

1) What CPT® code is most commonly billed for treating fecal incontinence utilizing the Acticon® device?

CPT® 46762 (Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter) is the most commonly billed code utilizing the Acticon device.

2) Are fecal incontinence treatments covered by Medicare, Medicaid and Commercial Payers?

Medicare covers items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

As a result, Medicare does not establish coverage policies for most services that are reasonable and necessary, i.e., appendectomy, colon resection, etc.

Along these lines, we wish to point out that most coverage policies which are established are developed and implemented by a Medicare Administrative Contractor (MAC) based on a local coverage determination (LCD). LCDs are most often developed to clarify the indications for a particular procedure.

Medicare Advantage Plans are required to provide the same as or better coverage than the traditional Medicare plan. Medicare Advantage Plans may have certain medical necessity items that must be met.

Medicaid coverage varies from state to state. It is recommended that you contact the Medicaid department in the appropriate state for specifics on their coverage and fee schedules and obtain prior authorization before a procedure is performed.

Commercial Payers may cover the Acticon procedure although some payers may have specific medical necessity requirements that need to be met. For example, Aetna considers the Acticon artificial bowel sphincter medically necessary for members 18 years of age or older with severe fecal incontinence who have failed, or are not candidates for medical interventions (e.g., pharmacotherapy, biofeedback, dietary management, strengthening exercises) or surgical sphincter repair (e.g., sphincteroplasty, post-anal repair or total pelvic floor repair). (See Clinical Policy Bulletin at Aetna.com)

3) Is prior authorization or pre-certification necessary for the anal sphincter procedure?

As a rule, Medicare does not require prior authorization for any procedure. Commercial or private insurance carriers (e.g., Aetna, Blue Cross, etc.) and some Medicare supplemental plans may require a prior authorization or precertification for surgical procedures. Therefore, it is recommended that you check with insurers (primary and secondary) to verify coverage and pre-certification requirements prior to performing any procedure.

4) What can be done if the patient is denied coverage by his health plan?

Patients should contact their insurance plan and request reconsideration. In addition, providers may appeal the denial and include a letter of medical necessity. Providers may contact the Health Care Affairs Department at 888-865-3373 for information on appeal assistance.

Disclaimer: While reasonable efforts have been made to ensure the accuracy of the information set forth, AMS, Inc. can not guarantee reimbursement for any product or procedure. Providers should report the codes that accurately describe the products and procedures furnished and the patient's medical condition. Providers should contact their payers if they have questions or need specific co-payment, coverage and billing/coding policies as well as to update the information described herein.

© January 2011 American Medical Systems, Inc.

Coding Resources:

1. CPT 2011. Current Procedural Terminology, Professional Edition. American Medical Association, Chicago, IL
2. Expert 2011: HCPCS Level II. Healthcare Common Procedure Coding System. American Medical Association. Ingenix, Salt Lake City, UT
3. EncoderPro.com. Ingenix, Inc. 2011, Salt Lake City, UT