

Medical Policy



Title: Sacral Nerve Neuromodulation / Stimulation for Pelvic Floor Dysfunction

Professional

Original Effective Date: September 20, 2005
Revision Date(s): October 19, 2009;
January 1, 2012; March 28, 2012;
January 15, 2013; October 16, 2013;
September 17, 2014
Current Effective Date: October 16, 2013

Institutional

Original Effective Date: November 18, 2005
Revision Date(s): January 1, 2012;
March 28, 2012; January 15, 2013;
October 16, 2013; September 17, 2014
Current Effective Date: October 16, 2013

State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact [Blue Cross and Blue Shield of Kansas Customer Service](#).

The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.

The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.

If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.

DESCRIPTION

Sacral nerve neuromodulation, also known as sacral nerve stimulation, is defined as the implantation of a permanent device that modulates the neural pathways controlling bladder or rectal function. This policy addresses use of SNM in the treatment of urinary or fecal incontinence, urinary or fecal nonobstructive retention, and chronic pelvic pain in patients with intact neural innervation of the bladder and/or rectum.

Background

Treatment using sacral nerve neuromodulation (SNM), also known as indirect sacral nerve stimulation (SNS), is one of several alternative modalities for patients with fecal or

urinary incontinence (urge incontinence, significant symptoms of urgency-frequency, or nonobstructive urinary retention) who have failed behavioral (e.g., prompted voiding) and/or pharmacologic therapies. Urge incontinence is defined as leakage of urine when there is a strong urge to void.

Urgency-frequency is an uncontrollable urge to urinate, resulting in very frequent, small volumes and is a prominent symptom of interstitial cystitis (also called bladder pain syndrome). Urinary retention is the inability to completely empty the bladder of urine. Fecal incontinence can arise from a variety of mechanisms, including rectal wall compliance, efferent and afferent neural pathways, central and peripheral nervous systems, and voluntary and involuntary muscles. Fecal incontinence is more common in women, due mainly to muscular and neural damage that may occur during vaginal delivery.

The SNM device consists of an implantable pulse generator that delivers controlled electrical impulses. This pulse generator is attached to wire leads that connect to the sacral nerves, most commonly the S3 nerve root. Two external components of the system help control the electrical stimulation. A control magnet is kept by the patient and can be used to turn the device on or off. A console programmer is kept by the physician and used to adjust the settings of the pulse generator.

Prior to implantation of the permanent device, patients undergo an initial testing phase to estimate potential response to treatment. The first type of testing developed was percutaneous nerve evaluation (PNE). This procedure is done with the patient under local anesthesia, using a test needle to identify the appropriate sacral nerve(s). Once identified, a temporary wire lead is inserted through the test needle and left in place for 4-7 days. This lead is connected to an external stimulator, which is carried by patients in their pocket or on their belt. The results of this test phase are used to determine whether patients are appropriate candidates for the permanent device. If patients show a 50% or greater reduction in symptom frequency, they are deemed eligible for the permanent device implanted (stage 1). The testing phase can last as long as several weeks, and if patients show a 50% or greater reduction in symptom frequency, they can proceed to stage 2 of the surgery, which is permanent implantation of the neuromodulation device. The 2-stage surgical procedure has been used in various ways. These include its use instead of PNE, for patients who failed PNE, for patients with an inconclusive PNE, or for patients who had a successful PNE to further refine patient selection.

The permanent device is implanted with the patient under general anesthesia. An incision is made over the lower back, and the electrical leads are placed in contact with the sacral nerve root(s). The wire leads are extended through a second incision underneath the skin, across the flank to the lower abdomen. Finally, a third incision is made in the lower abdomen where the pulse generator is inserted and connected to the wire leads. Following implantation, the physician programs the pulse generator to the optimal

settings for that patient. The patient can switch the pulse generator between on and off by placing the control magnet over the area of the pulse generator for 1–2 seconds.

Regulatory Status

In 1997, the Medtronic InterStim® Sacral Nerve Stimulation system received U.S. Food and Drug Administration (FDA) approval for marketing for the indication of urinary urge incontinence in patients who have failed or could not tolerate more conservative treatments. In 1999, the device received FDA approval for the additional indications of urgency-frequency and urinary retention in patients without mechanical obstruction. In 2006, the Medtronic InterStim II System received FDA approval for treatment of intractable cases of overactive bladder and urinary retention. The new device is smaller and lighter than the original system and is reported to be suited for those with lower energy requirements or small stature. The device also includes updated software and programming options. In 2011, the Medtronic InterStim System received FDA approval for the indication of chronic fecal incontinence in patients who have failed or could not tolerate more conservative treatments.

Note: This policy does not address pelvic floor stimulation which refers to electrical stimulation of the pudendal nerve. In addition, this policy does not address devices that provide direct sacral nerve stimulation in patients with spinal cord injuries. An example of such a device is the VOCARE® sacral nerve stimulator, which is intended for patients with complete spinal cord injury and neurogenic bladder.

POLICY

- A. Sacral nerve neuromodulation may be considered **medically necessary** for the treatment of urge incontinence, urgency-frequency syndrome, and non-obstructive urinary retention in patients when all of the following criteria are met:
1. Documented failure or intolerance to conventional conservative therapy (e.g., behavioral training such as bladder training, prompted voiding, or pelvic muscle exercise training, pharmacologic treatment for at least a sufficient duration to fully assess its efficacy;
AND
 2. The patient is an appropriate surgical candidate;
AND
 3. A successful percutaneous test stimulation, defined as at least 50% improvement in symptoms over a period of at least 1 week, was performed;
AND
 4. Incontinence is not related to a neurologic condition.

