Biofeedback is considered **investigational** as a treatment of **any** of the following miscellaneous conditions:

- Anxiety disorders
- Asthma
- Bell palsy
- Depression
- Hypertension
- Insomnia
- Movement disorders, such as motor function after stroke, injury, or lower-limb surgery
- Multiple sclerosis
- Orthostatic hypotension in patients with spinal cord injury
- Pain management during labor
- Posttraumatic stress disorder
- Prevention of preterm birth
- Raynaud disease
- Sleep bruxism
- Tinnitus

**Policy Guidelines**

**Coding**

Biofeedback for miscellaneous indications may be billed with the following CPT and HCPCS codes:

- **90901**: Biofeedback training by any modality
- **E0746**: Electromyography (EMG), biofeedback device

**Note:** Some Blue Shield of California (BSC) plans exclude coverage of biofeedback. Please check benefit plan descriptions for details. Biofeedback may be covered for some indications such as migraine headaches and constipation related to dyssynergia (see Related Policies section below).

**Biofeedback devices:** Unsupervised home use of a biofeedback device has not been well studied, and further is excluded from coverage per Blue Shield Evidence of Coverage (EOC) General Exclusions and Limitations.

**Description**

Biofeedback is a technique intended to teach patients self-regulation of certain physiologic processes that are otherwise impossible or extremely difficult to control. This review focuses on the use of biofeedback for treating miscellaneous indications—specifically, indications other than urinary and fecal incontinence, headache, and chronic pain.

**Related Policies**

- Biofeedback as a Treatment of Chronic Pain
- Biofeedback as a Treatment of Fecal Incontinence or Constipation
- Biofeedback as a Treatment of Headache
- Biofeedback as a Treatment of Urinary Incontinence in Adults
Biofeedback for Miscellaneous Indications

- Neurofeedback
- Treatment of Tinnitus

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

**Regulatory Status**

A large number of biofeedback devices have been cleared through the U.S. Food and Drug Administration’s 510(k) process since 1976.

**Rationale**

**Background**

Biofeedback is a technique intended to teach patients self-regulation of certain unconscious or involuntary physiologic processes. Biofeedback equipment converts physiological signals into outputs given to patients. The technique involves the feedback of a variety of types of information not usually available to the patient, followed by a concerted effort on the part of the patient to use this feedback to help alter the physiologic process in a specific way.

Biofeedback has been proposed as a treatment for a variety of diseases and disorders including anxiety, headaches, hypertension, movement disorders, incontinence, pain, asthma, Raynaud disease, and insomnia. The type of feedback used in an intervention (e.g., visual, auditory) depends on the nature of the disease or disorder being treated. This evidence review focuses on the use of biofeedback for the treatment of hypertension, anxiety, insomnia, asthma, movement disorders (e.g., motor function after stroke, injury, or lower-limb surgery), and other miscellaneous applications (i.e., conditions not addressed in other evidence reviews on biofeedback).

In addition, this evidence review focuses on biofeedback devices that measure and provide information on the physiologic processes such as heart rate, muscle tension, skin temperature, and blood flow. Electroencephalographic biofeedback, also called neurofeedback, which measures brainwave activity, is addressed elsewhere.

**Literature Review**

This review was informed by a 1995 Blue Cross Blue Shield Association Technology Evaluation Center (TEC) Assessment, which concluded that the evidence was insufficient to demonstrate the effectiveness of biofeedback for treatment of 9 conditions: anxiety disorders, headaches, hypertension, movement disorders, incontinence, pain, asthma, Raynaud disease, and insomnia.¹

Psychological treatments involve both nonspecific and specific therapeutic effects. Nonspecific effects (sometimes called placebo effects) occur as a result of therapist contact, positive expectancies on the part of the subject and the therapist, and other beneficial effects that occur as a result of being a patient in a therapeutic environment. Specific effects are those that occur only because of the active treatment, above any nonspecific effects that may be
present. This review focuses on identifying evidence that isolates the specific effect of biofeedback, apart from the nonspecific placebo effects. Because an ideal placebo control is problematic with psychological treatments and because treatment of chronic pain is typically multimodal, isolating the specific contribution of biofeedback is difficult. An ideal study design would be a randomized controlled trial (RCT) comparing biofeedback with a sham intervention; an alternative design would be an RCT comparing an intervention, such as exercise, with and without the addition of biofeedback. The following is a summary of the key literature to date.

