



# Medical Coverage Policy

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## Sacral Nerve and Tibial Nerve Stimulation for Urinary Voiding Dysfunction, Fecal Incontinence and Constipation

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### Related Coverage Resources

- [Biofeedback](#)
- [Electrical Stimulation Therapy and Devices](#)

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## Overview

This Coverage Policy addresses sacral nerve stimulation (SNS) and implantable tibial nerve stimulation as a treatment for the involuntary leakage of urine or stool and constipation.

## Coverage Policy

### Sacral Nerve Stimulation (SNS)

#### Urinary Voiding Dysfunction

**A screening trial of sacral nerve stimulation (SNS) with an external stimulator for either percutaneous nerve evaluation (PNE) or an implanted lead is considered medically necessary for the treatment of any of the following urinary voiding dysfunctions when there is failure, intolerance or contraindication to conservative medical management:**

- urinary urge incontinence
- nonobstructive urinary retention
- overactive bladder (OAB) symptoms, including urinary frequency and/or urgency, with or without incontinence

**Permanent SNS implantation for the treatment of urinary voiding dysfunction is considered medically necessary when there has been a beneficial clinical response to a screening trial of SNS as evidenced by at least a 50% improvement in reported symptoms.**

#### Fecal Incontinence

**A screening trial of sacral nerve stimulation (SNS) with an external stimulator for either percutaneous nerve evaluation (PNE) or an implanted lead is considered medically necessary for the treatment of fecal incontinence when ALL of the following criteria are met:**

- failure, intolerance, or contraindication to conservative medical management
- absence of a significant anorectal malformation or chronic inflammatory bowel disease involving the anus
- fecal incontinence is not secondary to another neurological condition such as peripheral neuropathy or complete spinal cord injury

**Permanent SNS implantation for fecal incontinence is considered medically necessary when there has been a beneficial clinical response to a screening trial of SNS as evidenced by at least a 50% improvement in reported symptoms.**

**SNS for the treatment of any other indication, including constipation is considered not medically necessary.**

### **Implantable Tibial Nerve Stimulation**

**Implantable tibial nerve stimulation for the treatment of urinary voiding dysfunction (e.g., overactive bladder, urinary urge incontinence), fecal incontinence and constipation is considered experimental, investigational or unproven.**

## **Health Equity Considerations**

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Syan et al. (2020) conducted a study that analyzed if racial and socioeconomic factors influenced the utilization of advanced therapies in commercially insured OAB patients. Through a query of Optum, a national claims database, they found that Asians and Hispanics were least likely to utilize SNS therapy and most likely to use PTNS compared to Blacks and Whites. Female gender, younger age (< 65), higher annual income  $\geq$  \$40K and prior use of oral medications were significantly associated with receiving advanced therapies. In addition, non-white race, lower education level (less than a bachelor's degree) and Northeast region were associated with a lower likelihood of receiving advanced therapies ( $p < 0.05$  for all).

## **General Background**

### **Sacral Nerve Stimulation (SNS)**

Sacral nerve stimulation (SNS), also known as sacral nerve neuromodulation, involves the implantation of a permanent device that modulates the neural pathways. The exact mechanism of action is unclear (Abello and Das, 2018). Sacral nerve stimulation (SNS) applies a low amplitude electrical current to a sacral nerve through an electrode that is placed through a corresponding sacral foramen. The stimulation of the sacral nerves leads to recruitment of the pelvic floor musculature and pelvic organs, leading to improvement in pelvic floor function. The third sacral foramen is the level at which an optimal response is most commonly elicited. The third sacral nerve root contains afferent sensory and efferent autonomic motor nerves and voluntary somatic fibers, which may, alone or in harmony, create the beneficial effect elicited by SNS (Mellgren, 2010).

Prior to the implantation of a permanent SNS system, patients are screened for potential therapeutic benefit by undergoing a screening trial period. There are two methods that can be used for screening prior to permanent implantation, a percutaneous nerve evaluation (PNE) or a two staged implantation approach. During a PNE, a non-anchored test lead is placed percutaneously at the sacral nerve site using a lead introducer, and then a percutaneous lead extension is connected to an external test stimulator. The external test stimulator device provides continuous stimulation. Following an adequate test period for efficacy or lack, thereof (efficacy

defined as a  $\geq 50\%$  subjective and/or objective response), the electrode is removed. If the screening trial is successful, a permanent lead and implantable pulse generator (IPG) may be placed in the operating room (Hassouna and Alabbad, 2018; Abello and Das, 2018).

The two staged implantation method is indicated for patients who fail PNE, for patients with an inconclusive PNE, for patients who had a successful PNE to refine patient selection further or instead of PNE. During the first stage, a permanent quadripolar tined lead is implanted, connected subcutaneously to a temporary extension lead and then connected to an external pulse generator. If the trial is successful, a second-stage procedure is done for placement of the permanent IPG. The trial period can vary between three days and up to two weeks. Shorter trials are typically done with PNE (3–5 days), while the longer trial periods up to two weeks can be done with the tined lead as it has a lower risk of lead migration. Complications to SNS include device-related pain, need for revision, infection, and neurologic complications (Hassouna and Alabbad, 2018; Abello and Das, 2018).

SNS has been proposed for the treatment of urinary voiding dysfunction, including intractable urinary urge incontinence, nonobstructive urinary retention, urinary urgency/frequency, fecal incontinence, and several other indications.

### **Urinary Voiding Dysfunction**

Urinary voiding dysfunction is usually defined as the inability to control urination. Urinary voiding disorders are generally divided into five types, depending on the pathophysiology involved: urge incontinence—a subtype is urgency-frequency syndrome, overflow incontinence, stress incontinence, mixed incontinence, functional incontinence.

Treatment options for urinary voiding disorders may include behavioral strategies, pharmacological interventions, temporary electrical stimulation, or reconstructive surgery. Less invasive modalities are generally used initially before irreversible, reconstructive surgery is considered.

Sacral nerve stimulation (SNS) may be indicated in patients who demonstrate at least 50% urinary incontinence symptom relief during test stimulation and who have failed or not tolerated more conservative treatments (e.g., behavioral strategies, pharmacological interventions). The criteria for a positive response vary slightly; however, at least a 50% improvement in one or more primary symptoms is considered the standard for a clinically significant response (Schmidt, 1999). It is not proposed for the treatment of stress incontinence, the most common type of urinary dysfunction (Hassouna, 2000).

The precise mode of action of neuromodulation on the lower urinary tract is unclear. When a nerve is stimulated, signals travel both toward the periphery and toward the central nervous system (Herbison, 2009). According to the manufacturer of the InterStim<sup>®</sup> System for Urinary Control (Medtronic, Inc., Minneapolis, MN), SNS is not intended for patients with mechanical obstruction such as benign prostatic hypertrophy, cancer, or urethral stricture. Medtronic also states that the safety and effectiveness of SNS has not been established for bilateral stimulation; patients with neurological disease origins; pregnancy, unborn fetus, and delivery; or for children under the age of 16 (Medtronic, Inc., 2019).

Sacral nerve stimulation is considered an appropriate treatment option for individuals with refractory voiding dysfunction, with failure of, or contradiction or intolerance to conservative medical management after a 50% improvement is noted in response to a screening trial.

