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Northwest Region Utilization Review
UR 50: Biofeedback Medical Necessity Criteria

Department: Non-Behavioral Health
Section: KPNW Region
Applies to: KPNW Region
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Number: UR 50
Effective: 12/08
Last Reviewed: 10/22, 9/26
Last Revised: 9/23, 8/24, 9/25

DEFINITIONS

Biofeedback (BFB) is a form of complementary or alternative medicine that measures a person's bodily processes and conveys such information in real time in order to raise the person's awareness and conscious control of the related physiological activities.

Coverage guidance: Biofeedback may be excluded from coverage. Check CM for exclusions or limitations.

Source	Policy
For Medicare Members	
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	30.1 "Biofeedback Therapy" 30.1.1 "Biofeedback Therapy for the Treatment of Urinary Incontinence"
Local Coverage Determinations (LCD)	None
Local Coverage Article	None
Kaiser Permanente Medical Policy for Medicare Members	UR 50 does not apply. For Medicare lines of business, apply the criteria in the NCDs to determine medical necessity.
For Medicaid Members	
OR Medicaid	UR 50 does not apply.
WA Medicaid	UR 50 does not apply
Commercial and Self-Funded Members	
OR Commercial	UR 50 applies
WA Commercial	UR 50 applies
Self-Funded Plans	UR 50 applies

CRITERIA FOR THE *INITIATION* OF BIOFEEDBACK

Biofeedback may be indicated for **1 or more** of the following:

1) Tension or migraine headache AND pharmacologic treatment is inadequate or not indicated by reason of **1 or more** of the following:
    a) insufficient or no response to multiple pharmacological (medication) treatment attempts
    b) intolerance of multiple pharmacologic treatment attempts
    c) patient has a preference for nonpharmacologic interventions

d) history of long-term, frequent, or excessive use of analgesic (pain medication) or medications that can aggravate headache
e) deficient stress-coping skills that remain a significant contributor to headache onset despite counseling of the patient by a qualified professional
f) pregnant patient
g) breast-feeding patient
h) patient attempting to become pregnant

2) Dyssynergic (muscle incoordination) constipation in adults as indicated by **ALL** of the following:
   a) evidence of dyssynergic constipation as indicated by **ONE or more** of the following:
      i) anorectal manometry shows dyssynergic motor pattern
      ii) non-relaxing puborectalis muscle (responsible for controlling bowel movements) while straining to expel the index finger during a rectal digital examination or paradoxic movement of pelvic floor on digital examination
      iii) proctography evidence of non-relaxing puborectalis
      iv) prolonged delay in transit time (greater than 20% retention of radiopaque markers 5 days after ingestion)
      v) prolonged expulsion of simulated stool (i.e. balloon expulsion test greater than one minute)
      vi) internal prolapse
      vii)levator spasm/proctalgia fugax
   b) inadequate response to diet, laxatives, exercise, or hydration therapy for constipation
   c) no finding of significant obstruction or partial obstruction on colonoscopy or barium enema
   d) no evidence of hypothyroidism
   e) no use of drugs known to be constipating (i.e. narcotic pain medications)

3) Stress and/or urge urinary incontinence (inability to control urination) in females and males as indicated by **ALL** of the following:
   a) the patient is cognitively (mentally) intact
   b) the patient has failed a trial of pelvic muscle exercise (PME) training. A failed trial is defined as one in which there is no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PMEs to increase periurethral muscle strength (responsible for controlling urination).

4) Voiding dysfunction/dyssynergia (muscle incoordination) in children, 5-18 years old, when indicated by **ALL** of the following:
   a) the patient is cognitively intact
   b) the patient has no spinal cord abnormalities that would interfere with normal voiding
   c) the patient has been evaluated by a Kaiser Permanente pediatric urologist who is recommending biofeedback based on **ALL** of the following:
      i) a failed trial of timed voiding
      ii) if patient is $\geq$12 years of age, a failed trial of proper relaxation techniques during voiding.
      iii) if patient is $\geq$16 years of age, a failed trial of pelvic floor exercises.
      iv) evidence of significant dyssynergia based on pelvic floor EMG during the active phase of voiding (EMG/electromyography tests the electrical activity of muscles).

