Clear Form

Harvard Pilgrim Health Care

Urinary Incontinence Surgeries
Medicare Advantage Prior Authorization Request Form — Fax: 866-874-0857

ONLY COMPLETED FORMS CAN BE PROCESSED
Harvard Pilgrim reserves the right to request additional clinical information.
Incomplete forms or lack of supporting documentation may delay response time.

Please check the box below only if request meets the definition of "expedited."

☐ Expedited: Medicare defines expedited requests as those where "applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function."

Patient Information	**Person Completing Form**
Patient name:	Name:
HPHC member ID #:	Phone #:
Date of birth:	Fax #:
Requesting Provider	**Servicing Provider/Facility**
Name:	Name:
HPHC provider ID #	Address
NPI #:	
Date of service:	HPHC provider ID # (*if known*)
Diagnosis:	Tax ID #:
ICD-10 code:	
Service type: ☐ Inpatient ☐ Outpatient ☐ Other	Number of visits/units requested:
Service location:	Authorization type:

Procedure code(s) — *Check all codes that apply*:

☐ 51715	☐ 51990	☐ 53442	☐ 53446	☐ 53449
☐ 51840	☐ 51992	☐ 53444	☐ 53447	☐ 57287
☐ 51841	☐ 53440	☐ 53445	☐ 53448	☐ 57288
☐ 51845				

If you have any questions about this process, please contact the Medicare Advantage Provider Service Center at **888-609-0692.**

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Click to view *Harvard Pilgrim's Medical Review Criteria for the Urinary Incontinence Surgeries Policy.*

Procedure	Criteria (check all that apply)
Artificial Urinary Sphincter (AUS) Surgery	Documentation confirms a member has on-going urinary incontinence due to intrinsic urethral sphincter deficiency (IUSD). ***Check all that apply:*** ☐ Epispadias-exstrophy, with history of failed bladder neck reconstruction ☐ Female with ongoing intractable urinary incontinence, and documentation confirms history of failure of *all*: ☐ Behavioral therapy ☐ Pharmacological therapy ***and*** ☐ Prior surgical treatment(s) for incontinence ☐ Requests for surgical procedures for members age 18 and over are reviewed using criteria listed below. (Requests for surgical procedures for members under age 18 are approved without review for medical necessity.) ☐ Member at least 6 months post-prostatectomy surgery has severe on-going incontinence following trials of behavioral and pharmacological therapies
Bladder Neck Suspension/Sling	Documentation confirms a female member with mild to moderate urinary incontinence and a negative urine culture. ***Check all that apply:*** ☐ Symptoms that interfere with Activities of Daily Living (ADLs) and Instrumental ADLs for at least 6 months ☐ Urge incontinence has been excluded ***or*** successfully treated with medication ☐ Documentation confirms member's medications are not contributing to symptoms
Periurethral Bulking Agents • Covered agents must be FDA-cleared.	***Check all that apply:*** ☐ Urinary incontinence caused by intrinsic sphincter deficiency, ***and*** ☐ Failure of 12 months of conservative therapy (e.g., exercise and pharmacotherapy), ***or*** ☐ Contraindication(s) to sling, ***or*** ☐ Previous sling failure in a member planning to have children, or a member with multiple co-morbidities ☐ Member with urethral hyper mobility ☐ Documented abdominal leak point remaining < 100 cm H2O after at least 12 months of conservative therapy (e.g. exercise and pharmacotherapy) ***or*** ☐ Contraindication(s) to sling, ***or*** ☐ Previous sling failure in a member planning to have children, or a member with multiple co-morbidities

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Urethral Sling Procedure	Documentation confirms a male with mild to moderate urinary incontinence and a negative urine culture. ***Check all that apply:*** Symptoms that interfere with Activities of Daily Living (ADLs) and Instrumental ADLs for at least 6 months Urge incontinence has been excluded by cystometry or urodynamics, ***or*** has been successfully treated with medication Documentation confirms member's medications are not contributing to stress incontinence
Describe previous treatments and outcomes, if applicable:	
I attest that this form has been completed by me or my designee and that all information is true and correct.	MD Name