Urinary and Fecal Incontinence: Diagnosis and Treatment

Policy Number: MMP049.09
Last Committee Approval Date: July 10, 2024
Effective Date: August 1, 2024

Instructions for Use

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Related Policies
None

Coverage Rationale

Urodynamic Studies, Non-Invasive (e.g., UroCuff®)

Medicare does not have a National Coverage Determination (NCD) for non-invasive urodynamics studies. Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exists and compliance with these policies required where applicable. For specific LCDs/LCAs, refer to the table for Urodynamic Studies - Non-Invasive (e.g., UroCuff®).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Radiofrequency (RF) Therapy for Treatment of Stress Urinary Incontinence (e.g., Viveve System)

Medicare does not have a National Coverage Determination (NCD) for RF therapy for treatment of stress urinary incontinence. Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Sacral Nerve Stimulation (SNS) for Fecal Incontinence

Medicare does not have a National Coverage Determination (NCD) for sacral nerve stimulation for the treatment of fecal incontinence. Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist and compliance with these policies required where applicable. For specific LCDs/LCAs, refer to the table for Sacral Nerve Stimulation for Fecal Incontinence.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy for Sacral Nerve Stimulation for Urinary and Fecal Indications.

PureWick™ Urine Collection System

Medicare does not have a National Coverage Determination (NCD) for PureWick™ Urine Collection System. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

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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 policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. 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
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence [Refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes]
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence
53899	Unlisted procedure, urinary system [when used to report Viveve system]
55899	Unlisted procedure, male genital system [when used to report UroCuff]
58999	Unlisted procedure, female genital system (nonobstetrical) [when used to report Viveve system or Transvaginal biomechanical mapping]
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)
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array

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HCPCS Code	Description
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system. [Refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes]

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Sacral Nerve Stimulation (SNS) for Fecal Incontinence				
N/A	N/A	A53017 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence	Part A and B MAC	Noridian
N/A	N/A	A53359 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence	Part A and B MAC	Noridian
N/A	N/A	A55835 Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence	Part A and B MAC	CGS

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NCD	LCD	LCA	Contractor Type	Contractor Name
Sacral Nerve Stimulation (SNS) for Fecal Incontinence				
N/A	L39543 Sacral Nerve Stimulation for the Treatment of Urinary and Fecal Incontinence	A59332 Billing and Coding: Sacral Nerve Stimulation for the Treatment of Urinary and Fecal Incontinence	Part A and B MAC	Palmetto
Urodynamic Studies - Non-Invasive (e.g., UroCuff®)				
N/A	N/A	A58543 Billing and Coding: Urodynamic Services - Non-invasive	Part A and B MAC	First Coast
N/A	N/A	A58541 Billing and Coding: Urodynamic Services - Non-invasive	Part A and B MAC	Novitas
N/A	L34056 Urodynamics	A56802 Billing and Coding: Urodynamics	Part A and B MAC	NGS

Medicare Administrative Contractor (MAC) with Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DE, LA, MD, MS, NJ, NM, OK, PA, TX, DC
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers	

Policy History/Revision Information

Date	Summary of Changes

08/01/2024	**Template Update**
	• Reformatted and reorganized policy; transferred content to new template
	• Changed policy type classification from “Coverage Summary” to “Medical Policy”
	• Updated *Instructions for Use*
	• Removed *Definitions* section
	Coverage Rationale
	• Removed content/language addressing:
	  ○ Conservative treatments
	  ○ Mechanical or hydraulic incontinence control devices
	  ○ Urodynamic studies (CPT codes 51725, 51726, 51727, 51728, 51729, 51736, 51741, 51792, and 51797)
	  ○ Collagen implant therapy
	  ○ Botulinum toxin type A for overactive bladder/urinary incontinence
	Urodynamic Studies, Non-Invasive (e.g., UroCuff®)
	• Removed reference link to the *Medicare Coverage Database*
	Radiofrequency (RF) Therapy for Treatment of Stress Urinary Incontinence (e.g., Viveve System)
	• Removed reference link to the *Medicare Coverage Database*

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Date	Summary of Changes
	Sacral Nerve Stimulation (SNS) for Fecal Incontinence • Removed reference link to the *Medicare Coverage Database* ***PureWick™ Urine Collection System*** • Removed reference link to the *Medicare Coverage Database* **Applicable Codes** • Updated list of applicable CPT/HCPCS codes (previously located in the *Coverage Guidelines* section); added 55899, 0672T, 53860, 53899, 58999, 64561, 64581, 64590, 64595, and E2001 **Centers for Medicare and Medicaid Services (CMS) Related Documents** • Added list of applicable *Medicare Administrative Contractors (MACS) with Corresponding States/Territories* • Added notation to indicate the Wisconsin Physicians Service Insurance Company (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information **Supporting Information** • Archived previous policy version MCS049.08

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

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

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. 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 this policy. 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.

Medicare Advantage Policies 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 Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the

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evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies 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 members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.

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