### Anxiety Disorders

#### Systematic Reviews

In 2017, Goessl et al published a meta-analysis on the effect of heart rate variability (HRV) biofeedback training on patients with stress and anxiety. HRV is a measure of cardiac vagal tone. Low HRV is associated with certain psychological states such as anxiety. The literature search identified 24 studies (total N=484 patients), published between 1976 and 2015, for inclusion. Sample sizes ranged from 5 to 106 patients (median, 14 patients). The Cochrane risk of bias tool was used to assess study quality. Many studies had high or unclear risk of bias due to the following factors: inadequate randomization descriptions, improper randomization, undescribed allocation concealment, and missing data that was either not described or mishandled; 13 studies included a comparison group (6 waitlist, 3 standard of care, 2 sham, 1 daily thought record, 1 progressive muscle relaxation). The average within-group effect size among the 24 studies, measured by Hedges' $g$, was 0.81, indicating a large effect on anxiety. The average between-group effect size among the 13 studies with comparators, also measured by Hedges’ $g$, was 0.83, indicating HRV had a larger effect on anxiety than the comparators.

In 2014, the Canadian Agency for Drugs and Technology in Health published a rapid response report on biofeedback for treating mood and anxiety disorders. Their systematic review of the literature did not identify any health technology assessments, systematic reviews, meta-analyses, RCTs, or nonrandomized studies evaluating biofeedback for the treatment of generalized anxiety disorder.

#### Randomized Controlled Trials

In 2016, Chen et al published an RCT comparing diaphragmatic breathing relaxation (DBR) with routine respiration activities in the treatment of 46 patients with anxiety. DBR is a technique that uses diaphragm muscle contractions to force air downward into the body, increasing diaphragm length and breathing efficiency. Outcomes were anxiety level, measured by Beck Anxiety Inventory, and 4 physiological measures (skin conductivity, peripheral blood flow, heart rate, breathing rate). All patients participated in an individualized 8-week course in breathing relaxation, but only 30 completed it. Fifteen were randomized to DBR training and 15 to routine breathing relaxation training. Researchers and patients were blinded to randomization, with only the trainer being aware of group allocation. After 8 weeks, the DBR group experienced statistically significant decreases in Beck Anxiety Inventory scores compared with baseline, while the control group did not experience significant decreases from baseline. The DBR group also experienced significant improvements in all 4 physiological measurements, while the control group did not.

#### Section Summary: Anxiety Disorders

A systematic review on HRV biofeedback found that biofeedback had a positive effect on anxiety levels, though the studies had small sample sizes and, in general, were of poor quality. An RCT evaluating diaphragmatic breathing relaxation also found a positive effect on anxiety, though this trial also had a small sample size. Additional higher quality research with larger sample sizes is needed.

### Asthma

In 2015, Yorke et al published a systematic review of studies evaluating nonpharmacologic interventions for the treatment of adults with asthma. The literature search, conducted through May 2014, identified 23 studies for inclusion. The nonpharmacologic interventions were organized...
into groups: relaxation-based therapies (n=9 studies); cognitive behavioral therapies (n=5 studies); biofeedback techniques (n=3 studies); and mindfulness (n=1 study). Five studies incorporated multicomponent interventions. The 3 biofeedback RCTs used different techniques: exhaled carbon dioxide capnography (pooled n=12)\(^6\); HRV using a physiograph (pooled n=94 patients)\(^7\); and respiratory sinus arrhythmia by electrocardiographic feedback and muscle tension by electromyography (EMG; pooled n=17 patients).\(^8\) Common outcomes in the 3 studies included peak expiratory flow and respiratory impedance. Two of the trials reported on medication use. While differences were detected in exhaled carbon dioxide, HRV, and muscle tension, no changes in forced expiratory volume in 1 second (FEV\(_1\)) were found and medication use decreased in only 1 trial. Reviewers concluded that larger sample sizes were needed to demonstrate effects and that, while certain parameters that patients received biofeedback on may have differed between treatment groups, those differences did not translate into meaningful clinical benefits.

**Section Summary: Asthma**
A recent systematic review identified 3 studies using 3 biofeedback techniques to treat asthma. The studies reported improvements in the parameters on which the patients received biofeedback, but those improvements did not impact clinical benefits such as decreased medication use or increased FEV\(_1\).

**Bell Palsy**
In 2008, Cardoso et al published a systematic review of studies on the effects of facial exercises on symptoms of Bell palsy.\(^9\) Studies including patients with unilateral idiopathic facial palsy treated with facial exercises associated with mirror and/or EMG biofeedback were included in this review. Four studies (total N=132 patients) met the eligibility criteria. The studies described mime therapy vs control (n=50 patients), mirror biofeedback exercise vs control (n=27 patients), “small” mirror movements vs conventional neuromuscular retraining (n=10 patients), and EMG biofeedback plus mirror training vs mirror training alone. The treatment length varied from 1 to 12 months. Reviewers concluded that “...because of the small number of randomized controlled trials, it was not possible to analyze if the exercises, associated either with mirror or EMG biofeedback, were effective. In summary, the available evidence from randomized controlled trials is not yet strong enough to become integrated into clinical practice.”

**Section Summary: Bell Palsy**
A systematic review identified 4 studies using 4 biofeedback techniques to treat Bell palsy. Sample sizes were small, and there was heterogeneity in the techniques used and length of treatments.

