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Medicare Advantage Policy Manual **Policy ID:** M-SUR154

Posterior Tibial Nerve Stimulation (PTNS)

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member.

The Medicare Advantage Medical Policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and the Centers of Medicare and Medicaid Services (CMS) policies, when available. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and in some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services.

DESCRIPTION

Posterior Tibial Nerve Stimulation (PTNS) is a minimally invasive neuromodulation system designed to deliver retrograde electrical stimulation to the sacral nerve plexus through percutaneous electrical stimulation of the posterior tibial nerve. The posterior tibial nerve contains mixed sensory motor nerve fibers that originate from L4 through S3, which modulate the innervation to the bladder, urinary sphincter and pelvic floor. The specific mechanism of action of neuromodulation is unclear, although theories include improved blood flow and change in neurochemical balance along the neurons. Neuromodulation may have a direct effect on the detrusor or a central effect on the micturition centers of the brain. *(Noridian LCA A52965)*

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals*	None

National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)	Posterior Tibial Nerve Stimulation Coverage R3 (A52965) *(The LCA provides a listing of covered indications for PTNS. The LCA also states, "The only reimbursable ICD-10-CM diagnosis codes" are those found within the LCA. Therefore, for all other indications (diagnoses), services will be considered not medically necessary.)* **Scroll to the "Public Version(s)" section at the bottom of the LCA for links to prior versions if necessary.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- All chart notes and medical records pertinent to the condition being treated.
    - For initial therapy, documentation of failed standard anticholinergic drug therapy, or that the patient demonstrates intolerance to the drug therapy, despite best efforts at management of side effects;
    - For maintenance therapy, documentation of improvement in overactive bladder (OAB) symptoms both during and at the end of the initial course of therapy, and initial improvement and why the need for additional treatments.
- Specific device name;
- Place of treatment.

REGULATORY STATUS

The Urgent® PC Neuromodulation System (Uroplasty, Inc.) – Formerly called the Stoller Afferent Nerve Stimulator (PerQ SANS System), received U.S. Food and Drug Administration (FDA) 510(k) approval for the treatment of overactive bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence.

CROSS REFERENCES

Electrical Stimulation and Electromagnetic Therapy Devices, Durable Medical Equipment, Policy No. M-83

Transanal Radiofrequency Treatment of Fecal Incontinence, Surgery, Policy No. M-129

Sacral Nerve Modulation/Stimulation for Pelvic Floor Dysfunction, Surgery, Policy No. M-134

REFERENCES

1. NCD for Bladder Stimulators (Pacemakers) (230.16)

CODING

NOTE: CPT codes for percutaneous implantation of neurostimulator electrodes (i.e., 64553, 64555, 64561, 64590) are not appropriate since PTNS uses percutaneously temporarily inserted needles and wires rather than percutaneously implanted electrodes that are left in place.

Codes	Number	Description
CPT	64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
	64999	Unlisted procedure, nervous system
HCPCS	L8679	Implantable neurostimulator, pulse generator, any type
	L8680	Implantable neurostimulator electrode, each *(Code non-covered by Medicare – see L8679)*

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*