

## Medical Policy

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# Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder

**Policy Number:** OCA 3.561

**Version Number:** 18

**Version Effective Date:** 03/01/19

### Product Applicability

**All Plan<sup>+</sup> Products**

#### Well Sense Health Plan

Well Sense Health Plan

#### Boston Medical Center HealthNet Plan

MassHealth

Qualified Health Plans/ConnectorCare/Employer Choice Direct

Senior Care Options ◊

### Notes:

+ Disclaimer and audit information is located at the end of this document.

◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member's product-specific benefit documents at [www.SeniorsGetMore.org](http://www.SeniorsGetMore.org) to determine coverage guidelines for Senior Care Options.

## Policy Summary

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The Plan considers the use of non-implantable pelvic floor electrical stimulation (PFES) to be **experimental and investigational** for all Plan members (regardless of age and gender) when used for the treatment of overactive bladder, urinary incontinence and/or fecal continence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation. Plan prior authorization is required.

It will be determined during the Plan's prior authorization process if the service is considered experimental and investigational for the requested indication. The Plan's *Medically Necessary* medical policy, policy number OCA 3.14, includes the product-specific definitions of medically necessary treatment and the Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12, specifies the product-specific definitions of experimental or investigational treatment. Review the following Plan medical policies for applicable clinical guidelines: *Biofeedback in an Outpatient Setting to Treat Bladder and/or Bowel Dysfunction (Including Incontinence)*, policy number OCA 3.969; *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)*, policy number OCA 3.562; and *Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions*, policy number OCA 3.563.

## Description of Item or Service

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**Non-Implantable Pelvic Floor Electrical Stimulation:** Treatment that includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.

**Pelvic Floor Electrical Stimulation (PFES):** Neuromuscular electrical stimulation through the pelvic floor by means of a non-implantable device with the goal of exercising and strengthening pelvic floor muscles. Electrical stimulation is delivered by vaginal probe or anal probe connected to an external generator. The physiological objectives of electrical stimulation are to produce muscle hypertrophy, to normalize the reflex activity of the lower urinary tract, and to increase circulation to muscles and the capillary system. The Plan considers all PFES to be experimental and investigational for the treatment of overactive bladder, urinary incontinence, and/or fecal incontinence.

**Pelvic Floor Magnetic Stimulation (also known as Extracorporeal Magnetic Stimulation or EMS):** Noninvasive electromagnetic stimulation of the pelvic floor musculature for the treatment of incontinence. During EMS therapy, a focused, time-varying magnetic field penetrates into the perineum and activates the motor neurons of the pelvic floor muscles. The pelvic muscles contract and relax with each magnetic pulse, thereby strengthening the muscles. The goal of this therapy is the rehabilitation of the pelvic floor musculature to reduce urinary incontinence. The magnetic system does not require an internal electrode; the patient sits fully clothed on a specialized chair with an embedded magnet, with the magnetic fields controlled by a separate power unit. Pelvic static magnetic stimulation may use a device that the individual wears with magnetic discs sewn into the undergarment (rather than a specialized magnetic chair). The Plan considers all magnetic stimulation to be experimental and investigational for the treatment of overactive bladder, urinary incontinence, and/or fecal incontinence.

## Medical Policy Statement

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The Plan considers the use of non-implantable pelvic floor electrical stimulation (PFES) to be experimental and investigational for all Plan members (regardless of age and gender) when used for the treatment of overactive bladder, urinary incontinence and/or fecal continence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.

Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder

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## Limitations

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The Plan considers the use of non-implantable pelvic floor electrical stimulation (PFES) to be experimental and investigational for all Plan members (regardless of age and gender) when used for the treatment of overactive bladder, urinary incontinence and/or fecal continence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.

## Definitions

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**Functional Urinary Incontinence:** All forms of involuntary urination without any structural anatomical or neurological deficit.

