



Urological Documentation

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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 a neurogenic bladder who is pregnant.
 - Patient has distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization and sterile lubricant, twice within the 12-month period 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.