- B. Other urinary/voiding applications of sacral nerve neuromodulation are considered **experimental / investigational**, including but not limited to treatment of stress incontinence or urge incontinence due to a neurologic condition, e.g., detrusor hyperreflexia, multiple sclerosis, spinal cord injury, or other types of chronic voiding dysfunction.
- C. Sacral nerve neuromodulation may be considered **medically necessary** for the treatment of fecal incontinence when all of the following criteria are met:
1. Chronic fecal incontinence of greater than 2 incontinent episodes on average per week with duration greater than 6 months or for more than 12 months after vaginal childbirth;
AND
 2. Documented failure or intolerance to conventional therapy (e.g., dietary modification, the addition of bulking and pharmacologic treatment for at least a sufficient duration to fully assess its efficacy, performed more than 12 months [or 24 months in case of cancer] previously);
AND
 3. The patient is an appropriate surgical candidate;
AND
 4. A successful percutaneous test stimulation, defined as at least 50% improvement in symptoms over a period of at least 1 week, was performed;
AND
 5. 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 fistulae) or chronic inflammatory bowel disease;
AND
 6. Incontinence is not related to another neurologic condition.
- D. Sacral nerve neuromodulation is **experimental / investigational** in the treatment of chronic constipation or chronic pelvic pain.

RATIONALE

Urinary Incontinence

Two randomized controlled trials (RCTs) on sacral nerve neuromodulation for urinary incontinence have been conducted. The larger study was sponsored by Medtronic and submitted to the U.S. Food and Drug Administration as part of the approval process.⁽³⁾ Findings have not otherwise been published. Based on this RCT, the 1998 TEC Assessment concluded that SNM reduced urge incontinence compared to control patients.⁽¹⁾ This well-designed trial, using

standardized clinical and functional status outcomes measurements, enrolled patients with severe urge incontinence who had failed extensive prior treatments. The magnitude of effect (approximately one-half of the patients became dry, three-quarters experienced at least 50% reduction in incontinence) was fairly large, probably at least as great as with surgical procedures, and larger than expected from a placebo effect or from conservative measures such as behavioral therapy or drugs. The therapy evaluation test, in which the device is turned off and patients thus serve as their own controls, provided further evidence that the effect on incontinence is due to electrical stimulation and demonstrates that the effect of SNM is reversible. The cohort analysis of the clinical trial provides some evidence that the effect of SNM is maintained for up to 2 years. There was a high rate of adverse events reported in this clinical trial. Most of the adverse events were minor and reversible; however, approximately one-third of patients required surgical revision for pain at the operative sites or migration of the leads.

In the RCT, 177 of 581 patients had urinary retention. Patients with urinary retention reported significant improvements in terms of volume catheterized per catheterization, a decrease in the number of catheterizations per day, and increased total voided volume per day. At 12 months postimplant, 61% of patients had eliminated the use of catheterization. A total of 220 of 581 (38%) had significant urgency-frequency symptoms. After 6 months, 83% of patients with urgency-frequency symptoms reported increased voiding volumes with the same or reduced degree of frequency. At 12 months, 81% of patients had reached normal voiding frequency. Compared to a control group, patients with implants reported significant improvements in quality of life, as evaluated by the Short Form-36 (SF-36) health survey.

An additional prospective RCT of 44 patients with urge incontinence was published in 2000.⁽⁴⁾ At 6 months, the implant group showed significantly greater improvement on standardized clinical outcomes, as compared to those receiving conservative therapy. The magnitude of effect was substantial. This study provides further evidence of the beneficial effect of SNM for urinary urge incontinence.

Case series continue to be published. A 2011 series by Groen and colleagues in The Netherlands reported the longest follow-up.⁽⁵⁾ A total of 60 patients had at least 5 years of follow-up after SNM for refractory idiopathic urge urinary incontinence. Success was defined as at least a 50% decrease in the number of incontinent episodes or pads used per day. The success rate was 52 of 60 (87%) at 1 month and gradually decreased to 37 (62%) at 5 years. The number of women who were completely continent was 15 (25%) at 1 month and 9 (15%) at 5 years. At the 5-year follow-up, SNM was still used by 48/60 (80%) women. A total of 57 adverse events were reported in 32 of 60 (53%) patients. The most frequent adverse events were hardware-related or pain or discomfort. There were a total of 23 reoperations in 15 patients. In most cases, pain problems were managed conservatively.

Findings from a large prospective series were reported in 2009 by White and colleagues.⁽⁶⁾ The study focused on complications associated with SNM in 202 patients with urge incontinence, urinary urgency, or urinary retention. At a mean follow-up of 37 months (range 7–84), 67 patients (30%) had experienced adverse events that required either lead or implantable pulse generator revisions. Complications included pain (3%), device malfunction secondary to trauma (9%), infection (4%), postoperative hematoma (2%), and lead migration (6%). In addition, 5% of patients underwent elective removal, 4% had device removal due to lack of efficacy, and 2%

required removal due to battery expiration. At the last follow-up, 172 patients (85%) had functional implanted units.

A 2009 Cochrane review evaluated the literature on implanted devices for urinary storage and voiding dysfunction in adults.⁽⁷⁾ The authors stated that, in spite of methodologic problems (generally poor quality studies), the evidence “seems clear that continuous stimulation offers benefits for carefully selected people with overactive bladder syndrome and for those with urinary retention but no structural obstruction.” They concluded that while some people benefit, more research is needed to improve patient selection, to carry out the implant, and to find why so many fail.

Conclusions: Data from RCTs and case series with long-term follow-up provides sufficient evidence to conclude that sacral nerve neuromodulation is effective and safe in selected patients with urge incontinence, urgency-frequency syndrome, and non-obstructive urinary retention.

