SHP Fecal Incontinence Treatments

AUTH: SHP Medical 300 v5 (AC)

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Link to Codes

Coverage

Return to top of *SHP Fecal Incontinence Treatments - AC*

See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Refer to Milliman for implanted electrical stimulator, sacral nerve.

Application to Products

Return to top of *SHP Fecal Incontinence Treatments - AC*

Policy is applicable to all products.

Authorization Requirements

Return to top of *SHP Fecal Incontinence Treatments - AC*

Pre-certification by the Plan is required.

Description of Item or Service

Return to top of *SHP Fecal Incontinence Treatments - AC*

Fecal Incontinence treatments are therapies or procedures used to assist with the involuntary loss of bowel movements.

Exceptions and Limitations

Return to top of *SHP Fecal Incontinence Treatments - AC*

- There is insufficient scientific evidence to support the medical necessity of fecal incontinence treatments as they are not shown to improve health outcomes upon technology review for the following:
    - Injectable bulking agents for fecal incontinence
    - Transanal radiofrequency therapy (also known as the Secca procedure)
    - Topical estrogen
    - Perianal electrical stimulation
    - Posterior tibial nerve stimulation
    - Rectal control system for vaginal insertion
    - Rectal inserts for fecal incontinence
- There is insufficient scientific evidence to support the medical necessity of fecal incontinence treatments for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

Return to top of *SHP Fecal Incontinence Treatments - AC*

- Fecal incontinence treatment is considered medically necessary for **1 or more** of the following
    - Biofeedback upon request for individuals who have the benefit
    - Acticon Neosphincter artificial bowel sphincter for indications of **ALL** of the following
        - Individual is 18 years of age or older
        - Individual has severe fecal incontinence
        - Individual has indications of **1 or more** of the following

        - Failed medical interventions (e.g., pharmacotherapy, biofeedback, dietary management, strengthening exercises)
        - Not a candidate for medical interventions (e.g., pharmacotherapy, biofeedback, dietary management, strengthening exercises)
        - Individual who has failed medical treatment, or has failed or is a not candidate for surgical sphincter repair (e.g., sphincteroplasty, post-anal repair, or total pelvic floor incontinence is considered severe when it results in the involuntary loss of solid stool or liquid stool on a weekly or more frequent basis)
    - Reusable Manual Pump Operated Enema Systems (including balloon, catheter, and all accessories, e.g., Peristeen Anal Irrigation System) (one system every three months) with **1 or more** of the following
        - Individual cannot use gravity operated systems
        - There has been trial and failure of gravity operated systems
- Types of fecal incontinence treatments are **NOT COVERED** for **ANY** of the following
    - Injectable bulking agents for fecal incontinence
    - Transanal radiofrequency therapy (also known as the Secca procedure)
    - Topical estrogen
    - Perianal electrical stimulation
    - Posterior tibial nerve stimulation
    - Rectal control system for vaginal insertion
    - Rectal inserts for fecal incontinence

Document History

Return to top of *SHP Fecal Incontinence Treatments - AC*

- Revised Dates:
    - 2022: September
    - 2021: November
    - 2021: March
    - 2020: March, November
    - 2019: April, 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
- Effective Date: August 2008

Coding Information

Return to top of *SHP Fecal Incontinence Treatments - AC*

- CPT/HCPCS codes covered if policy criteria is met:
    - CPT 90901 - Biofeedback training by any modality
    - CPT 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
    - CPT 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)
    - HCPCS A4453 - Rectal catheter for use with the manual pump-operated enema system, replacement only
    - HCPCS A4458 - Enema bag with tubing, reusable
    - HCPCS A4459 - Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type
- CPT/HCPCS codes considered not medically necessary per this Policy:
    - CPT 46999 - Unlisted procedure, anus
    - CPT 64566 - Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
    - HCPCS A4337 - Incontinence supply, rectal insert, any type, each
    - HCPCS A4563 - Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each
    - HCPCS L8605 - Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies

References

Return to top of *SHP Fecal Incontinence Treatments - AC*

References used include but are not limited to the following:

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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Codes

Return to top of *SHP Fecal Incontinence Treatments - AC*

CPT® : 46999, 64566, 90901, 90912, 90913
HCPCS: A4337, A4453, A4458, A4459, A4563, L8605

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