MEDICAL POLICY	Fecal Incontinence Treatments (Medicare Only)
Effective Date: 1/1/2022  1/1/2022 Medical Officer Date	Medical Policy Number: 228 Medical Policy Committee Approved Date: 2/19; 11/19; 8/2020; 08/2021; 11/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Sacral Nerve Stimulation	Local Coverage Article: Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence (A53017)
Manual Pump Enema Systems (e.g. Peristeen® anal irrigation system) and other enema supplies/products	Local Coverage Determination (LCD): Bowel Management Devices (L36267)
Vaginal Inserts (e.g. Eclipse™ Vaginal Insert System)	Local Coverage Article: Bowel Management Devices - Policy Article (A54516)

Per the Medicare Policy Manual commercial medical policies may be applied to Medicare coverage determinations in the absence of an appropriate NCD, LCD, LCA, or CMS Coverage Manual. Therefore, the commercial medical policy, **Fecal Incontinence Treatments (All Lines of Business Except Medicare),** *applies to the following services:*

- Biofeedback
- Bulking agents

- Transanal radiofrequency therapy (Secca procedure)
- Anal sphincter replacement (i.e. Acticon Neosphincter)
- Posterior tibial nerve stimulation (PTNS)

BILLING GUIDELINES

See related local coverage articles (LCAs) for billing assistance:

- Local Coverage Article: Bowel Management Devices - Policy Article (A54516)

Additional billing guidelines:

- The "C" codes listed below are only applicable when billed under the hospital outpatient prospective payment system (OPPS) and they should be submitted in place of HCPCS code A4240.
- CPT codes 90875, 90876, and/or 90901 may be used to bill biofeedback for the treatment of fecal incontinence, which is considered investigational and not covered.
- CPT code 64566 will deny as investigational and not covered when billed with ICD-10 codes F98.1, R151, R152, R150, R159 for fecal incontinence.
- Code A4459 is an all-inclusive code. Separate billing of any of the individual components is not allowed.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
A4290	Sacral nerve stimulation test lead, each
C1767	Generator, neurostimulator (implantable), non-rechargeable

C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
C1897	Lead, neurostimulator test kit (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
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
No PA Required Note: The following codes will deny as investigational when billed with a fecal incontinence diagnosis code.	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
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)
Not Covered	
A4453	Rectal catheter for use with the manual pump-operated enema system, replacement only
A4459	Manual pump enema system, includes balloon, catheter and all accessories, reusable, any type
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.
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
46999	Unlisted procedure, anus

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.