**U.S. Food and Drug Administration (FDA):** In 1997, the InterStim<sup>®</sup> Therapy System for Urinary Control (Medtronic, Inc., Minneapolis, MN) received premarket approval (P970004) from

the FDA “for the treatment of urinary urge incontinence in patients who have failed or could not tolerate more conservative treatments”. In 1999, a supplement expanded the indication to include “urinary retention, and significant symptoms of urgency/frequency”. In August 2001, the FDA approved the Model 3550-03 Twist-Lock Screening Cable and Model 3550-05 Percutaneous Extension and Tunneling Tool Kit for temporary SNS as part of a staged implant screening technique for patients who had inconclusive results following standard percutaneous testing. A supplement in 2002, granted approval for the revised indication: “InterStim Therapy for Urinary Control is indicated for the treatment of urinary retention and the symptoms of overactive bladder, including urinary urge incontinence and significant symptoms of urgency-frequency alone or in combination, in patients who have failed or could not tolerate more conservative treatments”. A supplement in 2020 granted approval for the InterStim Micro System with full-body MR conditional labeling, which is an updated version of the InterStim II System. The modifications include new SureScan MRI leads, an updated Verify Evaluation System that can accommodate newly developed leads, and related labeling updates (FDA, 2024). A supplement in 2022 granted approval for the InterStim X INS that features more than 10 years of battery life without the need to recharge, with low energy settings, the device can last up to 15 years (FDA, 2024; Medtronic, 2022).

In 2019, the Axonics Sacral Neuromodulation System (Axonics Modulation Technologies, Inc., Irvine, California) received premarket approval from the FDA “for the treatment of urinary retention and the symptoms of overactive bladder, including urinary urge incontinence and significant symptoms of urgency-frequency alone or in combination, in patients who have failed or could not tolerate more conservative treatments” (FDA, 2024).

#### **Literature Review - Sacral Nerve Stimulation (SNS) for Urinary Voiding Dysfunction:**

Several randomized clinical trials (RCTs), prospective case series, retrospective analyses and systematic reviews have demonstrated > 50% improvement in incontinence symptoms, decrease in the number of daily catheterizations required, an increase in the volume of urine obtained per void, and a decrease in post-void residual urine volume with the use of sacral nerve stimulation (SNS) (Szymański, et al., 2019; Tutolo, et al., 2018; Noblett, et al., 2014; Herbison, 2009; White, 2008; van Kerrebroeck, 2007, Sutherland, 2007). Adverse events reported include changes in stimulation sensation, loss of efficacy, pain at the implantation site, and the need for intravenous antibiotics.

Siegel, et al. (2015) published their results of a post-approval RCT (n=147) comparing SNS (n=70) to standard medical therapy (n=77) for OAB. Inclusion criteria were failed or not a candidate for conservative treatment, including pharmacotherapy. Exclusion criteria included severe or uncontrolled diabetes, neurological diseases such as multiple sclerosis, clinically significant peripheral neuropathy or complete spinal cord injury (e.g., paraplegia), symptomatic urinary tract infection, and primary stress incontinence. All subjects were required to discontinue OAB medications for four days prior to their initial voiding diary. The primary outcome measure of OAB therapeutic success defined as 50% improvement in average leaks/day or voids/day from baseline or a return to normal voiding frequency (< 8 voids/day). Secondary outcomes included quality of life measures. A total of 59 patients from the SNS group and 71 patients from the standard medical therapy group (anticholinergic or antimuscarinic medication) completed six-month follow-up. For the primary outcome, 61% of SNS subjects demonstrated therapeutic success at six months versus 42% of the standard medical therapy subjects (p<0.02). The SNS group also showed greater improvement in all domains of the quality-of-life scales compared to the standard medical therapy group (p<0.001). Adverse events related to the SNS device occurred in 30.5% (18/59) of subjects with a lead implant. OAB medication-related events occurred in 27.3% (21/77) of standard medical therapy subjects. Acknowledged study limitations include the homogeneous nature of the population and the lack of blinding. Study results

suggested that SNS results in a greater reduction of OAB symptoms and improvement in quality-of-life indicators than standard medical therapy.

A systematic review by Herbison et al. (2009), evaluated twelve reports of eight randomized studies of 500 adults with urge urinary incontinence, overactive bladder syndrome (i.e., urgency or frequency), and urinary retention. About 50% of patients in the stimulation group achieved complete continence or an improvement greater than 90% of the main incontinence symptoms. Eighty-seven percent of patients achieved a 50% improvement. In all reports, participants had failed conventional treatments before randomization. It is unclear whether the studies all used the same implant. The authors noted that several long-term studies had poor rates of follow-up. Thirty percent or more potentially eligible patients were not implanted and 30% or more of those implanted did not gain benefit. Overall continuous stimulation offered benefits for carefully selected individuals with overactive bladder syndrome and for those with urinary retention but no structural obstruction.

Van Kerrebroeck et al. (2007) reported long-term results of a five-year prospective multi-center study that evaluated the safety and efficacy of SNS in patients with refractory urge incontinence, urgency frequency, and retention. One hundred sixty-three patients enrolled in the study and after undergoing test stimulation 152 underwent SNS implantation. Implanted devices varied between patients. Three-day voiding diaries were collected annually for five years-diary variables differed according to the type of urinary disorder. Simple uroflow and quality of life questionnaires, such as the Short Form-36 and the Beck Depression Inventory were used. Detailed data were also collected on any concomitant treatment for the urological condition and on any therapy or patient related complications. Clinical success was defined as  $\geq 50\%$  improvement in baseline. For patients with urge incontinence mean leaking episodes per day decreased from 9.6 to 3.9 at five years. For patients with urgency frequency, mean voids per day decreased from 19.3 to 14.8 and mean volume voided per void increased from 92.3 ml to 165.2 ml. For patients with retention the mean volume per catheterization decreased from 379.9 ml to 109.2 ml, and the mean number of catheterizations decreased from 5.3 to 1.9. All changes were statistically significant ( $p < 0.001$ ). No life threatening or irreversible adverse events occurred; however, in 102 patients 279 device or therapy related adverse events were observed. At five years after implantation, 68% of patients with urge incontinence, 56% with urgency frequency and 71% with retention had successful outcomes.

There is sufficient high quality controlled clinical trial data to demonstrate the safety and effectiveness of sacral nerve stimulation for the treatment of individuals with refractory voiding dysfunction, with failure of, or contradiction or intolerance to conservative medical management after a 50% improvement is noted in response to a percutaneous screening trial.

### **Fecal Incontinence**

Fecal incontinence is the inability to control bowel movements leading to feces leaking from the rectum. The reported prevalence in the general population is 2% to 3%. Severe fecal incontinence can be socially isolating as an individual with the condition may alter his/her lifestyle to accommodate the likelihood of bowel leakage. Fecal incontinence may be caused by several factors including muscle damage, such as that experienced after childbirth, or after rectal surgery, or from damage to the nerves that control the anal muscle or regulate rectal sensation (Wald, 2016). Additionally, it may be caused by a reduction in the elasticity of the rectum, which shortens the time between the sensation of the stool and the urgent need to have a bowel movement. Surgery or radiation injury can scar and stiffen the rectum. Inflammatory bowel disease can also make the rectum less elastic. Treatment depends on the cause of the incontinence and may include dietary changes, drug therapy, bowel training, or surgery. Surgical treatment options for fecal incontinence include an overlapping sphincter repair, total pelvic floor reconstruction or, less commonly, artificial bowel sphincters (Fargo & Latimer, 2012). Fecal incontinence remains a

therapeutic problem in many patients when conservative measures, such as dietary advice, pelvic floor exercises and medical therapy with bulking agents, fails and sphincter repair is unsuccessful or inappropriate (Chan, 2008; Leroi, et al., 2005, Jarrett, et al., 2004). Sacral nerve stimulation (SNS) has been proposed for the treatment of fecal incontinence.

