Urinary Incontinence Treatment

Policy Number: HS-080

Original Effective Date: 2/2/2009


APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.
BACKGROUND

Applicable To:
- Medicaid
- Medicare

Urinary incontinence (UI) is the involuntary loss of urine that is a social or hygienic problem. UI is categorized as transient, urge, stress, overflow, mixed, and functional. It affects at least 15 million Americans and is more common in women as in men (AUAF, 2011). There are four types of UI (AUAF, 2011):

- **Stress UI** occurs when there is an increase in abdominal pressure caused by physical activities like coughing, laughing, sneezing, lifting, straining, getting out of a chair or bending over. Major risk factors include damage to pelvic muscles during pregnancy and childbirth as well as issues with menopause, or surgery.
- **Urge UI** is also known as “overactive bladder” and is accompanied by a sudden, strong urge to urinate and an inability to get to the toilet in time. Some individuals may leak urine with no warning. Risk factors include aging, obstruction of urine flow, inconsistent emptying of the bladder and a diet high in bladder irritants (such as coffee, tea, colas, chocolate and acidic fruit juices).
- **Mixed UI** is a combination of urge and stress incontinence.
- **Overflow UI** occurs when the bladder does not empty properly and the amount of urine produced exceeds the capacity of the bladder. It is characterized by frequent urination and dribbling. Poor bladder emptying occurs if there is an obstruction to flow or if the bladder muscle cannot contract effectively. This type of incontinence may be caused by an enlarged prostate, blockages in urethra (from tumor), urinary stones, scar tissue, swelling from infection, kinks caused by dropping of the bladder within the abdomen; weak bladder muscles, injury of nerves that affect the bladder, nerve damage (diabetes, alcoholism, Parkinson’s disease, multiple sclerosis, or spina bifida), medications (some anticonvulsants and antidepressants, that affect nerve signals to the bladder).
- **Neurogenic UI** is the the loss of normal bladder function caused by damage to part of the nervous system. Injury to the brain and spinal cord above the waist level produces a bladder that is unable to relax, or one that contracts too frequently. Such injuries include stroke, spinal cord injury, head injury and multiple sclerosis. A weak or inactive urinary sphincter is caused by injuries to the nerves that go from the spinal cord to the sphincter. These injuries happen with trauma or surgery, or a person may be born with them.

Risk Factors

The American Urological Association Foundation (AUAF) (2011) cites several risk factors for the development of urinary incontinence in women:

- Pregnancy, childbirth (mode of delivery), and number of children
- Hysterectomy
- Recurrent urinary tract or vaginal infections
- Other gynecologic factors
- Menopause

Risk factors among men and women include (AUAF, 2011):

- Gastrointestinal factors
- Diseases and disorders involving the nervous system muscles (e.g., multiple sclerosis, Parkinson’s disease, spinal cord injury and stroke)
- Enlarged prostate (men)
- Dehydration
- Overactive bladder
- Weakness of the muscles in the pelvis; holding the bladder in place; or of the sphincter muscles surrounding the urethra

Clinical Coverage Guideline
Diagnosis

Obtaining a patient’s medical history (family and surgical) and conducting a physical examination are the first steps for a urologist. A thorough physical examination looking for correctable causes of leakage, including impacted stool, constipation, prostate disease and prolapse or hernias, will be conducted. Usually a urinalysis and cough stress test will be performed at the first evaluation. If findings suggest further evaluation is necessary, tests such as cystoscopy\(^a\) or urodynamics\(^b\) may be recommended (AUAF, 2011).

\(^a\)Cystoscopy is performed by placing a small scope or camera through the urethra and into the bladder.

\(^b\)Urodynamics is an outpatient test that is done with a tiny tube in the bladder inserted through the urethra and often with a second small tube in the rectum. The bladder is filled and the patient is asked to void while pressure measurements are recorded.

To aid in the determination of treatment of urinary incontinence, electromyography (EMG) and a cystometrogram (CMG) should be used (MedLine, 2010).

An EMG checks the health of the muscles and the nerves that control the muscles. A nerve conduction velocity test is usually performed along with an EMG. EMG is most often used when people have symptoms of weakness, and examination shows impaired muscle strength. It can help to tell the difference between muscle weakness caused by injury of a nerve attached to a muscle and weakness due to neurologic disorders.

