

2011 Procedures Adult Criteria

Bladder Neck Suspension/Sling and Other Pelvic Surgical
Procedures, Female (Custom) - UDOH^(1, 2*RIN, 3*RIN, 4*RIN, 5*RIN, 6*RIN, 7, 8)

Created based on InterQual Subset: Bladder Neck Suspension/Sling, Female

Version: InterQual® 2011

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name	ID#	Phone#	
	Signature	Date		

ICD-9-CM: 59.4, 59.5, 59.6, 59.71, 59.79

INDICATIONS (choose one and see below)

- ☐ 100 Stress incontinence
- ☐ 200 Removal/Revision of Bladder Neck Suspension/Sling for stress incontinence
- ☐ 300 Removal/Revision of pelvic floor mesh (57287)
- ☐ Indication Not Listed (Provide clinical justification below)

- ☐ 100 Stress incontinence **[All]**^(9, 10)
- ☐ 110 Positive stress incontinence testing⁽¹¹⁾
- ☐ 120 Symptoms $\geq$ 6 mos^(12, 13)
- ☐ 130 Symptoms interfere with ADLs⁽¹⁴⁾
- ☐ 140 Urge incontinence **[One]**^(15, 16)
- ☐ 141 Excluded by cystometry/urodynamics⁽¹⁷⁾
- ☐ 142 Treated empirically with medications⁽¹⁸⁾
- ☐ 150 Urine culture negative⁽¹⁹⁾
- ☐ 160 Medications deemed noncontributory⁽²⁰⁾
- ☐ 170 Patient preference for Rx **[One]**
- ☐ 171 Patient desires surgical correction
- ☐ 172 Continued incontinence **after** Rx **[One]**⁽²¹⁾
- ☐ -1 Pelvic floor exercises $\geq$ 12 wks⁽²²⁾
- ☐ -2 Bladder training $\geq$ 12 wks⁽²³⁾

- ☐ 200 Removal/Revision of Bladder Neck Suspension/Sling for stress incontinence

- ☐ 300 Removal/Revision of pelvic floor mesh (57287) **[One]**

- ☐ 310 Removal

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- ☐ 320 Revision of pelvic floor mesh [One]
- ☐ 321 Documentation from provider stating that transvaginal surgical mesh products will not be used

Notes

(1)

These criteria include the following procedures:

Burch Colposuspension Procedure, Female
 Pubovaginal Sling Procedures, Female
 Retropubic Sling Procedures, Female
 Tension-free Vaginal Tape (TVT), Female
 Transobturator Suburethral Tape (TOT), Female
 Urethropexy, Female

(2)-RIN:

Stress incontinence is due to urethral hypermobility, blunting of the urethrovesical angle, or intrinsic sphincter dysfunction. Suspension of the urethra corrects the problem by changing the urethrovesical angle and stabilizing the urethra. A cystocele may also be present and warrants repair during the same surgery. The cystocele repair must be approved separately; see the "Colporrhaphy, Anterior" criteria subset in the *Obstetrics & Gynecology* category.

(3)-RIN:

Vaginal vault prolapse may also be present in patients with urinary stress incontinence. The vaginal vault repair must be approved separately; see the "Colpopexy" criteria subset in the *Obstetrics & Gynecology* category.

(4)-RIN:

Collagen injections, which are administered transurethally under local anesthesia, are used in the treatment of stress incontinence in patients who are poor candidates for surgery and for persistent or recurrent incontinence after suspension surgery (Keegan et al., Cochrane Database Syst Rev 2007; (3): CD003881). The most common complication after injection therapy is urge incontinence. Collagen injections are an alternative to surgery in selected patients, although the success rate is lower than surgery (Corcos et al., Urology 2005; 65(5): 898-904). These criteria do not cover collagen injections.

(5)-RIN:

For men with post prostatectomy stress incontinence, see the "Urethral Sling, Male" criteria subset.

(6)-RIN:

Utah Medicaid does not cover the implantation of transvaginal surgical mesh products because of the FDA advisory panel's recommendation regarding the serious adverse events associated with these products.

(7)

There is no single "best" surgical procedure for urinary stress incontinence (Wai, Obstet Gynecol Clin North Am 2009; 36(3): 509-519). Traditional bladder neck suspension, also called retropubic colposuspension, includes the Burch and the Marshall-Marchetti-Krantz procedure. These are effective treatment modalities with a 5-year continence rate of approximately 70% (Lapitan et al., Cochrane Database Syst Rev 2009; (4): CD002912). Pubovaginal or retropubic sling procedures, which involve midurethral placement of autologous tissue or a synthetic mesh and include tension-free vaginal tape (TVT), were introduced in the late 1990s and have become favored as minimally invasive treatment (American Urological Association (AUA), Guideline for the surgical management of female stress urinary incontinence: 2009 update. 2009). Transobturator sling procedures were developed to minimize the potential for bowel and bladder injuries associated with retropubic slings; they include transobturator suburethral tape (TOT) and the Monarc™ procedure. Retropubic and transobturator sling procedures have similar outcome success rates but complications associated with the two procedures differ (Richter et al., N Engl J Med 2010, 362: 2066-76). Which procedure to perform is a matter of clinical judgment.