The exact mechanism of action of SNS for fecal incontinence remains unclear. According to Gladman (2008), "Although it was initially thought that SNS would directly augment anal sphincter function and improve fecal incontinence, the observation that improved continence occurs without change in anal sphincter function has led to the suggestion that SNS has predominantly suprasphincteric effects. The mechanism of action of SNS is not conclusively proved and may involve direct effects peripherally on colorectal sensory or motor function, or central effects at the level of spinal cord or brain." Further neurophysiological research is necessary to understand the mechanisms of sacral neuromodulation" (Melenhorst, et al., 2007).

Indications and patient selection for the use of sacral nerve stimulation (SNS) for the treatment of fecal incontinence continue to evolve. Initial study eligibility included patients with a functionally deficient but morphologically intact anal sphincter. More recently, inclusion criteria has been extended to include those with external and internal sphincter defects, secondary to cauda equina syndrome, scleroderma, rectal prolapse repair, low anterior resection of the rectum, and partial spinal injuries (Gladman, 2008; Jarrett, et al., 2004).

**U.S. Food and Drug Administration (FDA):** In March 2011, Medtronic, Inc. (Minneapolis, MN) received premarket approval (P080025) from the FDA for the Medtronic InterStim® Sacral Nerve Stimulation Therapy System. This device is indicated for the treatment of chronic fecal incontinence in patients who have failed or are unable to tolerate more conservative treatments (FDA, 2024). A supplement in 2020 granted approval for the InterStim Micro System with full-body MR conditional labeling, which is an updated version of the InterStim II System. The modifications include new SureScan MRI leads, an updated Verify Evaluation System that can accommodate newly developed leads, and related labeling updates (FDA, 2024). A supplement in 2022 granted approval for the InterStim X INS that features more than 10 years of battery life without the need to recharge, with low energy settings, the device can last up to 15 years (FDA, 2024; Medtronic 2022).

In 2019, the Axonics Sacral Neuromodulation System (Axonics Modulation Technologies, Inc., Irvine, California) received premarket approval (P190006) from the FDA "for the treatment of chronic fecal incontinence in patients who have failed or are not candidates for more conservative treatments" (FDA, 2024).

**Literature Review - Sacral Nerve Stimulation (SNS) for Fecal Incontinence:** Randomized controlled data is limited regarding the effects of SNS; however, there is sufficient evidence to support the use of SNS for the treatment of fecal incontinence following a successful screening trial. A number of prospective case series and retrospective reviews have noted improvements in the frequency of incontinence episodes and quality of life measures as self-reported in bowel diaries and quality of life scales (Eggers, et al., 2024; Rydningen, et al., 2017; Hull, et al., 2013; Damon, et al., 2013; Devroede, 2012; Boyle, et al., 2011; Mellgren, 2011; Uludag, et al., 2011; Michelson, et al., 2010; Wexner, et al., 2010; Matzel, et al., 2009; Meurette, et al., 2009; Chan, 2008).

In a prospective uncontrolled trial investigating the effectiveness of SNS for fecal incontinence, Wexner et al. (2010) evaluated 285 patients. One hundred thirty-three patients underwent peripheral nerve stimulation and 120 of those individuals received permanent SNS. Mean follow-up was 28 months. Study participants were requested to complete a five-question bowel diary at baseline, during test stimulation, and at three, six, and 12 months and annually after study

closure. Quality of life and well-being were also assessed by additional questionnaires. At 12 months, 83% achieved therapeutic success defined as achieving  $\geq 50\%$  reduction in the number of incontinent episodes per week compared to the baseline; 85% achieved therapeutic success at 24 months. Forty percent of those receiving SNS achieved 100% improvement in incontinent episodes per week and incontinent days per week at 12 months. Incontinence episodes decreased from a mean of 9.4 per week at baseline to 1.9 at 12 months, and 2.9 at two years. Adverse event (AE) rates were high with 696 AEs reported. Three hundred seven AEs in 96 patients were related to the device or therapy. Twenty-six AEs were considered serious and included implant site pain, hematomas, lead fractures, lead migrations or dislodgments, extremity pain, skin irritation, paresthesia's, implant site infection, change in sensation of stimulation, urinary incontinence, and diarrhea. 10.8% of patients experienced implant site infection and 5.8% required surgical removal of the implant. Study limitations included an uncontrolled, nonrandomized design and short-term follow-up.

Mellgren et al. (2011) reported results of a three-year follow-up assessment of the trial by Wexner et al. Of 120 patients receiving chronic SNS, eighty-three patients completed part or all of the assessment, with 86% of patients reporting  $\geq 50\%$  reduction in the number of incontinent episodes per week compared with baseline. Perfect continence was reported by 40% of study participants. Improvements in the Fecal Incontinence Quality of Life scale were reported at 12, 24, and 36 months of follow-up. Device- or therapy-related adverse events included implant site pain (28%), paresthesia (15%), change in the sensation of stimulation (12%), and infection (10%). Limitations included an uncontrolled, nonrandomized study design.

Tan et al. (2011) performed a meta-analysis of thirty-four studies, including 944 patients undergoing peripheral nerve evaluation; 665 underwent permanent sacral nerve stimulation (SNS). Study design included twenty-eight prospective non-randomized trials; two retrospective trials, one prospective cross-sectional study, two double-blind cross-over trials, and a randomized controlled trial. Follow-up ranged from two weeks to 35 weeks. All studies reported on at least one outcome of interest. Studies were analyzed for functional outcomes (i.e., weekly incontinence episodes, Wexner (Cleveland) incontinence scores, and ability to defer defecation.), Quality of Life outcomes (i.e., SF-36 questionnaire), fecal incontinence quality of life (FIQL) questionnaire (the American Society of Colon and Rectal Surgery [ASCRS] quality of life questionnaire), anal manometry (i.e., resting and squeeze pressures), and rectal sensitivity (i.e., threshold, urge and maximum tolerable volumes). Regarding functional outcomes, twenty-eight studies reported on incontinence episodes per week; all studies reported a decrease following SNS, compared with conservative therapy ( $p < 0.001$ ). Sixteen studies reported at the time patients were able to defer defecation; seven of these were excluded from analysis as data were reported in groups. In the nine studies included in the analysis there was a significant increase in the ability to defer defecation following sacral nerve stimulation ([SNS],  $p < 0.001$ ). Regarding Quality of Life outcomes, there was an increase in the weighted mean difference of all SF-36 outcomes in favor of sacral nerve stimulation (SNS), with all but one (bodily pain,  $p = 0.13$ ) reaching significance. Overall, there was a significant increase in the SNS group in all subcategories of the FIQL questionnaire. In the studies included in the analysis for resting and squeeze pressure, both pressures were found to be significantly higher in the SNS group ( $p < 0.001$ ). Regarding rectal sensitivity, twenty-two studies reported on threshold, 21 on urge and 20 on maximum tolerable volumes. Outcomes were significant only for threshold volume ( $p = 0.03$ ). Decreases in urge volume and maximum tolerable volume did not reach statistical significance ( $p = 0.25$  and  $p = 0.48$ , respectively). The most common complications among the 665 patients that underwent permanent SNS implantation were pain or local discomfort (6%), lead displacement or breakage (4%), infection (3%) and sarcoma (3%). The authors noted that "the wide range of patients and consistently positive results in functional outcomes suggest that a placebo effect is unlikely; but further randomized controlled trials would be useful in confirming this." The authors also noted



that SNS improves functional outcomes and quality of life in patients with fecal incontinence where conventional non-surgical therapies have failed.

