Sentara® Health Plans

Medicaid

Fecal Incontinence Treatments

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Effective Date	8/2008
Next Review Date	9/15/2024
Coverage Policy	Medical 300
Version	7

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.*.

Purpose:

This policy addresses Fecal Incontinence Treatments.

Description & Definitions:

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

Criteria:

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

Fecal incontinence treatment is considered **not medically necessary** for uses other than those listed in the clinical criteria, to include but not limited to:

- Injectable bulking agents for fecal incontinence
- Perianal electrical stimulation
- Posterior tibial nerve stimulation
- Rectal control system for vaginal insertion
- Rectal inserts for fecal incontinence
- Topical estrogen
- Transanal radiofrequency therapy (also known as the Secca procedure)

Coding:

Medically necessary with criteria:

Coding	Description
90901	Biofeedback training by any modality
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
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)
A4453	Rectal catheter for use with the manual pump-operated enema system, replacement only
A4458	Enema bag with tubing, reusable
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type

Considered Not Medically Necessary:

Coding	Description
46999	Unlisted procedure, anus
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
A4337	Incontinence supply, rectal insert, any type, each
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies implant, anal canal, 1 ml, includes shipping and necessary supplies

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

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:
- 2023: September
- 2019: March
- 2017: December
- 2014: April
- 2011: April
- 2010: July

Effective Date:
- August 2008

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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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. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Fecal Incontinence, Biofeedback, Acticon Neosphincter, artificial bowel sphincter, pharmacotherapy, dietary management, strengthening exercises, sphincteroplasty, post-anal repair, total pelvic floor incontinence, sphincter repair, sacral nerve stimulation, SNS, sacral neuromodulation, Manual Pump Operated Enema Systems, InterStim, Peristeen Anal Irrigation System, SHP Medical 300, bowel incontinence, uncontrollable passage of feces, loss of bowel control, accidental bowel leakage, noninvasive cognitive therapy to retrain the pelvic floor and the abdominal wall muscles, Reusable Manual Pump Operated Enema Systems (Peristeen) - Anal Irrigation System to flush out lower bowel, InterStim - a neuromodulation device (sacral nerve stimulation), artificial bowel sphincter, SHP Injectable Bulking Agents for Rectal Incontinence, Solesta, SHP Medical 271, fecal incontinence, bulking agent, anoscopy, anorectal DxHA injections