(8)

Burch Colposuspension Procedure - Inpatient
 All others - Outpatient

(9)-DEF:

Stress incontinence is the involuntary loss of urine associated with activities that increase intra-abdominal pressure in the absence of an overdistended bladder or a bladder (detrusor) muscle contraction.

(10)

Situations that commonly provoke stress incontinence in susceptible patients include coughing, sneezing, and laughing. In women, stress incontinence most often results from a combination of urethral hypermobility and urethral sphincter deficiency. Behavioral therapy and surgical procedures remain the mainstay treatments for this condition (Ghoniem et al., Int Urogynecol J Pelvic Floor Dysfunct 2008; 19(1): 5-33).

(11)

Stress incontinence testing is used to confirm stress incontinence; tests include urethral function testing, Q-tip test, and leak-point pressure (cough, Valsalva) (Corcos et al., Can J Urol 2006; 13(3): 3127-3138). Which test to perform is a matter of clinical judgment.

(12)

Patients with stress incontinence usually experience small-volume loss of urine with coughing, sneezing, lifting, exercising, or other activities that increase intra-abdominal pressure. A urinary symptom or voiding diary may be beneficial for confirming stress incontinence.

(13)

Temporary stress incontinence may occur after vaginal delivery or surgery and may resolve with pelvic floor (Kegel) exercises and time.

(14)

Women with incontinence report that their symptoms limit their ability to enjoy daily activities, social interactions, travel, or personal relationships. Patients should be asked if they use protection (diapers, pads) and how many pads per day are used. Asking the patient if the incontinence "interferes with your day-to-day activities or bothers you in other ways" (as well as eliciting the amount and frequency of urine loss) provides a good estimate of the impact the incontinence has on the patient's life.

(15)-DEF:

Urge incontinence is the involuntary loss of urine associated with a sudden urge to void. It may be caused by inappropriate contraction of the bladder (detrusor) muscle, a condition called detrusor overactivity.

(16)

Unlike stress incontinence, urge incontinence may not be associated with an activity, like coughing or sneezing, which increases intra-abdominal pressure. Stress incontinence and urge incontinence often coexist. However, pharmacologic treatment of the urge component (detrusor instability) should precede surgical treatment to determine what, if any, stress component remains (Sutherland and Goldman, Med Clin North Am 2004; 88(2): 345-366).

(17)

Cystometry is the measurement of bladder pressures. Pressures are measured not only during filling but also at capacity and during voiding which makes this a basic test for urge incontinence. Contractions at low amounts of administered fluid (< 200 mL) are associated with urge incontinence rather than stress incontinence (Amir and Farrell, J Obstet Gynaecol Can 2008; 30: 717-27).

(18)

Anticholinergics (e.g., tolterodine, oxybutynin) are well established in the management of urge incontinence (Saks and Arya, Obstet Gynecol Clin North Am 2009; 36(3): 493-507). Newer anticholinergics are also available, each with theoretical advantages over the older agents.

(19)

UTI is a common cause of frequent and urgent urination, symptoms common to urinary incontinence (American College of Obstetricians and Gynecologists, Obstet Gynecol 2008; 111(3): 785-794). A negative urine culture ensures that symptoms are due to stress incontinence rather than UTI.

(20)

A variety of medications may cause or worsen stress incontinence, including alpha-blockers which reduce muscle tone at the bladder neck and urethra. Some medications cause stress incontinence indirectly, such as ACE inhibitors causing cough (as a side effect) which results in urinary leakage (Rahn and Roshanravan, Obstet Gynecol Clin North Am 2009; 36(3): 463-474).

(21)

Pharmacotherapy has a limited role in the management of stress incontinence (Saks and Arya, *Obstet Gynecol Clin North Am* 2009; 36(3): 493-507). Traditionally, alpha-agonists and estrogens have been used to treat stress incontinence; however, alpha-agonists have shown only modest effect, oral estrogen is no longer recommended for treating postmenopausal women, and long-term studies are needed before local estrogen can be recommended (Cody et al., *Cochrane Database Syst Rev* 2009; (4): CD001405).

(22)

Pelvic floor muscle (Kegel) exercises strengthen the voluntary periurethral muscles, with the goal of improving continence during episodes of increased intra-abdominal pressure. These techniques are most commonly used for treating stress incontinence (Dumoulin and Hay-Smith, *Cochrane Database Syst Rev* 2010; (1): CD005654).

(23)

Bladder training (also called bladder retraining) is a behavioral intervention for urinary incontinence which relies on patient education, scheduled voiding, and reinforcement strategies (French et al., *Prim Care* 2009; 36(1): 53-71, viii). This approach has been demonstrated to be helpful for patients with urge and stress incontinence.