DRAFT Medical Coverage Policy | Percutaneous and Subcutaneous Tibial Nerve Stimulation

EFFECTIVE DATE: 07|01|2026
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OVERVIEW

Percutaneous tibial nerve stimulation (PTNS); also known as posterior tibial nerve stimulation is an electrical neuromodulation technique used primarily for treating voiding dysfunction.

MEDICAL CRITERIA

Medicare Advantage Plans

CPT code 64566

Blue Cross & Blue Shield of Rhode Island (BCBSRI) follows the medical necessity criteria from the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations (NCD/LCD) for percutaneous tibial nerve stimulation. Please use the online tool for participating providers. See the Related Policies section.

Medicare Advantage Plans and Commercial Products

Use the following medical necessity criteria for Medicare Advantage Plans for CPT code 0587T and for Commercial Products for CPT codes 64566 and 0587T.

Percutaneous tibial nerve stimulation (PTNS) is considered reasonable and necessary when the following criteria are met:

- An evaluation by an appropriate specialist, usually a urologist or urogynecologist, has been performed and the specialist has determined that the patient is a candidate for PTNS; and
- The medical record documents that the member has a) been compliant with and failed a trial of symptom-appropriate behavioral therapy of sufficient length to evaluate potential efficacy, and b) been compliant with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four (4) to eight (8) weeks; and
- The voiding diary shows continued findings of overactive bladder syndrome (OBS); and
- The beneficiary 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; and
- Treatment will consist of an initial course of one 30-minute session per week for 12 weeks.

Treatments for relapse shall only be allowed for those patients who achieve a >50% decrease in OBS symptoms with the initial treatment and then relapse.

PRIOR AUTHORIZATION

Medicare Advantage Plans and Commercial Products

Prior authorization is required for Medicare Advantage Plans via the online tool for participating providers. and recommended for Commercial Products. See the Related Policies section.

POLICY STATEMENT

Medicare Advantage Plans and Commercial Products

Percutaneous tibial nerve stimulation (PTNS) for overactive bladder syndrome is medically necessary for Medicare Advantage Plans when the criteria in the web-based tool has been met and medically necessary for Commercial Products when the criteria above has been met.

Medicare Advantage Plans

Subcutaneous tibial nerve stimulation delivered by an implantable peripheral neurostimulator system (e.g., eCoin) is not covered for all indications, including individuals with non-neurogenic urinary dysfunction including overactive bladder as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Commercial Products
Subcutaneous tibial nerve stimulation delivered by an implantable peripheral neurostimulator system (e.g., eCoin) is not medically for all indications, including individuals with non-neurogenic urinary dysfunction including overactive bladder as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable coverage for surgery.

BACKGROUND

Common causes of non-neurogenic voiding dysfunction are pelvic floor neuromuscular changes (eg, from pregnancy, childbirth, surgery), inflammation, medication (eg, diuretics, anticholinergics), obesity, and psychogenic factors. Overactive bladder is a non-neurogenic voiding dysfunction characterized by urinary frequency, urgency, urge incontinence, and nonobstructive retention.

Neurogenic bladder dysfunction is caused by neurologic damage in patients with multiple sclerosis, spinal cord injury, detrusor hyperreflexia, or diabetes with peripheral nerve involvement. The symptoms include overflow incontinence, frequency, urgency, urge incontinence, and retention.

The current indication cleared by the U.S. Food and Drug Administration (FDA) for PTNS is overactive bladder and associated symptoms of urinary frequency, urinary urgency, and urge incontinence.

Altering the function of the posterior tibial nerve with PTNS is believed to improve voiding function and control. The mechanism of action is believed to be retrograde stimulation of the lumbosacral nerves (L4-S3) via the posterior tibial nerve located near the ankle. The lumbosacral nerves control the bladder detrusor and perineal floor.

Administration of PTNS consists of inserting a needle above the medial malleolus into the posterior tibial nerve followed by the application of low-voltage (10 mA, 1-10 Hz frequency) electrical stimulation that produces sensory and motor responses as evidenced by a tickling sensation and plantarflexion or fanning of all toes. Noninvasive PTNS has also been delivered with transcutaneous or surface electrodes. The recommended course of treatment is an initial series of 12 weekly office-based treatments followed by an individualized maintenance treatment schedule.

PTNS is less invasive than traditional sacral nerve neuromodulation which has been successfully used to treat urinary dysfunction but requires implantation of a permanent device. In sacral root neuromodulation, an implantable pulse generator that delivers controlled electrical impulses is attached to wire leads that connect to the sacral nerves, most commonly the S3 nerve root that modulates the neural pathways controlling bladder function.

