BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

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

Policy Number: OCA 3.561
Version Number: 23
Version Effective Date: 11/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth
☒ NH Medicare Advantage	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

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

Policy Summary

The Plan considers the use of non-implantable pelvic floor stimulation to be **experimental and investigational** or NOT medically necessary 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 (PFES) and/or pelvic floor magnetic stimulation. All requests for this service will be reviewed by a Plan Medical Director in accordance with Plan policies and procedures.

Clinical Criteria

The Plan considers the use of non-implantable pelvic floor stimulation, including pelvic floor electrical stimulation (PFES) or pelvic floor magnetic stimulation (also known as extracorporeal magnetic stimulation or EMS), to be experimental and investigational or NOT medically necessary due to limited

evidence documenting the clinical utility and clinical validity of the treatment for overactive bladder, urinary incontinence and/or fecal incontinence.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, CMS NCD 230.8 8 includes medically necessary indications for the use of a non-implantable pelvic floor electrical stimulator. 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 guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

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 Stated 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). Since 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 Clinical Criteria 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 this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Codes	Description: Codes Considered Experimental and Investigational or NOT Medically Necessary When Used for the Treatment of Overactive Bladder, Urinary Incontinence and/or Fecal Continence (and Billed with a Related Primary Diagnosis Code)
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended) Note: Supervised. The application of a modality that does not require direct, one-on-one, patient contact by the provider. Plan notes: 1. Code is NOT payable for the Senior Care Options and WellSense Medicare Advantage HMO products. 2. This code is also considered experimental and investigational or NOT medically necessary 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 *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)* medical policy, policy number OCA 3.562. 3. See the applicable medical policy or clinical criteria used for this CPT code when it is billed with a primary diagnosis NOT related to overactive bladder, urinary incontinence, and/or fecal incontinence.
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes Note: Constant attendance. The application of a modality that requires direct, one-on-one, patient contact by the provider. Plan notes: 1. This code is also considered experimental and investigational or NOT medically necessary 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 *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)* medical policy, policy number OCA 3.562. 2. See the applicable medical policy or clinical criteria for this CPT code when it is billed with a primary diagnosis NOT related to overactive bladder, urinary incontinence, and/or fecal incontinence.

HCPCS Codes	Description: Codes Considered Experimental and Investigational or NOT Medically Necessary When Used for the Treatment of Overactive Bladder, Urinary Incontinence and/or Fecal Continence (and Billed with a Related Primary Diagnosis Code)
E0740	Non-implanted pelvic floor electrical stimulator, complete system 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.
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care Plan note: This code is also considered experimental and investigational or NOT medically necessary 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 *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)* medical policy, policy number OCA 3.562.

ICD-10 Codes	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
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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Policy History

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: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

This policy replaced P*elvic 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 investigational. Updated references and coding.	Version 6	10/19/11: MPCTAC 11/29/11: QIC

Policy Revisions History			
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 *Pelvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* (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 *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* 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 Service, Definitions, Clinical Background Information, and References sections.	02/01/16 Version 12	10/21/15: MPCTAC 11/11/15: QIC

Policy Revisions History			
	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 changing the code list).	11/01/18 Version 17	10/17/18: MPCTAC
12/01/18	Review for effective date 03/01/19. Revised	03/01/19	12/19/18: MPCTAC

Policy Revisions History			
	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.	Version 18	
07/01/19	Review for effective date 08/01/19. Updated the Plan notes in the Applicable Coding section.	08/01/19 Version 19	07/17/19: MPCTAC
09/01/19	Review for effective date 10/01/19. Administrative changes made to the Other Applicable Policies, References, and Reference to Applicable Laws and Regulations sections.	10/01/19 Version 20	09/18/19: MPCTAC
09/01/20	Review for effective date 10/01/20. Administrative changes made to the References and Other Applicable Policies sections.	10/01/20 Version 21	09/16/20: MPCTAC
05/01/21	Review for effective date 06/01/21. Plan note revised in the Applicable Coding section. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and Limitations sections.	06/01/21 Version 22	05/19/21: MPCTAC
10/01/21	Review for effective date 11/01/21. Adopted new medical policy template; removed administrative sections and the Medical Policy Statement section renamed the Clinical Criteria section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Applicable Coding, and References sections. Removed the Limitations section.	11/01/21 Version 23	10/20/21: MPCTAC

Next Review Date

09/01/22

Authorizing Entity

MPCTAC

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.