A CMG measures the amount of fluid in the bladder when a patient first feels the need to urinate, when they are able to sense fullness, and when the bladder is completely full. In some cases, x-rays are taken during the test. This is called videourodynamics. The test will help determine the cause of bladder voiding dysfunction.

Treatment Options

Many treatment options exists for urinary incontinence including:

- Behavioral modification
- Pelvic floor training
- Periurethral injections
- Sub-urethral sling procedures
- Retropubic colposuspension
- Bladder neck needle suspension
- Anterior vaginal repair
- Pharmacological interventions
- Neuromodulation
- Temporary electrical stimulation
- Reconstructive surgery

Less invasive, first-tier behavioral and pharmacological interventions are advised and are often combined with temporary electrical stimulation before irreversible, reconstructive surgery is considered as a treatment choice.
The American Urological Association (AUA) made a 2009 recommendation on the surgical management of stress UI in women. This includes a complete evaluation, including an assessment of post-void residual volume, and counseling about the benefits and risks of both surgical and nonsurgical options. Treatment should be a collaborative effort between the surgeon and patient, taking into consideration both patient preferences and the surgeon’s judgment and expertise. Assessment of post-void residual urine volume should be undertaken as a part of fully evaluating the incontinent patient and assessing comorbidities – such as detrusor contractility and urinary retention – so that surgical techniques can be tailored accordingly.

The AUA Guideline Panel recommends a focused history, physical examination and demonstration of leakage with increasing abdominal pressure, along with urinalysis, cultures and other diagnostic measures (such as imaging, voiding diaries, cystoscopy and urodynamics) if needed. Patients with known or suspected neurogenic bladder, concomitant overactive bladder symptoms, excessive residual volume, dysfunctional voiding or prior lower urinary tract surgery may need further evaluation to confirm an SUI diagnosis. It is important to note that patients with urge incontinence without stress incontinence should not be offered a surgical procedure for stress incontinence. Patients with mixed incontinence (both urge and stress) with a significant stress component may benefit from surgical treatment. The Panel analyzed four categories of treatment options:

1. **Retropubic Suspensions.** Considered one of the most effective procedures for long-term success; patients should be educated on the complication rates of the procedure.

2. **Slings.** The AUA does not recommend the use of this treatment for patients with stress incontinence with a concurrent urethrovaginal fistula, urethral erosion, intraoperative urethral injury and/or urethral diverticulum. Using synthetic materials increase risks to the patient for adverse side effects. In addition, the bladder and urethra must be inspected either with a rigid or flexible cystoscope prior to the conclusion of the procedure, in order to detect potential intraoperative complications.

3. **Injectable Agents.** Collagen and other nondegradable synthetic agents are an option for patients who do not wish to undergo invasive surgery and understand that both efficacy and duration are inferior to surgery.

4. **Artificial Urinary Sphincters.** Use of artificial urinary sphincters is generally restricted to those with nonfunctioning urethras (e.g., spina bifida patients, male adults with post-prostatectomy incontinence and victims of trauma to the pelvic nerve). It may be an option for patients with severe intrinsic sphincteric deficiency who have failed other surgical procedures.

The American College of Obstetricians and Gynecologists (ACOG) (2005) made the following Level A recommendations that are based on good and consistent scientific evidence for women with incontinence:

- **Behavioral therapy,** including bladder training and prompted voiding, improves symptoms of urge and mixed incontinence and can be recommended as a noninvasive treatment in many women.
- **Pelvic floor training** appears to be an effective treatment for adult women with stress and mixed incontinence and can be recommended as a noninvasive treatment for many women.
- **Pharmacologic agents,** especially oxybutynin and tolterodine, may have a small beneficial effect on improving symptoms of detrusor over-activity in women.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- **Cystometric testing** is not required in the routine or basic evaluation of urinary incontinence.
- **Bulking agents** are a relatively noninvasive method of treatment for stress incontinence and can be used in women for whom any form of operative treatment is contraindicated.
- Long-term data suggest that Burch colposuspension and sling procedures have similar objective cure rates; therefore, selection of treatment should be based on patient characteristics and the surgeon’s experience.
- The **combination of a hysterectomy and a Burch colposuspension** does not result in higher continence rates than a Burch procedure alone.
- **Tension-free vaginal tape** and open Burch colposuspension have similar success rates.
- Anterior colporrhaphy, needle urethropexy, and paravaginal defect repair have lower cure rates for stress incontinence than Burch colposuspension.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- After the basic evaluation of urinary incontinence, simple cystometry is appropriate for detecting abnormalities of detrusor compliance and contractibility, measuring postvoid residual volume, and determining capacity.
- Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of postvoid residual volume, and urinalysis.

