Medical Affairs Policy

Service: Biofeedback Treatments and Devices
PUM 250-0003

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<tr>
<th>Medical Policy Committee Approval</th>
<th>03/17/17</th>
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<td>Effective Date</td>
<td>07/01/17</td>
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<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
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Note: Biofeedback is often a specific exclusion of the member’s certificate of coverage or treatment limits may apply.

Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

Description:

Biofeedback is a process used to teach individuals how to monitor and evaluate internal involuntary bodily functions (for example, respiration, blood pressure, muscle tension) and how to change these bodily functions through relaxation and similar techniques. Biofeedback therapy also involves use of electromyography (EMG), and biofeedback sensor devices that monitor physiologic function. Biofeedback has been proposed to treat a wide variety of conditions including asthma, addiction, chronic pain, bowel and bladder dysfunction, hypertension, and temporomandibular disorders.

Neurostimulation is also used to treat conditions treated with biofeedback. Neurostimulators are not biofeedback devices.

- For Percutaneous Tibial Nerve Stimulation (PTNS) and Sacral Nerve stimulation indications, see MCG.
- Pelvic floor neurostimulators are considered experimental, investigational, and unproven for urinary incontinence or dysfunction. See Non-Covered Services and Procedures Medical policy.

Although there is minimal peer-reviewed literature from controlled clinical trials, guidelines from medical professional organizations recommend biofeedback therapy for the treatment of constipation and incontinence in adults. The use of biofeedback for other conditions, the superiority of biofeedback over standard treatment for conditions, or for use in children is not supported by peer-reviewed literature from randomized controlled clinical trials. Various individual studies and evidenced based reviews of the literature
show that biofeedback may provide symptomatic improvement, the studies suffer from low quality and heterogeneity of the studies, involve different protocols of interventions, and various and different outcome measures. There is minimal evidence to provide recommendations for appropriate age to treat in children or the number of treatment sessions in adults or children.

**Indications of Coverage:**

A. Biofeedback is considered medically necessary in adults for constipation, fecal incontinence, or urinary incontinence when all the following criteria are met:

1. The patient is able to actively participate in the treatment, including being able to participate in home exercises

2. Correctable pathology does not exist that would prevent successful completion of the treatment

3. One of the following conditions is described:
   a. Sphincter or pelvic floor muscle wasting
   b. Intractable muscle spasms
   c. Abnormalities of spasticity, incapacitating muscle spasm, and/or muscle weakness of the involved muscles
   d. Need for pelvic floor retraining for urinary incontinence

B. Biofeedback for a child with dysfunctional voiding is considered medically necessary

C. Biofeedback for treatment of a behavioral health diagnosis (psychophysiological biofeedback), **if a covered benefit of the member’s health plan**, requires physician review.

D. Tension or migraine headache (**if a covered benefit of the member’s health plan**: AND Pharmacologic treatment inadequate or not indicated, due to **1 or more** of the following:

1. Deficient stress-coping skills that remain significant contributor to headache onset despite counseling of patient by a qualified professional
2. History of long-term, frequent, or excessive use of analgesic or medications that can aggravate headache
3. Insufficient or no response to multiple pharmacologic treatment attempts

4. Intolerance of multiple pharmacologic treatment attempts

5. Patient has preference for non-pharmacologic interventions

6. Pregnant or breast feeding patient

**Limitations of Coverage:**

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, deny as not medically necessary.

D. If a limit is not specified in the member’s certificate of coverage (health plan), more than **eight** sessions of biofeedback is considered not medically necessary.

E. EEG Biofeedback is considered experimental, investigational, and unproven to affect health outcomes.

F. Home biofeedback devices are considered not medically necessary as biofeedback training is best performed by a trained professional.

G. If used for fecal incontinence or constipation in children, deny as experimental, investigational, and unproven to affect health outcomes.

H. Intensive (more than one treatment per day) and/or inpatient biofeedback is considered not medically necessary.

**Documentation Required:**

- Office notes
References:


9. Wisconsin Physicians Service Medicare Local Coverage Determination (LCD) for Biofeedback. LCD PHYS-066. Revision effective date: 10/01/2010. Available at:


22. UpToDate Management of chronic constipation in adults. Literature review current through Jan 2017. Topic last updated Feb 1, 2017


**WPS / Arise Review History:**

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➢ Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin

*Approved by the Medical Director*