**Non-Neurologic Overactive Bladder (OAB):** Clinical diagnosis of overactive bladder (OAB) with symptoms not related to a neurological condition.

**Organic Urinary Incontinence:** Rare form of urinary incontinence caused by anatomical malformations such as abnormally located terminal portion of the ureter or malformed urethra.

**Overactive Bladder (OAB):** Symptom-based clinical diagnosis characterized by urinary urgency (hallmark symptom), urinary frequency (usually present) and nocturia (usually present), and with or without urgency urinary incontinence. A diagnosis of OAB requires exclusion of infection and other pathologic conditions. First-line treatment includes lifestyle interventions, pelvic floor exercises, bladder training, and antimuscarinic agents. If conservative therapy fails, treatments may include sacral nerve stimulation (neuromodulation) or surgical interventions such as augmentation cystoplasty or urinary diversion.

**Pathological Urinary Incontinence:** Organic and functional (or psychosomatic) causes of urinary incontinence.

**Pelvic Floor Muscle Training (PFMT):** Training used as a first-line conservative therapy to treat women with urgency urinary incontinence, stress urinary incontinence, and/or mixed urinary incontinence. PFMT utilizes pelvic floor muscles to increase urethral pressure and is believed to inhibit detrusor muscle contractions. PFMT (e.g., Kegel exercises) may be a self-directed regimen or a clinician-guided program and may or may not include biofeedback.

**Physiological Urinary Incontinence:** Urinary incontinence is regarded as normal in the first few years of life and is classified as pathological only after the fifth (5th) year of life has been completed (i.e., up to the child's sixth birthday). The range of normal continence development is very wide and can extend beyond the age of five (5) for "late developers."

**Urinary Incontinence:** The unintentional loss of urine and/or the inability to retain urine due to the loss of bladder control. The major types of urinary incontinence are listed below, as specified in items 1 through 5:

1. **Mixed Incontinence:** Urine losses caused by a combination of stress and urge incontinence, and are most common in women
2. **Overflow:** Urine loss that occurs when the amount of urine produced exceeds the bladder's holding capacity that can occur as a result of bladder obstruction or injury and in men as a result of an enlarged prostate
3. **Stress Incontinence:** Urine loss caused by increased intra-abdominal pressure that occurs during exercise, coughing, laughing, sneezing, and in men who have had prostate surgery
4. **Total:** Uncontrolled or continuous urinary leakage caused by neurological dysfunction, surgery, or anatomical defects
5. **Urge Incontinence:** Urine loss caused by involuntary bladder contractions that occurs more often in adults

**Urinary Retention:** A condition where the bladder overfills without causing the sensation of the need to urinate. Non-obstructive urinary retention is caused by a lack of coordination between the bladder and detrusor sphincter mechanisms or a weak or non-existent bladder contraction.

## Applicable Coding

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The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See the Plan’s reimbursement policies for the necessary billing guidelines, including codes that require modifiers; reimbursement policies are available at [www.bmchp.org](http://www.bmchp.org) for services rendered to members enrolled in a BMC HealthNet Plan product and reimbursement policies applicable for services rendered to Well Sense Health Plan members are available at [www.wellsense.org](http://www.wellsense.org).

