Coverage Summary

Incontinence: Urinary and Fecal Incontinence, Diagnosis and Treatments

Policy Number: I-001
Products: UnitedHealthcare Medicare Advantage Plans
Original Approval Date: 11/27/2006
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee
Last Review Date: 11/19/2019

Related Medicare Advantage Policy Guidelines:

- Biofeedback Therapy (NCD 30.1)
- Biofeedback Therapy for the Treatment of Urinary Incontinence (NCD 30.1.1)
- Bladder Stimulators (Pacemakers) (NCD 230.16)
- Electrical Continence Aid (NCD 230.15)
- Incontinence Control Devices (NCD 230.10)

- Non-Implantable Pelvic Floor Electrical Stimulator (NCD 230.8)
- Sacral Nerve Stimulation for Urinary Incontinence (NCD 230.18)
- Urological Supplies

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The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Diagnosis and treatment of urinary incontinence are covered in accordance with Medicare coverage criteria.

DME Face to Face Requirement: Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including incontinence treatment systems, pelvic floor stimulator, monitor, sensor and/or trainer). For DME Face to Face Requirement information, refer to the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

Guidelines/Notes:
1. Conservative Treatments
   Conservative treatments of urinary incontinence are covered. Examples include, but are not limited to:
   - Habit training
   - Prompted voiding
   - Routine/scheduled toileting
   - Kegel exercises

2. Mechanical or Hydraulic Incontinence Control Devices
   Mechanical or hydraulic incontinence control devices for the management of urinary incontinence are covered for members with permanent anatomic and neurologic dysfunctions of the bladder (e.g., artificial sphincter). This class of devices achieves control of urination by compression of the urethra. See the NCD for Incontinence Control Devices (230.10). (Accessed March 6, 2019)

3. Urodynamic Studies (Uroflowmetry or Cystometrogram)
   Uroflowmetric evaluations (also referred to as urodynamic voiding or urodynamic flow studies) are covered under Medicare for diagnosing various urological dysfunctions, including bladder outlet obstructions.
   See the NCD for Uroflowmetric Evaluations (230.2). (Accessed March 6, 2019)
   Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)

4. Radiofrequency (RF) Micro-remodeling for Stress Urinary Incontinence (e.g., Renessa™) (CPT code 53860)
   - Medicare does not have a National Coverage Determination (NCD) for radiofrequency micro-remodeling for stress urinary incontinence.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment A).
   - For states with no LCDs/LCAs, refer to the National Government Services LCD for Non-covered Services (L33629) for coverage guideline.
(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: March 19, 2019
- Accessed December 3, 2019

5. **Biofeedback Therapy**

Biofeedback is a method of treatment for urinary incontinence used as a tool to help patients learn how to perform pelvic muscle exercise (PME). Biofeedback-assisted PME involves the use of an electronic or mechanical device to relay visual and/or auditory evidence of pelvic floor muscle tone with the goal of improving awareness of pelvic floor musculature.

Biofeedback is covered for the treatment of stress and/or urges urinary incontinence for cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.

a. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase perirethral muscle strength.

b. Home use of biofeedback is not covered.

See the NCD for Biofeedback Therapy for the Treatment of Urinary Incontinence (30.1.1). (Accessed March 6, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)

6. **Collagen Implant Therapy**

Collagen implant therapy is covered when coverage criteria are met.

See the NCD for Incontinence Control Devices (230.10). (Accessed March 6 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)

Note: The member’s copayment for collagen implantation injection treatment is the office visit plus the injectable medication copayment, if any.

7. **Sacral Nerve Stimulation (SNS)**

Sacral nerve stimulation (SNS) is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome, and urinary retention when criteria are met.

See the NCD for Sacral Nerve Stimulation for Urinary Incontinence (230.18). (Accessed March 6, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)
8. **Non-implantable Pelvic Floor Electrical Stimulator**

Non-implantable pelvic floor electrical stimulators for stress and/or urge urinary incontinence are covered when criteria are met.

*See the NCD for Non-Implantable Pelvic Floor Electrical Stimulator (230.8). (Accessed March 6, 2019)*

9. **Electrical Continence Aid**

Electrical continence aid is a device consisting of a plastic plug, molded into the shape of the patient's anal canal, which contains two implanted electrodes that are connected by a wire to a small portable generator. An electrical current is produced which stimulates the anal musculature to cause a contraction sufficient to hold the plug in while allowing the patient to ambulate without incontinence.

Electrical continence aids are in the experimental stage of development and there is no valid scientific documentation of their effectiveness and safety. Therefore, they are not covered under Medicare since they cannot be considered to be reasonable and necessary for the treatment of an illness or injury or to improve the functioning of a malformed body member as required by §1862(a)(1) of the Act.