Examples of voiding dysfunction/dyssynergia include: dysfunctional elimination syndrome (DES), detrusor/sphincter dyssynergia, vesicoureteric reflux, pelvic floor dysfunction.

5) Fecal incontinence when **ALL** of the following exist:
    a) documentation of a treatment plan including goals and frequency of treatment
    b) the patient is motivated to actively participate in the treatment plan and is responsive to care plan requirements
    c) the patient is cognitively intact and deemed capable of participating in the treatment plan by the consulting physician
    d) the patient has some degree of rectal sensation and can voluntarily contract the external anal sphincter as determined by either manometry OR physical exam findings
    e) the patient does not have existing pathology that would prevent treatment completion.

6) The following pain related conditions when at least two appropriate treatment modalities have been tried and failed:
    a) temporo-mandibular joint syndrome (NOTE: TMJ services may be a benefit exclusion)
    b) cancer pain
    c) cervical (neck) strain

7) Muscle re-education of specific muscle groups when **ALL** of the following are met:
    a) the patient has one or more of the following:
        i. pathological muscle abnormalities of spasticity
        ii. incapacitating muscle spasm
        iii. muscle weakness
    b) conventional treatments (heat, cold, massage, exercise, support) have not been successful

CRITERIA FOR THE *CONTINUATION* OF BIOFEEDBACK

Treatment progress must be clearly documented in an updated plan of care/current progress summary at the end of each authorization period and/or when additional visits are being requested. Progress Note Documentation must include the following:

1. Current and previous level of functioning, including:
    - Objective tests or measurements of physical function
    - A description of the member's current level of functioning or impairment
2. Identification of any health conditions which could impede the member's ability to benefit from treatment
3. Objective measures of the member’s functional progress relative to each treatment goal, and a comparison to the previous progress report
4. Summary of member’s response to biofeedback, with documentation of any issues which have limited progress
5. Documentation of member’s participation in treatment as well as member/caregiver participation or adherence with a home exercise program (HEP), when applicable
6. Brief prognosis statement with clearly established discharge criteria
7. An explanation of any significant changes to the member’s plan of care and the clinical rationale for revising the plan of care
8. Recommended treatment techniques and/or modalities, their anticipated frequency and duration

CRITERIA FOR *DISCHARGE*

A member will be discharged from therapy when **any** of the following occurs:

1. Member no longer demonstrates functional impairment or has achieved goals set forth in the POC or has returned to their prior level of function
2. Member has adapted to impairment with assistive/adaptive equipment or devices
3. Member has been receiving services over an extended period of time and it cannot be determined whether the progress is due to therapeutic intervention or natural development, services can be discontinued.
4. Member is unable to participate in the plan of care due to medical, psychological, or social, complications
5. Member (and/or family/caregiver) is non-compliant with Home Exercise Program and/or lacks participation in scheduled therapy appointments

CLINICAL

Bogaards MC, ter Kuile MM. Treatment of recurrent tension headache: A meta-analytic review. Clin J Pain. 1994;10(3):174-190.

Vasconcelos M, Lima E, Caiafa L et al. Voiding dysfunction in children; pelvic-floor exercises or biofeedback therapy; a randomized study. Pediatr Nephrol. 2006 Dec;21(12):1858-64.

Kibar Y, Ors O, Demir E et al. Results of biofeedback treatment on reflux resolution rates in children with dysfunctional voiding and vesicoureteral reflux. Urology. 2007 Sep;70(3):563-7.

Barroso U Jr, Lordelo P, Lopes AA et al. Nonpharmacological treatment of lower urinary tract dysfunction using biofeedback and transcutaneous electrical stimulation: a pilot study. BJU Int. 2006 Jul;98(1):166-71.

Yagci S, Kibar Y, Akay O et al. The effect of biofeedback treatment on voiding and urodynamic parameters in children with voiding dysfunction. J Uro. 2005 Nov;174(5):1994-8.