



MASSACHUSETTS

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Medical Policy Neurofeedback

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Policy Number: 515

BCBSA Reference Number: 2.01.28 (For Plan internal use only)

NCD/LCD: N/A

Related Policies

- Biofeedback as a Treatment of Chronic Pain [#210](#)
- Biofeedback as a Treatment of Fecal Incontinence or Constipation [#308](#)
- Biofeedback as a Treatment of Urinary Incontinence [#173](#)
- Biofeedback for Miscellaneous Indications [#187](#)
- Biofeedback for the Treatment of Headache [#152](#)
- Quantitative Electroencephalography as a Diagnostic Aid for Attention-Deficit/Hyperactivity Disorder, [#554](#)

Policy

**Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Neurofeedback is considered [INVESTIGATIONAL](#).

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)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO BlueSM	This is not a covered service.
Medicare PPO BlueSM	This is not a covered service.

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; approx 20-30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy; approx 45-50 minutes
90901	Biofeedback training by any modality

Description

Disorders of the Central Nervous System

Various disorders involve abnormal brain activity, including autism spectrum disorder, insomnia and sleep disorders, learning disabilities, Tourette syndrome, traumatic brain injury, seizure disorders, premenstrual dysphoric disorder, menopausal hot flashes, depression, stress management, panic and anxiety disorders, posttraumatic stress disorder, substance abuse disorders, eating disorders, migraine headaches, stroke, Parkinson disease, fibromyalgia, tinnitus, and attention-deficit/hyperactivity disorder (ADHD).

Treatment

Neurofeedback is being investigated for the treatment of a variety of disorders. Neurofeedback may be conceptualized as a type of biofeedback that has traditionally used the electroencephalogram (EEG) as a source of feedback data. Neurofeedback differs from established forms of biofeedback in that the information fed back to the patient (via EEG tracings, functional magnetic resonance imaging, near-infrared spectroscopy) is a direct measure of global neuronal activity, or brain state, compared with feedback of the centrally regulated physiologic processes, such as tension of specific muscle groups or skin temperature. The patient may be trained to increase or decrease the prevalence, amplitude, or frequency of specified EEG waveforms (eg, alpha, beta, theta waves), depending on the changes in brain function associated with the particular disorder. It has been proposed that training of slow cortical potentials (SCPs) can regulate cortical excitability and that using the EEG as a measure of central nervous system functioning can help train patients to modify or control their abnormal brain activity. Upregulating or downregulating neural activity with real-time feedback of functional magnetic resonance imaging signals is also being explored.

Two EEG-training protocols (training of SCPs, theta/beta training) are typically used in children with ADHD. For training of SCPs, surface-negative and surface-positive SCPs are generated over the sensorimotor cortex. Negative SCPs reflect increased excitation and occur during states of behavioral or cognitive preparation, while positive SCPs are thought to indicate a reduction of cortical excitation of the underlying neural networks and appear during behavioral inhibition. In theta/beta training, the goal is to decrease activity in the EEG theta band (4 to 8 Hz) and increase activity in the EEG beta band (13 to 20 Hz), corresponding to an alert and focused but relaxed state. Alpha-theta neurofeedback is typically used in studies on substance abuse. Neurofeedback protocols for depression focus on alpha interhemispheric asymmetry and theta/beta ratio within the left prefrontal cortex. Neurofeedback for epilepsy has focused on sensorimotor rhythm up-training (increasing 12 to 15 Hz activity at motor strip) or altering SCPs. It has been proposed that learned alterations in EEG patterns in epilepsy are a result of operant conditioning and are not conscious or voluntary. A variety of protocols have been described for the treatment of migraine headaches.

Summary

Description

Neurofeedback describes techniques for providing feedback about neuronal activity, as measured by electroencephalogram biofeedback, functional magnetic resonance imaging, or near-infrared spectroscopy, to teach patients to self-regulate brain activity. Neurofeedback may use several techniques in an attempt to normalize unusual patterns of brain function in patients with various psychiatric and central nervous system disorders.

Summary of Evidence

For individuals who have attention-deficit/hyperactivity disorder (ADHD) who receive neurofeedback, the evidence includes randomized controlled trials (RCTs) and meta-analyses. Relevant outcomes are symptoms, functional outcomes, and quality of life. Several meta-analyses and at least 5 additional moderately sized RCTs (n range, 144 to 202 patients) have compared neurofeedback with methylphenidate, biofeedback, cognitive behavioral therapy, cognitive training, physical activity, or sham neurofeedback. Collectively, these studies found either small or no benefit of neurofeedback. A meta-analysis also found no effect of neurofeedback on objective measures of attention and inhibition. Studies that used active controls have suggested that at least part of the effect of neurofeedback may be due to attention skills training, relaxation training, and/or other nonspecific effects. Also, the beneficial effects of neurofeedback are more likely to be reported by evaluators unblinded to treatment (parents) than by evaluators blinded to treatment (teachers), suggesting bias in the nonblinded evaluations. Additional research with blinded evaluation of outcomes is needed to demonstrate the effect of neurofeedback on ADHD. However, the completion dates for some registered trials of neurofeedback in ADHD have passed without publication of results, suggesting the potential for publication bias. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have disorders other than ADHD (eg, chronic insomnia, epilepsy, substance abuse, pediatric brain tumors, and post-traumatic stress disorder) who receive neurofeedback, the evidence includes case reports, case series, comparative cohorts, small RCTs, and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and quality of life. For these other disorders, including psychiatric, neurologic, and pain syndromes, the evidence is poor, and several questions concerning clinical efficacy remain unanswered. Larger RCTs that include either a sham or active control are needed to evaluate the effect of neurofeedback for these conditions. However, the completion dates for some registered trials of neurofeedback in disorders other than ADHD have passed without publication of results, suggesting the potential for publication bias. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
8/2024	Annual policy review. Policy updated with literature review through April 26, 2024; references added. Policy statements unchanged.
8/2023	Annual policy review. References added. Policy statements unchanged.
8/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
8/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
8/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
7/2018	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2017	Annual policy review. New references added.
3/2016	Annual policy review. New references added.
8/2015	Annual policy review. New references added.
9/2014	Annual policy review. New references added.
10/2013	Annual policy review. New references added.

11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
2/2011	Reviewed - Medical Policy Group – Psychiatry and Ophthalmology. No changes to policy statements.
1/2011	Reviewed - Medical Policy Group – Neurology and Neurosurgery. No changes to policy statements.
12/3/2010	New policy describing ongoing non-coverage.

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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