Mowatt et al. (2008) performed a systematic review of three randomized studies involving a total of 38 patients. One study included 34 patients; each of the other studies included two patients. Thirty-one patients received sacral nerve stimulation (SNS). Two studies assessed the effects of SNS for fecal incontinence (n=36); one assessed the effects of SNS on constipation (n=2). All three studies had a double-blinded crossover design. According to the authors the very limited evidence suggests that for some selected patients, SNS can reduce episodes of fecal incontinence and urgency, and improve the ability to defer defecation, leading to a better quality of life. However, a minority may get worse despite apparently successful testing before permanent implantation.

Tjandra et al. (2008) published outcomes of the largest randomized controlled trial (RCT) to date involving 120 patients; 60 were randomized to the SNS group and 60 patients were randomized to best supportive therapy (i.e., pelvic floor exercises, bulking agents, dietary modifications, biofeedback). Fifty-four patients in the SNS group had  $\geq 50\%$  improvement in continence during the screening period with 53 patients undergoing SNS implantation. Follow-up was 12 months. Both groups were assessed at baseline, three, six, and 12 months.

The control group demonstrated no significant improvements in fecal continence as assessed by bowel diary, the Wexner score, and several quality-of-life scales. In the SNS group, mean incontinent episodes per week significantly improved at six and 12 months, as did mean incontinent days per week ( $p < 0.0001$  and  $0.0001$ , respectively). Urge and passive incontinence also improved. Ability to defer defecation improved significantly but the ability to completely empty the bowel was not affected. One hundred percent fecal competence was achieved in 47.2% of patients. According to the authors, improvement in quality of life was noted immediately after implantation of the SNS, with significant improvement in all domains ( $p < 0.0001$ ). None of the patients had worsening of fecal incontinence as a result of SNS. There were no statistically significant changes in the maximum resting and squeeze anal canal pressures in either group. Adverse events in the SNS group included seroma (2%), pain at the implant site (6%) and tingling in the vaginal area (9%). In the control group six patients complained of constipation due to Imodium use. The authors noted that the presence of a control group helps reject the concept of a placebo effect. Data suggested that SNS may result in a decrease in the number incontinent episodes per week.

The Agency for Healthcare Research and Quality (Shamliyan, et al., 2007) reported results of a systematic review of several studies examining the effects of electrical stimulation or neuromodulation (i.e., SNS) on fecal incontinence. AHRQ noted that individualized sacral nerve continuous stimulation improved incontinence in 89% of patients with severe baseline incontinence compared to 17 percent after sham stimulation. However, the treatments did not improve quality of life with random differences after active and sham stimulation. All randomized controlled trials (RCTs) reported small inconsistent differences in anal manometry outcomes after active stimulation compared to the control. According to AHRQ electrical stimulation did not improve fecal incontinence in the majority of RCTs. "The significant relative improvement after sacral nerve stimulation in patients with severe baseline incontinence requires future confirmation in a large well designed RCT with long-term follow-up.

Regarding the use of self-report questionnaires to assess fecal incontinence, AHRQ also noted "Few validated questionnaires and instrumental methods were examined to detect the presence and baseline of causes for fecal incontinence with no consensus on which test is the gold standard. Patient reports do not correlate well with anatomical and physiological measures and anal manometry does not correlate well with ultrasonography or sigmoidoscopy. The severity and

impact of incontinence on quality of life can be estimated from self-reported frequency, amount of leakage, and restrictions on daily activities, but not from instrumental methods. However, treatment decisions were made based on objective measures of incontinence. Instrumental physiological measurements that are associated with patient outcomes and may reflect better effects of different interventions should be analyzed in well-designed experiments.”

Leroi et al. (2005) reported outcomes from a randomized double-blind crossover study involving 34 patients with fecal incontinence. Patients initially underwent peripheral nerve evaluation testing and if  $\geq 50\%$  improvement in incontinence was demonstrated they progressed to sacral nerve stimulation (SNS) implantation. All thirty-four patients received SNS; 27 patients were randomized to the crossover period, and 24 completed the study.

Outcomes measured were frequency of fecal incontinence and urgency episodes, delay in postponing defecation, score severity, feeling of improvement, preference for ON or OFF mode of stimulation, quality of life, and manometric measurements. Follow-up was 12 months. There was a significant treatment effect with a decrease in the median frequency of FI episodes between the ON and OFF periods; however, median incontinence episodes decreased in both the ON and OFF periods (90% versus 76%, respectively), as did defecation postponement (89% versus 63%, respectively). There was no significant change in the frequency of urgency episodes, the delay in postponing defecation, or the number of bowel movements per week between the periods of stimulation. There was improvement in the Cleveland Clinic incontinence score from baseline but no statistically significant difference between scores in the ON compared to the OFF periods. Additionally, there was no correlation between changes in the frequency of urgency episodes, delay in postponing defecation, Cleveland Clinic score, and changes in anal resting pressure, maximal squeeze pressure, squeeze pressure duration, threshold, constant sensation, and maximum tolerated volumes between the baseline and final periods. No significant change in the maximum anal resting pressure, squeeze pressure increment, and duration of voluntary contraction was noted between the two stimulation periods. Data suggested a treatment effect in regard to the frequency of episodes with the use of SNS. Additionally, improvement was noted in incontinence scores from baseline compared to periods of stimulation results.

Although randomized controlled trial data are limited prospective and retrospective data suggest that sacral nerve stimulation (SNS) may improve the number of incontinence episodes and quality of life measures as reported by study participants. It is noted the number of adverse events reported in some studies is not insignificant with infection rates of 6–10.8%, and stimulator removal rates of 12%. However, SNS is considered an acceptable treatment for selected individuals with fecal incontinence.

### **Other Indications**

Less commonly SNS has been proposed for the treatment of various other conditions such as constipation and pelvic pain; however, data are limited and there is insufficient evidence in the peer-reviewed scientific literature to support safety and effectiveness (Maeda, et al., 2017, Pilkington, et al., 2017).

