Medical Policy
Biofeedback as a Treatment of Fecal Incontinence or Constipation

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Policy Number: 308
BCBSA Reference Number: 2.01.64
NCD/LCD: National Coverage Determination (NCD) for BIOFEEDBACK Therapy (30.1)

Related Policies
- Transanal Radiofrequency Treatment of Fecal Incontinence, #210
- Sacral Nerve Neuromodulation/Stimulation for Pelvic Floor Dysfunction, #153
- Biofeedback as a Treatment of Urinary Incontinence, #173

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Biofeedback for constipation in adults may be MEDICALLY NECESSARY for patients with dyssynergia-type constipation as demonstrated by meeting all 3 of the following criteria:
1. Symptoms of functional constipation that meet ROME III criteria
2. Objective physiologic evidence of pelvic floor dyssynergia demonstrated by inappropriate contraction of the pelvic floor muscles or less than 20% relaxation of basal resting sphincter pressure by manometry, imaging or EMG;
3. Failed a 3-month trial of standard treatments for constipation including laxatives, dietary changes, and exercises (as many of the previous as are tolerated).

Note: Rome III diagnostic criteria for functional constipation*
1. Must include two or more of the following:
   a. Straining during at least 25% of defecations
   b. Lumpy or hard stools in at least 25% of defecations
   c. Sensation of incomplete evacuation for at least 25% of defecations
   d. Sensation of anorectal obstruction/blockage for at least 25% of defecations
   e. Manual maneuvers to facilitate at least 25% of defecations (e.g., digital evacuation, support of the pelvic floor)
   f. Fewer than three defecations per week
2. Loose stools are rarely present without the use of laxatives
3. Insufficient criteria for irritable bowel syndrome
* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis
Rome III diagnostic criterion for dyssynergic defecation:
Inappropriate contraction of the pelvic floor or less than 20% relaxation of basal resting sphincter pressure with adequate propulsive forces during attempted defecation.

**Guidance on Biofeedback Protocol**
The recommended treatment course for patients with constipation who meet criteria is up to 6 biofeedback sessions over 3 months.

Biofeedback is considered **INVESTIGATIONAL** as a treatment of constipation in adults and children in all other situations.

Biofeedback is considered **INVESTIGATIONAL** as a treatment of fecal incontinence in adults and children.

**Medicare HMO Blue℠ and Medicare PPO Blue℠ Members**
BCBSMA covers biofeedback as a treatment of fecal incontinence and constipation for the following indications for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:
- When it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups, or
- For treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm; or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful.

BCBSMA does not cover biofeedback as a treatment of fecal incontinence for the following indication for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:
- The treatment of ordinary muscle tension states or for psychosomatic conditions.

**National Coverage Determination (NCD) for BIOFEEDBACK Therapy (30.1)**

**Prior Authorization Information**
Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required for outpatient services.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Commercial Managed Care (HMO and POS)</th>
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<tr>
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<td>Commercial PPO and Indemnity</td>
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**CPT Codes / HCPCS Codes / ICD Codes**
Inclusion or exclusion of a code 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 as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**CPT Codes**

<table>
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<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tr>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes</td>
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</tbody>
</table>
Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes.

Biofeedback training by any modality

Biofeedback training, perineal muscles, anorectal, or urethral sphincter, including EMG and/or manometry

**ICD-9 Diagnosis Coding**

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<th>Code Description</th>
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<tr>
<td>564.02</td>
<td>Outlet dysfunction constipation</td>
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<tr>
<td>787.61</td>
<td>Incomplete defecation</td>
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**ICD-10 Diagnosis Codes**

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**ICD-10 Procedure Codes**

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<th>ICD-10-PCS procedure codes:</th>
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<td>GZC9ZZZ</td>
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**Description**

Biofeedback, a technique intended to teach patients self-regulation of certain physiologic processes not normally considered to be under voluntary control, is used for various conditions and is proposed as a treatment of fecal incontinence and constipation.

Fecal incontinence in adults is the recurrent uncontrolled passage of fecal material. Pathophysiology of the disorder ranges from abnormalities in intestinal motility (diarrhea or constipation) to poor rectal compliance, impaired rectal sensation, or weak or damaged pelvic floor muscles. There is no increase in mortality attributable to fecal incontinence. Morbidity includes skin breakdown and urinary tract infections. Fecal incontinence may affect quality of life through restricting work, recreation, and activities related to “getting out of the house,” impaired social role function, diminished sexual activity, and increase of social isolation due to embarrassment. Fecal incontinence can bring about loss of independence and mobility. It is the second most common reason for elderly institutionalization. The most common causes of fecal incontinence in adults are obstetric trauma coupled with age-related degeneration, previous anorectal surgery, rectal prolapse, and perineal trauma. In many individuals, the condition is multifactorial, involving a combination of structural, physiological, and psychosocial factors. Conventional interventions to treat fecal incontinence include dietary recommendations (e.g., fiber), bowel and toilet scheduling, and medications (e.g., bulking or antidiarrheal agents).

