MASSACHUSETTS

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Medical Policy

Biofeedback as a Treatment of Fecal Incontinence or Constipation

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Policy Number: 308

BCBSA Reference Number: 2.01.64 (For Plan internal use only)

Related Policies

- 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 individuals with dyssynergia-type constipation as demonstrated by meeting all 3 of the following criteria:

1. Symptoms of functional constipation that meet ROME IV 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).

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.

Policy Guidelines

Rome IV diagnostic criteria for functional constipation[a]

1. Must include two or more of the following[b]:
   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.

[a] Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis
[b] For research studies, patients meeting criteria for opioid-induced constipation should not be given a diagnosis of functional constipation because it is difficult to distinguish between opioid side effects and other causes of constipation. However, clinicians recognize that these 2 conditions might overlap.

Rome IV 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.[c]

[c]These criteria are defined by age- and sex-appropriate normal values for the technique.

Guidance on Biofeedback Protocol
The recommended treatment course for patients with constipation who meet criteria is up to 6 biofeedback sessions over 3 months. This is consistent with the protocol used in key randomized trials showing benefit of biofeedback for selected patients.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.

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

CPT codes:	Code Description
90875	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
90876	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 45-50 minutes
90901	Biofeedback training by any modality
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
K59.02	Outlet dysfunction constipation
R15.0	Incomplete defecation

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
GZC9ZZZ	Biofeedback

Description

Fecal Incontinence and Constipation

Adults

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 the quality of life by 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 the 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 (eg, fiber), bowel and toilet schedules, and medications (eg, bulking or antidiarrheal agents).

Constipation refers to infrequent bowel movements and difficulty expelling stool during defecation. Primary constipation is 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, the 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.

Children

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 to restore 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
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.

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 the delay in response to a sensation of distension. For constipation, biofeedback aims to teach patients how to tighten and relax their external anal sphincter 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 feedback of pelvic floor muscles. The purpose is to strengthen the force of the pelvic floor muscle 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 pelvic floor muscle contractions in a simultaneous feedback display. The purpose of coordination training is to synchronize the contraction of the external anal sphincter with the relaxation of the internal anal sphincter. Biofeedback techniques convert the physiologic measures from an intra-anal electromyography sensor, anal manometric probe (measuring intra-anal pressure), or perianal surface electromyography electrodes to either a 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

Description
Biofeedback is a technique to teach individuals self-regulation of physiological processes not generally considered to be under voluntary control; a variety of approaches and devices are available. Among possible indications, biofeedback is proposed as a treatment for fecal incontinence and constipation.

Summary of Evidence
For individuals who have fecal incontinence who receive biofeedback, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life (QOL). One RCT reported a significantly greater decrease in fecal incontinence symptoms with biofeedback plus exercise training compared with exercise training alone; however, most trials have not shown a significant benefit. Systematic reviews have not found that biofeedback plus conventional therapy provides an additional benefit compared with conventional therapy alone. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have constipation other than dyssynergia-type constipation who receive biofeedback, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and QOL. A systematic review of RCTs found a benefit of biofeedback as a treatment for constipation in adults. Conclusions of the systematic review were limited by variability in patient populations (which combined both dyssynergia-type and non-dyssynergia-type), comparator groups, and outcome measures, and biofeedback was not clearly beneficial for nondyssynergia types of constipation. One systematic review conducted in children also found no clear benefit of biofeedback when added to medical management, and a second systematic review could not make a strong conclusion about the efficacy of biofeedback due to a low quality of evidence. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have dyssynergia-type constipation who receive biofeedback, the evidence includes RCTs and 2 systematic reviews. Relevant outcomes are symptoms, functional outcomes, and QOL. 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 that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
1/2025	Annual policy review. Policy updated with literature review through October 2, 2024; references added. Policy statements unchanged.
1/2024	Annual policy review. Policy updated with literature review through September 22, 2023; reference added. Minor editorial refinements to policy statements; intent unchanged.
1/2023	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
1/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2020	Clarified coding information.
1/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
12/2016	Annual policy review. New references added.
1/2016	Annual policy review. New references added.
3/2015	Annual policy review. New references added.
5/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
4/2014	Annual policy review. New references added.
1/2014	Coding information clarified.
7/2013	Annual policy review. New medically necessary indications described; investigational statement on constipation modified. Effective 7/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
10/2011	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
1/21/2011	New policy effective 1/21/2011 describing covered and non-covered indications.

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

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