MedStar Family Choice DISTRICT OF COLUMBIA		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1404.DC**	
Subject:	**INTERSTIM® for Fecal Incontinence**	
Section:	**Medical Non-Pharmacy Protocols**	
Initial Effective Date:	**10/01/2020**	
Revision Effective Date(s):		
Review Effective Date(s):		
Responsible Parties:	**Inna Kats, MD**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**NCQA 2020: UM 2C**	
Approved:	**Sharon Henry, RN** **Director, 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 enrollees of MedStar Family Choice (MFC).**

Scope: **MedStar Family Choice, District of Columbia**

Policy: **It is the policy of MFC to provide INTERSTIM therapy to appropriate enrollees 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.

References:

Local Coverage Article #A55835
https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=55835&ver=6&KeyWord=Sacral%20Nerve%20Stimulation&KeyWordLookUp=Title&KeyWordSearchType=Exact&bc=CAAAAAAAAAAA

Summary of Changes:	**10/20:** • New policy.