

Medical Standards & Research Pre-approval Form

This is a pre-requisite form provided upon request for the **"Pre-Authorization Form for Bundled Lymphedema and Lipedema services for Thiqa"**.

Please ensure all requested fields below are completed. This is a mandatory step to proceed further. Incomplete information may result in delays in processing the applicant's request. Please be aware that the provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Member's Name:
☐ New ☐ Established
- Date of Birth: / /
- Member's Card No.:
- Policy:
- Gender: ☐ Female ☐ Male
- Request's date: / /

PROVIDER INFORMATION

- Provider's Name:
- Ordering Clinician (ID no. & Name):
- Performing Provider Name:
- Performing Clinician Specialty (ID no. & Name):
- Referring Physician (ID no. & Name):

SERVICE REQUESTED

- Principal/Primary Diagnosis:
- ICD-10:
- Requested Procedural Service Code (SRVC):
- BMI:

Clinical Assessment & Condition Type

☐ Lymphedema

☐ Lipedema

☐ Both

Onset and Duration

Staging/Severity

(ISL for Lymphedema / Clinical for Lipedema)

Symptoms

Family History (for Lipedema)

Comorbidities

Differential Diagnoses Ruled Out

Quantitative Measures (lymphedema)

Lymphedema

☐ Stage I (Mild) ☐ Stage II (Moderate) ☐ Stage III (Severe)

Lipedema

☐ Type : _____ (1-5)

☐ Stage: _____ 1-4 (smooth/nodular/indurated skin)

☐ Pain ☐ Swelling ☐ Bruising ☐ Fatigue ☐ Recurrent Infections ☐ Mobility Impairment

☐ Others: _____

☐ Yes ☐ No, If yes please provide more details: _____

☐ Obesity (BMI 30-34.9) ☐ Obesity (BMI >35) ☐ Diabetes ☐ Venous Insufficiency

☐ Others: _____

☐ Yes ☐ No (e.g., Venous Disease)

☐ Volumetry differential (circumferential measurements and/or Perometry differential) >10% (if affected extremity dominant extremity) or >7% (affected extremity is nondominant extremity) OR

☐ Circumference Difference ≥ 2 cm at one or more standardized measurement points (e.g.-thigh, knee, mid-calf, or ankle).

Quantitative Measures (lipedema)	<input type="checkbox"/> Bioimpedance (L-Dex) differential of at least 10 units <input type="checkbox"/> Body Water Balance Index (BWBI) ECW/TBW Ratio > 0.39
	<input type="checkbox"/> Symmetrical and bilateral disproportionate fat distribution, often sparing the hands and feet, leading to a characteristic (column-like) or (stovepipe) known as (cuff sign) or (Fat pad sign) appearance. <input type="checkbox"/> Chronic pain or discomfort, exacerbated by touch or pressure interfering in everyday activity. <input type="checkbox"/> Easy Bruising or Spontaneous Bruising with minimal or no trauma, due to the fragile nature of the capillaries in lipedema fat tissue. <input type="checkbox"/> Firm or nodular subcutaneous tissue with distinct "dimpled" texture or localized fibrosis or increased resistance compared to unaffected tissue. <input type="checkbox"/> Stemmer's sign, non-pitting or minimally pitting edema. <input type="checkbox"/> Recurrent cellulitis and Skin ulceration. <input type="checkbox"/> Body Water Balance Index (BWBI) ECW/TBW Ratio (≤ 0.39).
Exclusion-Presence of one of the following:	<input type="checkbox"/> Venous disease (DVT, superior vena cava syndrome). <input type="checkbox"/> Congestive heart failure (CHF). <input type="checkbox"/> Medication-induced swelling. <input type="checkbox"/> Liver disease includes but is not limited to cirrhosis and hypoproteinemia. <input type="checkbox"/> Nephropathy includes end-stage renal disease. <input type="checkbox"/> Pregnancy. <input type="checkbox"/> Dye anaphylaxis. <input type="checkbox"/> Active infection of the affected extremity (cellulitis/erysipelas). <input type="checkbox"/> Active Cancer status <input type="checkbox"/> Morbid obesity

DIAGNOSTIC TESTS (ATTACH REPORTS)
☐ Lymphoscintigraphy/ICG Lymphography
☐ Ultrasound