**Depression**
The 2014 Canadian Agency for Drugs and Technology in Health report on biofeedback for mood and anxiety disorders (previously discussed in the Anxiety section),\(^3\) included a systematic review of the literature on biofeedback for depression. Other than 2 dissertations using HRV biofeedback, no health technology assessments, systematic reviews, meta-analyses, RCTs, or nonrandomized studies evaluating biofeedback for the treatment of depression were identified.

**Section Summary: Depression**
A 2014 Canadian agency report identified 2 dissertations using HRV biofeedback to treat depression. No peer-reviewed literature has been identified since the report that has evaluated biofeedback techniques to treat depression.

**Hypertension**

**Systematic Reviews**
A systematic review of studies on biofeedback for hypertension was published by Greenhalgh et al in 2009.\(^{10}\) Reviewers searched for RCTs that included adults with essential hypertension (defined as at least 140/90 mm Hg) and that compared biofeedback interventions, alone or in combination, with other therapies, to medication, sham biofeedback, no treatment, or another
behavioral intervention. Thirty-six trials (total N=1660 patients) met inclusion criteria. Trials generally had small sample sizes; only 4 included more than 100 patients. All were single-center, and most were conducted in the United States. Trials used a variety of biofeedback techniques including thermal biofeedback, galvanized skin response, pulse wave velocity, and HRV; some trials used more than 1 modality. Twenty studies evaluated biofeedback alone, 15 evaluated biofeedback combined with another intervention, and one had multiple arms and evaluated both types of interventions; only 4 trials included a sham biofeedback comparison group. Reviewers stated that they did not pool study findings due to differences in interventions and outcomes and the generally poor quality of the studies.

Reviewers reported that trials comparing biofeedback alone with no treatment or another behavioral intervention did not provide convincing evidence of the superiority of biofeedback. Only 1 of 5 trials that compared a biofeedback combination intervention (most commonly combined with relaxation) with a different behavioral treatment found the biofeedback intervention to be superior. Approximately half of the trials comparing a biofeedback combination with no treatment found a significant benefit to the biofeedback combination, but the specific effects of biofeedback could not be determined from this analysis. Only 1 trial compared a biofeedback combination intervention with sham biofeedback, and it did not find a significant difference in the efficacy of the 2 interventions. Four studies on biofeedback alone and another 4 on a combined biofeedback intervention reported data beyond 6 months; most of them found no significant differences in efficacy between the biofeedback and control groups.

Randomized Controlled Trials
Wang et al (2016) published an RCT evaluating the effect of direct blood pressure biofeedback on patients with prehypertension or stage I hypertension.11 A trained nurse instructed patients in blood pressure self-regulation by using slow diaphragmatic breathing and passive attitude. During the 8-week training (1 session per week), patients in the treatment group received real-time blood pressure feedback signals (n=29) and controls received pseudo-feedback signals (n=28). Outcomes were systolic and diastolic blood pressure, measured at baseline and 1 and 8 weeks after training. Both groups significantly decreased blood pressure following training. The decreases were equal in magnitude, suggesting that blood pressure self-regulation training can effectively lower blood pressure, regardless of the type of feedback signal.

Section Summary: Hypertension
Although there are a large number of RCTs evaluating biofeedback for treating hypertension, the evidence is insufficient due to the shortage of studies isolating the effect of biofeedback, the generally poor quality of trials, and the variability across interventions.

Motor Dysfunction after Stroke
Numerous RCTs and several systematic reviews of RCTs have been published. Systematic reviews have noted that RCTs have tended to have relatively small sample sizes, and only small RCTs were included in literature search updates.12,13 Recent systematic reviews and RCTs not included in the systematic reviews are discussed below.

Systematic Reviews
In 2017, Stanton et al updated a systematic review and meta-analysis published in 2011 (see below) which evaluated the effect of biofeedback on lower-limb activities in patients who have had a stroke.14 Only high-quality RCTs or quasi-RCTs with Physiotherapy Evidence Database (PEDro) scores greater than 4 were included. The literature search, conducted through September 2015, identified 18 trials (total N=429 patients) for inclusion. Training activities were walking (9 trials), standing (8 trials), and standing up (1 trial). Trials were small, with study populations ranging from 12 to 50 patients. Biofeedback techniques included weight distribution from a force platform or sensor (11 trials), muscle activity from EMG (3 trials), linear gait parameters (3 trials), and joint angle from a goniometer (1 trial). Visual feedback was used in 7 trials, auditory in 7 trials, and a combination of visual/auditory in 4 trials. Pooled standardized
mean difference of the short-term effect of biofeedback from 17 trials (n=417) was significant (0.50; 95% confidence interval [CI], 0.3 to 0.7). Long-term effects could not be calculated because only 4 trials provided that information.