**Literature Review - Sacral Nerve Stimulation for Other Indications:** Zerbib et al. (2017) reported results of the CONSTIMOD (Efficacy of Sacral Nerve Modulation in Severe Refractory Constipation), a multicenter, randomized, double-blind, placebo-controlled, crossover study (n=36 patients). Adult patients were selected if they had chronic constipation for over one year defined by at least two of the following criteria: two or fewer complete bowel movements per week; straining to evacuate at  $> 25\%$  of attempts, or sensation of incomplete evacuation after defecation on  $> 25\%$  of occasions. Other criteria for selection included absence of symptomatic response to standard therapies for at least three months. Exclusion criteria were constipation secondary to anorectal malformation, neurological disorders and/or opiates; previous colorectal

surgery of any type; or significant pelvic floor anatomical abnormality (e.g., rectocele, rectal prolapse). Responders to an initial three-week peripheral nerve evaluation (n=20) were offered permanent implantation of a pulse generator and assigned randomly in a crossover design to two eight-week intervals of active or sham stimulation. At the end of the two trial periods, the patients received active stimulation until the final evaluation at one year. The primary outcome measured was the proportion of patients with a response during each treatment period (stimulation on and off). Response was measured over the last three weeks of each of the eight-week treatment periods. Response to therapy was defined as at least three bowel movements per week and/or more than 50% improvement in symptoms. Secondary outcome measures included percentage of patients with a response at one year, effects of SNS on patients' daily bowel diary items, Wexner score, effect on QoL, visual analogue scale (VAS) score rating bowel habit, anorectal manometry parameters and colonic transit time. During the cross-over period, a positive response was observed in 12/20 and 11/20 patients after both active and sham stimulation periods, respectively (p=0.746). There was also no statistically significant difference between on and off periods for any item of the daily stool diary, Wexner score, VAS score, or QoL scores. At one year of follow-up, 16/20 patients were available for assessment; a total of 11 patients had a sustained clinical response. SNS was found to be associated with a significant improvement in QoL for symptoms (p<0.001), physical condition (p=0.003) and emotions (p=0.004). The mean difference in colonic transit times at baseline versus one-year follow-up was not found to be statistically significant (p=0.226). A total of nine serious adverse events occurred in eight patients, related to, pain, infection or dysfunction of the device. Study limitations included small sample size and loss to follow-up. These study results did not support the use of SNS for refractory constipation.

A Cochrane review of randomized or quasi-randomized trials (n=8 studies) by Thaha et al. (2015) assessed the effectiveness of SNS using implanted electrodes for the treatment of fecal incontinence and constipation in adults. Of the eight trials, two cross over studies (n=61 patients) assessed SNS for constipation. Patient in both studies underwent permanent SNS implantation following a three-week trial of temporary stimulation. Outcomes measured in studies included frequency of stools and constipation symptoms, as well as quality of life. In the larger trial (Dinning, et al. 2015 [n=59 patients]), SNS did not improve frequency of bowel movements. Reported adverse effects (73) included pain at site of the implanted pulse generator (32), wound infection (12), and urological (17) events. The authors found limited evidence to suggest that SNS can improve fecal incontinence in a subset of patients. However, SNS was not found to improve symptoms in patients with constipation. Study results are limited by the number of studies and small sample sizes.

At present, the role of SNS for indications other than urinary urge incontinence, nonobstructive urinary retention, urinary urgency/frequency syndrome, and fecal incontinence has not been established.

### **Professional Societies/Organizations**

**American College of Gastroenterology (ACG):** Wald et al. (2021) published guidelines regarding the management of benign anorectal disorders which included fecal incontinence. According to the ACG recommendations, "SNS can be recommended for patients with moderate to severe FI who have failed conservative measures, biofeedback, and other low-cost, low risk techniques". Grade of Recommendation: Strong recommendation based on low-quality evidence.

The guideline also mentioned that SNS has shown no benefit in treating constipation and cannot be recommended in patients with constipation of any type.

**American College of Obstetricians and Gynecologists (ACOG):** In a 2019 practice bulletin on fecal incontinence, the ACOG stated that sacral nerve stimulation can be considered as a surgical treatment option for women with fecal incontinence with or without anal sphincter disruption who

have failed conservative treatment. The ACOG stated that surgical treatment options should be reserved for those who have failed conservative measures (with the exception of fistulas or rectal prolapse) because these treatments provide short-term improvement and are associated with more frequent and more severe complications compared to nonsurgical treatments (ACOG, 2019).

**American College of Obstetricians and Gynecologists (ACOG)/American Urogynecologic Society (AUGS):** The 2015 (reaffirmed 2022) joint ACOG/AUGS Practice Bulletin for urinary incontinence in women stated that sacral neuromodulation can be considered for patients with refractory urinary urge incontinence who have failed conservative treatment, including bladder training, pelvic floor physical therapy with biofeedback, and pharmacologic treatment.

**American Society of Colon and Rectal Surgeons (ASCRS):** In 2023, the ASCRS updated the clinical practice guideline for the management of fecal incontinence without a change in the previous recommendation. The ASCRS stated that SNS may be considered as a first-line surgical option for incontinent patients with and without sphincter defects. Grade of Recommendation: conditional recommendation based on low quality evidence (Bordeianou, et al., 2023)

The ASCRS clinical practice guideline for the evaluation and management of constipation stated that SNS may be an effective treatment for patients with chronic constipation and successful peripheral nerve evaluation test when conservative measures have failed; however, it is not currently approved by the US Food and Drug Administration for this condition in the United States. Grade of Recommendation: Weak recommendation based on moderate quality evidence (Paquette, et al., 2016).

**American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU):** The updated 2019 AUA/ SUFU guideline on the diagnosis and treatment of non-neurogenic overactive bladder in adults addressed sacral neuromodulation as a treatment option. The guideline stated that sacral neuromodulation may be offered as a third line treatment in a carefully selected patient population. For example, patients with severe refractory OAB symptoms or who are not candidates for second-line therapy and are willing to undergo a surgical procedure (Gormley, et al., 2012; Lightner, et al 2019 [updated]).

In 2024, the AUA and SUFU gave an updated recommendation stating that clinicians should offer patients with OAB who have failed or were unable to tolerate pharmacotherapy or behavioral therapy, sacral neuromodulation. The authors stated these conservative therapies have high failure rates due to poor compliance and patient frustration and minimally invasive treatment options such as SNS has been associated with high success rates, durable efficacy, and excellent patient satisfaction (Cameron, et al., 2024).

### **Implantable Tibial Nerve Stimulation**

There are several implantable tibial nerve stimulation devices (eCoin<sup>®</sup>, RENOVA<sup>™</sup> iStim system, Bioness StimRouter System) that are being studied for the treatment of urinary tract dysfunction (e.g., overactive bladder, urinary urge incontinence).

These devices are surgically implanted in the posterior tibial nerve area and stimulated externally. The eCoin, a miniaturized leadless neurostimulator was recently approved by the FDA. The eCoin is inserted near the ankle, above the tibial nerve using only local anesthetic and is proposed to provide automatic, intermittent tibial nerve stimulation to reduce urge urinary incontinence without patient remote management (Valencia Technologies, Inc, 2022).

**U.S. Food and Drug Administration:** According to the FDA, eCoin<sup>®</sup> Peripheral Neurostimulator (Valencia Technologies Corporation, CA) received premarket approval (PMA) (P200036) on July

15, 2022. Per the FDA the eCoin® Peripheral Neurostimulator “is indicated to treat urgency urinary incontinence in patients intolerant to or having an inadequate response to other more conservative treatments or who have undergone a successful trial of percutaneous tibial nerve stimulation.” According to the FDA summary of safety and effectiveness data (SSED), two post-approval studies (PAS) are required. The first is continued follow-up of the “Pivotal Study of Subcutaneous Tibial Nerve Stimulation with eCoin® for OAB with Urinary Urge Incontinence” and report clinical outcomes, including all device-or procedure-related adverse events to FDA through five years post-implantation. The second is a prospective, single-arm, multi-center, observational study designed to collect effectiveness and safety data in a post-approval setting. Effectiveness will be determined at 12 and 24 months and continue to be collected for five years post-implantation of study subjects (FDA, 2024)

**Literature Review:** The overall body of literature reports that there is insufficient evidence to draw conclusions regarding the effectiveness of implantable tibial nerve stimulation for the treatment of urinary voiding dysfunction, fecal incontinence and constipation. Studies are of low quality with small patient populations and short-term follow-ups (Kaaki, et al., 2022; Gilling, et al., 2021; Rogers, et al., 2021; Dorsthorst, et al., 2020).

