



Sacral Nerve Stimulation for Urinary Incontinence

Clinical Coverage Criteria

Overview

Sacral nerve stimulation (SNS) is an implantable, permanent device that modulates the neural pathways controlling bladder function. This is one of several methods used to treat urinary urge incontinence, significant symptoms of urgency-frequency, or non-obstructive urinary retention, when other behavioral and/or pharmacologic therapies have failed.

Urge incontinence is the leakage of urine when there is a strong urge to void. Urgency-frequency is an uncontrollable urge to urinate resulting in very frequent, small volumes. Urinary retention is the inability to completely empty the bladder of urine.

Policy

Sacral nerve stimulation (SNS) requires Prior Authorization by Fallon Health. The below criteria must be met as supported by the treating provider(s) medical records

Fallon Health covers sacral nerve stimulation (SNS) as treatment for urge incontinence, urgency-frequency, and non-obstructive urinary retention when ALL of the following criteria are met:

1. The Patient has not responded to prior behavioral and pharmacologic interventions over 6 months of treatment; And
2. Incontinence is not related to a neurologic condition; And
3. Symptoms of incontinence have been present for at least 12 months and have resulted in significant disability, such as the limited ability to work or participate in activities outside of the home; And
4. A test stimulation has demonstrated a 50% or greater improvement in incontinence, as documented in voiding diaries submitted for review with the request.

Behavioral interventions include pelvic floor exercises, timed voids and fluid management. Based on the reason for the incontinence, pharmacologic interventions can include 2 different anti-cholinergic drugs or a combination of an anti-cholinergic and a tricyclic anti-depressant or alpha blockers and cholinergics, with antibiotics used for urinary tract infections.

Exclusions

- Any use of SNS that does not meet the above criteria.
- Any other applications for SNS have not been proven in the peer-reviewed literature and are considered investigational. These non-covered uses include but may not be limited to: Stress incontinence or urge incontinence due to a neurologic condition, such as
 - Neurogenic detrusor overactivity,
 - Multiple sclerosis,

- Spinal cord injury, and
- Other types of chronic voiding dysfunction.
- Implantable neurostimulator pulse generator HCPCS L8679, Implantable neurostimulator radiofrequency receiver L8682, Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver L8683, Implantable neurostimulator pulse generator, single array, L8685, Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension rechargeable, includes extension L8687, and External recharging system for implanted neurostimulator, replacement only. Are considered experimental/investigational and as such must meet coverage criteria under Fallon Heath's Experimental and Investigation Clinical Coverage Criteria.

Codes

Code type	Code	Description
CPT	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
	64581	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
	64585	Revision or removal of peripheral neurostimulator electrode array
	64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
	64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
HCPCS	A4290	Sacral nerve stimulation test lead, each
	L8680	Implantable neurostimulator electrode, each

References

1. Centers for Medicare & Medicaid Services. National Coverage Determination 230.18. Sacral Nerve Stimulation for Urinary Incontinence. Effective: January 1, 2002
2. Schmidt RA, et al. Sacral nerve stimulation for the treatment of refractory urinary urge incontinence. *J Urol.* 1999;162(2):352-357.
3. Shaker HS, Hassouna M. Sacral nerve root neuromodulation: An effective treatment for refractory urge incontinence. *J Urol.* 1998;159:1516-1519.
4. Altomare DF, Giannini I, Giuratrabocchetta S, Digennaro R. The effects of sacral nerve stimulation on continence are temporarily maintained after turning the stimulator off. *Colorectal Dis.* 2013 Dec;15(12):e741-8. doi: 10.1111/codi.12418.
5. Andretta E, Simeone C, Ostardo E, et al. Usefulness of sacral nerve modulation in a series of multiple sclerosis patients with bladder dysfunction. *J Neurol Sci.* 2014 Dec 15;347(1-2):257-61. doi: 10.1016/j.jns.2014.10.010.
6. Tsai PY, Wang CP, Hsieh CY, et al. Long-term sacral magnetic stimulation for refractory stress urinary incontinence. *Arch Phys Med Rehabil.* 2014 Dec;95(12):2231-8. doi: 10.1016/j.apmr.2014.07.010.
7. Matzel KE, Chartier-Kastler E, Knowles CH, et. al. Sacral Neuromodulation: Standardized Electrode Placement Technique. *Neuromodulation.* 2017 Dec;20(8):816-824. doi: 10.1111/ner.12695.

8. Ammirati E, Giammò A, Manassero A, Carone R. Neuromodulation in urology, state of the art. *Urologia*. 2019 Aug 1:391560319866075. doi: 10.1177/0391560319866075. [Epub ahead of print]

Policy History

Origination date: 12/22/2003
Approval(s): Utilization Management Committee: 06/2003
Technology Assessment Committee: 07/2000, 11/21/2003, 11/15/2012, 09/24/2014 (updated coding to reflect current codes, updated references) 09/23/2015 (updated references) 09/15/2016 (updated references), 09/26/2017 (updated references), 08/22/2018 (updated references), 09/10/2019 (updated references)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.