Medical Policy

Percutaneous Tibial Nerve Stimulation for Voiding Dysfunction

Table of Contents
- Policy: Commercial
- Policy: Medicare
- Authorization Information
- Coding Information
- Description
- Policy History
- Information Pertaining to All Policies
- References

Policy Number: 583
BCBSA Reference Number: 7.01.106
NCD/LCD: Local Coverage Determination (LCD): Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396)

Related Policies
- Biofeedback as a Treatment of Fecal Incontinence or Constipation, #308
- Biofeedback as a Treatment of Urinary Incontinence, #173
- Botulinum Toxin, #006
- Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence, #471
- Pelvic Floor Stimulation as a Treatment of Urinary Incontinence, #470
- Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT), #172
- Sacral Nerve Neuromodulation/Stimulation, #153
- Transanal Radiofrequency Treatment of Fecal Incontinence, #309

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Percutaneous tibial nerve stimulation for an initial 12-week course* is considered MEDICALLY NECESSARY for individuals with non-neurogenic urinary dysfunction including overactive bladder who have both:
- failed behavioral therapy following an appropriate duration of 8 to 12 weeks without meeting treatment goals; and
- failed pharmacologic therapy following 4 to 8 weeks of treatment without meeting treatment goals.

Maintenance therapy* using monthly percutaneous tibial nerve stimulation is considered MEDICALLY NECESSARY for individuals following a 12-week initial course of percutaneous tibial nerve stimulation that resulted in improved urinary dysfunction meeting treatment goals.
*Management criteria would be **once-per-week for 12 weeks and once-per-month afterward for maintenance treatments.**

*Annual evaluation by a physician may be performed to ensure efficacy is continuing for maintenance percutaneous tibial nerve stimulation treatments.

Percutaneous tibial nerve stimulation is considered **INVESTIGATIONAL** for all other indications, including but not limited to the following:
- Neurogenic bladder dysfunction
- Fecal incontinence.

**Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

Local Coverage Determinations (LCDs) for National Government Services, Inc.

Local Coverage Determination (LCD): Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396)

**Note:** To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website at https://www.cms.gov for information regarding your specific jurisdiction.

**Prior Authorization Information**

**Inpatient**
- For services described in this policy, precertification/preauthorization **IS REQUIRED** if the procedure is performed inpatient.

**Outpatient**
- For services described in this policy, see below for situations where prior authorization **might be required** if the procedure is performed out:patient.

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is <strong>not required.</strong></td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required.</strong></td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is <strong>not required.</strong></td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is <strong>not required.</strong></td>
</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**

_Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member._

_Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable._

_The following codes are included below for informational purposes only; this is not an all-inclusive list._

_The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:_
CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64566</td>
<td>Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming</td>
</tr>
</tbody>
</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

ICD-10 Diagnosis Coding

<table>
<thead>
<tr>
<th>ICD-10-CM-diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N32.81</td>
<td>Overactive bladder</td>
</tr>
<tr>
<td>N39.41</td>
<td>Urge incontinence</td>
</tr>
<tr>
<td>N39.42</td>
<td>Incontinence without sensory awareness</td>
</tr>
<tr>
<td>N39.43</td>
<td>Post-void dribbling</td>
</tr>
<tr>
<td>N39.44</td>
<td>Nocturnal enuresis</td>
</tr>
<tr>
<td>N39.45</td>
<td>Continuous leakage</td>
</tr>
<tr>
<td>N39.46</td>
<td>Mixed incontinence</td>
</tr>
<tr>
<td>N39.490</td>
<td>Overflow incontinence</td>
</tr>
<tr>
<td>N39.492</td>
<td>Postural (urinary) incontinence</td>
</tr>
<tr>
<td>N39.498</td>
<td>Other specified urinary incontinence</td>
</tr>
<tr>
<td>R32</td>
<td>Unspecified urinary incontinence</td>
</tr>
<tr>
<td>R35.0</td>
<td>Frequency of micturition</td>
</tr>
<tr>
<td>R39.15</td>
<td>Urgency of urination</td>
</tr>
</tbody>
</table>

Description

Voiding Dysfunction

Common causes of non-neurogenic voiding dysfunction are pelvic floor neuromuscular changes (eg, from pregnancy, childbirth, surgery), inflammation, medication (eg, diuretics, anticholinergics), obesity, and psychogenic factors. Overactive bladder is a non-neurogenic voiding dysfunction characterized by urinary frequency, urgency, urge incontinence, and nonobstructive retention.

Neurogenic bladder dysfunction is caused by neurologic damage in patients with multiple sclerosis, spinal cord injury, detrusor hyperreflexia, or diabetes with peripheral nerve involvement. The symptoms include overflow incontinence, frequency, urgency, urge incontinence, and retention.

Treatment

Approaches to the treatment of incontinence differentiate between urge incontinence and stress incontinence. Conservative behavioral management such as lifestyle modification (eg, dietary changes, weight reduction, fluid management, smoking cessation) along with pelvic floor exercises and bladder training are part of the initial treatment of overactive bladder symptoms and both types of incontinence. Pharmacotherapy is another option, and different medications target different symptoms. Some individuals experience mixed incontinence.

If behavioral therapies and pharmacotherapy are unsuccessful, percutaneous tibial nerve stimulation (PTNS), sacral nerve stimulation, or botulinum toxin may be recommended.

Percutaneous Tibial Nerve Stimulation

The current indication cleared by the U.S. Food and Drug Administration (FDA) for PTNS is overactive bladder and associated symptoms of urinary frequency, urinary urgency, and urge incontinence.