Fecal Incontinence

In 2011, Tan and colleagues published a meta-analysis of randomized trials and observational studies published between 2000 and 2008 on sacral nerve neuromodulation for treating fecal incontinence.⁽⁸⁾ They identified a total of 34 studies that reported on at least one of their outcomes of interest and clearly documented how many patients underwent temporary and permanent SNM. Only one of these studies was an RCT (Tjandra et al. 2008), discussed in more detail below.⁽⁹⁾ In the 34 studies, a total of 944 patients underwent temporary sacral nerve stimulation and 665 subsequently underwent permanent SNS implantation. There were 279 patients who did not receive permanent implantation, and 154 of these were lost to follow-up. Follow-up in the studies ranged from 2 weeks to 35 weeks. In a pooled analysis of findings of 28 studies, there was a statistically significant decrease in incontinence episodes per week with SNM compared to maximal conservative therapy (weighted mean difference: -6.83; 95% confidence interval [CI]: -8.05 to -5.60, $p < 0.001$). Fourteen studies reported incontinence scores, and when these results were pooled, there was also a significantly greater improvement in scores with SNS compared to conservative therapy (weighted mean difference: -10.57, 95% CI: -11.89 to -9.24, $p < 0.001$).

In 2008, Tjandra and colleagues published an RCT with 120 patients with severe fecal incontinence.⁽⁹⁾ Patients were randomly assigned to receive sacral nerve stimulation or best supportive therapy, consisting of pelvic floor exercises with biofeedback, bulking agents, and dietary management with a team of dietitians. Exclusion criteria included neurologic disorders and external anal sphincter defects of more than 120 degrees of the circumference, although a “high proportion” of the patients had pudendal neuropathy. The study was not blinded. Of the 60 patients randomized to SNS, 54 (90%) had successful test stimulation and 53 decided to proceed with implant of the pulse generator. At baseline, the SNS group had an average of 9.5 incontinent episodes per week, and the controls had 9.2. Both groups had an average of 3.3 days per week with incontinence. At 12-month follow-up, episodes had decreased to 1 day per week with 3.1 episodes in the SNS group, but had not changed in the control group (mean 3.1 days per week with 9.4 episodes). Complete continence was achieved in 22 of the 53 SNS patients (42%) and 13 patients (24%) improved by 75% to 99%. None of the patients had worsening of fecal continence. Adverse events included pain at implant site (6%), seroma (2%), and excessive tingling in the vaginal region (9%).

A key observational study was the 16-site multicenter FDA investigational device exemption study of SNS in 120 patients with fecal incontinence. Findings were initially reported by Wexner and colleagues in 2010.⁽¹⁰⁾ To be included in the study, patients had to complain of chronic fecal incontinence with duration greater than 6 months or for more than 12 months after vaginal childbirth, defined as greater than 2 incontinent episodes on average per week. All patients had failed or were not candidates for more conservative treatments. Exclusion criteria included congenital anorectal malformation; previous rectal surgery, if performed within the last 12 months (or 24 months in case of cancer); defects of the external anal sphincter over 60 degrees; chronic inflammatory bowel disease; visible sequelae of pelvic radiation; active anal abscesses and fistulae; neurologic diseases such as clinically significant peripheral neuropathy or complete spinal-cord injury; and anatomic limitations preventing the successful placement of an electrode. A total of 285 patients were evaluated for potential enrollment; 133 were enrolled and underwent acute test stimulation, and 120 showed at least 50% improvement during the test phase and received a permanent stimulator. Thirty-four of the 120 patients exited the study for a variety of reasons both related (i.e., lack of efficacy in 6 and implant site infection or skin irritation in 5) and unrelated to the implant (i.e., death of a local principal investigator). Analysis based on the initial 133 patients showed a 66% success rate (>50% improvement), while analysis based on 106 patients who were considered completed cases at 12 months showed an 83% success rate. The success rate based on the 120 patients who received a permanently implanted stimulator would fall between these 2 figures. Of 106 cases included in the 12-month results, perfect continence (100% improvement) was reported in approximately 40%, while an additional 30% of patients achieved 75% or greater improvement in incontinent episodes. Success was lower in patients with an internal anal sphincter defect (65%, n=20) compared with patients without a defect (87%, n=86).

Three-year and five-year findings were subsequently published. In 2011, Mellgren and colleagues reported on the 120 patients who received a permanently implanted stimulator.⁽¹¹⁾ Mean length of follow-up was 3.1 years, and 83 (69%) completed at least part of the 3-year follow-up assessment. In an intention-to-treat analysis using the last observation carried forward, 79% of patients experienced at least a 50% reduction in the number of incontinent episodes per week compared to baseline, and 74% experienced at least a 50% reduction in the number of incontinent days per week. In a per-protocol analysis at 3 years, 86% of patients experienced at least a 50% reduction in the number of incontinent episodes per week, and 78% experienced at least a 50% reduction in the number of incontinent days per week. By the 3-year follow-up, a total of 334 adverse events that were potentially device-related had been reported in 99 patients; 67% of these occurred within the first year. The most frequently reported adverse events among the 120 patients were implant site pain (28%), paresthesia (15%), implant site infection (10%), diarrhea (6%), and extremity pain (6%). Six infections required surgical intervention (5 device removals and 1 device replacement). In 2012, Hull and colleagues reported outcomes in 72 patients (60% of the 120 implanted patients) who had completed a 5-year follow-up visit.⁽¹²⁾ Sixty-four (89%) of the patients who contributed bowel diary data at 5 years had at least a 50% improvement from baseline in weekly incontinent episodes and 26 of the 72 patients (36%) had achieved total continence. It is uncertain whether outcomes differed in the 40% of patients who were missing from the 5-year analysis.

