# Sacral Nerve Stimulation for Urinary Incontinence (NCD 230.18)

Guideline Number: MPG269.09
Approval Date: January 11, 2023

Terms and Conditions

Table of Contents Page



Related Medicare Advantage Coverage Summary

- Urinary and Fecal Incontinence, Diagnosis and Treatments

## Policy Summary

See Purpose

### Overview

Sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome, and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

### Guidelines

The following limitations for coverage apply to all three indications:

- Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
- 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 three indications are excluded.
- Patient must have had 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.
- Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|---|---|
| 64561 | Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed |
| 64581 | Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) |

*CPT® is a registered trademark of the American Medical Association*

| Diagnosis Code | Description |
|---|---|
| N30.10 | Interstitial cystitis (chronic) without hematuria |
| N30.11 | Interstitial cystitis (chronic) with hematuria |
| N36.44 | Muscular disorders of urethra |
| N39.41 | Urge incontinence |
| N39.42 | Incontinence without sensory awareness |
| N39.46 | Mixed incontinence |
| N39.490 | Overflow incontinence |
| N39.492 | Postural (urinary) incontinence |
| N39.498 | Other specified urinary incontinence |
| R15.9 | Full incontinence of feces |
| R32 | Unspecified urinary incontinence |
| R33.0 | Drug induced retention of urine |
| R33.8 | Other retention of urine |
| R33.9 | Retention of urine, unspecified |
| R35.0 | Frequency of micturition |
| R39.11 | Hesitancy of micturition |
| R39.14 | Feeling of incomplete bladder emptying |
| R39.15 | Urgency of urination |
| R39.191 | Need to immediately re-void |
| R39.192 | Position dependent micturition |

# References

## CMS National Coverage Determinations (NCDs)

NCD 230.18 Sacral Nerve Stimulation For Urinary Incontinence
Reference NCD: NCD 160.7 Electrical Nerve Stimulators

## CMS Local Coverage Determinations (LCDs) and Articles

| LCD | Article | Contractor | Medicare Part A | Medicare Part B |
|---|---|---|---|---|
| N/A | A53017 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence | Noridian | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| N/A | A53359 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence | Noridian | AS, CA, GU, HI, MP, NV | AS, CA, GU, HI, MP, NV |
| N/A | A55835 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence | CGS | OH, KY | OH, KY |

### CMS Benefit Policy Manual

Chapter 32; § 40 Sacral Nerve Stimulation

### CMS Transmittal(s)

Transmittal 2202, Change Request 11005, Dated 11/09/2018 (Coding Revisions to National Coverage Determination)
Transmittal 10193, Change Request 11655, Dated 06/19/2020 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)–July 2020 Update)

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

| Date | Summary of Changes |
|---|---|
| 01/11/2023 | • Routine review; no change to guidelines<br>• Archived previous policy version MPG269.08 |

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS"

basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.



*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.