Medical Policy:
Fecal Incontinence Treatment

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.ME.63	6/13/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

ConnectiCare utilizes the definitions in the table below for this guideline.

Anal incontinence	Involuntary loss of solid or liquid feces or flatus
Severe fecal incontinence	Involuntary loss of solid or liquid feces or flatus on a weekly, or more, frequent basis
Conservative medical interventions	Dietary management, pharmacotherapy, strengthening exercises

Guideline

Any of the following treatments is considered medically necessary for severe fecal incontinence when any conservative intervention has failed:

1. Anal sphincter repair
2. Colostomy — member has failed/is not a candidate for medical interventions or surgical sphincter repair (e.g., post-anal repair, sphincteroplasty or total pelvic floor repair, biofeedback pelvic training [check member benefits])
3. Acticon™ Neosphincter artificial bowel sphincter — member is ≥ 18 years of age and has failed/is not a candidate for medical interventions or surgical sphincter repair (e.g., post-anal repair, sphincteroplasty, or total pelvic floor repair)

4. Sacral nerve stimulation (sacral neuromodulation) for chronic fecal incontinence — member has had an inadequate response to conservative treatments and has a weak but structurally intact anal sphincter

   Note: A 2–3-week trial with a temporary percutaneous peripheral nerve electrode must be completed before implantation with a permanent implantable pulse generator (e.g., InterStim®) can be considered. Implantation is considered medically necessary when there is a ≥ 50 % improvement in incontinence symptoms derived from the temporary percutaneous peripheral nerve stimulation.

Limitations/Exclusions

The Acticon Neosphincter is not considered medically necessary when the above criteria are not met and when its use is contraindicated. (I.e., incontinence complicated by irreversibly obstructed proximal segment of bowel, poor candidacy for surgery or anesthesia, etc.)
The following interventions are not considered medically necessary due to insufficient evidence of therapeutic value:

1. Radiofrequency energy delivery (e.g., Secca Therapy)
2. Perianal electrical stimulation
3. Injectable bulking agents (e.g., Solesta®) (0377T)
4. Vaginal bowel control (e.g., eclipse system™) (A4563) (Covered for Medicare members only)
5. Injection of autologous myoblast cells
6. Injection of mesenchymal stem cells
7. Topical estrogen
8. Tibial nerve stimulation
9. Pudendal nerve terminal motor latency
10. Interna® Dermal Regeneration FENIX™ Continence Restoration System

Procedure Codes

64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
64581	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable implantable neurostimulator pulse generator

L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator
L8695	External recharging system for battery (external) for use with implantable neurostimulator

Diagnosis Codes

A04.71	Enterocolitis due to Clostridium difficile, recurrent
A04.72	Enterocolitis due to Clostridium difficile, not specified as recurrent

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Specialty matched clinical peer review.