



Clinical Review Criteria Related to Sacral Nerve Stimulation and Electrical Percutaneous Tibial Nerve Stimulation

I. Criteria for Approval

- A. Minuteman Health Insurance (MHI) considers Sacral Nerve Stimulation and Electrical Percutaneous Tibial Nerve Stimulation to be medically necessary for the diagnosis of urinary urge incontinence, urgency-frequency syndrome, and urinary retention, as long as the following criteria are met:
 - 1. Condition refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy)
 - 2. Anatomical abnormalities of the lower urinary tract and active urinary tract infections are excluded.
 - 3. For Sacral Nerve Stimulators
 - a. A successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.
 - b. Adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated

II. Required Documentation

- A. Letter of medical necessity or office notes documenting the above criteria are met

III. What is Not Covered

- A. Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above 3 indications are excluded.
- B. Patients with interstitial cystitis, chronic pelvic floor pain, non-obstructive urinary retention are excluded.
- C. Patients for whom this is the first line of treatment are excluded

ICD-9 Codes and Descriptions

625.6 Stress incontinence, female
788.20 Non-obstructive urinary retention
788.30 Urinary incontinence unspecified
788.31 Urge incontinence
788.32 Male stress incontinence NEC
788.33 Mixed incontinence (male and female)
788.34 Incontinence without sensory awareness
788.41 Urge/frequency

References:

NCQA Standard, UM2, Clinical Criteria for Utilization Management Decisions, Element A

CMS: National Coverage Determination (NCD) for Sacral **Nerve** Stimulation For Urinary Incontinence (230.18)
(Last Accessed 8/29/16)

CMS: Local Coverage Determination (LCD) for Percutaneous Tibial Nerve Stimulation (PTNS) (L31523)
Effective date 5/22/2011
(Last Accessed 8/29/16)

Hayes Medical Technology Directory. Implantable Sacral Nerve Stimulation for Urinary Voiding Dysfunction. Lansdale PA: Hayes, Inc. Copyright 2010 Winifred S. Hayes, Inc. Pub.2010 July, Updated search June 6, 2013
(Last Accessed 8/29/16)

Hayes Medical Technology Directory. Electrical Percutaneous Tibial Nerve Stimulation for Urinary Voiding Dysfunction. LansdalePA: Hayes, Inc. Copyright 2008, Winifred S. Hayes, Inc. 2008 September , Updated search March, 2012
(Last Accessed 8/29/16)

Summary of Changes:

02/09/2017

- III., What is Not Covered: Added C.: Patients for whom this is the first line of treatment are excluded
- Last-accessed dates changed under Source/Citation Section