Sentara Health Plans

Medicaid

Urinary Incontinence Treatments, Medical 130

Table of Content

Description & Definitions
Criteria
Document History
Coding
Policy Approach and Special Notes
References
Keywords

Effective Date	11/1/2026
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Coverage Policy	Medical 130
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Urinary incontinence is a dysfunction which is the inability to hold urine in the bladder (leakage) and inability to pass urine out of the bladder (retention). There are different treatments available to reduce leakage.

Criteria:

Urinary Incontinence Treatments are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Autologous muscle-derived cell therapy
- Autologous myoblast transplantation (0991T, 0999T, 1000T)
- Leva Pelvic Health System (S9002)
- Pelvic Wand (Intravaginal electrical stimulation) (E1399)
- Protect PNS System (wireless microtechnology neuromodulation of the posterior tibial nerve) for the treatment of overactive bladder and the associated symptoms of urinary urgency, urinary frequency, and urge incontinence (0587T, 0588T, 0589T, 0590T)
- Purewick suction device (E2001)
- Subcutaneous tibial nerve stimulation (0988T, 0816T, 818T)

Document History:

Revised Dates:

- 2026: July – Implementation date of November 1, 2026. Updated exceptions. Updated CPT codes to include 0587T, 0558T, 0589T, 0590T, 0816T, 0818T, 0988T, 0991T, 0999T, 1000T.
- 2025: September – Full annual review. Remove biofeedback and urethral bulking agents to use MCG A-0330 and A-0268 and codes associated with them. Remove additional indications of coverage in favor of other MCG guidelines. Updated to new format, policy effective 1/1/2026.
- 2024: October – Added HCPCS S9002 to not covered section
- 2023: October
- 2023: August
- 2022: October

- 2021: December
- 2020: December
- 2019: October
- 2016: January
- 2015: March, August, September
- 2014: October
- 2013: January, March, April, May, July
- 2012: April, November
- 2010: March, April, August
- 2009: January, April

Reviewed Dates:

- 2019: March
- 2017: December
- 2014: April
- 2011: April
- 2010: July

Origination Date: August 2008

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
E1399	Misc Code (Intravaginal electrical stimulation)
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system
S9002	Intravaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device
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
0588T	Revision or removal of percutaneously placed 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
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters

0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters
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
0818T	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 and subfascial
0988T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous and subfascial
0991T	Cystourethroscopy, with low-energy lithotripsy and acoustically actuated microspheres, including imaging
0999T	Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed
1000T	Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
  - Use Milliman Guidelines:
    - Artificial Urinary Sphincter (A-0267)
    - Biofeedback (A-0330)
    - Implanted Electrical Stimulator, Sacral Nerve (A-0645)
    - Percutaneous Tibial Nerve Stimulation (PTNS) (A-0699)
    - Sling Procedures, Male (A-0563)
    - Urethral Bulking Agent Injections (A-0268)
    - Urethral Suspension Procedures (S-850)
- Authorization requirements
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans**

- Special Notes:
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22)_Final.pdf.
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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(2026). Retrieved May 21, 2026, from Virginia Department of Medical Assistance Services: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library#gsc.tab=0&gsc.q=urinary%20incontinence&gsc.sort=

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NCD: Incontinence Control Devices (230.10). (1996, Oct 07). Retrieved May 21, 2026, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=241&ncdver=1&keyword=incontinence&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

NCD: Non-Implantable Pelvic Floor Electrical Stimulator (230.8). (2006, Jun 19). Retrieved May 21, 2026, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=231&ncdver=2&keyword=pelvic%20floor&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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Keywords:

SHP Urinary Incontinence Treatments, SHP Medical130, behavioral modification training, bladder training, prompted voiding, pelvic muscle exercise, Detrusor instability, Urge incontinence, Urinary frequency, Fistula, Urethral ectopy, Bladder calculi, Urethral diverticula, Overflow incontinence, Periurethral bulking agents, carbon-coated zirconium oxide particles, Durasphere, calcium hydroxylapatite particles, Coaptite, silicone elastomer/polydimethylsiloxane, Macroplastique, Marshall test, cystography, urodynamic testing, postvoid residual urine test, weighted vaginal cones, pessary, Urethral inserts , biofeedback, Endoscopic injection of bulking agents, pelvic floor rehabilitation, peripheral nerve

evaluation, sacral nerve stimulation, Permanent sacral nerve stimulator, Interstim, Deflux®, Artificial urinary sphincter implantation, Pelvic Floor Rehabilitation, Electrical Nerve Stimulation, Transcutaneous, PTNS, Electrical Stimulation, Behavioral therapy, bladder training, pelvic muscle exercises, cones, pessaries,Pharmacotherapy, anticholinergics, Serotonin–norepinephrine reuptake inhibitors, SNRI's, Condom catheter, Percutaneous Tibial Nerve stimulation, Intermittent catheterization, Indwelling catheter, transurethral, suprapubic, pulse generator, percutaneous peripheral nerve stimulation, sling procedure, Transurethral Radiofrequency Therapy, Renessa Procedure, Pelvic floor electrical stimulators, Mechanical incontinence control devices, hydraulic incontinence control devices, collagen implant