Sacral Nerve Stimulation

Sacral nerve stimulation (SNS) is currently intended for the treatment of intractable urinary urge incontinence, non-obstructive urinary retention, and urgency/frequency syndrome in adults. SNS is generally indicated in members who demonstrate at least 50% incontinence symptom relief during percutaneous test stimulation and who have failed or not tolerated more conservative treatments (e.g., behavioral strategies, pharmacological interventions).

Pelvic Floor Electrical Stimulation

Pelvic floor electrical stimulation can be performed in a clinical setting or at home. Electrodes can be placed either externally and internally; the treatment varies in stimulus frequency, stimulus intensity, treatment duration, number of sessions, and treatment days per week. During each treatment session, a frequency of 5 to 100 hertz (Hz) is used for 15 to 20 minutes once or twice daily. In most cases, vaginal, anal, and surface electrodes are used; removable electrodes are placed in the vagina or rectum (plug electrodes) or around the dorsum of the penis (butterfly electrodes). Electrodes may also be placed on the pre-sacral skin to convey electrical impulses to the nerve roots that supply the pudendal and pelvic nerves to the bladder.

Collagen Implant

A collagen implant, which is injected into the submucosal tissues of the urethra and/or the bladder neck and into tissues adjacent to the urethra, is a prosthetic device used in the treatment of stress urinary incontinence resulting from intrinsic sphincter deficiency (ISD). ISD is a cause of stress urinary incontinence in which the urethral sphincter is unable to contract and generate sufficient resistance in the bladder, especially during stress maneuvers.

Coaptite®

The U.S. Food and Drug Administration (2013) approved Coaptite®, a permanently implanted device used to treat women who have stress urinary incontinence due to poorly functioning urethral sphincter muscles. The device is a tooth paste-like gel that is injected into the wall of the urethra near the bladder. After injection, Coaptite® bulks the wall of the urethra to help prevent uncontrolled urination. Coaptite® is used in adult women who have stress urinary incontinence due to poorly functioning urethral sphincter muscles. Women with stress urinary incontinence tend to experience uncontrolled urination during exercise or certain other body movements such as sneezing and coughing. One cause of stress urinary incontinence is a weakness of urethral sphincter muscles, which help open and close the tube from the bladder that drains urine (urethra). Coaptite® is intended to prevent urine from accidentally leaking out of the bladder in women with poorly functioning urethral muscles by bringing the walls of the urethra closer together. Using a small tube to view the bladder (cystoscope3), the gel mixture is injected into the wall of the urethra. After injection, a part of the gel vanishes in a few months but the solid particles remain to provide for bulking of the urethral wall.

In a clinical study, approximately 34% of women were dry at 1 year after receiving Coaptite® and 58% had slight to significant improvement (improvement includes dry) in their incontinence (based on which activities caused urine leakage). In 10% of women, incontinence worsened. Approximately 63% of women required repeat injections to achieve satisfactory results. In terms of the amount of leakage, 62% had a reduction of = 50% urine leakage after treatment, compared to pretreatment leakage. An unanticipated side effect noted during the study was dissection of
the device through tissue leading to: 1) tissue erosion requiring corrective surgery in one patient, and 2) elevation of the bladder wall causing ureteral obstruction in another patient. Patient’s medical history and improper injection technique may have contributed to these serious side effects. Common side effects of the treatment included urination difficulty (Retention) in 41% patients, blood in urine in 20%, painful urination (dysuria) in 15% patients, urinary tract infection (UTI) in 8%, a feeling of sudden urge to urinate without incontinence (urgency) in 8%, frequent urination in 7%, and incontinence by a sudden urge to urinate in 6%.

