Priority Health	BILLING POLICY No. 036
UROLOGICAL SUPPLIES	
Effective date: Aug. 1, 2024 **Date of origin: May 2024**	**Review dates: 11/2024, 2/2025**

The purpose of this policy is to identify the payment policy and documentation requirements associated with urological supplies.

APPLIES
Commercial plans

DEFINITION
Priority Health will limit the quantity of urological supplies in accordance with the Centers for Medicare and Medicaid Services (CMS) coverage policies. The medical necessity for use of supplies above the amounts specified in this policy must be well documented in the member's medical record and should be submitted with an appeal for review of items exceeding the limits.

POLICY SPECIFIC INFORMATION
Documentation requirements

- We're aligning with CMS standard documentation requirements for supplies and DME, as outlined in article A55426. Reference this article for documentation requirements.
- Documentation must support refill requests as outlined in the article above.
- Supplies should not be dispensed for more than a 3-month quantity.
- A written order for supplies must be on file and dated prior to the date the member receives the supplies.
- The narrative in the NTE Segment of the electronic claim should outline the number of months being billed. This is in addition to the description of the supplies being provided (if applicable).
- Supplies with a date of service (DOS) during or before a discharge date for an inpatient facility stay will be denied.
- Proof of delivery must be detailed in the medical record. Failure to detail the date of delivery as outlined by CMS in the standard documentation requirements article may result in denial of claim or overpayment recovered.

Place of service
Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Urological supply maximum quantities

INDWELLING CATHETERS
No more than one catheter per month is payable for routine catheter maintenance:

- A4310
- A4311
- A4312
- A4313
- A4314

- A4315
- A4316
- A4353
- A4354

CATHETER INSERTION TRAY
One insertion tray will be payable per episode of indwelling catheter insertion:

- A4310
- A4311
- A4312
- A4313
- A4314
- A4315
- A4316
- A4353
- A4354

URINARY DRAINAGE COLLECTION SYSTEM
Maximum quantity of supplies:

- A4341 – 1 per month
- A4315 – 1 per month
- A4316 – 1 per month
- A4354 – 1 per month
- A5112 - 1 per month
- A4357 – 2 per month
- A4358 – 2 per month
- A5102 - 3 per month

CONTINUOUS IRRIGATION OF INDWELLING CATHETERS
More than one irrigation tubing set (A4355) per day for continuous catheter irrigation will be denied as not payable.

INTERMITTENT CATHETERIZATION
Maximum quantity of supplies for intermittent catheterization is 200 per month:

- A4332
- A4351
- A4352
- A4353

EXTERNAL CATHETERS/URINARY COLLECTION DEVICES
The utilization of male external catheters (A4349) should not exceed 35 per month.
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.
INFLOW DEVICE
The inFlow device (A4341) is allowable as an alternative to intermittent catheterization for cases where Permanent Urinary Retention (PUR) due to Impaired Detrusor Contractility (IDC) is present. One inFlow

device is payable every 29 days. Claims for the inFlow device billed more than once every 29 days will be denied.

MISCELLANEOUS SUPPLIES

- Appliance cleaner (A5131) – 1 unit per month
- External urethral clamp or compression device (A4356) – 1 unit every 3 months
- Tape (A4450, A4452) – 10 units per month
- Adhesive skin attachment (A4333) – 3 units per week
- Leg strap (A4334) – 1 unit per month

Other items that may be used for incontinence will not be separately paid. These items are not prosthetic devices nor are they required for the effective use of a prosthetic device. This list may not be all inclusive:

- Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250)
- Catheter care kits (A9270)
- Adhesive remover (A4455, A4456) (Coverage remains for use with ostomy supplies.)
- Catheter clamp or plug (A9270)
- Non-Disposable underpads (A4553)
- Disposable underpads, e.g., Chux (A4554)
- Diapers, or incontinent garments, disposable or reusable (A4520)
- Drainage bag holder or stand (A9270)
- Urinary suspensory without leg bag (A9270)
- Measuring container (A9270)
- Urinary drainage tray (A9270)
- Gauze pads (A6216, A6217, A6218) and other dressings (coverage remains under other benefits, e.g. surgical dressings)
- Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270)
- Disposable external urethral clamp or compression device, with pad and/or pouch, (A4360)

MODIFIERS
KX modifier must be appended to indicate that policy criteria has been met.

MEDICARE
Medicare NCD, LCD or article policy criteria should be followed.
KX, GA, GY, GZ Modifiers – Per CMS local coverage determinations, one of these modifiers are required for claim processing Medicare DME items. Review applicable LCD for additional guidelines.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim

submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 11, 2024	Added "Place of service" section
Feb. 13, 2025	Added "Disclaimer" section