

## Coverage for Pelvic Floor Biofeedback Therapy (1998)

The Continence Coalition of the Society of Urological Nurses and Associates (SUNA) and the Wound Ostomy and Continence Nurses (WOCN) endorsed by the Association of Rehabilitation Nurses (ARN)

Urinary Incontinence (UI) is expensive to Medicare, both directly and through preventable consequences. Biofeedback is effective in reducing UI and in reducing UI's associated costs. We share HCFA's concerns regarding potential misuse of CPT codes for pelvic floor rehabilitation, specifically 90900, 90901 and 90911 but we are convinced that these procedures should be reimbursed when appropriately applied. We believe that clinicians who provide behavioral treatments for UI should be consulted when reimbursement policy is determined for pelvic floor biofeedback therapy.

The cost-effective, outcome-oriented treatment of chronic incontinence requires a focused, thorough assessment and a step-wise approach to control leakage and its complications. Failure to treat UI leads to more costly complications including falls, urinary tract infection, skin breakdown, prolonged acute care stays, and increased skilled nursing facility admissions. According to Hu, in 1995 alone the total US expenditure for UI in persons over 65 was approximately \$27.8 billion.<sup>1</sup> These costs increased 164% per person compared to 1984 estimates.

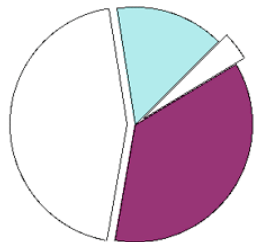
While it is commonly known that UI is expensive, it is important to note that almost half of these costs represent Medicare expenses for medical services. This contradicts the commonly held view that UI is merely a social and hygienic problem whose costs are primarily borne by society. Specifically, only 8% of the medical costs associated with urinary incontinence are for evaluation and treatment and only a minuscule portion of that was spent on behavioral treatments — the recommended first-line treatment. The remaining 92% of medical costs represent often preventable sequelae.

The increased likelihood of falls indirectly caused by UI results in especially high exposure for Medicare and the many managed care organizations who accept risk for Medicare recipients. Many hip fractures in elders can be traced back to nocturia (getting up often to urinate at night), especially nocturia in the presence of urgency (having to rush to the toilet). The risk of a hip fracture increases when cognitive impairment occurs in the presence of a urinary tract infection, when specific medications such as anticholinergics are used to treat incontinence, and when loss of sleep related to nocturia occurs.

The cost of incontinence also includes longer hospital stays and increased skilled nursing facility costs. When two persons with similar demographic profiles and similar diagnosis enter an acute care hospital, the patient with incontinence can be expected to stay 2 - 3 days longer than the continent person due to treatment of the bladder dysfunction or its complications. While Medicare typically covers only the first 100 days of each skilled nursing facility admission, it is known that institutionalization opens a

revolving door to acute care. The "100 day period" frequently restarts after discharge. Because of the physical and psychosocial sequelae of incontinence, the risk of the "revolving door phenomenon" is particularly significant for incontinent persons.

Estimated UI Costs<sup>1</sup> (Light colors = Medicare costs)



Blue = Community caretaking \$4.20 billion

Purple = Pads & Laundry \$10.2 billion

White (big) = Medical Expenditures for Adverse Consequences \$12.40 billion

White (small) = Evaluation \$0.3898 & Treatment \$0.6432 = \$1.06 billion

**Non-medical = \$14.4 billion including**

**\$ in Billions**

*Caretaking*

4.229

*Pads & Laundry*

10.2

**Medical Costs = \$13.5 billion including**

*Evaluation*

0.39

*Treatment*

Behavioral

0.012

Pharmaceutical

0.011

*Adverse Consequences*

UTI

4.181

Falls

0.059

Skin Irritation

0.38

Prolonged Hospitalizations

6.229

Additional SNF Admissions

1.351

**Total Costs**

27.8

While Kegel exercises are the time honored approach for treating UI through pelvic muscle rehabilitation (PMR), it has been shown that verbal or written instructions do not

prepare patients adequately.<sup>2</sup> When a specially trained nurse provides instruction and coaching, PMR demonstrates excellent short and long-term effectiveness in managing stress, urge, and mixed urinary incontinence.<sup>3,4</sup> Further, it has been shown that such training requires digital, mechanical, or electronic confirmation of proper muscle use to the patient.<sup>5</sup> Without biofeedback, many neurologically impaired patients could not benefit from muscle rehabilitation at all.

Specifically, biofeedback:

- Provides keys to often hidden muscle activity
- Translates muscle responses into more understandable events
- Provides powerful and instant information on muscle performance
- Demonstrates the effectiveness of efforts to control pelvic muscles

Biofeedback of the pelvic floor muscles is indicated for patients requiring:

- Rehabilitation of severely impaired pelvic musculature
- Assistance with muscle identification, isolation, or fine motor control
- Training for voluntary muscle relaxation with functional urethral or anal obstruction

The Continence Coalition represents the Society of Urologic Nurses and Associates (SUNA) and the Wound, Ostomy, and Continence Nurses (WOCN). In addition, the Association of Rehabilitation Nurses (ARN) has endorsed this position statement. Together, these groups represent almost 17,500 nurses including the majority of nurse specialists who provide behavioral therapies for incontinence. Working closely with their collaborating physicians, continence care nurses from these organization provide evaluation, behavioral (conservative) treatment and management, and long-term follow-up to patients with voiding and defecation dysfunction.

Pelvic floor biofeedback is one of the many behavioral methods offered by continence care nurses. The SUNA, WOCN, and ARN via the Continence Coalition, can offer important insights regarding behavioral and conservative approaches to voiding and defecation dysfunction including urinary and fecal incontinence. We consider pelvic muscle biofeedback to be an important treatment alternative for stress, urge, mixed urinary incontinence and for fecal incontinence yet we recognize that it is critical that this therapy be applied judiciously.

We therefore request the following:

- HCFA draft a national policy explicitly directing carriers to cover biofeedback of the urethral and anal sphincter when indicated for the treatment of urinary and fecal incontinence.
- Biofeedback be limited to carefully selected patients based on medical necessity following a standardized evaluation and in settings where the full range of behavioral therapies are available.

- Via the Continence Coalition, select continence nurse specialists from the SUNA, WOCN and ARN be provided an opportunity to offer assistance, as HCFA determines how pelvic floor biofeedback and other behavioral therapies should best be made available to Medicare beneficiaries.

## References

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