Several small case series have reported long-term follow-up. For example, in 2012, George and colleagues reported on 23 patients who underwent SNS for fecal incontinence after a successful trial of temporary stimulation.⁽¹³⁾ Over a median follow-up of 9.5 years, 12 of the 23 patients

(48%) maintained full continence. Two patients lost efficacy at 4 years and 5 years, respectively and had the device removed. Nine patients required a change of battery after a mean of 7 years. Three patients died of unrelated causes. In 2008, Matzel and colleagues reported long-term outcomes from 12 patients with severe incontinence (average of 54% incontinent episodes per week) who underwent SNS between 1994 and 1999.⁽¹⁴⁾ In 3 patients, the device was removed because of pain or neurologic disease; the remaining 9 patients showed continued efficacy over an average 10-year follow-up (range 7–14 years). Complete continence was achieved in 5 patients (42% of 12), and 3 patients (25%) had less than 10% incontinent episodes. Pulse generator exchange was required in 8 of the 9 patients after a mean of 7 years for battery fatigue.

In 2011, Maeda and colleagues published a systematic review of studies on complications following permanent implantation of a SNS device for fecal incontinence and constipation.⁽¹⁵⁾ The authors identified 94 articles. The vast majority of studies addressed fecal incontinence. A combined analysis of data from 31 studies on SNS for fecal incontinence reported a 12% suboptimal response to therapy (149 of 1,232 patients). A review of complications reported in the studies found that the most commonly reported complication was pain around the site of implantation, with a pooled rate of 13% (81/621 patients). The most common response to this complication was repositioning the stimulator, followed by explantation of the device and reprogramming. The second most common adverse event was infection, with a pooled rate of 4% (40/1025 patients). Twenty-five of the 40 infections (63%) led to explantation of the device.

Conclusions: With longer term results from 1 randomized controlled trial with 120 patients, prospective case series and a pooled analysis of data from the RCT and observational studies, evidence is considered sufficient to conclude that sacral nerve neuromodulation/stimulation improves outcomes when used for the treatment for chronic fecal incontinence in well-selected patients who have failed conservative therapy.

Constipation

In 2013, Thomas and colleagues published a systematic review of controlled and uncontrolled studies evaluating sacral nerve stimulation for treatment of chronic constipation.⁽¹⁶⁾ The authors identified 11 case series and 2 blinded cross-over studies. Sample sizes in the case series ranged from 4 to 68 patients implanted with a permanent SNS device; in 7 of the 11 studies, fewer than 25 patients underwent SNS implantation. Among the 2 cross-over studies, one included 2 patients implanted with an SNS device. The other, a 2012 study by Knowles and colleagues⁽¹⁷⁾, evaluated temporary stimulation only in 14 patients. Patients were included if they were diagnosed with evacuatory dysfunction and rectal hyposensitivity and had failed maximal conservative treatment. They were randomized to 2 weeks of stimulation with the SNS device turned on and 2 weeks with the SNS device turned off, in random order. There was no wash-out period between treatments. The primary efficacy outcome was change in rectal sensitivity and was assessed using 3 measures of rectal sensory thresholds. The study found a statistically significantly greater increase in rectal sensitivity with the device turned on in 2 of the 3 measures. Among the secondary outcome measures, there was a significantly greater benefit of active treatment on the percentage of successful bowel movements per week and the percentage of episodes with a sense of complete evacuation. In addition to its small sample size, the study was limited by the lack of a wash-out period between treatments i.e., there could have been a carry-over effect when the device was used first in the “on” position. Moreover, the authors noted that the

patients were highly selected; only 14 of the approximately 1800 patients approached met the eligibility criteria and agreed to participate in the study.

One of the larger case series was published in 2010 by Kamm and colleagues.⁽¹⁸⁾ This was a prospective study conducted at multiple sites in Europe. The study included 62 patients who had idiopathic chronic constipation lasting at least 1 year and had failed medical and behavioral treatments. Constipation was defined as at least one of the following: fewer than 2 bowel movements per week, straining to evacuate in at least 25% of attempts or a sensation of incomplete evacuation on at least 25% of occasions. Forty-five of the 62 (73%) met criteria for permanent implantation during the 3-week trial period. Criteria included an increase in evacuation frequency to at least 3 per week, or a 50% reduction in either frequency of straining during evacuation or in episodes with sensation of incomplete evacuation. After a median follow-up of 28 months (range 1-55 months) after permanent implantation, 39 of 45 (87%) patients were classified as treatment successes (i.e., met same improvement criteria as were used to evaluate temporary stimulation). There was a significant increase in the frequency of bowel movements from a median of 2.3 per week at baseline to 6.6 per week at latest follow-up ($p < 0.001$). The frequency of spontaneous bowel movements (i.e., without use of laxatives or other stimulation) increased from a median of 1.7 per week at baseline to 4.3 per week at last follow-up; $p = 0.0004$. A total of 101 adverse events were reported; 40 (40%) of these were attributed to the underlying constipation or an unrelated diagnosis. Eleven serious adverse events related to treatment were reported (the authors did not specify whether any patients experienced more than 1 serious event). The serious adverse events included a deep postoperative infection ($n = 2$), superficial erosion of lead through the skin ($n = 1$), persistent postoperative pain at the site of implantation ($n = 2$), conditions leading to lead revision ($n = 4$), and device failure ($n = 2$). The study has been criticized for including a large number of patients who had more than 2 bowel movements per week at study entry.

