

Urinary Incontinence Therapy

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Urinary incontinence therapy consists of various behavioral, exercises, and physical medicine techniques designed to alleviate urinary incontinence by enabling the patient to gain voluntary control over the discharge of urine. These techniques include behavioral training, pelvic muscle exercises (PME), such as the Kegel exercise, and the use of vaginal weights, biofeedback, and electrical stimulation of the pelvic floor. These techniques may be the first choice in treatment options before pharmacological or surgical treatments are undertaken.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

POLICY POSITION

1. Urinary incontinence therapy may be considered medically necessary when ALL of the following are met:
 - Individual history and physical which may include;
 - Validated incontinence screening questionnaire; and
 - Three-day voiding diary; and
 - Cough stress test; and
 - Measurement of postvoid residual PVR volume; and
 - Urinalysis to evaluate for urinary tract infection and to exclude hematuria, proteinuria, and glycosuria; and
 - Assessment of the patient’s cognitive and functional status; and
 - Assessment of other medical problems that may contribute to incontinence; and
 - Discussion of the effect of symptoms on the individual’s quality of life.

- Treatment plan
 - Individuals must be able to understand and perform the training, retraining and/or exercises prescribed to benefit from UI therapies.
 - The duration and frequency of treatment will vary from individual to individual. Requests for additional urinary incontinence therapy sessions should be reviewed on an individual consideration basis by a Medical Director after review of treatment plan information from the provider.

The following behavioral and therapeutic approaches may be considered medically necessary for the nonsurgical/nonpharmacological treatment of UI:

- Bladder retraining; or
- Habit training or timed voiding; or
- PME/Kegel which may be augmented by the use of biofeedback, electrical stimulation of the pelvic floor, or the use of vaginal weights; or
- Myofacial release and pelvic floor relaxation exercise.

Urinary continence therapy not meeting the criteria as indicated in this policy is considered not medically necessary.

2. Nonimplantable pelvic floor electrical stimulators

Non-implantable pelvic floor electrical stimulators may be considered medically necessary for the treatment of stress and/or urge urinary incontinence when ALL of the following conditions are met

- Individual is cognitively intact; and
- Individual 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 continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle.

Nonimplantable pelvic floor electrical stimulators not meeting the criteria as indicated in this policy are considered not medically necessary.

3. Mechanical/hydraulic incontinence aids

A pessary, a plastic device that fits into the vagina to help support the uterus and bladder, may be considered medically necessary for the treatment of women with stress or mixed UI, and for the treatment of pelvic organ (uterine) prolapse.

All other uses not meeting the criteria as indicated in this policy, are considered experimental and investigational and therefore noncovered as the safety and/or effectiveness cannot be established by the available peer-reviewed literature.

ELIGIBLE PROCEDURE CODES

CPT codes	Description
53899	General procedure, urinary system.
57160	Fitting and insertion of pessary or other intravaginal support device.
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient.

90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (list separately in addition to code for primary procedure).
97032	Application of a modality to 1 or more areas; electrical stimulation 9 manual), each 15 minutes.
97530	Therapeutic activities, direct (one on one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.

ELIGIBLE DIAGNOSIS CODES FOR PROCEDURE CODE E0740

Codes						
N39.3	N39.41	N39.46	N39.490			

NONCOVERED SERVICES

Extracorporeal magnetic innervation (ExMI™) treatment is considered experimental/investigational and, therefore noncovered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Experimental/investigational (E/I) services are not covered regardless of place of service.

Urinary Incontinence Therapy is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a comorbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

INTERNAL SOURCES
Clinical Policy Management Committee – July 29, 2021

Proprietary Information – Blue Cross and Blue Shield Association. Intraoperative Neurophysiologic Monitoring. Medical Policy Reference Manual 7.01.58. Review Date: May, 2021

POLICY UPDATE HISTORY

<Date>	<Event>