For individuals who have non-neurogenic urinary dysfunction including overactive bladder and have failed behavioral and pharmacologic therapy who receive an initial course of PTNS, the evidence includes randomized sham-controlled trials, randomized controlled trials (RCTs) with an active comparator, and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The Sham Effectiveness in Treatment of Overactive Bladder Symptoms (SUmiT) and the Overactive Bladder Innovative Therapy (OrBIT) trials are 2 key industry-sponsored RCTs. Systematic reviews that included these and other published trials have found short-term

reductions in voiding dysfunction with PTNS. The largest, highest quality study was the double-blind, sham-controlled SUmiT trial, which reported a statistically significant benefit of PTNS versus sham at 12 weeks. In an additional, small sham-controlled trial, a 50% reduction in urge incontinent episodes was attained in 71% of the PTNS group compared with 0% in the sham group. The nonblinded OrBIT trial found that PTNS was noninferior to medication therapy at 12 weeks. Adverse events were limited to local irritation effects. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Additionally, clinical input was sought to help determine whether the use of maintenance PTNS for individuals with non-neurogenic urinary dysfunction including overactive bladder who have failed behavioral and pharmacologic therapy and respond to an initial course of PTNS would provide a clinically meaningful improvement in the net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 3 physician respondents identified by specialty societies. For individuals with non-neurogenic urinary dysfunction including overactive bladder who have failed behavioral and pharmacologic therapy and respond to an initial course of PTNS, clinical input supports this use provides a clinically meaningful improvement in net health outcome and indicates this use is consistent with generally accepted medical practice.

For individuals who have overactive bladder syndrome that has failed behavioral and pharmacologic therapy who respond to an initial course of PTNS and who receive maintenance PTNS, the evidence includes observational studies and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The SUmiT and OrBIT trials each included extension studies that followed individuals who responded to the initial course of PTNS and continued to receive periodic maintenance therapy. There is variability in the interval between and frequency of maintenance treatments, and an optimal maintenance regimen remains unclear. There are up to 36 months of observational data available, reporting that there is a durable effect for some of these patients. While comparative data are not available after the initial 12-week treatment period, the observational data support a clinically meaningful benefit for use in individuals who have already failed behavioral and pharmacologic therapy and who respond to the initial course of PTNS. Percutaneous tibial nerve stimulation may allow such individuals to avoid more invasive interventions. Adverse events appear to be limited to local irritation for both short- and long-term PTNS use. Typical regimens schedule maintenance treatments every 4-6 weeks. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

PTNS has been proposed as a treatment for non-neurogenic and neurogenic bladder syndromes and fecal incontinence.

For individuals who have neurogenic bladder dysfunction who receive PTNS, the evidence includes several RCTs and a systematic review of RCTs and observational data. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Only a few RCTs evaluating tibial nerve stimulation for treating neurogenic bladder have been published to date, and all but 1 performed transcutaneous stimulation rather than PTNS. Studies varied widely in factors such as study populations and comparator interventions. Study findings have not reported that tibial nerve stimulation significantly reduced incontinence symptoms and improved other outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have fecal incontinence who receive PTNS, the evidence includes several RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The available RCTs have not found a clear benefit of PTNS. None of the sham-controlled trials found that active stimulation was superior to sham for achieving a reduction in mean weekly fecal incontinence episodes. The larger sham-controlled randomized trial did find a significantly greater decrease in the absolute number of weekly incontinence episodes in the active treatment group, but the overall trial findings did not suggest the superiority of PTNS over sham treatment. An additional sham-controlled randomized trial did not identify a benefit of PTNS over sham stimulation. A meta-analysis of a

single RCT and several observational studies reported that patients receiving sacral nerve stimulation experienced significant benefits compared with patients receiving PTNS. A post hoc analysis of the larger trial suggested a subset of patients with fecal incontinence (those without concomitant obstructive defecation) may benefit from PTNS. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have urge urinary incontinence and urinary urgency who receive transcutaneous tibial nerve stimulation, the evidence includes an RCT and a nonrandomized study. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The results of the available studies did not show a clear benefit of transcutaneous tibial nerve stimulation. The RCT showed statistically significant improvements in the primary outcome measure. However, the primary outcome was a composite score of patient reported outcomes. A secondary analysis on individual symptoms showed no significant difference between the active therapy arm and the sham arm for voids or urgency leaks. The nonrandomized open-label, single-arm study showed statistically significant improvements in daily voids, incontinence episodes, and urgency episodes. However, minimal clinically important differences were not reported for these outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

CODING

Medicare Advantage Plans and Commercial Products

The following CPT code(s) is medically necessary for Medicare Advantage Plans when the criteria in the web-based tool has been met and medically necessary for Commercial Products when the criteria above has been met.

64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

The following CPT code(s) is medically necessary for Medicare Advantage Plans and Commercial Products when the criteria above has been met.

0587T Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve

The following CPT code(s) is not covered for Medicare Advantage Plans and not medically necessary for Commercial Products:

0816T Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous

RELATED POLICIES

Prior Authorization via Web-Based Tool for Procedures
Medicare Advantage Plans National and Local Coverage Determinations

PUBLISHED

Provider Update, May 2026
Provider Update, October 2024
Provider Update, December 2023
Provider Update, January 2023
Provider Update, November 2021

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