

Biofeedback

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[Instructions for Use](#)

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Related Medicare Advantage Policy Guidelines
<ul style="list-style-type: none"> Biofeedback Therapy (NCD 30.1) Biofeedback Therapy for the Treatment of Urinary Incontinence (NCD 30.1.1)

Coverage Guidelines

Biofeedback is covered in accordance with Medicare coverage criteria.

Biofeedback therapy is covered only 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. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

Refer to the [NCD for Biofeedback Therapy \(30.1\)](#). (Accessed May 27, 2021)

Biofeedback for the treatment of stress and/or urge urinary incontinence is covered when criteria are met. Refer to the:

- [NCD for Biofeedback Therapy for the Treatment of Urinary Incontinence \(30.1.1\)](#). (Accessed May 27, 2021)
- Coverage Summary titled [Urinary and Fecal Incontinence, Diagnosis and Treatments](#)

Home use of biofeedback is not covered. Refer to the [NCD for Biofeedback Therapy for the Treatment of Urinary Incontinence \(30.1.1\)](#). (Accessed June 3, 2020)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. (Accessed May 27, 2021)

Policy History/Revision Information

Date	Summary of Changes
06/14/2021	<ul style="list-style-type: none"> Routine review; no change to coverage guidelines Archived previous policy version MCS006.01

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy

and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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