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MEDICAL POLICY – 7.01.579

Posterior Tibial Nerve Stimulators

Ref. Policy: MP-129

Effective Date:	July 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	June 24, 2024	2.01.540 Biofeedback for Incontinence
Replaces:	N/A	

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Introduction

Urinary incontinence is the involuntary leakage of urine. Types of urinary incontinence include stress incontinence, urge incontinence, overflow incontinence, or mixed incontinence. Posterior tibial nerve stimulation (PTNS) is a minimally invasive way to treat urinary incontinence and overactive bladder. It uses a small, thin needle inserted near the ankle and electrical pulses to retrain the nerves that control bladder function. This policy describes when PTNS may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Device	Medical Necessity
Posterior tibial nerve stimulators (PTNS)	**Posterior tibial nerve stimulators (PTNS) for treatment of urinary incontinence may be considered medically necessary**

Device	Medical Necessity
	for the treatment of adult urinary incontinence when ALL of the following indications and criteria are met: • Individual has previously been diagnosed with overactive bladder (OAB) and/or urinary incontinence • Documented failed conservative management efforts (e.g., pharmacological treatment, PME, behavioral, etc.), including two anticholinergic drugs taken for at least four weeks • Individual is at least 18 years of age **Note:** See Related Information below for **Limitations**

Coding

Code	Description
CPT	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
ICD-10 Codes Covered if Selection Criteria are Met	
N39.41	Urge incontinence
N39.42	Incontinence without sensory awareness
N39.44	Nocturnal enuresis
N39.45	Continuous leakage
N39.46	Mixed incontinence
N39.490	Overflow incontinence
N39.498	Other specified urinary incontinence
R32	Unspecified urinary incontinence
R39.15	Urgency of urination

Related Information

Limitations

- Initial treatment is limited to 30-minute sessions once a week for 12 weeks.
- The individual must have documented evidence of at least 50% improvement in incontinence symptoms after the initial 12 sessions for continued coverage.
    - Continued treatment is covered for 1 session every 1-2 months for no more than 3 years.

Stress and neurogenic incontinence would not be expected to improve with posterior tibial nerve stimulators.

Evidence Review

Background

It is estimated that over 25 million adult Americans suffer from urinary incontinence, with women being twice as likely as men to have urinary incontinence. The Mayo Clinic categorizes urinary incontinence into the following types: stress, urge, overflow, functional, and mixed.

Posterior tibial nerve stimulation (PTNS), a minimally invasive procedure, consists of insertion of an acupuncture needle above the medial malleolus into a superficial branch of the posterior tibial nerve. An adjustable low voltage electrical impulse (10mA, 1-10 Hz frequency) travels via the posterior tibial nerve to the sacral nerve plexus to alter pelvic floor function by neuromodulation. PTNS is used to treat overactive bladder syndrome and associated symptoms.

References

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4. Hayes Health Technology Assessment. Percutaneous Tibial Nerve Stimulation for the Treatment of Lower Urinary Tract Dysfunction. Publication Date: April 15, 2019. Annual Review Date: April 1, 2022.
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7. Peters, K., et al. 12 week results from the Sumit Trial: percutaneous tibial nerve stimulation vs validated sham in those exposed to pharmacologic therapy. Poster, 2010 International Continence Society, Toronto, Canada. **https://www.ics.org/Abstracts/Publish/105/000125.pdf**. Accessed May 21, 2024.

History

Date	Comments
09/16/19	New policy, approved August 13, 2019, effective January 1, 2020. Posterior tibial nerve stimulators (PTNS) for treatment of urinary incontinence may be considered medically necessary for the treatment of adult urinary incontinence when all indications and criteria are met.
10/01/20	Annual Review, approved September 17, 2020. No changes to policy statement, references updated.
10/01/21	Annual Review, approved September 23, 2021. No changes to policy statement, references updated.
01/01/23	Annual Review, approved December 12, 2022. No changes to policy statement, references updated. Changed the wording from "patient" to "individual" throughout the policy for standardization.
11/01/23	Annual Review, approved October 23, 2023. No changes to policy statement, references updated.
07/01/24	Annual Review, approved June 24, 2024. No changes to policy statement, references updated.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy only applies to Individual Plans.