Medical Policy

Non-Implantable Pelvic Floor Electrical Stimulator

Description

A pelvic floor electrical stimulator is a device which is used in the treatment of urinary incontinence by delivering an electrical current to the muscles of the pelvic floor, causing them to contract.

Policy

For Medicare Members
A pelvic floor electrical stimulator may be considered reasonable and necessary when the following criteria are met:

- Must be ordered by the Member's treating physician.
- The member is cognitively intact with a diagnosis of stress and/or urge incontinence who has failed a documented trial of pelvic muscle exercise training. A failed trial is defined as the completion of a four-week plan of pelvic muscle exercises that are designed to increase periurethral strength with no clinically significant improvement.

For Non-Medicare Members

New Hampshire Medicaid Members:
A pelvic floor electrical stimulator may be considered reasonable and necessary when the following criteria are met:

- Must be ordered by the Member's treating physician.
- The member is cognitively intact with a diagnosis of stress and/or urge incontinence who has failed a documented trial of pelvic muscle exercise training. A failed trial is defined as the completion of a four-week plan of pelvic muscle exercises that are designed to increase periurethral strength with no clinically significant improvement.

Commercial Members:
The E0740 Pelvic Floor Stimulator is considered experimental and investigational for all indications, therefore, a non-covered item.

HCPCS Level II Codes and Description

E0740	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or

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trainer

Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions

References

Blue Cross Blue Shield of Massachusetts, Policy Number : 470. BCBSA Reference Number: 1.01.17

Centers for Medicare and Medicaid Services, "NCD for Non-Implantable Pelvic Floor Electrical Stimulator (230.8)," Publication 100.3, Manual Section 230.8, Version 2, CIM

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60-24, effective 6/19/2006. Accessed December 18, 2017; reviewed December 12, 2018. Reviewed 1/28/19, 12-06-19.

Applicable URAC Standard

Core 8	Staff operational tools and support

Change/Authorization History

Revision Number	Date	Description of Change	Prepared/Reviewed by	Approved by	Review Date:	Effective Date:
A	Nov.2006	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01		Annual Review / no changes	Susan Glomb	Ken Fasse	Dec.2008	
02	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec. 2009	
03	12-03-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010	
04	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri		
05	11-18-11	Annual Review. Added Reference to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011	
06	04-04-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri		
07	11-29-12	Annual Review – No changes	Susan Glomb	Dr. B. Almasri	Nov 12	
08	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri		
09	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
10	12-04-15	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2015	

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11	12-02-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016	
12	12-18-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2017	
13	12-12-18	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2018	
14	1-28-19	Updated to indicate that for Commercial members the E0740 is experimental/investigational and non-covered. Added references.	Carol Dimech	Dr. C. Lerchin	January 2019	
15	12-06-19	Annual review. No additional changes.	Carol Dimech	Dr. C. Lerchin	December 2019	December 2019