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 serivces 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)	**Lymphedema** ☐ Stage I (Mild) ☐ Stage II (Moderate) ☐ Stage III (Severe) **Lipedema** ☐ Type : _____ (1-5) ☐ Stage: _____ 1-4 (smooth/nodular/indurated skin)
Symptoms	☐ Pain ☐ Swelling ☐ Bruising ☐ Fatigue ☐ Recurrent Infections ☐ Mobility Impairment ☐ Others:
Family History (for Lipedema)	☐ Yes ☐ No, If yes please provide more details: _____ _____ _____
Comorbidities	☐ Obesity (BMI 30-34.9) ☐ Obesity (BMI >35) ☐ Diabetes ☐ Venous Insufficiency ☐ Others:_____ _____
Differential Diagnoses Ruled Out	☐ Yes ☐ No (e.g., Venous Disease)
Quantitative Measures **(lymphedema)**	☐ 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).

	☐ Bioimpedance (L-Dex) differential of at least 10 units ☐ Body Water Balance Index (BWBI) ECW/TBW Ratio > 0.39
Quantitative Measures **(lipedema)**	☐ Symmetrical and bilateral disproportionate fat distribution, often sparing the hands and feet, 8 leading to a characteristic (column-like) or (stovepipe) known as (cuff sign) or (Fat pad sign) appearance. ☐ Chronic pain or discomfort, exacerbated by touch or pressure interfering in everyday activity. ☐ Easy Bruising or Spontaneous Bruising with minimal or no trauma, due to the fragile nature of the capillaries in lipedema fat tissue. ☐ Firm or nodular subcutaneous tissue with distinct "dimpled" texture or localized fibrosis or increased resistance compared to unaffected tissue. ☐ Stemmer's sign, non-pitting or minimally pitting edema. ☐ Recurrent cellulitis and Skin ulceration. ☐ Body Water Balance Index (BWBI) ECW/TBW Ratio (≤0.39).
Exclusion- Presence of one of the following:	☐ Venous disease (DVT, superior vena cava syndrome). ☐ Congestive heart failure (CHF). ☐ Medication-induced swelling. ☐ Liver disease includes but is not limited to cirrhosis and hypoproteinemia. ☐ Nephropathy includes end-stage renal disease. ☐ Pregnancy. ☐ Dye anaphylaxis. ☐ Active infection of the affected extremity (cellulitis/erysipelas). ☐ Active Cancer status ☐ 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**)	☐ 59-01 ☐ 59-02 ☐ 59-03 ☐ 59-04 ☐ 59-05 ☐ 59-06* ☐ 59-07 ☐ 59-08 ☐ 59-09 ☐ 59-11 ☐ 59-12
Primary Site CPT(**Include all applicable CPT codes)**	☐ 15876 ☐ 15877☐ 15878☐ 15878☐ 38999
Additional Site(s)/Limb(s) Treated	Specify:
Additional Same Procedure Codes/**Specify Quantity**	☐ 59-01 QTY:___ ☐ 59-02 QTY:___ ☐ 59-03 QTY:___ ☐ 59-04 QTY:___☐ 59-05 QTY:___ ☐ 59-06* QTY: ___ ☐ 59-07 QTY:___ ☐ 59-08 QTY:___☐ 59-09 QTY:___ ☐ 59-10 QTY:___ ☐ 59-11 QTY:___ ☐ 59-12 QTY:___
Additional Different Procedure Codes/ **Specify Quantity**	☐ 59-01 QTY:___ ☐ 59-02 QTY:___ ☐ 59-03 QTY:___ ☐ 59-04 QTY:___☐ 59-05 QTY:___ ☐ 59-06* QTY: ___ ☐ 59-07 QTY:___ ☐ 59-08 QTY:___☐ 59-09 QTY:___ ☐ 59-10 QTY:___ ☐ 59-11 QTY:___ ☐ 59-12 QTY:___

Secondary Site CPT(**Include all applicable CPT codes)**	☐ 15876 ☐ 15877☐ 15878☐ 15878☐ 38999
Short Description	
Complexity (if 59-06-xx)*	☐ 01 Low
	☐ 02 Medium
	☐ 03 High
	Justification: (one or multiple complexity)
Multiple Techniques	☐ Yes ☐ No
Bio-Bridge Implant (for 59-01/59-02)	☐ Yes ☐ 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 #