Medical Policy:
Posterior Tibial Nerve Stimulation for Voiding Dysfunction

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.ME.67	3/14/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

Percutaneous Tibial Nerve Stimulation (PTNS)	A technique of electrical neuromodulation for the treatment of voiding dysfunction in patients who have failed behavioral and /or pharmacologic therapies. This is the least invasive form of neuromodulation used to treat overactive bladder (OAB) and the associated symptoms of urinary urgency, urinary frequency and urge incontinence. Common causes of voiding dysfunction are pelvic floor dysfunction (e.g., from pregnancy, childbirth, surgery), inflammation, medication (e.g., diuretics and anticholinergics), obesity, psychogenic factors, and disease (e.g., multiple sclerosis, spinal cord injury, detrusor hyper-reflexia). PTNS treatment consists of a series of short-term insertions of a percutaneous needle electrode for approximately 30 minutes, with intermittent neuromodulation while the needle electrode remains in place. The neurostimulator includes a lead set with surface electrodes and a needle electrode, which produces an adjustable electrical pulse that travels to the sacral nerve plexus via the tibial nerve. The sacral nerve plexus then regulates the bladder and the pelvic floor functionality.

Increased Daytime Frequency	The complaint by the individual who considers that he/she voids too often during the day.
Nocturia	The complaint that the individual has to wake at night one or more times to urinate.
Urgency	The complaint of a sudden compelling desire to pass urine, which is difficult to defer.
Urinary Incontinence	The complaint of any involuntary leakage of urine.

Guideline

Treatment with PTNS for OAB in the office setting is considered medically necessary when the member has been evaluated by an appropriate specialist (e.g., urologist or urogynecologist) who has determined that the member is a candidate for PTNS.

Limitations/Exclusions

1. Initial course of PTNS treatment is defined as one 30-minute session per week for 12 consecutive weeks.
2. Continuation of PTNS is covered for members who complete and show response to the 12-week treatment regimen.
   Response is defined as ≥ 50% improvement in voiding symptoms (based on documentation such as patient voiding diaries). The treatment regimen for continued PTNS is tailored to each individual member; typically 1 treatment administered every 2–3 weeks (26 treatments per 12 month maximum).
3. Treatment with PTNS is not considered medically necessary for any of the following conditions due to insufficient evidence of therapeutic value (list not all-inclusive):
   a. Chronic pelvic pain
   b. Constipation
   c. Fecal incontinence
   d. Voiding dysfunction secondary to a neurological condition
4. Implantable tibial nerve stimulation (e.g., eCoin Peripheral Neurostimulator System) is not considered medically necessary due to insufficient evidence of therapeutic value.
5. Wearable PTNS devices such as the Vivally® System (HCPCS A4545, E0737) or Zida Wearable Neuromodulation System (A4545, E0736) are not considered medically necessary due to insufficient evidence of therapeutic value

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Applicable Procedure Codes

64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

Applicable ICD-10 Diagnosis Codes

N32.81	Overactive bladder
N39.41	Urge incontinence
R35.0	Frequency of micturition
R39.15	Urgency of urination

References

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Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Mar. 14, 2025	Transferred policy content to individual company branded template
EmblemHealth ConnectiCare	Mar. 14, 2025	Removed failure/intolerance of behavioral/medical management as a prerequisite for PTNS
EmblemHealth ConnectiCare	Nov. 8, 2024	Added Vivally and Zita as investigational device examples of wearable stimulation
EmblemHealth ConnectiCare	Jan. 19, 2023	eCoin added as an investigational device example to implantable nerve stimulation
EmblemHealth ConnectiCare	Jan. 8, 2021	Removed in-office treatment sessions and voiding diary prerequisites.
EmblemHealth ConnectiCare	Jan. 10, 2020	Added implantable TNS to Limitations/Exclusions as investigational.
EmblemHealth ConnectiCare	Jul. 12, 2019	The indication of failure/intolerance/contraindication to pharmacotherapy with ≥ 2 anticholinergic medications and/or smooth muscle relaxants was clarified to include overactive bladder and β3 agonist medications.