An additional study, published by Maeda and colleagues in 2010, focused on reporting adverse events.⁽¹⁹⁾ The study was a chart review and included 38 patients with constipation who received permanent SNS after a successful trial period. At the time that charts were reviewed, a mean of 25.7 months had elapsed since implantation. A total of 58 reportable events were identified in 22 of the 38 (58%) patients. A median of 2 (range 1-9) events per patient were reported; 26 of 58 events (45%) were reported in the first 6 months after device implantation. The most common reportable events were lack or loss of efficacy (26 of 58 events, 45%), and pain (16 events, 28%). Twenty-eight (48%) of the events were resolved by reprogramming. Surgical interventions were required for 19 (33%) of the events, most commonly permanent electrode replacement (14 events). Three of 38 (8%) patients discontinued use of the device due to reportable events. Conclusions: Only 2 small controlled studies are available, both cross-over studies; 1 had only 2 patients and the other had methodological limitations. In addition, there are several, mainly small, case series. This represents insufficient evidence to permit scientific conclusions about the efficacy and safety of sacral nerve neuromodulation/stimulation for patients with constipation.

Chronic Pelvic Pain

Several case series have evaluated sacral neuromodulation for treating chronic pelvic pain. For example, in 2012 Martelluci and colleagues reported on 27 patients with chronic pelvic pain (at least 6 months) who underwent testing for SNM implantation.⁽²⁰⁾ After a 4-week temporary stimulation phase, 16 of 27 patients (59%) underwent implantation of an Interstim device. In the

16 implanted patients, mean pain on a visual analogue scale (VAS) was 8.1 prior to implantation and 2.1 at the 6- and 12-month follow-ups. An earlier study by Siegel and colleagues reported on 10 patients and stated that 9 of the 10 experienced a decrease in pain with SNS stimulation.(21)

Conclusions: Data from several small case series with heterogenous patients represents insufficient evidence that sacral nerve neuromodulation/stimulation is safe and effective for treating chronic pelvic pain.

Trial Stimulation Techniques

As described in the background section above, there are 2 types of trial stimulation before permanent implantation of a neuromodulation device. These are percutaneous nerve evaluation (PNE) and stage 1 (lead implantation) of a 2-stage surgical procedure. The PNE was the initial method of trial stimulation and has been the standard of care prior to permanent implantation of the device. There are concerns about possible suboptimal sensitivity of the PNE test due to lead migration, and the stage-1 lead implantation is an alternate trial stimulation modality. Comparative rates of lead migration and rates of progressing to permanent implantation are useful outcomes in that there may be reduced sensitivity of the PNE test due to lead dislodgement. However, due to the potential placebo effect of testing, it is also important to compare the long-term efficacy of SNM after these 2 trial stimulation techniques. In addition, it would be useful to have data on the optimal approach to using the 2-stage surgical procedure. As mentioned previously in the background section, the 2-stage surgical procedure has been used in various ways including instead of PNE, for patients who failed PNE, for patients with an inconclusive PNE, and for patients who had a successful PNE to further refine patient selection.

No RCTs were identified that evaluated long-term health outcomes (e.g., reduction in incontinence symptoms) after trial stimulation with PNE versus stage-1 lead implantation. There are limited data on the issue of rates of failure after SNM in patients selected using the 2-stage test. Leong and colleagues, in a single-center prospective study published in 2011, evaluated 100 urge incontinence patients with both PNE and the first stage of the 2-stage technique (i.e., patients served as their own controls).(22) Patients were first screened with the PNE and, afterwards, with lead implantation. Response to testing was based on diary data for 3 consecutive days after receiving each type of lead. In the test phase, 47 patients (47%) had a positive response to PNE, and 69 (69%) had a positive response to the first-stage lead placement test. All patients who responded to PNE also responded to stage-1 testing. The 69 patients who responded to stage-1 testing underwent implantation. They were then followed for a mean of 26 months, and 2 patients (3% of those with a positive test) had failed therapy. Although this study showed a low rate of failure, only 22 individuals had a successful test with the stage-1 technique but not with PNE. This is a small number of patients on which to base conclusions about the comparative efficacy of the 2 techniques. In addition, the order of testing could have impacted findings. All patients had PNE testing prior to first-stage lead implantation and could have been biased by their first test. Stronger study designs would be to randomize the order of testing or to randomize patients to receive one type of testing or the other.

In 2002, Scheepens and colleagues conducted an analysis of 15 patients with urinary incontinence or retention who had a good initial response to PNE but then failed PNE in the longer term (i.e., days 4-7 of testing).(23) These 15 patients underwent stage 1 of the 2-stage technique. One patient failed the first stage and was explanted. Of the remaining 14 patients, 2 were explanted later due to lack of efficacy of sacral neuromodulation. The other 12 patients

were followed for a mean of 4.9 years and voiding diary data showed improvement in nearly all incontinence symptoms. There was a low failure rate after stage-1 testing, but this is a small sample size, and stage-1 testing was not compared to another trial stimulation method, e.g., PNE.

In 2010, Marcelissen and colleagues published findings in 92 patients with urinary symptoms who underwent trial evaluation for SNM treatment.(24) Patients initially underwent PNE (n=76) or stage-1 surgery (n=16). Patients who had a negative PNE (n=41) then underwent stage-1 evaluation. A total of 11 of 16 (63%) patients had a positive initial stage-1 test and were implanted with a SNM device. Thirty-five of 76 (46%) patients had a positive initial PNE test and underwent permanent implantation. There were 41 patients (54% of those undergoing PNE) who had a negative test and then had stage-1 surgical evaluation. Eighteen of 41 (44%) had a positive stage-1 test and underwent implantation. Altogether there were 64 patients who underwent implantation of an SNM device. Mean follow-up was 51 months. Thirty-eight of 64 patients (59%) implanted experienced clinical success at last follow-up, defined as greater than 50% improvement in symptoms reported in a voiding diary. Clinical success rate was not reported separately by trial stimulation method.

