Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines: **Percutaneous Tibial Nerve Stimulation (PTNS)**

Effective: October 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Posterior or percutaneous tibial nerve stimulation (PTNS) is an external, non-surgical form of neuromodulation aimed at stimulating the nerves that supply the bladder and pelvic floor to treat symptoms of overactive bladder (OAB). Common causes of voiding dysfunction are pelvic floor dysfunction (e.g., pregnancy, childbirth, surgery), inflammation, medication (e.g., diuretics and anticholinergics), obesity, psychogenic factors, and disease (e.g., multiple sclerosis, spinal cord injury, detrusor hyper-reflexia).

PTNS is a simple and the least invasive form of neuromodulation that does not involve a permanently implanted device and therefore, can be performed in an office-based setting.

Clinical Guideline Coverage Criteria

Percutaneous Posterior tibial nerve stimulation (PTNS) for the treatment of non-neurogenic urinary dysfunction, including overactive bladder symptoms may be considered medically necessary, up to a maximum of 12 weeks when **ALL** of the following conditions are met:

1. A specialist (e.g., urologist or urogynecologist) confirms the Member is a good candidate for PTNS with documentation that supports the need for PTNS therapy initiation; **and**
2. Urinary dysfunction has persisted for at least 12 months and the condition has resulted in moderate to severe OAB symptoms (e.g., urinary urgency, frequency, urge incontinence); **and**
3. Failure of behavioral therapy for at least 8 to 12 weeks to control symptoms (e.g., pelvic floor physical therapy, prompted voiding); **and**
4. Failure, contraindication, or intolerance to two appropriate medications (e.g., beta-3 agonists, anticholinergics/ antimuscarinics), for at least 4 weeks duration prior to the PTNS therapy.

Note: Treatment consists of an initial course of one 30-minute session per week for a duration of 12 weeks. Maintenance therapy may be medically necessary when there is documented evidence of at least 50% improvement in incontinence

symptoms (e.g., decreased urinary urgency, frequency, and/or incontinence) after the initial 12 sessions. Continued coverage may be allowed at a frequency of 1 session every 1 to 2 months for no more than three years

Limitations

In addition, The Plan does not cover the following:

1. If the member has no improvement in overactive bladder symptoms after 12 PTNS treatments, continued treatment is considered not medically necessary
2. Percutaneous tibial nerve stimulation is considered not medically necessary for all other indications, including but not limited to neurogenic bladder dysfunction, fecal incontinence, chronic pelvic pain, constipation, and voiding dysfunction secondary to a neurological condition
3. The Plan will not cover implantable tibial nerve stimulation as this is considered not medically necessary

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

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

List of Medically Necessary ICD-10 Codes

Code	Description
N32.81	Overactive bladder
N39.41	Urge incontinence
N39.42	Incontinence without sensory awareness
N39.43	Post-void dribbling
N39.44	Nocturnal enuresis
N39.45	Continuous leakage
N39.46	Mixed incontinence
N39.490	Overflow incontinence
N39.492	Postural (urinary) incontinence
N39.498	Other specified urinary incontinence
R32	Unspecified urinary incontinence
R35.0	Frequency of micturition
R39.15	Urgency of urination

References:

1. Cameron AP, Chung DE, Dielubanza EJ, et al. The AUA/SUFU Guideline on the Diagnosis and Treatment of Idiopathic Overactive Bladder. J Urol. 2024;212(1):11-20. doi:10.1097/JU.0000000000003985.
2. Centers for Medicare and Medicaid Services (CMS). LCD - Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396). October 24, 2019. Accessed June 2, 2026.
3. Coolen RL, Groen J, Scheepe JR, Blok BFM. Transcutaneous Electrical Nerve Stimulation and Percutaneous Tibial Nerve Stimulation to Treat Idiopathic Nonobstructive Urinary Retention: A Systematic Review. Eur Urol Focus. 2021;7(5):1184-1194. doi:10.1016/j.euf.2020.09.019.
4. Gormley EA, Lightner DJ, Faraday M, Vasavada SP; American Urological Association; Society of Urodynamics, Female Pelvic Medicine. Diagnosis and treatment of overactive bladder (nonneurogenic) in adults: AUA/SUFU guideline amendment. J Urol. 2015;193(5):1572-1580.
5. Ho FCS, He C, Yao HH, O'Connell HE, Gani J. Efficacy of sacral neuromodulation and percutaneous tibial nerve stimulation in the treatment of chronic nonobstructive urinary retention: A systematic review. Neurourol Urodyn.

2021;40(5):1078-1088. doi:10.1002/nau.24694.
6. Kyaw HY, Krause HG, Goh JTW. Percutaneous tibial nerve stimulation for the overactive bladder: A single-arm trial. *Aust N Z J Obstet Gynaecol*. 2024;64(5):501-505. doi:10.1111/ajo.13822.
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8. Padmanabhan P, Zwaans BMM, Wu C, Boldt RJ. Percutaneous tibial neuromodulation initial therapy compliance and subsequent third-line treatment patterns. *Neurourol Urodyn*. 2024;43(5):1157-1170. doi:10.1002/nau.25448.
9. Tahmasbi F, Salehi-Pourmehr H, Naseri A, et al. Effects of posterior tibial nerve stimulation (PTNS) on lower urinary tract dysfunction: An umbrella review. *Neurourol Urodyn*. 2024;43(2):494-515. doi:10.1002/nau.25343.
10. Wang M, Jian Z, Ma Y, Jin X, Li H, Wang K. Percutaneous tibial nerve stimulation for overactive bladder syndrome: a systematic review and meta-analysis. Int Urogynecol J. 2020;31(12):2457-2471. doi:10.1007/s00192-020-04429-8.
11. Xiong SC, Peng L, Hu X, Shao YX, Wu K, Li X. Effectiveness and safety of tibial nerve stimulation versus anticholinergic drugs for the treatment of overactive bladder syndrome: a meta-analysis. Ann Palliat Med. 2021;10(6):6287-6296. doi:10.21037/apm-21-339.

Approval And Revision History

August 17, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for an effective date of November 1, 2022

Subsequent endorsement date(s) and changes made:

- October 18, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- April 17, 2024: Reviewed by MPAC, renewed without changes, effective June 1, 2024
- June 13, 2024: Reviewed by MPAC, renewed without changes
- May 21, 2025: Reviewed by MPAC for annual review; minor changes to overview section and clarified appropriate medications (e.g., beta-3 agonists, anticholinergics/ antimuscarinics), effective July 1, 2025
- June 18, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- May 20, 2026: Reviewed by MPAC; administrative update to guideline template, and Tufts Health One Care removed from MNG and moved service to our Prior Authorization list, see more information on our Prior Authorization Resources Page linked at the top of this policy effective effective July 1, 2026
- July 15, 2026: Reviewed by MPAC for annual review, THP Commercial removed as applicable line of business; prior authorization removed and a list *of Medically Necessary ICD-10 Codes* added, effective October 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.