Rogers et al. (2021) conducted a prospective, open-label, single arm trial that evaluated the safety and efficacy of the eCoin® for the treatment of refractory urgency urinary incontinence (UUI). Adults aged 18–80 with daily UUI who were intolerant or had an inadequate response to, at least one second or third-line therapy prior to enrollment were included in the study. One-hundred thirty-seven patients had the eCoin implanted subcutaneously using only local anesthetic in the medial lower leg above the fascia. Four weeks after implantation with minimal swelling confirmed, the device was activated. The eCoin delivered automated stimulation sessions for the duration of the study. Automated stimulation sessions occur for 30-minute durations every three days for 18 weeks and every four days thereafter. The primary outcomes measured the efficacy and safety of the device. Efficacy was measured by the proportion of patients who achieved a 50% or greater reduction from baseline in urgency urinary incontinence episodes after 48 weeks of therapy. Safety outcome measured device-related adverse events at the same time point. After activation, patients had follow-up visits at four, eight, 12, 24, 36 and 48 weeks. At each follow-up, a 3-day voiding diary was collected and the OAB Questionnaire, Patient Global Impression of Improvement, and a custom Likert scale on subject satisfaction questionnaires were administered. Patients were questioned about adverse events, initiation of OAB medications, any other changes to their history or comments regarding the device. Reprogramming was offered at the eight, 24 and 36-week visits. At 48 weeks post-activation, participants replied to a non-validated questionnaire detailing their experience with the device, implant procedure and their attitudes towards eCoin compared to other therapies. The primary efficacy analysis showed 68% of the intention to treat population (n=132) experienced at least a 50% reduction in urgency urinary incontinence episodes at 48 weeks post-activation; 16% of implanted subjects experienced device-related events through 52 weeks post-implantation. Author noted limitations included the lack of blinding and comparison along with the short-term follow-up. The authors concluded that eCoin demonstrated clinical benefit for treating overactive bladder syndrome with automatic delivery of an intermittent low-duty cycle and implanted with a minimally invasive, brief procedure. Additional long term randomized control trials with large patient populations are needed to validate the outcomes of the study. No health disparities were identified by the investigators.

### **Professional Societies/Organizations**

**American Society of Colon and Rectal Surgeons (ASCRS):** In 2023, the ASCRS updated the clinical practice guideline for the management of fecal incontinence. The ASCRS stated that “treatments for FI that are not currently approved for use in the United States by the Food and

Drug Administration (FDA), have become unavailable in the United States, or lack clinical data to support their use are beyond the scope of this guideline” (Bordeianou, et al., 2023).

**American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU):** The AUA/SUFU guideline on the diagnosis and treatment of non-neurogenic OAB in adults addressed using PTNS as a treatment option. The guideline stated that clinicians may offer PTNS as third-line treatment in a carefully selected patient population, characterized by moderately severe baseline incontinence and frequency and willingness to comply with the PTNS protocol. Additionally, the guidelines stated that patients must also have the resources to make frequent office visits both during the initial treatment phase and to obtain maintenance treatments in order to achieve and maintain treatment effects. This determination was based on evidence the AUA categorized as Grade C because of the primarily observational designs, varying patient inclusion criteria and short follow-up in most studies (Gormley, et al., 2012; Lightner, et al 2019 [updated]).

## Medicare Coverage Determinations

	<b>Contractor</b>	<b>Determination Name/Number</b>	<b>Revision Effective Date</b>
NCD	National	Sacral Nerve Stimulation For Urinary Incontinence (230.18)	1/1/2002
LCD	National Government Services, Inc.	Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396)	10/24/2019
LCD	Palmetto	Sacral Nerve Stimulation for the Treatment of Urinary and Fecal Incontinence (L39543)	11/5/2023

Note: Please review the current Medicare Policy for the most up-to-date information. (NCD = National Coverage Determination; LCD = Local Coverage Determination)

## Coding Information

**Notes:**

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Sacral Nerve Stimulation (SNS)**

**Considered Medically Necessary as a screening trial for sacral nerve stimulation (SNS) when criteria in the applicable policy statements listed above are met:**

<b>CPT®* Codes</b>	<b>Description</b>
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)

<b>HCPCS Codes</b>	<b>Description</b>
C1778	Lead, neurostimulator (implantable)
C1897	Lead, neurostimulator test kit (implantable)

**Considered Medically Necessary for permanent SNS implantation when criteria in the applicable policy statements listed above are met:**

<b>CPT®* Codes</b>	<b>Description</b>
64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver

<b>HCPCS Codes</b>	<b>Description</b>
A4290	Sacral nerve stimulation test lead, each
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682	Implantable neurostimulator radiofrequency receiver
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

**Considered Experimental/Investigational/Unproven when used to report Implantable tibial nerve stimulation for the treatment of urinary voiding dysfunction (e.g., overactive bladder, urinary urge incontinence), fecal incontinence and constipation:**

<b>CPT®* Codes</b>	<b>Description</b>
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and

CPT®* Codes	Description
	receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters

**\*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.**

## References

1. Abello A, Das AK. Electrical neuromodulation in the management of lower urinary tract dysfunction: evidence, experience and future prospects. *Ther Adv Urol*. 2018 Feb 22;10(5):165-173.
2. American College of Obstetricians and Gynecologists (ACOG). Practice Bulletin No. 210 Summary: Fecal Incontinence. *Obstet Gynecol*. 2019 Apr;133(4):837-839.
3. American College of Obstetricians and Gynecologists (ACOG). Committee on Practice Bulletins—Gynecology and the American Urogynecologic Society. ACOG Practice Bulletin. Clinical management guidelines for obstetrician-gynecologists. Number 155. Urinary incontinence in women. *Obstet Gynecol*. 2015 Nov;126(5):e66-81. Reaffirmed 2022.
4. Bordeianou LG, Thorsen AJ, Keller DS, Hawkins AT, Messick C, Oliveira L, Feingold DL, Lightner AL, Paquette IM. The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Management of Fecal Incontinence. *Dis Colon Rectum*. 2023 May 1;66(5):647-661.
5. Boyle DJ, Murphy J, Gooneratne ML, Grimmer K, Allison ME, Chan CL, et al. Efficacy of sacral nerve stimulation for the treatment of fecal incontinence. *Dis Colon Rectum*. 2011 Oct;54(10):1271-8.
6. Cameron AP, Chung DE, Dielubanza EJ, Enemchukwu E, Ginsberg DA, Helfand BT, et al. The AUA/SUFU Guideline on the Diagnosis and Treatment of Idiopathic Overactive Bladder. *Journal of Urology* [Internet]. 2024 Jul 1.
7. Chan M, Tjandra JJ. Sacral nerve stimulation for fecal incontinence: external anal sphincter defect vs intact anal sphincter. *Dis Colon Rectum*. 2008 Jul;51(7): 1015-1025.



