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TO: Dr.	FROM: CESCO Medical
FAX NUMBER:	DATE:
PHONE NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
RE:	DOB:

☐ URGENT	☑ FOR REVIEW	☐ PLEASE COMMENT	☑ PLEASE REPLY	☐ PLEASE RECYCLE

If you believe that you have received this fax in error, please follow these instructions:

The Following is the verbiage from the Medicare LCD for qualifying coverage criteria for INTERMITTENT 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.

Intermittent catheterization (self-catheter) is covered when basic coverage criteria (above) are met and the beneficiary or caregiver can perform the procedure. For each episode of covered catheterization, Medicare will cover one catheter and an individual packet of lubricant.

Use of a Coude (curved) tip catheter 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.

MEDICARE REQUIRES CURRENT CHART NOTES THAT STATE THE ABOVE INFORMATION

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INTERMITTENT 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?

_____**/day Number of times, per day, that the Patient performs self-catheterization.**

Supply Items	Quantity per Month
1. **Self Catheters**	**/** _____
2. **Lube Jelly Tubes**	**/** _____
3. **Lube Jelly Packets**	**/** _____
4. _____	**/** _____
5. _____	**/** _____

Length of Need *(MAX of 12 months)* _____ Months

_____ _____
Physician Signature Date