



ADMINISTRATIVE POLICY AND PROCEDURE

Policy #:	1404	
Subject:	INTERSTIM® for Fecal Incontinence	
Section:	Care Management	
Initial Effective Date:	10/01/2011	
Revision Effective Date(s):	07/18	
Historical Revision Date(s):	12/12, 10/13, 10/14, 07/17	
Review Effective Date(s):		
Historical Review Date(s):	10/15, 10/16	
Responsible Parties:	Patryce Toyce, MD	
Responsible Department(s):	Utilization Management	
Regulatory References:	NCQA 2018: UM 2C	
Approved:		
	Theresa Bittle, RN AVP Clinical Operations	Patryce A. Toyce, MD Chief Medical Officer

Purpose: To define the process for the Prior Authorization of INTERSTIM implantable Sacral Nerve Stimulator for treatment of chronic fecal incontinence for members of MedStar Family Choice (MFC).

Scope: MedStar Family Choice, MD

Policy: It is the policy of MFC to provide INTERSTIM therapy to appropriate members of MFC who meet the authorization criteria below.

Background:

- A. MedStar Family Choice will require prior authorization for the INTERSTIM sacral nerve stimulation system for bowel incontinence. Authorization will be given for FDA-approved indications (The FDA has already approved this device for urinary incontinence).
- B. INTERSTIM is currently approved by the FDA for the following indication(s):
 - 1. Chronic fecal incontinence when the following conditions are met:
 - a. Chronic fecal incontinence of greater than 2 incontinent episodes on average per week with duration greater than 6 months; and

- b. Documented failure or intolerance to conventional therapy (e.g., dietary modification, the addition bulking and pharmacologic treatment) for at least a sufficient duration to fully assess its efficacy,
- c. The patient is an appropriate surgical candidate; and
- d. A successful percutaneous test stimulation, defined as at least 50% improvement in symptoms, was performed; and
- e. The condition is not related to an anorectal malformation (e.g., congenital anorectal malformation; defects of the external anal sphincter over 60 degrees; visible sequelae of pelvic radiation; active anal abscesses and fistula) or chronic inflammatory bowel disease; and
- f. Incontinence is not related to another neurologic condition such as peripheral neuropathy or complete spinal cord injury.

Procedure:

1. Requests for INTERSTIM for fecal incontinence therapy will be processed in accordance with MedStar Family Choice Policy 110A; UM Process.
2. Requests for off-label uses of INTERSTIM for fecal incontinence may be submitted to a Medical Director for individual consideration.

Summary of Changes:	<p>07/18:</p> <ul style="list-style-type: none"> • Removed references to DC health plans. • Updated reference. • Added Historical Revision Dates and Revision Effective Dates; Modified Effective Date to Initial Effective Dates, and added Historical Review Dates and Review Effective Dates. <p>07/17:</p> <ul style="list-style-type: none"> • Added citation for UM Process Policy 110 A & B. <p>10/16:</p> <ul style="list-style-type: none"> • Added regulatory reference. <p>10/15:</p> <ul style="list-style-type: none"> • No changes.
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