8. Damon H, Barth X, Roman S, Mion F. Sacral nerve stimulation for fecal incontinence improves symptoms, quality of life and patients' satisfaction: results of a monocentric series of 119 patients. *Int J Colorectal Dis.* 2013 Feb;28(2):227-33.
9. Devroede G, Giese C, Wexner SD, Mellgren A, Collier JA, Madoff RD, et al. Quality of life is markedly improved in patients with fecal incontinence after sacral nerve stimulation. *Female Pelvic Med Reconstr Surg.* 2012 Mar-Apr;18(2):103-12.
10. Dorsthorst MJT, Digesu GA, Tailor V, Gore M, van Kerrebroeck PE, van Breda HMK, et al. 3-Year Followup of a New Implantable Tibial Nerve Stimulator for the Treatment of Overactive Bladder Syndrome. *J Urol.* 2020 Sep;204(3):545-550.
11. Eggers E, Crouss T, Beausang J, Smith D, Spector S, Saracco B, Adams A, Dickinson T, Lipetskaia L. Long-term Outcomes of Sacral Nerve Stimulation on the Treatment of Fecal Incontinence: A Systematic Review. *Neuromodulation.* 2024 Aug 17:S1094-7159(24)00649-4.
12. Fargo MV, Latimer KM. Evaluation and management of common anorectal conditions. *Am Fam Physician.* 2012 Mar 15;85(6):624-30.
13. Gilling P, Meffan P, Kaaki B, MacDiarmid S, Lucente V, Clark M, et al. Twelve-month Durability of a Fully-implanted, Nickel-sized and Shaped Tibial Nerve Stimulator for the Treatment of Overactive Bladder Syndrome with Urgency Urinary Incontinence: A Single-Arm, Prospective Study. *Urology.* 2021 Nov;157:71-78.
14. Gladman MA, Knowles CH. Surgical treatment of patients with constipation and fecal incontinence. *Gastroenterol Clin North Am.* 2008 Sep;37(3):605-25, viii.
15. Gormley EA, Lightner DJ, Burgio KL, Chai TC, Clemens JQ, Culkin DJ, Das AK, Foster HE Jr, Scarpero HM, Tessier CD, Vasavada SP; American Urological Association; Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline. *J Urol.* 2012 Dec;188(6 Suppl):2455-63.
16. Hassouna M, Siegel S, Lycklama A. Sacral Nerve Stimulation Study Group. Sacral neuromodulation in the treatment of urgency-frequency symptoms: a multicenter study on efficacy and safety. *J Urol.* 2000;163:1849-1854.
17. Hassouna M, Alabbad A. Sacral Nerve Neuromodulation. In: Krames ES, Peckham PH, Rezai AR. *Neuromodulation; Comprehensive Textbook of Principles, Technologies, and Therapies.* 2nd ed. St. Louis, MO: Elsevier Ltd; 2018. Ch 122. pgs 1451-1454.
18. Herbison GP, Arnold EP. Sacral neuromodulation with implanted devices for urinary storage and voiding dysfunction in adults. *Cochrane Database Sys Rev.* 2009 Apr 15;(2):CD004202.
19. Hull T, Giese C, Wexner SD, Mellgren A, Devroede G, Madoff RD, et al. Long-term durability of sacral nerve stimulation therapy for chronic fecal incontinence. *Dis Colon Rectum.* 2013 Feb;56(2):234-45.
20. Jarrett MED, Mowatt G, Glazener CM, Fraser C, Nicholls RJ, Grant AM, et al. Systematic review of sacral nerve stimulation for faecal incontinence and constipation. *Br J Surg.* 2004 Dec;91(12):1559-69.

21. Kaaki B, English S, Gilling P, Meffan P, Lucente V, MacDiarmid S, et al. Six-Month Outcomes of Reimplantation of a Coin-Sized Tibial Nerve Stimulator for the Treatment of Overactive Bladder Syndrome With Urgency Urinary Incontinence. *Female Pelvic Med Reconstr Surg*. 2022 May 1;28(5):287-292
22. Leroi AM, Parc Y, Lehur PA, Mion F, Barth X, Rullier E, et al. Efficacy of sacral nerve stimulation for fecal incontinence: results of a multicenter double-blind crossover study. *Ann Surg*. 2005 Nov;242(5):662-9.
23. Lightner DJ, Gomelsky A, Souter L, Vasavada SP. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline Amendment 2019. *J Urol*. 2019;202(3):558-563.
24. Maeda Y, Kamm MA, Vaizey CJ, Matzel KE, Johansson C, Rosen H, et al. Long-term outcome of sacral neuromodulation for chronic refractory constipation. *Tech Coloproctol* 2017 Apr;21(4):277-286.
25. Matzel KE, Lux P, Heuerr S, Besendorf er M, Zhang W. Sacral nerve stimulation for faecal incontinence: long-term outcome. *Colorectal Dis*. 2009 Jul;11(6):636-41.
26. Medtronic, Inc. Indications, Safety, and Warnings Sacral Neuromodulation. ©2024 Medtronic, Inc. Updated October 2019. Accessed August 14, 2023. Available at URL address: <https://www.medtronic.com/us-en/healthcare-professionals/products/urology/sacral-neuromodulation-systems/interstim-ii/indications-safety-warnings.html>
27. Medtronic, Inc. Medtronic receives FDA approval for InterStim X™ system, the next generation of the most personalized sacral nerve stimulation therapy for bladder and bowel control. ©2024 Medtronic, Inc. February 22, 2022. Accessed Aug 14, 2024. Available at URL address: <https://news.medtronic.com/2022-02-22-Medtronic-receives-FDA-approval-for-InterStim-X-TM-system,-the-next-generation-of-the-most-personalized-sacral-nerve-stimulation-therapy-for-bladder-and-bowel-control>
28. Melenhorst J, Koch SM, Uludag O, van Gemert WG, Baeten CG. Sacral neuromodulation in patients with faecal incontinence: results of the first 100 permanent implantations. *Colorectal Dis*. 2007 Oct;9(8):725-30.
29. Mellgren A. Fecal incontinence. *Surg Clin North Am*. 2010 Feb;90(1):185-94, Table of Contents.
30. Mellgren A, Wexner SD, Collier JA, Devroede G, Lerew DR, Madoff RD, et al. Long-term efficacy and safety of sacral nerve stimulation for fecal incontinence. *Dis Colon Rectum*. 2011 Sep;54(9):1065-1075.
31. Meurette G, La Torre M, Regenet N, Robert-Yap J, Lehur PA. Value of sacral nerve stimulation in the treatment of severe faecal incontinence: a comparison to the artificial bowel sphincter. *Colorectal Dis*. 2009 Jul;11(6):631-5.
32. Michelson HB, Thompson-Fawcett M, Lundby M, Krogh K, Laurberg s, Buntzen S. Six years of experience with sacral nerve stimulation for fecal incontinence. *Dis Colon Rectum*. 2010 Apr;53(4):414-21.