A 2011 systematic review and meta-analysis by Stanton et al was updated in 2017. A total of 22 trials with 591 participants met inclusion criteria; in the update, reviewers only included high-quality trials (see above).

A systematic review by Zijlstra et al, published in 2010, focused on studies evaluating biofeedback-based training to improve mobility and balance in adults older than 60 years of age. Although the review was not limited to studies on motor function after stroke, more than half of the studies included older adults poststroke. For review inclusion, studies had to include a control group of patients who did not receive biofeedback and to assess at least 1 objective outcome measure. A total of 21 studies, including 17 RCTs, met selection criteria. Twelve (57%) of the 21 studies included individuals poststroke, 3 included older adults who had lower-limb surgery, and 6 included frail older adults without a specific medical condition. Individual studies were small, ranging from 5 to 30 patients. The added benefit of using biofeedback could be evaluated in 13 (62%) of 21 studies. Nine of the 13 studies found a significantly greater benefit with interventions that used biofeedback compared with control interventions. However, the outcomes assessed were generally not clinical outcomes but laboratory-based measures related to executing a task (e.g., moving from sitting to standing) in a laboratory setting and platform-based measures of postural sway. Only 3 studies reported long-term outcomes, and none of them reported a significant effect of biofeedback.

Randomized Controlled Trials
In 2017, Kim published an RCT on the effect of EMG on upper-extremity functions in patients who have had a stroke. Patients were randomized to traditional rehabilitation therapy (n=15) or traditional rehabilitation therapy plus EMG biofeedback training (n=15). Upper-limb function was measured by Fugl-Meyer Assessment (FMA) and Manual Function Test (MFT), and activities of daily living were measured using the FIM instrument. Both FMA and MFT scores improved significantly more in the patients receiving EMG biofeedback. However, there was not a significant difference in FIM score improvement between groups.

In 2016, Yang published an RCT on the effect of biofeedback weight-bearing training on the ability to sit/stand/sit and on stability among patients who have had a stroke. Patients were randomized to biofeedback weight-bearing training (n=15) or functional weight-bearing training (n=15). Outcomes were time to sit/stand/sit and stability (measured by BioRescue, which detects an area of center of pressure). Comparison statistics were calculated for pre- and posttraining results, and between treatment groups. Both outcomes significantly improved in the biofeedback group but not in the control group.

In 2016, Ghomashchi published an RCT evaluated the effect of visual biofeedback on postural balance disorders in patients who have had a stroke. Patients received conventional physical therapy and balance training exercises. During balance training, 16 patients were randomized to visual biofeedback and 15 patients to no visual information. Outcomes were the center of pressure and approximate entropy. Both groups experienced improvements in postural control, with no significant differences between rehabilitation methods.

Section Summary: Motor Dysfunction after Stroke
The evidence base on biofeedback for improving motor function after stroke is limited by small studies, and there is variability by type, duration, and intensity of interventions. In addition, the outcome measures used were primarily assessments of motor activity that were based in a laboratory or research setting. The applicability of improvements in these types of measures to clinical outcomes, such as the ability to perform activities of daily living or the rate of falls, is unknown. In addition, few studies have reported long-term outcomes. Due to these limitations,
the efficacy of biofeedback for improving mobility and balance in older adults cannot be
drawn from the evidence published to date.

**Motor Dysfunction after Lower-Limb Injury or Surgery**
A 2010 systematic review by Silkman and McKeon evaluated the effectiveness of EMG
biofeedback for improving muscle function during knee rehabilitation after injury.20 Four RCTs
that compared knee rehabilitation exercise programs with and without biofeedback were
identified. Sample sizes in individual studies ranged from 26 to 60 patients. Two of the 4 studies
found a statistically significantly greater benefit in the programs that included biofeedback,
while the others did not. The positive studies assessed intermediate outcomes (e.g., contraction
values of the quadriceps muscles). None of the studies were designed to assess functional
outcomes.

**Section Summary: Motor Dysfunction after Lower-Limb Injury or Surgery**
A systematic review identified 4 RCTs. Evidence from these trials was limited due to small sample
sizes, inconsistent results, and the measurement of intermediate outcomes rather than functional
outcomes.

**Multiple Sclerosis**
A 2016 crossover study by van der Logt et al evaluated the effect of vibrotactile biofeedback for
trunk sway on balance control in patients with multiple sclerosis.21 Ten patients performed a
series of stance and gait tasks while trunk sway was measured using a SwayStar device
attached to the waist. Patients underwent the series of tasks with and without an add-on to the
SwayStar device, which provided patients with direction-specific vibrotactile feedback during
the tasks. When patients performed the tasks with vibrotactile biofeedback, there was a general
reduction in trunk sway, though not all the reductions differed significantly with trunk sway when
performing the tasks without vibrotactile biofeedback. Studies with larger sample sizes are
needed.

