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TO: <b>Dr.</b>	FROM: <b>CESCO Medical</b>
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RE:	DOB:

<input type="checkbox"/> URGENT	<input checked="" type="checkbox"/> FOR REVIEW	<input type="checkbox"/> PLEASE COMMENT	<input checked="" type="checkbox"/> PLEASE REPLY	<input type="checkbox"/> PLEASE RECYCLE
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**The Following is the verbiage from the Medicare LCD for qualifying coverage criteria for EXTERNAL MALE CATHETERS:**

Urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that beneficiary within 3 months. The beneficiary must have a permanent impairment of urination. This does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the medical record, including the judgment of the treating practitioner, indicates the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met

Male external catheters (condom-type) 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. 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.

*URINARY DRAINAGE COLLECTION SYSTEM* – 2 per month of each style is usual maximum. Leg Bags are only allowed for ambulatory or wheelchair bound beneficiaries.

**\*MEDICARE REQUIRES CURRENT  
CHART NOTES THAT STATE THE  
ABOVE INFORMATION\***

**MALE EXTERNAL CATHETER SUPPLY Rx**

Dr. \_\_\_\_\_

NPI # \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis (ICD-10) \_\_\_\_\_

Date of Face to Face Exam \_\_\_\_\_

Y     N     **Does the patient have permanent urinary incontinence or  
Permanent urinary retention? (Longer than 3 months)**

Y     N     **Is the patient having a 60-day episode of Home Health Care for  
any reason?**

	Supply Items	Quantity per Month
1.	<u><b>Condom Catheters</b></u>	/ <u><b>35</b></u>
2.	<u><b>Leg Bag</b></u>	/ <u><b>2</b></u>
3.	<u><b>Drain Bag</b></u>	/ <u><b>2</b></u>
4.	<u><b>Extension Tubing</b></u>	/ <u><b>2</b></u>
5.	<u><b>Catheter Leg Strap-Cloth</b></u>	/ <u><b>1</b></u>
6.	<u><b>Catheter Leg Strap-Adhesive</b></u>	/ <u><b>12</b></u>

Length of Need (*MAX of 12 months*) \_\_\_\_\_ Months

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date