33. Mowatt G, Glazener C, Jarrett M. Sacral nerve stimulation for fecal incontinence and constipation in adults: a short version Cochrane review. *Neurourol Urodyn*. 2008;27(3):155-61.
34. Noblett K, Siegel S, Mangel J, Griebing TL, Sutherland SE, Bird ET, et al. Results of a prospective, multicenter study evaluating quality of life, safety, and efficacy of sacral neuromodulation at twelve months in subjects with symptoms of overactive bladder. *Neurourol Urodyn*. 2014 Dec 24.
35. Paquette IM, Varma M, Ternent C, Melton-Meaux G, Rafferty JF, Feingold D, et al. The American Society of Colon and Rectal Surgeons' Clinical Practice Guideline for the Evaluation and Management of Constipation. *Dis Colon Rectum*. 2016 Jun;59(6):479-92.
36. Pilkington SA, Emmett C, Knowles CH, Mason J, Yiannakou Y; NIHR CapaCITY working group; Pelvic floor Society. Surgery for constipation: systematic review and practice recommendations: Results V: Sacral Nerve Stimulation. *Colorectal Dis*. 2017 Sep;19
37. Rogers A, Bragg S, Ferrante K, Thenuwara C, Peterson DK. Pivotal Study of Leadless Tibial Nerve Stimulation with eCoin® for Urgency Urinary Incontinence: An Open-Label, Single Arm Trial. *J Urol*. 2021 Aug;206(2):399-408.
38. Rydningen M, Dehli T, Wilsgaard T, Rydning A, Kumle M, Lindsetmo RO, et al. Sacral neuromodulation compared with injection of bulking agents for faecal incontinence following obstetric anal sphincter injury - a randomized controlled trial. *Colorectal Dis*. 2017 May;19(5):O134-O144.
39. Schmidt RA, Jonas U, Oleson KA, Janknegt RA, Hassouna MM, Siegel SW, et al. Sacral nerve stimulation for treatment of refractory urinary urge incontinence. Sacral Nerve Stimulation Study Group. *J Urol*. 1999 Aug;162(2):352-57.
40. Shamliyan T, Wyman J, Bliss DZ, Kane RL, Wilt TJ. Prevention of urinary and fecal incontinence in adults. Evidence Report/Technology Assessment No. 161. (Prepared by the University of Minnesota Evidence-based Practice Center under Contract No. Contract No. 290-02-0009) AHRQ Publication No. 08-E003. Rockville, MD. Agency for Healthcare Research and Quality. December 2007.
41. Siegel S, Noblett K, Mangel J, Griebing TL, Sutherland SE, Bird ET, et al. Results of a prospective, randomized, multicenter study evaluating sacral neuromodulation with InterStim therapy compared to standard medical therapy at 6-months in subjects with mild symptoms of overactive bladder. *Neurourol Urodyn*. 2015 Mar;34(3):224-30.
42. Sutherland SE, Lavers A, Carlson A, Holtz C, Kesha J, Siegel SW. Sacral nerve stimulation for voiding dysfunction: One institution's 11-year experience. *Neurourol Urodyn*. 2007;26(1):19-28; discussion 36.
43. Syan R, Zhang CA, Enemchukwu EA. Racial and Socioeconomic Factors Influence Utilization of Advanced Therapies in Commercially Insured OAB Patients: An Analysis of Over 800,000 OAB Patients. *Urology*. 2020 Aug;142:81-86.
44. Szymański JK, Słabuszewska-Jóźwiak A, Zaręba K, Jakiel G. Neuromodulation - a therapeutic option for refractory overactive bladder. A recent literature review. *Wideochir Inne Tech Maloinwazyjne*. 2019 Dec;14(4):476-485.

45. Tan E, Ngo NT, Darzi A, Shenouda M, Tekkis PP. Meta-analysis: sacral nerve stimulation versus conservative therapy in the treatment of faecal incontinence. *Int J Colorectal Dis.* 2011 Mar;26(3):275-94.
46. Thaha MA, Abukar AA, Thin NN, Ramsanahie A, Knowles CH. Sacral nerve stimulation for faecal incontinence and constipation in adults. *Cochrane Database Syst Rev.* 2015 Aug 24;(8):CD004464.
47. Tjandra JJ, Chan MKY, Yeh CH, Murray-Green C. Sacral nerve stimulation is more effective than optimal medical therapy for severe fecal incontinence: a randomized, controlled study. *Dis Colon Rectum.* 2008 May;51(5):494-502.
48. Tutolo M, Ammirati E, Heesakkers J, Kessler TM, Peters KM, Rashid T, Sievert KD, et al. Efficacy and safety of sacral and percutaneous tibial neuromodulation in non-neurogenic lower urinary tract dysfunction and chronic pelvic pain: a systematic review of the literature. *Eur Urol* 2018 Jan 11.
49. Uludag O, Mellenhorst J, Koch M, van Gemert WG, Dejong CHC, Baeten CG, Sacral neuromodulation: long-term outcome and quality of life in patients with faecal incontinence. *Dis Colon Rectum*, 2011 Oct; 13(10):1162-6.
50. U. S. Food and Drug Administration (FDA). 510(k) premarket notification database. Product codes EZW, QON. Page last updated: Aug 12, 2024. Accessed Aug 19, 2024. Available at URL address: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm>
51. van Kerrebroeck PE, van Voskuilen AC, Heesakkers JP, Lycklama a Nijholt AA, Siegel S, Jonas U, et al. Results of sacral neuromodulation therapy for urinary voiding dysfunction: outcomes of a prospective, worldwide clinical study. *J Urol.* 2007 Nov;178(5):2029-34.
52. Wald A. Update on the Management of Fecal Incontinence for the Gastroenterologist. *Gastroenterol Hepatol (N Y).* 2016 Mar;12(3):155-64.
53. Wald A, Bharucha AE, Limketkai B, Malcolm A, Remes-Troche JM, Whitehead WE, Zutshi M. ACG Clinical Guidelines: Management of Benign Anorectal Disorders. *Am J Gastroenterol.* 2021 Oct 1;116(10):1987-2008.
54. Wexner SD, Collier JA, Devroede G, Hull T, McCallum R, Chan M, et al. Sacral nerve stimulation for fecal incontinence: results of a 120-patient prospective multicenter study. *Ann Surg.* 2010 Mar;251(3):441-9.
55. White WM, Dobmeyer-Dittrich C, Klein FA, Wallace LS. Sacral nerve stimulation for treatment of refractory urinary retention: long-term efficacy and durability. *Urology.* 2008 Jan;71(1):71-4.
56. Yamashiro J, de Riese W, de Riese C. New Implantable Tibial Nerve Stimulation Devices: Review of Published Clinical Results in Comparison to Established Neuromodulation Devices. *Res Rep Urol.* 2019 Dec 23;11:351-357.
57. Zerbib F, Siproudhis L, Lehur PA, Germain C, Mion F, Leroi AM, et al. Randomized clinical trial of sacral nerve stimulation for refractory constipation. *Br J Surg.* 2017 Feb;104(3):205-213.

## Revision Details

Type of Revision	Summary of Changes	Date
Annual review	<ul style="list-style-type: none"> <li>• Removed policy statement for:               <ul style="list-style-type: none"> <li>○ Replacement/revision of a sacral nerve stimulator</li> <li>○ Percutaneous tibial nerve stimulation</li> </ul> </li> <li>• Revised policy statement for sacral nerve stimulation for any other indication</li> </ul>	10/15/2024
Annual review	<ul style="list-style-type: none"> <li>• Updated to new template and formatting standards.</li> <li>• Removed policy statement for PTNS maintenance therapy and number of treatments allowed.</li> <li>• Removed EIU policy statement for PTNS for fecal incontinence and constipation.</li> </ul>	10/15/2023

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