Several studies, e.g., Borawski and colleagues (2006)(25) and Bannowsky and colleagues (2008), (26) compared the response rates during the test phase in patients with urinary incontinence symptoms and found higher rates of response with the stage-1 test than with PNE. In these studies, more people who received the stage-1 test went on to undergo implantation. The Borawski et al. study was an RCT with 30 patients (13 received PNE and 17 received the stage-1 test). The Bannowsky et al. study was not randomized; 42 patients received a PNE, and 11 patients received a stage-1 test. Neither study, however, followed patients once they had a device implanted so they do not provide data on the relative success rate of SNM after these 2 test procedures. With this type of study (i.e., without follow-up after implantation), it is not possible to conclude whether the 2-stage procedure reduced false-negatives (i.e., selected more people who might benefit) or increased false-negatives (i.e., selected more people who might go on to fail).

In review articles such as Baxter and Kim 2010 lead migration was described as a potential problem with the PNE technique, but no studies were identified that quantified the rate of lead migration in large numbers of patients. (27) No published studies were available comparing trial stimulation techniques in patients with non-urinary conditions e.g., fecal incontinence.

Clinical Input Received through Physician Medical Societies and Academic Medical Centers

In response to requests, input was received through 4 Physician Specialty Societies and 2 Academic Medical Centers while this policy was under review in 2012. While the various Physician Specialty Societies and Academic Medical Centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the Physician Specialty Societies or Academic Medical Centers, unless otherwise noted. Reviewers from 2 Specialty Societies and 2 Academic Medical Centers provided opinions regarding the possible medical necessity of implantable leads for test stimulation, as part of a 2-stage process for device implantation. All 4 respondents supported the use of implantable leads for test stimulation as an alternative to percutaneous test stimulation, for patients who failed percutaneous test stimulation

and/or for patients with inconclusive percutaneous test stimulation. Reasons for support included a longer period of interrupted treatment with stage-1 stimulation due to less lead migration and a higher rate of positive tests compared to percutaneous test stimulation.

SUMMARY

There is sufficient evidence to conclude that sacral nerve neuromodulation/stimulation is effective and safe in selected patients with urge incontinence, urgency-frequency, and non-obstructive urinary retention. In addition, the evidence is considered sufficient for sacral nerve neuromodulation to be an option for the treatment for chronic fecal incontinence in well-selected patients who have failed conservative therapy. Therefore, SNM may be considered medically necessary under specific conditions in the above patients. Not all patients will benefit, and the adverse event rate for this procedure is high. Patients should therefore be provided with adequate information to make an informed choice regarding the potential risks and benefits of this procedure.

Limited evidence reports that more patients have a positive stimulation trial when stage-1 surgery is used compared to PNE and that the majority of patients with a positive stage-1 test experience a reduction in symptoms after permanent implantation. This evidence does not determine with certainty that health outcomes are improved with the stage-1 trial stimulation. However, due to the available evidence, as well as strong clinical support for surgical lead placement as an alternative to percutaneous test stimulation, surgical lead placement may be considered medically necessary for otherwise eligible patients.

The literature on sacral nerve stimulation for constipation or chronic pelvic pain remains insufficient to evaluate the effect of this technology on health outcomes; thus SNM is considered investigational for these indications.

Practice Guidelines and Position Statements

French implant centers provided a 2010 position statement on sacral nerve stimulation for the management of patients with fecal incontinence, based on review of the evidence and a formal consensus process.(28)

Indications:

- Severe fecal incontinence, i.e., at least one or more episodes of fecal incontinence per week and/or a significant change in the patient's quality of life.
- Without any significant damage (>30% of the anal circumference) to the external anal sphincter, with or without previous repair
- Failed conservative therapy (diet, antidiarrheals and bulking agents, treatment of incomplete rectal evacuation by any means, and rehabilitation with biofeedback training)
- Double fecal and urinary incontinence (excluding stress urinary incontinence).

Contraindications:

- Congenital anorectal malformation
- Flatus incontinence alone
- Recent rectal surgery
- Present external rectal prolapse
- Chronic bowel diseases
- Chronic diarrhea
- Altered bowel habit associated with abdominal pain
- Stoma present

- Complete bilateral or spinal nerve lesions
- Inappropriate surgical candidate (i.e., bleeding, pregnancy, anatomical limitations, skin disease risking infection, psychiatric disease)

Potential Contraindications:

- Fecal incontinence associated with constipation
- Non-active inflammatory bowel disease
- Progressive incomplete neurological disease

In 2007, the National Institute for Clinical Evidence (NICE) guideline on management of fecal incontinence recommended, "a trial of temporary sacral nerve stimulation should be considered for people with faecal incontinence in whom sphincter surgery is deemed inappropriate...All individuals should be informed of the potential benefits and limitations of this procedure and should undergo a trial stimulation period of at least 2 weeks to determine if they are likely to benefit. People with faecal incontinence should be offered sacral nerve stimulation on the basis of their response to percutaneous nerve evaluation during specialist assessment, which is predictive of therapy success."(29)

Practice Guidelines from the American College of Gastroenterology (ACG) in 2004 on the diagnosis and management of fecal incontinence found limited evidence in favor of sacral nerve stimulation.(30) The ACG concluded that the precise indication for SNS, its comorbidity, its long-term outcome, and efficacy remain to be defined.

In 2004 (reaffirmed 2008), the American College of Obstetricians and Gynecologists (ACOG) recommended that sacral nerve stimulation be considered as a treatment option for chronic pelvic pain.

