Clinical Review Criteria Related to Biofeedback for Urinary Diagnoses

I. Criteria for Approval

A. Biofeedback is considered medically necessary for stress and/or urge incontinence in cognitively intact persons. Biofeedback is used in combination with pelvic muscle exercises to aid in strengthening the pelvic muscles that control urinary continence resulting in reduction of symptoms associated with urinary incontinence.

B. In-plan Gynecologists and GYN urologists are required to notify Minuteman Health, Inc. (MHI) of this service. All other providers in or out of plan must meet ALL the following criteria:

1. Diagnosis of urinary urge incontinence, urgency-frequency syndrome, and urinary retention.

2. Failed a documented four-week trial of pelvic muscle exercise training (PME).

3. The patient is motivated to actively participate in the treatment plan, including being responsive to the care plan requirements such as practice and follow–through at home.

The patient is cognitively intact and is physically capable of participating in the treatment plan, training is performed one on one, with face–to-face involvement with the member and practitioner

II. Required Documentation

A. Documentation of unsuccessful past treatments: pharmacological, physical therapy and/or exercise treatments.

B. The plan of care should include: goals of therapy and measurable objectives.

III. What is Not Covered

A. Patients with urinary obstruction, neurogenic bladder and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.

B. Home use of biofeedback is not covered.
IV. CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

CPT Codes
90901 Biofeedback training by any modality  
90911 Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or Manometry

ICD 10 Codes
N36.42 Intrinsic sphincter deficiency (ISD)  
N39.3 Stress incontinence (female)  
R32 Unspecified urinary incontinence  
N39.41 Urge incontinence  
N39.3 Stress incontinence (female) (male)  
N39.46 Mixed incontinence

HCPCS Codes
E0746 Electromyography (EMG), biofeedback device

V. References

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A

(Last Accessed 3/3/17)

(Last Accessed 3/3/17)

(Last Accessed 3/3/17)
VI. Summary of Changes

06/29/2017

- III., What is Not Covered: Added B.: Home use of biofeedback is not covered.
- Added new disclaimer, updated references and last accessed dates

VII. Review Dates

MHI Review Dates: 1/1/14, 10/23/14, 10/7/15, 6/30/16, 06/29/2017
Medical Guideline Disclaimer
The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member’s benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.