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 neuromodulation/stimulation

For Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠ members

Effective Oct. 11, 2020

Sacral nerve neuromodulation/stimulation

We provide coverage for this procedure for adult members who meet medical necessity criteria. Submit 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 we cannot authorize it, we will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. We will retrospectively monitor compliance with this authorization requirement.

Applicable procedure codes: *64561, *64581

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

Q Is this request for URINARY INCONTINENCE for a patient with ANY of the following (A-D)? A. Urge incontinence. B. Urgency-frequency syndrome. C. Nonobstructive urinary retention. D. 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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Q Does the patient's medical record document failure or intolerance to AT LEAST TWO of the following conventional therapies for treating URINARY INCONTINENCE (A-E)? A. Behavioral bladder training. B. Prompted voiding. C. Pelvic muscle exercise training. D. Maximal medication therapy (dose and duration), unless contraindicated or not tolerated. E. 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 of the following (A-B)? A. 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). B. Chronic inflammatory bowel disease.

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

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

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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 BOTH of the following (A-B)? A. The patient has completed a trial period for at least 48 hours. B. The patient has had at least 50 percent improvement in symptoms during the trial period. A ☐ Possible answers: ☐ Yes ☐ No ☐ N/A