Altering the function of the posterior tibial nerve with PTNS is believed to improve voiding function and control. The mechanism of action is believed to be retrograde stimulation of the lumbosacral nerves (L4-
S3) via the posterior tibial nerve located near the ankle. The lumbosacral nerves control the bladder detrusor and perineal floor.

Administration of PTNS consists of inserting a needle above the medial malleolus into the posterior tibial nerve followed by the application of low-voltage (10 mA, 1-10 Hz frequency) electrical stimulation that produces sensory and motor responses as evidenced by a tickling sensation and plantarflexion or fanning of all toes. Noninvasive PTNS has also been delivered with transcutaneous or surface electrodes. The recommended course of treatment is an initial series of 12 weekly office-based treatments followed by an individualized maintenance treatment schedule.

PTNS is less invasive than traditional sacral nerve neuromodulation (see medical policy #153), which has been successfully used to treat urinary dysfunction but requires implantation of a permanent device. In sacral root neuromodulation, an implantable pulse generator that delivers controlled electrical impulses is attached to wire leads that connect to the sacral nerves, most commonly the S3 nerve root that modulates the neural pathways controlling bladder function.

PTNS has also been proposed as a treatment for non-neurogenic and neurogenic bladder syndromes and fecal incontinence.

**Summary**

Percutaneous tibial nerve stimulation (PTNS; also known as posterior tibial nerve stimulation) is an electrical neuromodulation technique used primarily for treating voiding dysfunction.

The following conclusions are based on a review of the evidence, including but not limited to, published evidence and clinical expert opinion, solicited via BCBSA’s Clinical Input Process.

For individuals who have non-neurogenic urinary dysfunction including overactive bladder and have failed behavioral and pharmacologic therapy who receive an initial course of PTNS, the evidence includes randomized sham-controlled trials, randomized controlled trials (RCTs) with an active comparator, and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The Sham Effectiveness in Treatment of Overactive Bladder Symptoms (SUmiT) and the Overactive Bladder Innovative Therapy (OrBIT) trials are 2 key industry-sponsored RCTs. Systematic reviews that included these and other published trials have found short-term reductions in voiding dysfunction with PTNS. The largest, highest quality study was the double-blinded, sham-controlled SUmiT trial, which reported a statistically significant benefit of PTNS vs sham at 12 weeks. In an additional, small sham-controlled trial, a 50% reduction in urge incontinent episodes was attained in 71% of PTNS group compared with 0% in the sham group. The nonblinded OrBIT trial found that PTNS was noninferior to medication therapy at 12 weeks. Adverse events were limited to local irritation effects. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have overactive bladder syndrome that has failed behavioral and pharmacologic therapy who respond to an initial course of PTNS who receive maintenance PTNS, the evidence includes observational studies and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The SUmiT and the OrBIT trials each included extension studies that followed individuals who responded to the initial course of PTNS and continued to receive periodic maintenance therapy. There is variability in the interval between and frequency of maintenance treatments, and an optimal maintenance regimen remains unclear. There are up to 36 months of observational data available, reporting that there is a durable effect for some of these patients. While comparative data are not available after the initial 12-week treatment period, the observational data support a clinically meaningful benefit for use in individuals who have already failed behavioral and pharmacologic therapy and who respond to the initial course of PTNS. PTNS may allow such individuals to avoid more invasive interventions. Adverse events appear to be limited to local irritation for both short- and long-term PTNS use. The published evidence supports a meaningful improvement in the net health outcome. Evidence reported through clinical input further supports that this use provides a clinically meaningful improvement in net health outcome and is
consistent with generally accepted medical practice. Typical regimens schedule maintenance treatments every 4-6 weeks. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have neurogenic bladder dysfunction who receive PTNS, the evidence includes several RCTs and a systematic review of RCTs and observational data. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Only a few RCTs evaluating tibial nerve stimulation for treating neurogenic bladder have been published to date, and all but one performed transcutaneous stimulation rather than PTNS. Studies varied widely in factors such as study populations and comparator interventions. Study findings have not reported that tibial nerve stimulation significantly reduced incontinence symptoms and improved other outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have fecal incontinence who receive PTNS, the evidence includes several RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The available RCTs have not found a clear benefit of PTNS. Neither of the sham-controlled trials found that active stimulation was superior to sham for achieving the primary outcome, at least a 50% reduction in mean weekly fecal incontinence episodes. The larger sham-controlled randomized trial did find a significantly greater decrease in the absolute number of weekly incontinence episodes in the active treatment group, but the overall trial findings did not suggest the superiority of PTNS over sham treatment. A meta-analysis of a single RCT and several observational studies reported that patients receiving sacral nerve simulation experienced significant benefits compared with patients receiving PTNS. A post hoc analysis of the larger trial suggested a subset of patients with fecal incontinence (those without concomitant obstructive defecation) may benefit from PTNS. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2015</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>11/2013</td>
<td>Not medically necessary indications described for Medicare HMO and PPO Blue. Effective 10/25/2013. Removed ICD-9 diagnosis codes 596.51, 788.31, 788.33, 788.34, 788.39, 788.41, 788.63, changed LCD to L31391 as L31523 is no longer effective and changed prior authorization information for Medicare HMO and PPO Blue as 64566 is not covered per LCD: L31391.</td>
</tr>
<tr>
<td>6/2013</td>
<td>New references from BCBSA National medical policy.</td>
</tr>
</tbody>
</table>


Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References