*See the NCD for Electrical Continence Aid (230.15). (Accessed March 6, 2019)*

*Note: This electrical stimulator device is used in the treatment of fecal incontinence.*

10. **Bladder Stimulators (Pacemakers)**

Bladder stimulators (pacemakers) are not covered. The use of spinal cord electrical stimulators, rectal electrical stimulators, and bladder wall stimulators is not considered reasonable and necessary. Therefore, no program payment may be made for these devices or for their implant. *See the NCD for Bladder Stimulators (Pacemakers) (230.16). (Accessed March 6, 2019)*

11. **Posterior Tibial Nerve Stimulation (PTNS) (CPT Code 64566)**

- *Medicare does not have a National Coverage Determination for PTNS for urinary control.*
- *Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment B).*
- *For states with no LCDs/LCAs, refer to the Novitas LCD for Surgery: Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control (L35011) for coverage guideline.*

*IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.*

- *Committee approval date: November 19, 2019*
- *Accessed December 3, 2019*

12. **Solesta® for Fecal Incontinence (HCPCS code L8605)**

- *Medicare does not have a National Coverage Determination (NCD) for Solesta®.*
- *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.*

*For coverage guideline, refer to the UnitedHealthcare Commercial Medical Policy for Omnibus Codes.*

*IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA
is found, then use the above referenced policy).

- Committee approval date: March 19, 2019
- Accessed November 6, 2019

13. Botulinum Toxin Type A for Overactive Bladder/Urinary Incontinence

- Medicare does not have a National Coverage Determination (NCD) for botulinum toxin type A.
- Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist and compliance with these policies required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment C).
- For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy for Botulinum Toxins A and B for coverage guidelines.
  (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LC/LCA is found, then use the above referenced policy).
- Committee approval date: March 19, 2019
- Accessed December 3, 2019

II. DEFINITIONS

Posterior Tibial Nerve Stimulation (PTNS): A minimally invasive procedure, consists of insertion of a percutaneous needle above the medial malleolus into a superficial branch of the posterior tibial nerve. An adjustable low voltage electrical impulse (10mA, 1-10 Hz frequency) travels via the posterior tibial nerve to the sacral nerve plexus to alter pelvic floor function by neuromodulation. Multiple LCDs for Posterior Tibial Nerve Stimations (PTNS); available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)

Sacral Nerve Stimulation: Implantation of a permanent device that modulates the neural pathways controlling bladder function. This treatment is one of several alternative modalities for patients with urge urinary incontinence whose incontinence has been refractory to behavioral and pharmacologic treatment. This treatment involves electrical stimulation of the sacral nerves in the lower region of the spine via a totally implantable system. System components include a lead, an implantable pulse generator and an extension that connects the lead to the pulse generator. It is expected that the physician performing this service has completed a training course in the use and implantation of the device. Multiple LCDs for Sacral Nerve Stimulation; available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 6, 2019)

III. REFERENCES

See above
IV. REVISION HISTORY

11/19/2019  Guideline 11 [Posterior Tibial Nerve Stimulation (PTNS) (CPT Code 64566)]
- Revised coverage guidelines to indicate:
  o Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist [for some states] and compliance with these policies is required where applicable
  o For states with no LCDs/LCAs, refer to the Novitas LCD for Surgery: Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control (L35011)

Attachments
- Updated LCD Availability Grids to reflect the most current reference links

V. ATTACHMENTS

Attachment A - LCD Availability Grid
Radiofrequency (RF) Micro-remodeling for Stress Urinary Incontinence (e.g., Renessa™) (CPT code 53860)

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33629 (A57812)</td>
<td>Non-covered Services</td>
<td>A and B MAC</td>
<td>National Government Services, Inc</td>
<td>CT, IL, MN, WI, VT, NY, MA, ME, NH, RI</td>
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<td>L36954 (A56506)</td>
<td>Non-covered Services other than CPT® Category III Non-covered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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End of Attachment A
## Attachment B - LCD Availability Grid

### Posterior Tibial Nerve Stimulation (PTNS)

(CPT Code 64566)

CMS website accessed December 3, 2019

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<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
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<tr>
<td>L33396</td>
<td>Posterior Tibial Nerve Stimulation for Voiding Dysfunction</td>
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<td>MAC - Part A and B</td>
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<td>L33443</td>
<td>Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control</td>
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<td>L33406</td>
<td>Posterior Tibial Nerve Stimulation (PTNS)</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc</td>
<td>FL, PR, VI</td>
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<td>(A57770)</td>
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<td>L35011</td>
<td>Surgery: Posterior Tibial Nerve Stimulation (PTNS) for Urinary Control</td>
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<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<td>A52965</td>
<td>Posterior Tibial Nerve Stimulation Coverage</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
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<td>A55104</td>
<td>Posterior Tibial Nerve Stimulation Coverage</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
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End of Attachment B
## Attachment C - LCD Availability Grid

**Botulinum toxin type A for Overactive Bladder/Urinary Incontinence**

CMS website accessed December 3, 2019

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<tr>
<th>LCD ID</th>
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<th>Contractor</th>
<th>States</th>
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<td>L35172</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
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</tr>
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<td>L34635</td>
<td>Botulinum Toxin Type A &amp; Type B</td>
<td>MAC Part A and B</td>
<td>Wisconsin Physicians Service</td>
<td>IN, IA, KS, MI, MO, NE</td>
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<td>L34635</td>
<td>Botulinum Toxin Type A &amp; Type B</td>
<td>MAC Part A</td>
<td>Wisconsin Physicians Service</td>
<td>AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY</td>
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<td>L33274</td>
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<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<td>L33458</td>
<td>Chemodenervation</td>
<td>A and B MAC</td>
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End of Attachment C