A 2015 RCT by MacKay et al evaluated the addition of biofeedback to standard care in 40
patients with relapsing-remitting multiple sclerosis patients.22 The standard of care psychosocial
intervention consisted of relaxation, mindfulness, social support, and education. All patients
attended 1-hour training and assessment sessions at weekly intervals. During the first session, all
patients had training in mindfulness breathing exercises and progressive muscle relaxation
techniques. Patients randomized to the biofeedback arm received additional instruction on the
use of biofeedback equipment for self-regulation. Following the 3 weekly sessions, patients were
instructed to practice the exercises at home, with or without the use of biofeedback equipment.
Outcomes included breathing rate and anxiety, depression, fatigue, and muscle tension
measures. At the end of treatment, there were no statistically significant differences between
groups in any outcomes. However, some variables were marginally significant. The difference
between the intervention group and the control group in breathing rate was 3.06 beats per
minute (95% CI, -0.17 to 6.28 beats per minute; p=0.06) and the difference in muscle tension was
-13.91 µV (95% CI, -30.06 to 2.25 µV; p=0.09). Both groups had similar amounts of provider
contact, so nonspecific intervention effects were not an issue.

**Section Summary: Multiple Sclerosis**
Two RCTs using biofeedback techniques for the treatment of multiple sclerosis were identified.
The sample sizes were small, with marginally significant differences between the biofeedback
groups and control groups. Additional research with larger sample sizes is needed.

**Orthostatic Hypotension in Patients with Spinal Cord Injury**
Gillis et al (2008) conducted a systematic review to identify and describe the body of literature
pertaining to the nonpharmacologic management of orthostatic hypotension during the early
rehabilitation of persons with spinal cord injury.23 Participants with any level or degree of
completeness of spinal cord injury and any time elapsed since their injuries were included.
Interventions must have measured at least systolic blood pressure and have induced orthostatic
stress in a controlled manner and have attempted to control orthostatic hypotension during an orthostatic challenge. Thirteen studies (total N=138 patients) were included in the review. Four distinct nonpharmacologic interventions for orthostatic hypotension were identified: application of compression and pressure to the abdominal region and/or legs (3 studies), upper-body exercise (2 studies), functional electrical stimulation applied to the legs (6 studies), and biofeedback (2 studies). The 2 studies with 3 patients using biofeedback techniques reported an average of 39% increase in systolic blood pressure. The authors concluded that “...The clinical usefulness of compression/pressure, upper body exercise and biofeedback for treating OH [orthostatic hypotension] has not been proven.”

Section Summary: Orthostatic Hypotension in Patients with Spinal Cord Injury
A systematic review of the nonpharmacologic management of orthostatic hypotension in patients with spinal cord injury identified 2 studies using biofeedback. While the studies showed that biofeedback raised systolic blood pressure effectively, these studies only assessed 3 patients. Additional research with larger sample sizes is needed.

Pain Management During Labor
In 2011 a Cochrane review evaluated RCTs on biofeedback for managing pain during labor.24 Reviewers identified 4 RCTs published between 1982 and 2000 (total N=186 women). The studies were highly variable in terms of intervention modalities and outcomes measured, and thus findings were not pooled. In addition, reviewers judged the trials to be at high risk of bias (e.g., unclear description of blinding and randomization methods). Overall, they found little difference in reported outcomes (e.g., rates of Cesarean section, pharmacologic pain relief in women receiving biofeedback vs control interventions). Due to the small number of studies and small pooled sample size, the evidence did not support drawing conclusions about the effectiveness of biofeedback in labor pain control.

Section Summary: Pain Management During Labor
A Cochrane review identified 4 RCTs using biofeedback techniques to manage pain during labor. Pooled estimates were not possible due to heterogeneity in techniques and outcomes. Trials were also deemed high risk.

Posttraumatic Stress Disorder
The 2014 Canadian Agency for Drugs and Technology in Health report on biofeedback for mood and anxiety disorders (previously discussed),3 included a systematic review of the literature on biofeedback for posttraumatic stress disorder (PTSD). One systematic review was identified; it was published in 2014 by Wahbeh et al and addressed various complementary and alternative medicine approaches to treating PTSD.25 Four of 33 studies that met selection criteria of the Wahbeh review addressed biofeedback. Among the biofeedback studies were 1 RCT, 1 nonrandomized trial, and 2 case series. The controlled trials either had mixed results or did not find a significant benefit of biofeedback. Reviewers gave the biofeedback evidence a grade C for unclear or conflicting scientific evidence.

Section Summary: Posttraumatic Stress Disorder
A systematic review of complementary and alternative medicine approaches to treating PTSD identified 4 studies using biofeedback techniques. Results from these studies were inconsistent. Larger controlled trials are needed.