CPT Codes	<b>Description: Codes Considered Experimental and Investigational When Used for the Treatment of Overactive Bladder, Urinary Incontinence and/or Fecal Continence (and Billed with a Related Primary Diagnosis Code)</b>
97014	<p>Application of a modality to 1 or more areas; electrical stimulation (unattended)</p> <p>Note: Supervised. The application of a modality that does not require direct, one-on-one, patient contact by the provider.</p> <p>Plan notes:</p> <ol style="list-style-type: none"> <li>1. CPT code 97014 is NOT a payable code for the Senior Care Options product. See HCPCS code G0283.</li> <li>2. Review the Limitations section of this policy for Plan guidelines on the use of non-implantable pelvic floor electrical stimulation (PFES) for the treatment of overactive bladder, urinary incontinence and/or fecal incontinence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.</li> <li>3. This code is also considered experimental and investigational when it is used to bill for transcutaneous posterior tibial nerve stimulation (TPTNS)/transcutaneous electrical nerve stimulation (TENS) to treat overactive bladder, urinary incontinence, and/or fecal incontinence, as stated in the Plan’s <i>Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)</i> medical policy, policy number OCA 3.562.</li> <li>4. See the Plan’s <i>CPT Code Look-up Tool</i> for prior authorization guidelines and all applicable medical policies for this CPT code when it is billed with a primary diagnosis NOT related to overactive bladder, urinary incontinence, and/or fecal incontinence; the look-up tool is available at <a href="http://www.bmchp.org">www.bmchp.org</a> for BMC HealthNet Plan and Senior Care Options members and posted at <a href="http://www.wellsense.org">www.wellsense.org</a> for Well Sense Health Plan members.</li> </ol>

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97032	<p>Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</p> <p>Note: Constant attendance. The application of a modality that requires direct, one-on-one, patient contact by the provider.</p> <p>Plan notes:</p> <ol style="list-style-type: none"> <li>1. Review the Limitations section of this policy for Plan guidelines on the use of non-implantable pelvic floor electrical stimulation (PFES) for the treatment of overactive bladder, urinary incontinence and/or fecal incontinence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.</li> <li>2. This code is also considered experimental and investigational when it is used to bill for transcutaneous posterior tibial nerve stimulation (TPTNS)/transcutaneous electrical nerve stimulation (TENS) to treat overactive bladder, urinary incontinence, and/or fecal incontinence, as stated in the Plan's <i>Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)</i> medical policy, policy number OCA 3.562.</li> <li>3. See the Plan's <i>CPT Code Look-up Tool</i> for prior authorization guidelines and all applicable medical policies for this CPT code when it is billed with a primary diagnosis NOT related to overactive bladder, urinary incontinence, and/or fecal incontinence; the look-up tool is available at <a href="http://www.bmchp.org">www.bmchp.org</a> for BMC HealthNet Plan and Senior Care Options members and posted at <a href="http://www.wellsense.org">www.wellsense.org</a> for Well Sense Health Plan members.</li> </ol>
<b>HCPCS Codes</b>	<b>Description: Codes Considered Experimental and Investigational When Used for the Treatment of Overactive Bladder, Urinary Incontinence and/or Fecal Continence (and Billed with a Related Primary Diagnosis Code)</b>
E0740	<p>Non-implanted pelvic floor electrical stimulator, complete system</p> <p>Plan note: Code used for non-implantable pelvic floor electrical stimulation (PFES) and pelvic floor magnetic stimulation. The Plan considers non-implantable PFES to be experimental and investigational, as specified in the Medical Policy Statement and Limitations sections.</p>

