Sacral Nerve Stimulation and Percutaneous Nerve Stimulation

Policy Number: **M20260826046**

Effective Date: **10/1/2026**

Sponsoring Department: **Health Care Services**

Impacted Department(s): **Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)

✦ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan

✦ Medicare, if yes, which plan(s): ☒MAPD; ☒PDP; ☒ISNP; ☒CSNP

✦ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual

☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

This section is intended to list specific LOB products that are excluded from adhering to this policy (due to differences in law/regulations). If not applicable, please indicate N/A.

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for sacral nerve stimulation and percutaneous nerve stimulation.

Policy:

Background:

This policy addresses both sacral nerve stimulation and percutaneous nerve stimulation.

Sacral nerve stimulation involves the implantation of a permanent device used to modulate the sacral nerve, which influences the behavior of the bladder, bowel, sphincter, and pelvic floor. There are two stages to the procedure: test stimulation and implant. Members keep diaries of their voiding or bowel behavior prior to and during the test stimulation period. The test stimulation period is usually 5-7 days. A trial stimulation should be performed in the practitioner's office to test patient response prior to the actual implantation of the neurostimulator. The success of the test stimulation is

based on a comparison of the diary at baseline, during the test period, and following stimulation. Only members with successful test stimulation are considered candidates for surgical implantation.
Sacral nerve stimulation is an alternative treatment modality for members with significant symptoms of urge incontinence, frequency-urgency syndrome, non-obstructive urinary retention, or fecal incontinence who have failed conventional therapies. Sacral nerve stimulation has also been proposed as treatment for constipation and pain.
Percutaneous (posterior) nerve stimulation is a technique of electrical stimulation of the tibial nerve which has been proposed as a treatment option for urinary incontinence. Altering the function of the posterior tibial nerve with percutaneous tibial nerve stimulation is believed to improve voiding function and control. Percutaneous nerve stimulation consists of a battery powered, external pulse generator that delivers a low voltage electrical impulse using a needle electrode placed near the ankle as an entry point. The stimulator's impulses travel along the tibial nerve to the nerves in the spine that control pelvic floor function.

Documentation of the medical necessity for an implantable neuroprosthesis must be submitted upon request. Documentation must include, but is not limited to, the following:

- clinical history of urinary incontinence/urinary retention or fecal incontinence;
- medical therapies attempted and results of such therapies; or
- test stimulation results.

Sacral nerve stimulation for urinary incontinence or fecal incontinence with an implantable neuroprosthesis (InterStim) is covered on a case-by-case basis, subject to the criteria listed below.

Percutaneous Tibial Nerve Stimulation medical record documentation: Compliance and voiding diaries for a minimum of three days must be kept and provided to document the patient has been compliant with first- and second-line therapies without sufficient improvement prior to receiving PTNS. Compliance and voiding diaries for a minimum of three days must be kept and provided during PTNS treatment and to document any symptoms of relapse.
Treatments for relapse shall only be allowed for those members who achieve a >50% decrease in OBS symptoms with the initial treatment and then relapse. Treatments for relapse would not be expected to occur more often than one to two sessions every one to two months.

Commercial and Self-Funded: sacral nerve stimulation and percutaneous nerve stimulation may be covered utilizing the criteria below.

Medicare Advantage: There is currently a National Coverage Determination (NCD) for sacral nerve stimulation for urinary incontinence and a Local Coverage Determination (LCD) for posterior tibial nerve stimulation for voiding dysfunction. Please refer to the links listed in the Reference section for Medicare Advantage members.

MediSource, MediSource Connect, Child Health Plus and Essential Plan: percutaneous nerve stimulation may be covered utilizing the criteria below.

Clinical Indications

Urinary Incontinence

Percutaneous screening trial of a Sacral Nerve Stimulator for urinary incontinence is considered medically necessary when **ALL** of the following criteria are met:

- Member must have urge incontinence, frequency-urgency syndrome, or non-obstructive urinary retention for at least 12 months
- Member must be refractory to conservative therapies (i.e., pelvic floor exercises, bladder training, timed voids, diet modification, fluid management)
- **1 or more** of the following:

    - Member has a diagnosis of chronic, idiopathic, non-obstructive, urinary retention with a failure of a four-to-eight-week trial of 1 or more of the following:
        - Failed or not well-tolerated intermittent catheterization
        - One medication
    - Members have a diagnosis of urgency-frequency syndrome, overactive bladder, or urge incontinence with a failure of a four-to-eight-week trial of two different medications
- Member must maintain a voiding diary. The diary must contain the date, description of incontinence episodes, and the response to conservative therapies
- Member must be able to demonstrate adequate ability to record voiding diary data such that the clinical results of the implant procedure can be properly evaluated

Permanent sacral nerve stimulation implantation for urinary incontinence as medically necessary when **ALL** of the following criteria are met:

- Member has met the criteria for a screening trial of sacral nerve stimulation; member must have had successful test stimulation in order to support subsequent implantation. Test stimulation duration is three-to-seven days. Before a member is eligible for permanent implantation, the member must demonstrate a minimum of a 50% or greater improvement in baseline symptoms through test stimulation
- Improvement is measured through a voiding diary
- Member must provide a urinary voiding diary for the duration of the screening trail of sacral nerve stimulation. The urinary voiding diary must contain the date, description of incontinence episodes, and the response to sacral nerve stimulation
- Member must be able to operate the implantable pulse generator
- The sacral nerve stimulator implanted must be an FDA approved device

<u>Fecal Incontinence</u>

Percutaneous screening trial of Sacral Nerve Stimulator (SNS) for fecal incontinence is considered medically necessary when **ALL** of the following criteria are met:

