MedStar Family Choice		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1404**	
Subject:	**INTERSTIM® for Fecal Incontinence**	
Section:	**Medical Non-Pharmacy Protocols**	
Initial Effective Date:	**10/01/2011**	
Revision Effective Date(s):	**07/18, 07/19, 07/20**	
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 Toye, MD**	
Responsible Department(s):	**Utilization Management**	
Regulatory References:	**NCQA 2020: UM 2C**	
Approved:	**Theresa Bittle, RN** **AVP Clinical Operations**	**Patryce A. Toye, 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**

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 110; 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:	**07/20:** • Updated Section from Care Management to Medical Non-Pharmacy Protocols. • Updated Regulatory References to reflect 2020 NCQA Standards. **07/19:** • Updated NCQA Reference to reflect 2019 Standards. • Removed "Maryland" from scope. • Removal of "A" from policy number. **07/18:** • Removed references to DC health plans. • Updated reference. • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **07/17:** • Added citation for UM Process Policy 110 A & B. **10/16:** • Added regulatory reference. **10/15:** • No changes.