Subject: Sacral Nerve Stimulation for Urinary Voiding Dysfunction and/or Fecal Incontinence*

Updated: December 8, 2009

Department(s): Utilization Management

Policy: Sacral nerve stimulation for urinary voiding dysfunction and/or fecal incontinence is reimbursable under Plans administered by QualCare, Inc.

Objective: To assure proper and consistent reimbursement and to delineate criteria for coverage of a specific intervention.

Procedure:

A. Voiding Dysfunction

1. Sacral nerve stimulation is covered for the following types of urinary voiding dysfunction that have been present for at least 12 months and interfere with activities of daily living:
   a. Urinary urge incontinence (ICD-9 788.31)
   b. Non-obstructive urinary retention (788.20, 788.21, 788.29)
   c. Urinary urgency/urinary frequency syndrome (788.41)

2. Sacral nerve stimulation is covered only after failure of, or in the presence of contraindications to or intolerance of, the following:
   a. For urge incontinence or urgency/frequency syndrome: pharmacotherapy, (e.g., anticholinergics) or behavioral therapy (e.g., pelvic floor exercise, biofeedback)
b. For non-obstructive urinary retention: pharmacotherapy (e.g., alpha-blockers, cholinergics), intermittent catheterization

3. Prior to implantation of a permanent sacral nerve stimulator for voiding dysfunction, there must be a trial of the device that results in at least a 50% decrease in symptoms as measured through voiding diaries. Implantation of a trial device requires the presence of criterion 2.a or 2.b above.

B. Fecal incontinence

1. Sacral nerve stimulation is covered for chronic fecal incontinence (786.7) that interferes with activities of daily living.

2. Sacral nerve stimulation is covered only after failure of, or in the presence of contraindications to or intolerance of, the following:

   a. Pharmacotherapy (e.g., anticholinergics), biofeedback, dietary management, strengthening exercises.

3. Prior to implantation of a permanent sacral nerve stimulator for fecal incontinence, there must be a 2- to 3-week trial of a temporary stimulator with significant benefit as reported by the patient.

C. The applicable CPT codes are:

1. for the temporary device: 64561 (percutaneous implantation of neurostimulator electrodes)
2. for the permanent device: 64581 (incision for implantation of neurostimulator electrodes)
3. for the generator: 64590 (insertion or replacement of peripheral…neurostimulator pulse generator or receiver)
4. 64595 (revision or removal of peripheral…neurostimulator pulse generator or receiver)
D. The applicable **HCPCS codes** for the stimulator pulse generators are: **L8685, L8686, L8687, L8688, L8689, L8695**.

E. Sacral nerve stimulation procedures are considered same-day surgery. Any request for sacral nerve stimulation other than as a same-day surgery procedure requires medical review.

References


Das AK, Carlson AM, Hull M. Improvement in depression and health-related quality of life after sacral nerve stimulation therapy for treatment of voiding dysfunction. Urol 2004;64(1):62-68 (Jul)

*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.