Constipation refers to infrequent bowel movements and difficulty expelling stool during defecation. Primary constipation is generally categorized into 3 groups. The most common type is normal-transit constipation in which there is a normal rate of stool movement, but patients feel constipated and may complain of abdominal pain and/or bloating. In the second type, slow-transit constipation, stool moves more slowly through the colon and individuals often experience a limited urge to defecate. The third type, dyssynergic defecation, refers to a loss of ability to coordinate contractions of the pelvic floor muscles and to relax the anal sphincter during defecation. Patients often report an inability to defecate despite the urge to do so. There are also secondary causes of constipation such as the use of certain medications,
including opioids and psychoactive drugs; neurologic, endocrine, or metabolic disorders; structural abnormalities; and lifestyle factors. Conventional treatment includes dietary changes (ie, adequate fiber and fluid intake), use of supplemental bulking substances, exercises, and medications. In children, most cases of fecal incontinence and constipation are functional, in which structural, endocrine, or metabolic diseases have been ruled out. Factors contributing to functional incontinence and constipation are fear and/or pain associated with large, hard stools. This leads to retentive posturing in approximately half the children with chronic constipation (ie, the avoidance of defecation by purposefully contracting the external anal sphincter, also termed anismus or paradoxical sphincter contraction). Customary or conventional medical intervention includes dietary changes, bowel and toilet scheduling, softening agents, and education. Behavioral interventions aim at restoring normal bowel habits through toilet training, reward and incentive contingency management programs, desensitization of phobia and fear, or skill-building and goal-setting techniques with home practice. Counseling and psychotherapy provide support to the child and address social and psychological problems.

Biofeedback training for fecal incontinence focuses on improving the ability to voluntarily contract the external anal sphincter and puborectalis muscles in response to rectal filling and to decrease delay in response to a sensation of distension. For constipation, the aim of biofeedback is to teach patients how tighten and relax their external anal sphincter in order to pass bowel movements. Biofeedback attempts to improve rectal sensory perception, strength, coordination, or some combination of these 3 components. Sensory training involves inducing intrarectal pressure using a balloon feedback device. A manometric balloon probe is inserted into the rectum, and the balloon is filled with air to produce a sensation of rectal filling. Strength training uses either anal canal pressure (manometric) or intra-anal electromyography (EMG) feedback of pelvic floor muscles (PFM). The purpose is to strengthen the force of the PFM contraction without including rectal distention. Some training increases endurance (duration of external anal sphincter contraction) as well as peak strength. Coordination training uses pressure feedback of intrarectal balloon distention with a water-perfused catheter or Schuster-type balloon probe and PFM contractions in a simultaneous feedback display. The purpose of coordination training is to synchronize the contraction of the external anal sphincter with relaxation of the internal anal sphincter.

Biofeedback techniques convert the physiologic measures from an intra-anal EMG sensor, anal manometric probe (measuring intra-anal pressure), or perianal surface EMG electrodes to either visual or audio display for feedback. Ultrasound has also been used to show patients’ contraction of the anal sphincter on a screen. Biofeedback training is done alone, or in combination with other behavioral therapies designed to teach relaxation. Training sessions are performed in a quiet, nonarousing environment.

**Summary**

Biofeedback is a technique to teach patients self-regulation of physiological processes not generally considered to be under voluntary control; a variety of approaches and devices are available. Among other possible indications, biofeedback is proposed as a treatment of fecal incontinence and constipation. The evidence for biofeedback in patients who have fecal incontinence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. Whereas 1 RCT found that there was a significantly greater decrease in fecal incontinence symptoms with biofeedback plus exercise training than with exercise training alone, most trials did not show a significant benefit. Systematic reviews have not found that biofeedback provides additional benefit when offered in conjunction with conventional therapy compared with conventional therapy alone. The evidence is insufficient to determine the effects of the technology on health outcomes.

The evidence for biofeedback in patients who have dyssynergia-type constipation includes RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. Several well-conducted RCTs focusing on patients with dyssynergia-type constipation have reported benefits in a subgroup of patients meeting well-defined criteria. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.
The evidence for biofeedback in patients who have constipation other than dyssynergia-type constipation includes RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. A systematic review of RCTs found a benefit of biofeedback as a treatment of constipation in adults. Conclusions of the systematic review were limited by variability in patient populations, comparison groups, and outcome measures and biofeedback was not clearly beneficial for any other type of constipation. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

<table>
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<tr>
<td>12/2016</td>
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<td>1/2016</td>
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<td>3/2015</td>
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<td>5/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
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<tr>
<td>1/2014</td>
<td>Coding information clarified.</td>
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<tr>
<td>7/2013</td>
<td>BCBSA National medical policy review.</td>
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<td>New medically necessary indications described; investigational statement on constipation modified. Effective 7/1/2013.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References

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