of the following signs, symptoms or laboratory findings:

- Fever (oral temperature greater than 38º C [100.4º F])
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
- Physical signs of prostatitis, epididymitis, orchitis
- Increased muscle spasms
- Pyuria (greater than 5 white blood cells [WBCs] per high-powered field)

Usual Maximum of Supplies Code

	Number per Month
A4332	200
A4351	200
A4352	200
A4353	200

Use of a Coude (curved) tip catheter (A4352) in female beneficiaries is rarely reasonable and necessary. When a Coude tip catheter is used (either male or female beneficiaries), there must be documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter. This documentation must be available upon request. If documentation is requested and does not substantiate medical necessity, claims will be denied as not reasonable and necessary.

EXTERNAL CATHETERS/URINARY COLLECTION DEVICES

Male external catheters (condom-type) or female external urinary collection devices are covered for beneficiaries who have permanent urinary incontinence when used as an alternative to an indwelling catheter.

The utilization of male external catheters (**A4349**) generally should not exceed 35 per month. Greater utilization of these devices must be accompanied by documentation of medical necessity.

Male external catheters (condom-type) or female external urinary collection devices will be denied as not reasonable and necessary when ordered for beneficiaries who also use an indwelling catheter.

Specialty type male external catheters (A4326) such as those that inflate or that include a faceplate or extended wear catheter systems are covered only when documentation substantiates the medical necessity for such a catheter. If documentation does not justify the medical need claims will be denied as not reasonable and necessary.

For female external urinary collection devices, more than one meatal cup (A4327) per week or more than one pouch (A4328) per day will be denied as not reasonable and necessary.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.