Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Preview questionnaire: Sacral nerve stimulation

For BCN HMO℠ (commercial) and BCN Advantage℠ members

For Blue Cross Medicare Plus Blue℠ PPO members

Sacral nerve stimulation

Services must meet medical necessity criteria. Submit prior authorization requests through the e-referral system. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and the plan cannot authorize it, the plan will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.

Applicable procedure codes: *64561 and *64581

See below for the questions you'll encounter for this procedure in the e-referral system.

1.*The Sacral Nerve Neuromodulation/Stimulation Questionnaire is required Questionnaire Assessment.
2.Please attach any clinical information you would like BCBSM to consider for this request from the patients medical record up in the Case Communication field.

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Sacral Nerve Neuromodulation/Stimulation

Answering the question(s) below will provide additional information needed to process your request.

Q Is this request for urinary incontinence for a patient with ANY of the following (1-4)? 1. Urge incontinence. 2. Urgency-frequency syndrome. 3. Non-obstructive urinary retention. 4. Over active bladder.

A [ ] Possible answers: ☐ Yes ☐ No ☐ N/A

Q Is this a request for urinary incontinence that is due to stress incontinence?

A [ ] Possible answers: ☐ Yes ☐ No ☐ N/A

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See below for the questions you'll encounter for this procedure in the e-referral system. (cont'd.)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient's medical record document failure or intolerance to AT LEAST TWO of the following conventional therapies for treating urinary incontinence (1-5)? 1. Behavioral bladder training. 2. Prompted voiding. 3. Pelvic muscle exercise training. 4. Maximal medication therapy (dose and duration), unless contraindicated or not tolerated. 5. Surgical corrective therapy (unless contraindicated or it has been determined that the patient would not benefit from corrective surgery)? A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is this request for chronic fecal incontinence AND more than two incontinent episodes per week for more than 6 months (or more than 12 months after vaginal childbirth)? A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Does the patient's medical record document failure or intolerance to conventional therapies for treating fecal incontinence (for example, dietary modification, the addition of bulking agents, maximal medication management (dose and duration)? A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is the patient's fecal incontinence related to EITHER anorectal malformation (for example, congenital anorectal malformation; defects of the external anal sphincter over 60 degrees; visible sequelae of pelvic radiation; active anal abscesses and fistulae) OR chronic inflammatory bowel disease? A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A

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See below for the questions you'll encounter for this procedure in the e-referral system. (cont'd.)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Has the patient had rectal surgery in the past 12 months OR the past 24 months for a patient with cancer? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is the incontinence (urinary or fecal) related to a neurologic condition (for example, detrusor hyperreflexia, multiple sclerosis or spinal cord injury)? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is this request for a TRIAL period of sacral nerve stimulation? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A
Q Is this a request for a PERMANENT implantation of sacral nerve stimulation device AND the patient has completed a trial period for at least 1 week AND the patient has had at least 50 percent improvement in symptoms during the trial period? A ⌄ Possible answers: ☐ Yes ☐ No ☐ N/A