

## MEDICAL POLICY – 7.01.579

## Posterior Tibial Nerve Stimulators

Ref. Policy: MP-129

Effective Date: Jul. 1, 2025

Last Revised: Jun. 23, 2025

Replaces: N/A

RELATED MEDICAL POLICIES:

2.01.540 Biofeedback for Incontinence

Select a hyperlink below to be directed to that section.

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[EVIDENCE REVIEW](#) | [REFERENCES](#) | [HISTORY](#)



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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
	<p><b>for the treatment of overactive bladder and/or adult urinary incontinence when ALL of the following indications and criteria are met:</b></p> <ul style="list-style-type: none"> <li>• The individual has previously been diagnosed with overactive bladder (OAB) and/or urinary incontinence</li> <li>• Documented failed conservative management efforts (e.g., pharmacological treatment, PME, behavioral, etc.)</li> <li>• The individual is at least 18 years of age</li> </ul> <p><b>Note:</b> See Related Information below for <a href="#">Limitations</a></p>

## Coding

Code	Description
<b>CPT</b>	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
<b>ICD-10 Codes Covered if Selection Criteria are Met</b>	
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

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## 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

N/A

## References

1. Cameron AP, Chung DE, Dielubanza EJ, et al. The AUA/SUFU Guideline on the Diagnosis and Treatment of Idiopathic Overactive Bladder. *Journal of Urology*. 2024;212(1):11-20. doi:10.1097/JU.0000000000003985
2. Lukacz ES. Urgency urinary incontinence/overactive bladder (OAB) in females: Treatment. UpToDate. Published online March 19, 2025. <https://www.uptodate.com/contents/urgency-urinary-incontinence-overactive-bladder-oab-in-females-treatment>. Accessed May 19, 2025.

## 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



Date	Comments
	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.
07/01/25	Annual Review, approved June 23, 2025. Minor updates made to policy criteria. Background section removed. 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. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2025 Premera All Rights Reserved.

**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.