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G0283	<p>Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care</p> <p>Plan notes:</p> <ol style="list-style-type: none"> <li>1. Review the Limitations section of this policy for Plan guidelines on the use of non-implantable pelvic floor electrical stimulation (PFES) for the treatment of overactive bladder, urinary incontinence and/or fecal incontinence; this includes pelvic floor electrical stimulation and/or pelvic floor magnetic stimulation.</li> <li>2. This code is also considered experimental and investigational when it is used to bill for transcutaneous posterior tibial nerve stimulation (TPTNS)/transcutaneous electrical nerve stimulation (TENS) to treat overactive bladder, urinary incontinence, and/or fecal incontinence, as stated in the Plan's <i>Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)</i> medical policy, policy number OCA 3.562.</li> <li>3. See the Plan's <i>CPT Code Look-up Tool</i> for prior authorization guidelines and all applicable medical policies for this CPT code when it is billed with a primary diagnosis NOT related to overactive bladder, urinary incontinence, and/or fecal incontinence; the look-up tool is available at <a href="http://www.bmchp.org">www.bmchp.org</a> for BMC HealthNet Plan and Senior Care Options members and posted at <a href="http://www.wellsense.org">www.wellsense.org</a> for Well Sense Health Plan members.</li> </ol>
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ICD-10 Codes	<b>Description: One (1) of the Following Primary ICD-10 Diagnosis Codes is Required When Billing with a CPT Code or HCPCS Code for Pelvic Floor Stimulation Used to Treat Overactive Bladder, Urinary Incontinence and/or Fecal Incontinence</b>
N32.81	Overactive bladder
N32.9	Bladder disorder, unspecified
N39.3	Stress incontinence ( female) (male)  Plan note: This diagnosis code is used for stress incontinence regardless of the individual's gender.
N39.41-N39.43	Other specified urinary incontinence
N39.45-N39.46	Other specified urinary incontinence
N39.490	Other specified urinary incontinence; overflow incontinence
N39.498	Other specified urinary incontinence (reflex incontinence) (total incontinence)
R15.0-R15.9	Fecal incontinence
R32	Unspecified urinary incontinence
R33.0-R33.9	Retention of urine
R35.0	Frequency of micturition
R39.14	Feeling of incomplete bladder emptying
R39.15	Urgency of urination

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## Clinical Background Information

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Urinary incontinence, or the unintentional loss of urine, is a major problem in the United States that can negatively impact the quality of life predominately in women and the elderly populations. Incontinence has several causes; women are most likely to develop urinary incontinence either during pregnancy and childbirth, or after the hormonal changes of menopause due to weakened muscles of the pelvis. Older men can become incontinent as the result of prostate surgery. Other possible risk factors for the development of urinary incontinence include pelvic trauma, hysterectomy, recurrent urinary tract infections, spinal cord damage, advanced age, caffeine, and medications such as diuretics, sedatives, beta-blockers, over-the-counter cold remedies and diet tablets.

First line treatment options for urinary incontinence include pharmacotherapy, followed by minimally invasive treatment options that may include intravesical injection of Botox, sacral nerve stimulation, and/or posterior tibial nerve stimulation. When non-invasive treatment is unsuccessful, surgical interventions may include reconstructive surgery, placement of slings, placement of compression devices, cystoplasty, and/or urinary diversion.

Pelvic floor electrical stimulation (PFES) is intended as a possible alternative to surgery for urinary incontinence that fails to respond to pelvic exercises. PFES involves placing electrodes vaginally, anally, percutaneously, or transurethrally. Electrical current is applied to the electrodes via a wire connected to the external stimulator device. Treatment regimens performed in an outpatient setting vary from 20-minute sessions twice a week to daily sessions. PFES is believed to enhance the beneficial effects of Kegel exercises by continuously exercising the correct muscles without active participation of the patient. The treatment is used to strengthen and tone the sphincter and pelvic floor muscles and improve the patient's muscle awareness. Possible side effects include vaginal irritation, occasional episodes of pain, tingling of the thigh, vaginal infection, urinary tract infection, and/or local reaction to the electrode gel. Other proposed treatment options for urinary incontinence include sacral nerve stimulation and posterior tibial nerve stimulation. The Plan considers this treatment experimental and investigational for the treatment of urinary incontinence and/or fecal incontinence.

Magnetic stimulators and several electrical stimulators and have been cleared by the U.S. Food and Drug Administration (FDA) for the treatment of incontinence. The current clinical evidence is insufficient to reach conclusions about the efficacy of pelvic floor electrical stimulation as a treatment for fecal incontinence. Additional data from large, well-designed, long-term randomized trials are also needed to establish the efficacy of magnetic stimulation of the pelvic floor muscles for the treatment of urinary incontinence and/or fecal incontinence.