- ☐ Limb Circumference Measurements (Pre- and Post-Conservative)
- ☐ MRI Findings
- ☐ Photography
- ☐ Other:

COMPLETE DECONGESTIVE THERAPY HISTORY (CDT) (REQUIRED PREREQUISITE)				
Therapy Type	Duration (Months)	Frequency	Outcome/Reason for Failure	Provider Name/Date
Complete Decongestive Therapy (CDT: Manual Lymphatic Drainage + Compression)				
Pneumatic Compression				
Bandaging Compression				
Psychosocial Support				
Exercise/Graded Activity Program				
Weight Management (if BMI >30)				

*Fill in the Complexity level below with justification for multiple complexity

Surgical Intervention	
Primary Site/Limb Treated	Specify:
Primary Limb Procedures Code (Include all services codes)	<input type="checkbox"/> 59-01 <input type="checkbox"/> 59-02 <input type="checkbox"/> 59-03 <input type="checkbox"/> 59-04 <input type="checkbox"/> 59-05 <input type="checkbox"/> 59-06* <input type="checkbox"/> 59-07 <input type="checkbox"/> 59-08 <input type="checkbox"/> 59-09 <input type="checkbox"/> 59-11 <input type="checkbox"/> 59-12
Primary Site CPT(Include all applicable CPT codes)	<input type="checkbox"/> 15876 <input type="checkbox"/> 15877 <input type="checkbox"/> 15878 <input type="checkbox"/> 15878 <input type="checkbox"/> 38999
Additional Site(s)/Limb(s) Treated	Specify:
Additional Same Procedure Codes/ Specify Quantity	<input type="checkbox"/> 59-01 QTY:___ <input type="checkbox"/> 59-02 QTY:___ <input type="checkbox"/> 59-03 QTY:___ <input type="checkbox"/> 59-04 QTY:___ <input type="checkbox"/> 59-05 QTY:___ <input type="checkbox"/> 59-06* QTY: ___ <input type="checkbox"/> 59-07 QTY:___ <input type="checkbox"/> 59-08 QTY:___ <input type="checkbox"/> 59-09 QTY:___ <input type="checkbox"/> 59-10 QTY:___ <input type="checkbox"/> 59-11 QTY:___ <input type="checkbox"/> 59-12 QTY:___
Additional Different Procedure Codes/ Specify Quantity	<input type="checkbox"/> 59-01 QTY:___ <input type="checkbox"/> 59-02 QTY:___ <input type="checkbox"/> 59-03 QTY:___ <input type="checkbox"/> 59-04 QTY:___ <input type="checkbox"/> 59-05 QTY:___ <input type="checkbox"/> 59-06* QTY: ___ <input type="checkbox"/> 59-07 QTY:___ <input type="checkbox"/> 59-08 QTY:___ <input type="checkbox"/> 59-09 QTY:___ <input type="checkbox"/> 59-10 QTY:___ <input type="checkbox"/> 59-11 QTY:___ <input type="checkbox"/> 59-12 QTY:___

Secondary Site CPT(Include all applicable CPT codes)	<input type="checkbox"/> 15876 <input type="checkbox"/> 15877 <input type="checkbox"/> 15878 <input type="checkbox"/> 15878 <input type="checkbox"/> 38999
Short Description	
Complexity (if 59-06-xx)*	<input type="checkbox"/> 01 Low
	<input type="checkbox"/> 02 Medium
	<input type="checkbox"/> 03 High
	Justification: (one or multiple complexity)
Multiple Techniques	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bio-Bridge Implant (for 59-01/59-02)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Attach original invoice if applicable)
Expected Surgical Duration	_____ Hours
Anticipated Inpatient Stay	_____ Days
Post-Op Plan	
Risks/Expected Outcomes	

Supporting Documents Checklist (Kindly Attach All of The Below)

Clinical notes/history/exam ☐

Diagnostic Imaging/reports ☐

CDT records ☐

Patient Consent ☐

Surgeon's Certification

I hereby certify that the proposed intervention meets medical necessity criteria as per DOH standards and protocols, with conservative therapy failure documented. The bundle includes all pre-operative, intra-operative, and post-operative services (excluding Bio-Bridge implant).

Surgeon's Signature

Date

Printed Name

DOH License #

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