Prevention of Preterm Birth
One small RCT was identified. In 2014, Sepmann et al published data on 48 women who had experienced threatened preterm labor between the 24th and 32nd gestational week.26 Twenty-four patients received 6 biofeedback sessions over 2 weeks, and the other 24 patients were in a usual care group. Preterm delivery occurred in 3 (13%) patients in the biofeedback group and 8 (33%) patients in the control group; the difference between groups was not statistically significant (p > 0.05). Other gestational outcomes data, such as the gestational duration and birthweight, also did not differ significantly between groups.
Section Summary: Prevention of Preterm Birth
A single RCT was identified; it used biofeedback techniques to prevent preterm birth. There was no statistically significant difference between the biofeedback group and the control group in regard to the number of preterm deliveries or birth weight. Additional research is needed.

Raynaud Disease
A 2009 systematic review on complementary and alternative medicine in the treatment of Raynaud disease included literature on biofeedback.27 Reviewers identified 5 trials using biofeedback techniques, and they reported a variety of outcomes. A pooled analysis of findings from 4 trials (n=110 patients) on the change in frequency of attacks (typically extremities feel cold and numb) favored the sham-control group over the biofeedback group (weighted mean difference, -1.21; 95% CI, -1.68 to -0.73; p<0.000). Several trials had more than 2 arms; in the preceding analysis, only the arms comparing active with sham biofeedback were included.

The trial that was given the highest quality rating by the systematic reviewers and with the largest sample size was the Raynaud’s Treatment Study, published in 2000.28 This was a randomized comparison of sustained-release nifedipine and thermal biofeedback in 313 patients with primary Raynaud disease. In addition to these 2 treatment groups, there were 2 control treatments: pill placebo and EMG biofeedback. EMG biofeedback was chosen as a control because it did not address the physiological mechanism of Raynaud disease. The mean attack rate at 1 year (the primary study outcome) was 0.16 in the thermal biofeedback group, 0.23 in the EMG biofeedback group, 0.07 in the nifedipine group, and 0.21 in the placebo group. Nifedipine significantly reduced Raynaud attacks compared with placebo (p<0.002), but thermal feedback did not differ significantly from EMG biofeedback (0.37). There was not a significant difference in attack rates in the nifedipine and thermal biofeedback groups for the primary outcome (p=0.08).

Section Summary: Raynaud Disease
A systematic review identified 5 trials using biofeedback techniques for the treatment of Raynaud disease. A meta-analysis of four of these trials showed more favorable outcomes for the patients in the sham-control group.

Sleep Bruxism
Systematic Reviews
In 2014, Wang et al published a systematic review of RCTs and non-RCTs on biofeedback treatment for sleep bruxism.29 Seventeen articles was reviewed, and 7 studies with (total N=240 participants) met the inclusion criteria. Studies were generally small; only 2 included more than 50 participants. Four studies used audio biofeedback, two used contingent electric stimulation, and one used visual biofeedback. Treatment duration ranged from 1 night to 6 weeks. In 4 studies, the duration of treatment was 2 weeks. Three of the studies were considered at moderate risk of bias, and the other four were considered at high risk of bias. The primary outcome of the analysis was the number of sleep bruxism episodes per hour detected by EMG recording. Only 2 studies (n=27 patients) reported this outcome and had data suitable for meta-analysis. A pooled analysis did not find a statistically significant difference between the biofeedback and control groups (mean difference, -4.47; 95% CI, -12.33 to 3.38). Findings were not pooled for any other outcomes.

Randomized Controlled Trials
One of the larger RCTs (N=57) examined changes in sleep bruxism following treatment with a cognitive behavioral therapy program consisting of problem solving, progressive muscle relaxation, nocturnal biofeedback, and training of recreation and enjoyment.30 Similar levels of improvements were observed for the occlusal splint group and for the multicomponent cognitive behavioral program. The effects of biofeedback were not isolated in this study, and thus conclusions cannot be drawn about its effectiveness compared with occlusal splinting.
In 2015, Sato et al published a study on the use of EMG biofeedback training for daytime clenching and its effect on sleep bruxism. Patients were monitored for 5 hours of daytime and night time and were randomized to EMG biofeedback (n=7) or to a control group (n=5). Patients in the biofeedback group received a small auditory signal in the daytime when clenching activity was detected. There were significant decreases in EMG events during weeks 2 and 3 in the biofeedback group during the daytime, and the decreases in events carried over into the night time. There were no decreases in EMG events in the control group.

Section Summary: Sleep Bruxism
A systematic review identified 17 studies using biofeedback techniques to treat sleep bruxism. Pooled analyses of 2 studies with the same outcome (number of sleep bruxism episodes per hour) did not find a significant difference between the biofeedback and control groups. Heterogeneity in biofeedback techniques, outcomes measured, and treatment duration did not permit additional pooled analyses. An RCT published after the review that tested EMG biofeedback reported significant reductions in clenching activity in the biofeedback group, though the sample size was small. Additional research is needed with larger samples.