CODING

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CPT/HCPCS

- | | |
|-------|---|
| 64561 | Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) |
| 64581 | Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) |
| 64585 | Revision or removal of peripheral neurostimulator electrode array |
| 64590 | Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling |
| 64595 | Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver |

- 95970 Electronic analysis of implanted neurostimulator pulse generator system (eg,, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple or complex brain, spinal cord or peripheral (ie,, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
- A4290 Sacral nerve stimulation test lead, each
- E0745 Neuromuscular stimulator, electronic shock unit
- E1399 Durable medical equipment, miscellaneous (would include bulk leads, needles, and cables)
- L8680 Implantable neurostimulator electrode, each
- L8685 Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
- L8686 Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
- L8687 Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
- L8688 Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

ICD-9 Diagnoses

- 787.60 Incontinence of feces; full incontinence of feces
- 787.61 Incontinence of feces; incomplete defecation
- 787.62 Incontinence of feces; fecal smearing
- 787.63 Incontinence of feces; fecal urgency
- 788.20 Retention of urine, unspecified
- 788.21 Incomplete bladder emptying
- 788.29 Other specified retention of urine
- 788.30 Urinary incontinence, unspecified
- 788.31 Urge incontinence
- 788.32 Stress incontinence, male
- 788.33 Mixed incontinence, (male) (female)
- 788.34 Incontinence without sensory awareness
- 788.35 Post-void dribbling
- 788.36 Nocturnal enuresis
- 788.37 Continuous leakage
- 788.38 Overflow incontinence
- 788.39 Other urinary incontinence
- 788.41 Urinary frequency

ICD-10 Diagnoses (Effective October 1, 2015)

- N39.41 Urge incontinence
- R15.1 Fecal smearing
- R15.2 Fecal urgency
- R15.9 Full incontinence of feces
- R35.0 Frequency of micturition
- R39.14 Feeling of incomplete bladder emptying

REVISIONS

10-19-2009	Policy added to the bcbsks.com web site.
01-01-2012	In Coding section: Revised CPT nomenclature for the following codes: 64561, 64581, 95970, 95971
03-28-2012	Updated the Medical Policy Title from "Sacral Nerve Modulation / Stimulation for Urinary Dysfunction."
	Updated Description section.
	In the Policy section: <ul style="list-style-type: none"> • In Item A, revised the following language: "Sacral nerve neuromodulation may be considered medically necessary in patients with one or more of the following: <ol style="list-style-type: none"> 1. urge incontinence 2. urgency-frequency 3. non-obstructive urinary retention" • In Item A, inserted the following criteria: "1. documented failure or intolerance to conventional therapy (e.g., behavioral training such as bladder training, prompted voiding, or pelvic muscle exercise training, pharmacologic treatment for at least a sufficient duration to fully assess its efficacy, and/or surgical corrective therapy); AND 2. the patient is an appropriate surgical candidate; AND 3. a successful Percutaneous test stimulation, defined as at least 50% improvement in symptoms over a period of at least 2 weeks, was performed; AND 4. conditions is not related to a neurologic condition." • In Item B, inserted "urge incontinence due to a neurologic conditions, e.g., detrusor hyperreflexia, multiple sclerosis, spinal cord injury," • In Item C, revised the following language "Sacral nerve neuromodulation is also experimental / investigational in the treatment of fecal incontinence, chronic constipation, or chronic pelvic pain." Liberalization was made with regard to fecal incontinence. The treatment of chronic constipation or chronic pelvic pain continues to be considered experimental /investigational.
	Updated the Rationale section.
	In the Coding section: <ul style="list-style-type: none"> • Updated nomenclature. • Added Diagnosis codes: 787.60, 787.62, 787.63
	Updated the Reference section.
01-15-2013	In the Coding section: <ul style="list-style-type: none"> ▪ Updated nomenclature for CPT code 64561 (effective 01-01-2013)
10-16-2013	Updated Description section.

	<p>In Policy section:</p> <ul style="list-style-type: none"> ▪ In Item A, added "syndrome" to read "...medically necessary for the treatment of urge incontinence, urgency-frequency syndrome,..." ▪ In Item A, #3, replaced "2 weeks" with "1 week" ▪ In Item A, #4, replaced "condition" with "incontinence". ▪ In Item C, #4, replaced "2 weeks" with "1 week". ▪ In Item C, #6, removed "such as peripheral neuropathy or complete spinal cord injury" to read "incontinence is not related to another neurologic
	Updated Rationale section.
	<p>In Coding section:</p> <ul style="list-style-type: none"> ▪ Added ICD-10 Diagnosis codes (Effective October 1, 2014)
	Updated Reference section.
09-17-2014	Description, Rationale, and Reference sections reviewed with no updates.
	<p>In Coding section:</p> <ul style="list-style-type: none"> ▪ Added CPT codes 64585 and 64595. ▪ Added ICD-9 Diagnosis codes: 787.61, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39