Transurethral Radiofrequency Micro-Remodeling

The Renessa® System (Novasys Medical Inc.) consists of an RF generator and probe. The probe is inserted through the urethra into the bladder, and is anchored in the bladder outlet by inflation of a balloon at its tip. A series of 4 needles arranged concentrically around the probe shaft just beneath the balloon are deployed into the tissue after which pulses of RF energy lasting 60 to 90 seconds are administered. The RF energy raises the temperature in the vicinity of the needle tips to 65˚C to 75˚C. These temperatures are high enough to break down tissue proteins in the region of the needle tip but do not lead to tissue destruction. As these small lesions heal, the urethral tissue becomes firmer and less likely to open involuntarily under pressure. The process, which is also called micro-remodeling, is performed by a gynecologist or urologist, takes around 20 minutes, and has a recovery time of around 2 hours. The procedure has been carried out under conscious sedation, but preliminary data indicate it can also be performed in the office. The available evidence on the efficacy and safety of transurethral RF therapy with the Renessa system for treatment of SUI is very limited. Moreover, there has been no evaluation of the long-term health outcomes or complications following this procedure, and it is unknown how it compares with alternative technologies. Further studies incorporating blinded assessment of objective outcomes and longer follow-up are needed to confirm the efficacy and safety of this procedure.

POSITION STATEMENT

Applicable To:
- Medicaid – All Markets
- Medicare – All Markets

Exclusions

The urinary incontinence treatments are considered experimental and investigational and not a covered benefit:
- Transurethral radiofrequency micro-remodeling using the Renessa® system (Novasys Medical Inc)
- Transvaginal radiofrequency bladder neck suspension
- Percutaneous tibial nerve stimulation
- Extracorporeal magnetic stimulation (Neocontrol™ System)
- Transurethral Macroplastique injection
- Transobturator tape procedure
- Artificial urinary sphincter for all other indications not listed above.

Coverage

Covered urinary incontinence treatments are listed below; member must meet at least ONE of the following:

1) Sacral nerve stimulation is considered medically necessary and a covered benefit if ALL of the following criteria are met:
   - Member has a diagnosis of 788.31 Urinary Urge Incontinence, 788.20 Non-Obstructive Urinary Retention OR 788.31, 788.32, 788.33, 788.41 Urinary Urgency-Frequency Syndrome; AND,
   - The member has shown a documented positive response to a percutaneous trial of sacral stimulation*; AND,
   - The member has not responded to conventional therapy, including documented behavioral, pharmacologic, and/or surgical corrective therapy.
*NOTE: Before a member is eligible for permanent implantation, the member must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through a voiding diary.

OR,

2) Non-implantable pelvic floor electrical stimulation is considered medically necessary if ALL of the following criteria are met:
   - Member has a diagnosis of 625.6 Stress and/or 788.31, 788.33 Urinary Urge Incontinence; AND,
   - Member is cognitively intact; AND,
   - Member has failed a documented trial of pelvic muscle exercise (PME) training**.

   **NOTE: A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

OR,

3) Injectable periurethral bulking agents (e.g., Coaptite [calcium hydroxyapatite], Contigen [glutaraldehyde crossed-linked collagen], Durasphere [carbon-coated spheres/beads], Macroplastique [polydimethylsiloxane], Uryx [ethylene vinyl alcohol copolymer], or other FDA approved bulking agents for urinary incontinence) are considered medically necessary for members who:
   - Have not responded to conventional treatments; AND,
   - Have intrinsic Sphincter Deficiency (ISD).

Members whose incontinence does not improve after 3 treatments with bulking agents are considered treatment failures and are not likely to respond to this therapy. In such cases, further treatment with bulking agents is not considered medically necessary.

Injections of bulking agents are not a covered benefit and are considered experimental/investigational in the following circumstances:
   - Previous pelvic radiation therapy; OR,
   - Unstable or noncompliant bladder; OR,
   - Neurogenic bladder; OR,
   - Members with severe allergies manifested by a history of anaphylaxis, or history or presence of multiple severe allergies; OR,
   - Members with an acute condition involving Cystitis, Urethritis, or Infection; OR,
   - Members undergoing or planning to undergo desensitization injections to meat products.

In addition, Coaptite® should not be used in patients who have: a significant history of urinary tract infections without resolution current or acute conditions of cystitis or urethritis a fragile urethral mucosal lining.

NOTE: Prior to collagen implant therapy, a skin test for collagen sensitivity must be administered and evaluated over a 4 week period.