Tinnitus
A 2009 RCT by Weise et al investigated the efficacy of a biofeedback-based cognitive behavioral treatment for tinnitus in Germany. Tinnitus patients (N=130) were randomized to an intervention group or a waiting-list control group. Treatment consisted of 12 sessions of a biofeedback-based behavioral intervention over a 3-month period. The primary outcome measures were global tinnitus annoyance and a daily rating of tinnitus disturbance (measured by a Tinnitus Questionnaire) and a daily diary (using visual analog scale scores). Patients in the waiting-list group participated in the treatment after the intervention group had completed the treatment. Results showed reductions in tinnitus annoyance, diary ratings of loudness, improvements in feelings of controllability, changes in coping cognitions, and changes in depressive symptoms in the biofeedback group. The Tinnitus Questionnaire total score has a potential range of 0 to 84. The preassessment mean in the Tinnitus Questionnaire total score was 54.7, and the postassessment mean was 32.5.

Section Summary: Tinnitus
A single RCT was identified that evaluated the use of a biofeedback technique to treat patients with tinnitus. While improvements were reported in the biofeedback group, additional research would be needed to confirm these results.

Other Indications
No current evidence was identified for the use of biofeedback techniques to treat other indications including insomnia.

Summary of Evidence
For individuals with anxiety disorders who receive biofeedback, the evidence includes a systematic review and an RCT published after the review. Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic review on heart rate variability biofeedback and the RCT on diaphragmatic breathing relaxation reported the positive effects of these treatments on anxiety. However, the trials had small sample sizes (median, 14 participants) and study quality was generally poor. Additional limitations included improper randomization, allocation concealment, and inadequate descriptions of randomization or missing data. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with asthma who receive biofeedback, the evidence includes 3 RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. Each RCTs used a different biofeedback technique, which provided patients with information on carbon dioxide, heart rate, and respiratory sinus arrhythmia. While the trials reported improvements in each parameter on which the patients received biofeedback, the improvements did not impact clinical
outcomes such as medication use and forced expiratory volume. The evidence is insufficient to
determine the effects of the technology on health outcomes.

For individuals with Bell palsy who receive biofeedback, the evidence includes 4 RCTs. Relevant
outcomes are symptoms, functional outcomes, and quality of life. The RCTs evaluated the
efficacy of adding mirror and/or electromyography biofeedback to facial exercises. Sample
sizes were small, and there was heterogeneity across techniques used and length of treatments.
The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with depression who receive biofeedback, the evidence includes an RCT.
Relevant outcomes are symptoms, functional outcomes, and quality of life. The RCT evaluated
the effect of neurofeedback training on the ability of patients to control emotional responses.
While patients undergoing treatment were better able to decrease their emotional responses
compared with controls, the sample size was small and additional research with larger
populations is needed. The evidence is insufficient to determine the effects of the technology on
health outcomes.

For individuals with hypertension who receive biofeedback, the evidence includes a systematic
review and an RCT published after the review. Relevant outcomes are symptoms, functional
outcomes, and quality of life. The systematic review identified 36 RCTs, though sample sizes were
small and overall study quality poor. Various biofeedback techniques were used: thermal,
galvanized skin response, pulse wave velocity, and heart rate variability. Results across trials did
not consistently show a benefit of biofeedback. Conclusions were limited due to the
heterogeneity across interventions and the generally poor quality of the trials. The evidence is
insufficient to determine the effects of the technology on health outcomes.

For individuals with motor dysfunction after stroke who receive biofeedback, the evidence
includes systematic reviews and RCTs published after the systematic reviews. Relevant outcomes
are symptoms, functional outcomes, and quality of life. A systematic review identified 18 high-
quality trials using the following biofeedback techniques: weight distribution on a platform
sensor, muscle activity from electromyography, linear gait parameters, and joint angle from a
goniometer. Feedback was visual, auditory, or both. Outcome measures were primarily
assessments of motor activity in research settings, rather than clinical outcomes such as rate of
falls or ability to perform activities of daily living. Pooled effects showed improvements in motor
function in the short term. The evidence is limited due to the variability in type, duration, and
intensity of the interventions and lack of long-term outcomes. The evidence is insufficient to
determine the effects of the technology on health outcomes.

For individuals with motor dysfunction after lower-limb injury or surgery who receive biofeedback,
the evidence includes a systematic review. Relevant outcomes are symptoms, functional
outcomes, and quality of life. The systematic review identified 4 RCTs evaluating the use of
electromyography biofeedback. Sample sizes were small, with half of the trials reporting
significant benefits of biofeedback and the other half reporting no difference between study
groups. The evidence is insufficient to determine the effects of the technology on health
outcomes.

For individuals with multiple sclerosis who receive biofeedback, the evidence includes 2 RCTs.
Relevant outcomes are symptoms, functional outcomes, and quality of life. One trial used
vibrotactile biofeedback and the other provided patients with heart rate and muscle tension
biofeedback. Sample sizes were small, and trialists reported marginally significant differences
between study groups. The evidence is insufficient to determine the effects of the technology on
health outcomes.