- Member has severe, chronic fecal incontinence (fecal incontinent episodes of frank fecal incontinence of fecal material > 2 times per week for a duration of > 6 months [1 year-post vaginal birth], with a Wexner's incontinence score of >12)
- The severity of the fecal incontinence result in significant disability which interfere with the ability to perform activities of daily living (e.g., the frequency and/or severity of leakages restrict the member's ability to work or participate in activities outside the home)
- Failure of conservative medical management performed for ≥ 12 months including **ALL** of the following:
    - Pelvic floor exercises and biofeedback
    - Dietary management including **ALL** of the following:
        - Avoid foods that may cause loose or more frequent stools (e.g., spicy foods, fatty or greasy foods, caffeinated beverages, diet foods or drinks, sugar-free gum or candy, and alcohol)
        - Eat smaller frequent meals
        - Increase fiber in the diet
    - Pharmacotherapy including **ALL** of the following:
        - Bulking substances such methylcellulose
        - Anti-diarrhea medications such as loperamide and diphenoxylate
        - Anticholinergic medications
- Member must maintain a bowel diary. The bowel diary must contain the date, description of incontinence episodes, and the response to conservative therapies
- Sphincter surgery is either not indicated or is contraindicated (defect in the external anal sphincter muscle)

- Absence of a significant anorectal malformation or chronic inflammatory bowel disease involving the anus
- Fecal incontinence is not secondary to another neurological condition such as peripheral neuropathy or complete spinal cord injury

Permanent sacral nerve stimulation implantation for fecal incontinence as medically necessary when **ALL** of the following criteria are met:

- Member has met the criteria for a screening trial of sacral nerve stimulation
- Member has experienced a beneficial clinical response to a percutaneous screening trial of SNS as evidenced by at least a 50% improvement in reported symptoms
- Member must provide a bowel diary for the duration of the screening trail of sacral nerve stimulation. The bowel diary must contain the date, description of incontinence episodes, and the response to sacral nerve stimulation

Replacement of Sacral Nerve Stimulator

Replacement of a sacral nerve stimulator for urinary or fecal management is covered when ALL of the following criteria are met:

- Documentation includes initial date of implantation, that member has been compliant with device and is expected to continue to benefit from device
- Documentation that device is no longer functioning adequately, cannot be repaired, and is no longer covered by warranty

Percutaneous Tibial Nerve Stimulation

Percutaneous tibial nerve stimulation (PTNS) is covered for members with a diagnosis of overactive bladder (OAB) as a third-line treatment when **ALL** of the following criteria are met:

- An evaluation by a urologist or urogynecologist has been performed and the specialist has determined that the member is diagnosed with overactive bladder (OAB) and a candidate for PTNS
- The medical record documents **ALL** of the following:
    - The member has been compliant with and failed a trial of symptom-appropriate behavioral therapy of sufficient length to evaluate potential efficacy (a six month trial of diet and fluid intake modification, behavioral therapy, or pelvic exercises)
    - The member has been compliant with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four to eight weeks
- The voiding diary shows continued findings of overactive bladder syndrome (OBS)
- The member has documented a willingness to attend in-office treatment sessions, to comply with the behavioral therapies and to continue to keep voiding diaries including documentation of behavioral therapy compliance
- Treatment will consist of an initial course of one 30-minute session per week for 12 weeks

Exclusions

Sacral nerve stimulation is **NOT COVERED** for **ANY** of the following indications related to urinary control:

- Stress incontinence
- Urge incontinence due to a neurological condition such as, but not limited to, Multiple Sclerosis, or spinal cord injury, or diabetes
- Mechanical urethral obstruction, such as benign prostatic hypertrophy, cancer, or urethral stricture
- Pregnancy
- Member less than 16 years of age
- Other types of chronic voiding dysfunction

- Member who has not demonstrated a minimum of 50% or greater improvement through test stimulation
- Member is unable to operate the implantable pulse generator

Sacral nerve stimulation is **NOT COVERED** for **ANY** of the following indications related to bowel control:

- Pregnancy
- Member less than 18 years of age
- Members with progressive, systemic neurological diseases
- Member who has not demonstrated a minimum of 50% or greater improvement through test stimulation
- Member is unable to operate the implantable pulse generator
- The condition is not related to an anorectal malformation (e.g., congenital anorectal malformation; defects of the external sphincter over 60 degrees, visible sequelae of pelvic radiation; active anal abscesses or fistulae), or chronic inflammatory bowel disease

Sacral nerve stimulation is **NOT COVERED** for **ANY** of the following indications:

- Chronic constipation
- Pain, including chronic pelvic pain
- Interstitial cystitis
- Replacement of any Sacral Nerve Stimulator desired due to advanced technology is considered not medically necessary

Electrical Percutaneous Tibial Nerve Stimulation is **NOT COVERED** for **ANY** of the following indications:

- Electrical Percutaneous Tibial Nerve Stimulation is not medically necessary for members with urinary stress or neurogenic incontinence

Pre-Authorization Required? Yes ☒ No ☐

Definitions

Enter definitions here. Remember to **bold** words throughout Policy section that require definitions. Definitions should be included when: 1) The word may be unclear or may mean something different, in different situations/contexts; 2) The word is not commonly used or known. Please refer to the Policy Writing Toolkit for additional information and direction.

References

Related Policies, Processes and Other Documents

Enter name of all Independent Health policies, processes or other documents that relates or that is referenced within this policy.

Non-Regulatory References

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Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Policy Author / Owner	Notes
10/1/2026	Health Care Services	New Policy

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