REFERENCES

1. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Sacral nerve stimulation for the treatment of urge incontinence. TEC Assessments 1998; Volume 13, Tab 18.
2. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Sacral nerve stimulation for the treatment of refractory urinary urgency/frequency in adults. TEC Assessments 2000; Volume 15, Tab 7.
3. Food and Drug Administration (FDA). Summary of Safety and Effectiveness: Medtronic Interstim System for Urinary Control. Available online at: http://www.accessdata.fda.gov/cdrh_docs/pdf/P970004S004b.pdf. Last accessed April, 2013.
4. Weil EH, Ruiz-Cerda JL, Eerdmans PH et al. Sacral root neuromodulation in the treatment of refractory urinary urge incontinence: a prospective randomized clinical trial. Eur Urol 2000; 37(2):161-71.
5. Groen J, Blok BF, Bosch JL. Sacral neuromodulation as treatment for refractory idiopathic urge urinary incontinence: 5-year results of a longitudinal study in 60 women. J Urol 2011; 186(3):954-9.
6. White WM, Mobley JD, 3rd, Doggweiler R et al. Incidence and predictors of complications with sacral neuromodulation. Urology 2009; 73(4):731-5.
7. Herbison GP, Arnold EP. Sacral neuromodulation with implanted devices for urinary storage and voiding dysfunction in adults. Cochrane Database Syst Rev 2009; (2):CD004202.
8. Tan E, Ngo NT, Darzi A et al. Meta-analysis: sacral nerve stimulation versus conservative therapy in the treatment of faecal incontinence. Int J Colorectal Dis 2011; 26(3):275-94.
9. Tjandra JJ, Chan MK, Yeh CH et al. Sacral nerve stimulation is more effective than optimal medical therapy for severe fecal incontinence: a randomized, controlled study. Dis Colon Rectum 2008; 51(5):494-502.
10. Wexner SD, Collier JA, Devroede G et al. Sacral nerve stimulation for fecal incontinence: results of a 120-patient prospective multicenter study. Ann Surg 2010; 251(3):441-9.

11. Mellgren A, Wexner SD, Collier JA et al. Long-term efficacy and safety of sacral nerve stimulation for fecal incontinence. *Dis Colon Rectum* 2011; 54(9):1065-75.
12. Hull T, Giese C, Wexner SD et al. Long-term durability of sacral nerve stimulation therapy for chronic fecal incontinence. *Dis Colon Rectum* 2013; 56(2):234-45.
13. George AT, Kalmar K, Panarese A et al. Long-term outcomes of sacral nerve stimulation for fecal incontinence. *Dis Colon Rectum* 2012; 55(3):302-6.
14. Matzel KE, Lux P, Heuer S et al. Sacral nerve stimulation for faecal incontinence: long-term outcome. *Colorectal Dis* 2008; 11(6):636-41.
15. Maeda Y, Matzel K, Lundby L et al. Postoperative issues of sacral nerve stimulation for fecal incontinence and constipation: a systematic literature review and treatment guideline. *Dis Colon Rectum* 2011; 54(11):1443-60.
16. Thomas GP, Dudding TC, Rahbour G et al. Sacral nerve stimulation for constipation. *Br J Surg* 2013; 100(2):174-81.
17. Knowles CH, Thin N, Gill K et al. Prospective randomized double-blind study of temporary sacral nerve stimulation in patients with rectal evacuatory dysfunction and rectal hyposensitivity. *Ann Surg* 2012; 255(4):643-9.
18. Kamm MA, Dudding TC, Melenhorst J et al. Sacral nerve stimulation for intractable constipation. *Gut* 2010; 59(3):333-40.
19. Maeda Y, Lundby L, Buntzen S et al. Sacral nerve stimulation for constipation: suboptimal outcome and adverse events. *Dis Colon Rectum* 2010; 53(7):995-9.
20. Martellucci J, Naldini G, Carriero A. Sacral nerve modulation in the treatment of chronic pelvic pain. *Int J Colorectal Dis* 2012; 27(7):921-6.
21. Siegel S, Paszkiewicz E, Kirkpatrick C et al. Sacral nerve stimulation in patients with chronic intractable pelvic pain. *J Urol* 2001; 166(5):1742-5.
22. Leong RK, De WSG, Nieman FH et al. PNE versus 1st stage tined lead procedure: a direct comparison to select the most sensitive test method to identify patients suitable for sacral neuromodulation therapy. *Neurourol Urodyn* 2011; 30(7):1249-52.
23. Scheepens WA, Van KGA, De BRA et al. Long-term efficacy and safety results of the two-stage implantation technique in sacral neuromodulation. *BJU Int* 2002; 90(9):840-5.
24. Marcelissen TA, Leong RK, de BRA et al. Long-term results of sacral neuromodulation with the tined lead procedure. *J Urol* 2010; 184(5):1997-2000.
25. Borawski KM, Foster RT, Webster GD et al. Predicting implantation with a neuromodulator using two different test stimulation techniques: a prospective randomized study in urge incontinent women. *Neurourol Urodyn* 2007; 26(1):14-8.
26. Bannowsky A, Wefer B, Braun PM et al. Urodynamic changes and response rates in patients treated with permanent electrodes compared to conventional wire electrodes in the peripheral nerve evaluation test. *World J Urol* 2008; 26(6):623-6.
27. Baxter C, Kim JH. Contrasting the percutaneous nerve evaluation versus staged implantation in sacral neuromodulation. *Curr Urol* 2010; 11(5):310-4.
28. Leroi AM, Parc Y, Lehur PA et al. Efficacy of sacral nerve stimulation for fecal incontinence: results of a multicenter double-blind crossover study. *Ann Surg* 2005; 242(5):662-9.
29. National Institute for Clinical Evidence (NICE). Faecal incontinence: the management of faecal incontinence in adults. NICE clinical guideline 49. 2007. Available online at: <http://www.nice.org.uk/CG49>. Last accessed March, 2013.
30. Rao SS, American College of Gastroenterology Practice Parameters C. Diagnosis and management of fecal incontinence. American College of Gastroenterology Practice Parameters Committee. *Am J Gastroenterol* 2004; 99(8):1585-604.

31. American College of Obstetricians and Gynecologists (ACOG). Chronic pelvic pain: ACOG practice bulletin no. 51 2004 (reaffirmed 2008). Last accessed March, 2013.

Other References

1. Blue Cross and Blue Shield of Kansas Urology Liaison Committee, August 2009; August 2014.