Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP302

Section: Medical Benefit Policy

Subject: Percutaneous Posterior Tibial Nerve Stimulation (PTNS)

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Percutaneous Posterior Tibial Nerve Stimulation (PTNS)

II. Purpose/Objective:

To provide a policy of coverage regarding Percutaneous Posterior Tibial Nerve Stimulation (PTNS)

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Percutaneous Posterior Tibial Nerve Stimulation (PTNS) is a procedure that delivers retrograde access to the sacral nerve plexus via electrical stimulation of the posterior tibial nerve. Also referred to as posterior tibial nerve stimulation, this treatment is a minimally invasive form of neuromodulation used to treat overactive bladder (OAB) and the associated symptoms of urinary urgency, urinary frequency and urge incontinence.

INDICATIONS:
Percutaneous Posterior tibial nerve stimulation (PTNS) for the treatment of overactive bladder symptoms may be considered medically necessary, up to a maximum of 12 weeks when **ALL** of the following conditions are met:

- The member has had urinary dysfunction for at least 12 months and the condition has resulted in significant disability (i.e., the urinary urgency, frequency and or the severity of symptoms are limiting the member's ability to participate activities of daily living); **and**
- anatomical abnormalities of the lower urinary tract and active urinary tract infections have been excluded; **and**
- There is medical record evidence that the member has tried a minimum of 2 medications (e.g., alpha blockers and anticholinergics, and antibiotics for urinary tract infections) that have failed, are not well-tolerated, or are unable to be used due to contraindications.

LIMITATIONS:
The typical course of treatment will be considered to be 12 treatments of PTNS, 30 minutes, once-weekly.

Treatment beyond the initial 12 sessions will be allowed at a frequency of 1 every 1 to 2 months for up to two years if symptomatic improvement is documented.

Medicaid Business Segment:
This service will be considered for coverage only through a program exception.

EXCLUSIONS:
If the insured individual exhibits no improvement in OAB symptoms after 12 PTNS treatments, continued treatment is considered not medically necessary, and **NOT COVERED**

PTNS for the treatment of all other indications, is considered experimental, investigational or unproven and, is **NOT COVERED.**

Subcutaneous tibial nerve stimulation (STNS) {e.g.., eCoin System, REVI System} is considered **UNPROVEN** and therefore **NOT COVERED** for any indication. There is insufficient evidence in the published peer-reviewed medical literature to show this technology imparts improved outcomes compared to current standard technologies.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Percutaneous Posterior tibial nerve stimulation
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

CPT/HCPCS:
64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes Programming
0587T Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming and imaging guidance when performed, posterior tibial nerve
0588T Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve

0589T Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters

0590T Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters

0816T Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous

0817T Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial

0818T Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous

0819T Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually

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