At the time of the Plan's most recent policy review, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 230.8 includes medically necessary indications for the use of a non-implantable pelvic floor electrical stimulator. CMS covers pelvic floor electrical stimulation with a non-implantable stimulator for the treatment of stress urinary incontinence and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training (with a failed documented trial defined as no documented clinically

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significant improvement in urinary incontinence after completing four [4] weeks of PME training designed to increase periurethral muscle strength). No CMS clinical criteria were identified for pelvic floor magnetic stimulation for urinary incontinence or fecal incontinence or the use of pelvic floor electrical stimulation (PFES) for fecal incontinence. Verify CMS medical criteria for non-implantable pelvic floor electrical stimulator for the specified indication in the applicable NCD or local coverage determination (LCD) and coverage guidelines in effect on the date of the prior authorization request for a Senior Care Options member.

Proposed treatment for urinary incontinence may include (but are not limited to) additional services specified in the following NCDs: NCD 30.1.1 for biofeedback therapy; NCD 230.10 for incontinence control devices, including mechanical/hydraulic incontinence control devices and collagen implants; and/or NCD 230.18 for sacral nerve stimulation for urinary incontinence. According to NCD 230.16, the use of bladder stimulators, spinal cord electrical stimulators, rectal electrical stimulators, and/or bladder wall stimulators are not considered reasonable and necessary for Medicare beneficiaries, and CMS does not reimburse for these devices or for their implantation. At the time of the Plan's most recent policy review, no NCD was found from CMS for posterior tibial nerve stimulation for the treatment of incontinence and/or for any other indication; LCD L34436 and LCD L33396 were identified for posterior tibial nerve stimulation applicable to Massachusetts. No related NCD or LCD was found for the treatment of fecal incontinence. Determine if applicable CMS criteria are in effect for the requested service in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member by evaluating the requested treatment and clinical indication(s) for the service or device.

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Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 10/03/06	12/03/06 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

\*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12

\*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

\*Effective Date for the Senior Care Options Product(s): 01/01/16

This policy replaced *Pelvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* medical policy, policy number OCA 3.56, as of 05/01/13 for criteria related to pelvic floor stimulation for the treatment of incontinence. The policy was titled *Non-Implantable Pelvic Floor Electrical Stimulation for Urinary Incontinence* from 05/01/13 to 01/31/16. The policy title was *Pelvic Floor Stimulation for the Treatment of Incontinence* from 02/01/16 to 02/28/19. Effective 03/01/19, the policy title has been changed to *Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder*.

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
09/11/07	Updated template, added coding, approved by MPCTAC.	Version 2	09/11/07: MPCTAC 09/25/07: Utilization Management Committee (UMC) 10/15/07: Quality Improvement Committee (QIC)
09/09/08	No changes.	Version 3	09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC
09/22/09	Updated references, no changes to criteria.	Version 4	09/22/09: MPCTAC 10/28/09: QIC
09/01/10	Updated template and references, no changes to criteria.	Version 5	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Updated limitations to include that sacral nerve stimulation for the treatment of fecal incontinence and posterior tibial nerve stimulation for the treatment of symptoms associated with overactive bladder are considered experimental and	Version 6	10/19/11: MPCTAC 11/29/11: QIC

Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder

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## Policy Revisions History

	investigational. Updated references and coding.		
07/20/12	Off cycle review for Well Sense Health Plan: Updated title, revised Summary statement, added posterior tibial stimulation to Description of Item or Service, reformatted Medical Policy Statement, updated Definitions, revised language in Applicable Coding section, updated code list.	Version 7	08/13/12: MPCTAC 09/13/12: QIC
12/01/12	Separated pelvic floor electrical stimulation, sacral nerve stimulation, and posterior tibial nerve stimulation into three separate policies; policy formerly titled <i>Pelvic Floor/Sacral Nerve Stimulation for Urinary Incontinence</i> (formerly policy number OCA: 3.65). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, Definitions, Applicable Coding, and Clinical Background Information sections. Referenced <i>Posterior Tibial Nerve Stimulation, Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions, Biofeedback for Urinary Incontinence, Experimental and Investigation Treatment, and Medically Necessary</i> policies. Reformatted and added criteria in Medical Policy Statement section, updated and added references, and added limitations. Revised applicable code list.	Version 8	12/19/12: MPCTAC 01/31/13: QIC
12/01/13	Review for effective date 02/01/14. Updated references.	02/01/14 Version 9	12/18/13: MPCTAC 01/21/14: QIC
12/01/14	Review for effective date 05/01/15. Updated references. Added ICD9/ICD10 diagnosis codes for urinary incontinence to the Applicable Coding section. Updated introductory paragraph in the Applicable Coding section.	05/01/15 Version 10	12/17/14: MPCTAC 01/14/15: QIC
10/01/15	Review for effective date 12/01/15. Updated template with list of applicable products and corresponding notes.	12/01/15 Version 11	10/21/15: MPCTAC 11/11/15: QIC
10/21/15	Review for effective date 02/01/16. Updated Summary, Description of Item or	02/01/16 Version 12	10/21/15: MPCTAC 11/11/15: QIC

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	Service, Definitions, Clinical Background Information, and References sections. Updated criteria in the Medical Policy Statement and Limitations sections. Revised the title of the policy.		
11/25/15	Review for effective date 02/01/16. Revised language in the Applicable Coding section. Plan note added to HCPCS code G0283.	02/01/16 Version 13	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
10/01/16	Review for effective date 12/01/16. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement and Limitations sections; no change to criteria. Removed ICD-9 diagnosis codes and Plan notes added to applicable codes.	12/01/16 Version 14	10/19/16: MPCTAC 11/09/16: QIC
12/01/16	Industry-wide change to applicable code description (HCPCS code E0740) effective 01/01/17.	01/01/17 Version 15	Not applicable because industry-wide change in code description.
10/01/17	Review for effective date 01/01/18. Revised criteria in the Medical Policy Statement and Limitations sections (designating service experimental and investigational for the treatment of urinary incontinence and/or fecal incontinence). Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Plan notes updated in the Applicable Coding section and revised code list; diagnosis codes added for fecal incontinence and applicable procedure codes considered experimental and investigational for specified indications.	01/01/18 Version 16	10/18/17: MPCTAC
10/01/18	Review for effective date 11/01/18. Administrative changes made to the Policy Summary, References, and Other Applicable Policies sections. Administrative change made to the Applicable Coding section (using ICD-10 diagnosis code range rather than individual diagnosis codes without	11/01/18 Version 17	10/17/18: MPCTAC

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## Policy Revisions History

	changing the code list).		
12/01/18	Review for effective date 03/01/19. Revised the policy title. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, and References sections. Criteria updated in the Medical Policy Statement and Limitations sections. Revised the diagnosis codes and Plan notes in the Applicable Coding section.	03/01/19 Version 18	12/19/18: MPCTAC

### Last Review Date

12/01/18

### Next Review Date

10/01/19

### Authorizing Entity

MPCTAC

### Other Applicable Policies

Medical Policy - *Biofeedback in an Outpatient Setting to Treat Bladder and/or Bowel Dysfunction (Including Incontinence)*, policy number OCA 3.969

Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12

Medical Policy - *Medically Necessary*, policy number OCA 3.14

Medical Policy - *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)*, policy number OCA 3.562

Medical Policy - *Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions*, policy number OCA 3.563

Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31

Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31

Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.31

Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108

Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy SCO 4.108

Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18

Reimbursement Policy - *Non-Participating Provider*, policy number WS 4.5

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Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38

Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38

Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number 4.608

Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number SCO 4.608

Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number WS 4.28

## Reference to Applicable Laws and Regulations

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78 FR 48164-69. Centers for Medicare & Medicaid Services (CMS). Medicare Program. Revised Process for Making National Coverage Determinations. 2013 Aug 7. Accessed at:

<https://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf>

### Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.