Urinary Incontinence

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Urinary incontinence is the inability to voluntarily control voiding of urine from the bladder. There are 4 prevalent types of Urinary incontinence in adults: stress, urge or overactive bladder, overflow, and mixed (stress and urge) incontinence.

Stress Incontinence is generally caused by an incompetent urethral mechanism which arises from damage to the urethral sphincter or weakening of the bladder neck support that typically occurred during childbirth for women. In men, Stress Incontinence is usually a consequence of prostate related treatment procedures. Urge incontinence is usually associated with an over-activity of the detrusor muscle. Overflow incontinence may be due to an underactive detrusor muscle or obstruction of the urethra resulting in the over-distension of the bladder and therefore overflow of urine.

Note:

Please see member handbook for biofeedback coverage for urinary incontinence. Real-Time ultrasound imaging/biofeedback for urinary incontinence is not separately reimbursable.

See MCG for Sacral Nerve Stimulation criteria

Criteria

Commercial

Prior authorization is required

I. Percutaneous Tibial Nerve Stimulation (PTNS)

A. Initiation of Percutaneous Tibial Nerve Stimulation

PacificSource may consider NON-Implanted Percutaneous Tibial Nerve Stimulation (PTNS) (e.g., Urgent PC Neuromodulation system) medically necessary when **ALL** the following criteria is met:

1. Diagnosis of urge/overactive bladder incontinence, or mixed incontinence with symptoms that have persisted for over 3 months.
2. All other causes of incontinence have been ruled out (e.g., anatomical variances, infection, multiple sclerosis, Parkinson disease)
3. Failure of at least 3 months of conservative medical management that includes **BOTH** of the following:
    - Behavioral therapy (e.g., pelvic floor muscle training timed voids and fluid management)
    - Pharmacotherapy (failed at least 2 medications e.g., oral/transdermal anticholinergic and/or antimuscarinics medications), unless contraindicated

Note: When **ALL** the above criteria have been met, a total of 12, 30-minute, once per week treatments will be initially approved.

B. Continuation of Percutaneous Tibial Nerve Stimulation after the initial 12 treatments

PacificSource may consider Percutaneous Tibial Nerve Stimulation (PTNS) (e.g., Urgent PC Neuromodulation system) to be medically necessary for additional treatments when **ALL** the following have been met:

1. The above criteria for initial treatment have been met
2. At least 50% decrease in symptoms is documented (e.g., record of bladder events, voiding diary)

Note: When the above criteria have been met an additional 9 treatments, one per month. may be approved.

Medicaid

PacificSource Community Solutions follows the criteria hierarchy described in the Clinical Criteria Used in UM Decisions policy for coverage of services to treat urinary incontinence and considers services medically necessary when:

- The condition and service(s) pair on a funded line of the HERC Prioritized List of Health Services, and
- Any relevant Guideline criteria is met, and
- Service(s) are medically necessary and appropriate for the specific member.
- None of the limitations or exclusions outlined in OARs 410-141-3825 and 410-120-1200 apply.

Additional coverage options for unfunded conditions and services are provided as described in Covered Services OAR 410-141-3820.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0002 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Notes 47, 192, 193, 236 and Excluded services E2, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

For diagnostic services not appearing on the Prioritized List, PCS utilizes the OHP's Diagnostic Procedure Code Group 1119 and covers these services when medically necessary and appropriate for the specific member as described in Covered Services OAR 410-141-3820. Services may be limited or excluded if the service meets the criteria outlined in OARs 410-141-3825 and 410-120-1200.

PCS follows the "Unlisted and Unspecified Procedure Codes" policy for requests for unlisted codes.

Medicare

PacificSource Medicare follows National Coverage Determination 230.8 for coverage of Non-Implantable Pelvic Floor Electrical Stimulator.

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow commercial criteria within a specific PacificSource policy, as applicable, or external criteria for determination of coverage and medical necessity coverage.

Experimental/Investigational/Unproven

PacificSource considers Percutaneous Tibial Nerve Stimulations (PTNS) for any other indications than listed above to be experimental, investigational, or unproven

PacificSource considers the following modalities for treatment of urinary incontinence to be experimental, investigational, or unproven:

- Bariatric Surgery
- Vaginal Electrogalvanic Stimulation
- Vaginal Laser Therapy (Genityte laser treatments)
- Extracorporeal magnetic stimulation (EMS) (e.g., NeoControl® system) or extracorporeal magnetic innervation (ExMI) units (including chair units)*****
- Non-implanted pelvic muscle stimulation devices (e.g., Apex, Attain, Flyte, Leva Pelvic Health System, INNOVO)
- Pudendal nerve stimulation
- Lyrette™ Transurethral Radiofrequency Tissue Remodeling System (previously known as Renessa) transurethral radiofrequency remodeling

Note: * indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

53860 Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence –

53899 Unlisted procedure, urinary system –

64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment

E0715 Intravaginal device intended to strengthen pelvic floor muscles during Kegel exercises

E0716 Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during Kegel exercises

E0740 Incontinence treatment system; pelvic floor stimulator, monitor, sensor and/or trainer-

E1399 Durable medical equipment, miscellaneous-

S9002 Intravaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device

Definitions

Electrical Stimulation - involves the use of electrodes, which provide a mild electrical current to the pelvic floor muscles. E-stim has emerged as a possible alternative to surgery for patients who have failed to respond to conservative treatment. Pelvic floor stimulators use a pulsed current to assist the patient with pelvic floor muscle contractions. The Minnova® PFS product (Empi, Inc.) and the Pathway™ STM-10 (Prometheus Group) are examples of a pelvic floor stimulators.

Magnetic Stimulation - Extracorporeal magnetic stimulation (EMS), also known as extracorporeal magnetic innervation therapy (ExMI), uses a changing magnetic field to induce electrical depolarization of the nerves and muscles of the pelvic floor. To use the device, the patient sits fully clothed in a specialized chair in which the perineum rests on the central axis of a pulsating magnetic field. (e.g., NeoControl® Pelvic Floor Therapy System by Neotonus, Inc.).

Mixed incontinence - simultaneous symptoms of multiple types of incontinence, most often due to overactive bladder and stress incontinence.

Percutaneous Tibial Nerve Stimulation - Indirect stimulation of the sacral nerve performed by injecting a needle into the skin just above the ankle and attaching electrical stimulation to the needle (e.g., The Urgent PC Neuromodulation System by Uroplasty, Inc.).

Overflow incontinence- type of incontinence occurs when you are unable to completely empty your bladder and then urine leaks out unexpectedly.

Stress Incontinence - type of incontinence is related to pressure to the urinary bladder from pregnancy, sneezing, lifting heavy objects, exercise, including some medical conditions.

Urge Incontinence or Overactive Bladder (OAB) - type of incontinence is characterized by such a strong urge to urinate that the patient has problems reaching the restroom in time. It is usually a result of injury to nerves or muscles which help control urinary flow, but it can also be caused by some medical conditions.

Related Policies

Bariatric Surgery

Clinical Criteria Used in UM Decisions

Clinical Resources Used for Medical Necessity Determinations When No Other UM Clinical Criteria or Guideline Exists

Durable Medical Equipment - General or Unspecified

Coding Guidelines for Claims Editing (Line-Item Bill Auditing)

References

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Appendix

Policy Number:

Effective: 11/1/2020 **Next review:** 12/1/2026

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0001 through 0003

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