In male members, the evaluation must include a complete history and physical examination and a simple cystometrogram to determine that the bladder fills and stores properly. The member then is asked to stand upright with a full bladder and to cough or otherwise exert abdominal pressure on his bladder. If the member leaks, the diagnosis of ISD is established.

In female members, the evaluation must include a complete history and physical examination (including a pelvic exam) and a simple cystometrogram to rule out abnormalities of bladder compliance and abnormalities of urethral support. Following that determination, an abdominal leak point pressure (ALLP) test is performed. Leak point pressure, stated in cm H2O, is defined as the intra-abdominal pressure at which leakage occurs from the bladder (around a catheter) when the bladder has been filled with a minimum of 150 cc fluid. If the patient has an ALLP of less than 100 cm H2O, the diagnosis of ISD is established.

Members whose incontinence does not improve with 5 injection procedures (5 separate treatment sessions) are considered treatment failures, and no further treatment of urinary incontinence by collagen implant is covered. Members who have a reoccurrence of incontinence following successful treatment with collagen implants in the
past (e.g., 6-12 months previously) may benefit from additional treatment sessions. Coverage of additional sessions may be allowed but must be supported by medical justification.

OR,

4) Vaginal cones are considered medically necessary and a covered benefit if ALL of the following criteria are met:
   - When used in combination with pelvic muscle exercises (Kegel’s exercise); AND,
   - Member has a diagnosis of 625.6 or 788.32 Simple (pure) Stress Urinary Incontinence

OR,

5) Pessary (bladder neck support prosthesis), a plastic device that fits into the vagina to help support the uterus and bladder, is considered medically necessary and a covered benefit if ALL of the following criteria are met:
   - Member is female and has a diagnosis of 625.6 Stressed or 788.33 Mixed Urinary Incontinence

OR,

6) Tension-free vaginal tape procedures are considered medically necessary and a covered benefit if ALL of the following criteria are met:
   - Member is female; AND,
   - Has failed behavioral and pharmacological treatments; AND,
   - Has a diagnosis of 625.6 Stress Urinary Incontinence

OR,

7) Colposuspension and sling procedures are considered medically necessary and a covered benefit if ALL of the following criteria are met:
   - Member has a diagnosis of 625.6 or 788.32 or 788.33 Stress Urinary Incontinence; AND,
   - Member is refractory to conservative management

OR,

8) Biofeedback that is performed in a doctor’s office as an alternative to treating urinary incontinence is considered medically necessary if the following criteria are met (CMS, 2001):
   - Member has a failed a documented trial of pelvic muscle exercise (PME) training. Member must have no clinically significant improvement in urinary incontinence after completing 4 weeks of an ordered plan of pelvic muscle exercises to increase periurethral muscle strength.

OR,

9) Implantation of an artificial urinary sphincter (AUS) is considered medically necessary for the treatment of urinary incontinence (UI) due to intrinsic urethral sphincter deficiency (IUSD) for members with any of the following indications:
   - Children with intractable UI due to IUSD who are refractory to behavioral or pharmacological therapies and are unsuitable candidates for other types of surgical procedures for correction of UI; OR
   - Members who are 6 or more months post-prostatectomy who have had no improvement in the severity of UI despite trials of behavioral and pharmacological therapies; OR
   - Members with epispadias-exstrophy in whom bladder neck reconstruction has failed; OR
   - Women with intractable UI who have failed behavioral, pharmacological, and other surgical treatments.

CODING

Covered CPT® Codes
11950 Subcutaneous injection of filing material (e.g. collagen), 1 cc or less
11951 Subcutaneous injection of filing material (e.g. collagen), 1.1 to 5.0 cc
11952 Subcutaneous injection of filing material (e.g. collagen), 5.1 to 10.0 cc
11954 Subcutaneous injection of filing material (e.g. collagen), over 10.0 cc

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51715  Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51840  Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple
51841  Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); complicated (eg, secondary repair
51990  Laparoscopy, surgical; urethral suspension for stress incontinence
51992  Laparoscopy, surgical; sling operation for stress incontinence (e.g., fascia or synthetic)
53440  Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)
53442  Removal or revision of sling for male urinary incontinence (e.g., fascia or synthetic)
53444  Insertion of tandem cuff (dual cuff)
53445  Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446  Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447  Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
53448  Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
53449  Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
57160  Fitting and insertion of pessary or other intravaginal support device
57287  Removal or revision of sling for stress incontinence (e.g., fascia or synthetic)
57288  Sling operation for stress incontinence (e.g., fascia or synthetic)
57290  Application of surface (transcutaneous) neurostimulator
57291  Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
57450  Application of a modality to one or more areas; electrical stimulation (unattended)
57451  Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
URINARY
INCONTINENCE TREATMENT
HS-080

