

Clinical Policy: Posterior Tibial Nerve Stimulation for Voiding Dysfunction

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[Coding Implications](#)

[Revision Log](#)

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Description

Posterior tibial nerve stimulation (PTNS), also known as peripheral tibial nerve stimulation, is a minimally invasive form of electrical neuromodulation used to treat overactive bladder (OAB) syndrome and associated symptoms of urinary urgency, urinary frequency, and urge urinary incontinence. This policy describes the medical necessity requirements for posterior tibial nerve stimulation.

Policy/Criteria

- I.** It is the policy of health plans affiliated with Centene Corporation® that PTNS is **medically necessary** for the treatment of moderate to severe urinary dysfunction and OAB symptoms when all of the following criteria are met:
 - A.** Urinary dysfunction has persisted for at least 12 months and the condition has resulted in significant disability (i.e., the urinary urgency, frequency and/or the severity of symptoms are limiting the member's ability to participate in activities of daily living); and
 - B.** There has been a failure of, contraindications to, or intolerance to conservative medical management (e.g. pharmacotherapy with alpha blockers and cholinergics and/or antibiotics for urinary tract infections); and
 - C.** Service is provided in accordance with the standard treatment regimen of 30-minute weekly sessions for 12 weeks.
- II.** It is the policy of health plans affiliated with Centene Corporation that once a month maintenance treatments with PTNS is **medically necessary** for patients who experience significant improvement in their OAB symptoms after the 12 initial treatments. Treatment frequency may vary depending on return of symptoms.
- III.** It is the policy of health plans affiliated with Centene Corporation that PTNS beyond 12 months or when there is no improvement in urinary dysfunction is **investigational**.

Background

The term "voiding dysfunction" has been used to refer to urinary incontinence, urinary retention and symptoms of frequency and urgency. OAB is a specific type of voiding dysfunction that includes any of the following symptoms: urinary frequency, urinary urgency, urge incontinence and nocturia. OAB can significantly impact quality of life; including physical function, sexual function and social interactions. Treatments for OAB include lifestyle changes, bladder training, pelvic floor muscle training and anticholinergic (anti-muscarinic) drugs.

PTNS involves indirect modulation of the specific nerve that controls bladder function (i.e., the sacral nerve plexus) via stimulation of the posterior tibial nerve accessed just above the ankle.

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This minimally invasive form of neuromodulation consists of insertion of a 34-gauge needle electrode approximately 5 centimeters (cm) cephalad to the medial malleolus and 2 cm posterior to the tibia near the tibial nerve. A surface electrode is placed on the medial aspect of the foot. The needle electrode is connected via a lead wire to a low-voltage electrical stimulator. Stimulation is administered at a current level of 0.5 to 9 milliamperes (mA) at 20 hertz (Hz) and continues for 30 minutes. Initial treatment regimens typically consist of 12 weekly sessions, with responders exhibiting some symptom improvement after 6 to 8 sessions. Maintenance treatment sessions may be required to sustain the response to treatment.¹

National Institute for Health and Care Excellence

Current evidence on PTNS for OAB syndrome shows that it is efficacious in reducing symptoms in the short and medium term. There are no major safety concerns. Therefore the procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit.²

American Urological Association

Clinicians may offer PTNS as third-line treatment in a carefully selected patient population, characterized by moderately severe baseline incontinence and frequency and willingness to comply with the PTNS protocol. Patients must also have the resources to make frequent office visits both during the initial treatment phase and to obtain maintenance treatments in order to achieve and maintain treatment effects because treatment effects dissipate once treatment ceases. The most common protocol is the application of 30 min of stimulation once a week for 12 weeks (the trial duration; for continued benefit, weekly stimulation would have to continue).³

Studies to date evaluating PTNS for the treatment of OAB conclude there is evidence of benefit, although most studies have been small and report short-term outcomes after 12 weeks of treatment. A small study of 33 PTNS responders who continued therapy for 6-12 months reported excellent durability through 12 months.⁴ Another small study reported sustained safety and efficacy of PTNS for the treatment of OAB symptom control over 24 months with initial success after 12 weekly treatments, followed by a 14-week prescribed tapering protocol and a personalized treatment plan with an average of 1.3 treatments per month.⁵

Coding Implications

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CPT® Codes	Description
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

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HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N39.41-N39.9	Other specified urinary incontinence
R32	Unspecified urinary incontinence
R35.0-R35.8	Polyuria
R39.81	Functional urinary incontinence

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP368 Posterior Tibial Nerve Stimulation for Voiding Dysfunction	10/16	10/16

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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