

MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number

The MEDICAL Policy Statement detailed above



D. Policy

I. CareSource considers ProACT adjustable continence therapy medically necessary when **ALL** the following clinical criteria are met:

- A. Member is at least 45 years of age.
- B. Member underwent radical prostatectomy or transurethral resection of the prostate at least 12 months prior without radiation therapy.
- C. Member has documented primary stress urinary incontinence arising from intrinsic sphincter deficiency of at least 12 months duration.
- D. Member has documentation of conservative therapy failure.
- E. Member experiences at least 3 incontinence episodes per day.
- F. Member has positive 24-hour pad weight test (at least 8-gram pad weight increase demonstrated in two 24-hour pad weight tests).

II. Limitations/Exclusions

ProACT is contraindicated in patients with any of the following:

- A. urge incontinence
- B. detrusor instability or over-activity
- C. residual volume of at least 100ml or at least 25% of the total bladder capacity after voiding
- D. active systemic or urinary tract infections
- E. history of bladder stones
- F. hemophilia or other bleeding disorders
- G. UI resulting from detrusor instability
- H. UI resulting from overactive bladder
- I. reduced bladder compliance
- J. residual urine volume exceeding 100 cubic centimeters after voiding
- K. suspected bladder cancer
- L. radiotherapy within the past 6 months

E. Conditions of Coverage

N/A

F. Related Policies/Rules

N/A

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