Related HCPCS Codes
A4290 Sacral nerve stimulation test lead, each
A4335 Incontinence Supply, miscellaneous (assign for Vaginal Cones, Tension Free Vaginal Tape as there are no specified codes to date)
A4561 Pessary, rubber, any type
A4562 Pessary, non-rubber, any type
C1767 Generator, neurostimulator (implantable), nonrechargeable [when specified as sacral nerve stimulator]
C1771 Repair device, urinary, incontinence, with sling graft
C1778 Lead, neurostimulator (implantable)
C1787 Patient programmer, neurostimulator
C1815 Prosthesis, urinary sphincter (implantable)
C1816 Receiver and/or transmitter, neurostimulator (implantable)
C1883 Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1897 Lead, neurostimulator test kit (implantable)
C2631 Repair device, urinary, incontinence, without sling graft
E0740 Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer
L8603 Collagen Implant, Injectable bulking agent, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
L8606 Synthetic implant, Injectable bulking agent, urinary tract, 1 ml syringe, includes shipping and necessary supplies
L8679 Implantable neurostimulator, pulse generator, any type [when specified as sacral nerve stimulator]
L8680 Implantable neurostimulator electrode, each [when specified for sacral nerve stimulator]
L8681 Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
L8682 Implantable neurostimulator radiofrequency receiver
L8683 Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8684 Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
L8685 Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686 Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension [when specified as sacral nerve stimulator]
L8687 Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688 Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689 External recharging system for implanted neurostimulator, replacement only
L8695 External recharging system for battery (external) for use with implantable neurostimulator
Q3031 Collagen skin test
S8270* Enuresis alarm, using auditory buzzer and/or vibration device
*S- Codes are NON COVERED FOR MEDICARE

Covered ICD-10-PCS Codes
00HU0MZ - 00HU4MZ Medical/Surgical, Central Nervous System, Insertion, Spinal Canal, Neurostimulator Lead
00HV0MZ - 00HV4MZ Medical/Surgical, Central Nervous System, Insertion, Spinal Cord, Neurostimulator Lead
0THB0LZ - 0THB4LZ Medical/Surgical, Urinary System, Insertion, Bladder, Artificial Sphincter
0TQD0ZZ - 0TQD8ZZ Medical/Surgical, Urinary System, Repair, Urethra
0TUC07Z - 0TUC87Z Medical/Surgical, Urinary System, Supplement, Bladder Neck, Autologous Tissue Substitute
0UHG7GZ - 0UHG8GZ Medical/Surgical, Female Reproductive System, Insertion, Intraluminal Device, Pessary
3E0K3GC Administration, Physiological Systems & Anatomical Regions, Introduction, Other therapeutic substance, Other substance

Covered ICD-10-CM Diagnosis Codes
N36.41 - N36.44 Urethral functional and muscular disorders
N39.3 Stress incontinence (female) (male)
N39.41 Urge incontinence
N39.46 Mixed incontinence
R33.8 - R33.9 Retention of urine

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R35.0  Polyuria
Z45.31  Encounter for adjustment and management of implanted visual substitution device
Z45.320 - Z45.328  Encounter for adjustment and management of implanted hearing device
Z45.49  Encounter for adjustment and management of other implanted nervous system device
Z46.2  Encounter for fitting and adjustment of other devices related to nervous system and special senses

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>1/4/2018, 2/2/2017</td>
<td>• Approved by MPC. No changes.</td>
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<tr>
<td>2/2/2016</td>
<td>• Approved by MPC. Inclusion of artificial urinary sphincter (AUS) criteria.</td>
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<td>• Approved by MPC. No changes.</td>
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<td>• Approved by MPC. No changes.</td>
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<td>• Approved by MPC. Expanded Background section (including professional medical organization statements. Added statement on biofeedback for treatment of urinary incontinence; added CMS reference (2001).</td>
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<td>• Approved by MPC. No changes.</td>
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