For individuals with orthostatic hypotension due to spinal cord injury who receive biofeedback,
the evidence includes a case report and a case series. Relevant outcomes are symptoms,
functional outcomes, and quality of life. The case report and case series collectively provided
information on 3 patients given visual and auditory feedback. Patients were able to raise their systolic blood pressure by an average of 39%. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who need pain management during labor who receive biofeedback, the evidence includes 4 RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. A Cochrane review assessed the four selected trials as having a high risk of bias due to unclear descriptions of blinding and randomization methods. Due to the heterogeneity in biofeedback methods and outcomes measured, pooled analyses could not be performed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with posttraumatic stress disorder who receive biofeedback, the evidence includes an RCT, a nonrandomized study, and 2 case series. Relevant outcomes are symptoms, functional outcomes, and quality of life. The studies had small sample sizes and inconsistent results. A systematic review of the 4 studies rated the evidence a grade C for conflicting scientific evidence. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are susceptible to preterm birth who receive biofeedback, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, and quality of life. In the RCT, patients in the treatment group received heart rate variability biofeedback. Patients receiving the treatment experienced a decrease in perceived chronic stress, but there was no significant difference in the number of preterm births, gestational duration, or birthweight. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with Raynaud disease who receive biofeedback, the evidence includes a systematic review. Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic review identified 5 RCTs using biofeedback techniques. Pooled analysis was performed on four of these trials. Reduction in frequency of attacks was significantly lower in the sham-control group. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with sleep bruxism who receive biofeedback, the evidence includes a systematic review and an RCT published after the review. Relevant outcomes are symptoms, functional outcomes, and quality of life. The systematic review identified 7 randomized and nonrandomized studies using biofeedback techniques. Studies were generally small, used different techniques, measured different outcomes, and were assessed as having either moderate or high risk of bias. Two studies reported the number of bruxism episodes per hour and a pooled analysis of these studies showed no significant differences between biofeedback groups and control groups. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with tinnitus who receive biofeedback, the evidence includes a single RCT. Relevant outcomes are symptoms, functional outcomes, and quality of life. Treatment consisted of a biofeedback-based behavioral intervention over a 3-month period. The treatment group experienced improvements in tinnitus annoyance, loudness ratings, controllability, coping cognitions, and depressive symptoms. Additional studies are needed to confirm the results of this single trial. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

American Psychiatric Association
The 2010 American Psychiatric Association guidelines on the treatment of patients with major depressive disorder did not list biofeedback as a potential treatment.33
The 2004 Association guidelines on the treatment of patients with acute stress disorder and posttraumatic stress disorder mentioned use of biofeedback to augment relaxation techniques. The guidelines suggested that biofeedback could provide patients with instantaneous feedback on physiological measures such as blood flow and muscle contraction, which would enable patients to exert some degree of control over those measures to relieve tension and anxiety.

**American Academy of Sleep Medicine**

In 2008, the American Academy of Sleep Medicine released guidelines on the evaluation and management of chronic insomnia in adults. The guidelines listed biofeedback as one of several behavioral or psychological therapies to reduce chronic somatic arousal.

**Scottish Intercollegiate Guidelines Network**

The 2010 Scottish Intercollegiate Guidelines Network guidelines on the management of patients with stroke indicated that, based on evidence from 2 systematic reviews, “EMG [electromyographic] biofeedback is not recommended as a routine treatment for gait, balance or mobility problems after stroke.”

**U.S. Preventive Services Task Force Recommendations**

No U.S. Preventive Services Task Force recommendations for the use of biofeedback have been identified.

**Medicare National Coverage**

Medicare’s National Coverage Determination for Biofeedback Therapy (30.1) has indicated: “Biofeedback therapy is covered under Medicare 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, and support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.”

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Summary of Key Trials</th>
</tr>
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<tr>
<td><strong>NCT No.</strong></td>
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<tr>
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<tr>
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<tr>
<td>NC02237885</td>
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<tr>
<td>NC03030326</td>
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</table>

NCT: national clinical trial.
References


**Documentation for Clinical Review**

- No records required

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**IE**

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>90875</td>
<td>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); 30 minutes</td>
</tr>
<tr>
<td></td>
<td>90876</td>
<td>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); 45 minutes</td>
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<tr>
<td></td>
<td>90901</td>
<td>Biofeedback training by any modality</td>
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<td>HCPCS</td>
<td>E0746</td>
<td>Electromyography (EMG), biofeedback device</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>GZC 9ZZZ</td>
<td>Biofeedback</td>
</tr>
</tbody>
</table>

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2010</td>
<td>New policy Combined with the previously existing BSC Medical Policy: Neurofeedback</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>04/05/2013</td>
<td>Policy revision with position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>09/30/2014</td>
<td>Policy title change from Biofeedback</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>10/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.