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Medical Policy

Biofeedback in an Outpatient Setting to Treat Incontinence or Constipation

Policy Number: OCA 3.969
Version Number: 16
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Product Applicability	☒ **All Plan+ Products**
Well Sense Health Plan ☒ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☒ MassHealth ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options ◊

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member's product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers biofeedback for the treatment of urinary incontinence (stress, urgency, mixed, or overflow urinary incontinence), fecal incontinence, and/or dyssynergia-type constipation to be medically necessary when medical criteria are met for a Plan member (regardless of gender) and the service is provided in an outpatient setting. The Plan considers biofeedback for all other indications to be experimental and investigational, including but not limited to the treatment of another voiding dysfunction and/or defecatory dysfunction (e.g., idiopathic constipation, total incontinence). Plan prior authorization is required.

It will be determined during the Plan's prior authorization process if the service is considered experimental or investigational for the requested use. Review the Plan's *Medically Necessary* medical policy, policy number OCA 3.14, for the product-specific definitions of medically necessary treatment. See the Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12, for the product-specific definitions of experimental or investigational treatment. **An additional Plan prior authorization is NOT required for biofeedback provided in an inpatient setting when the inpatient admission has been authorized by the Plan.**

Description of Item or Service

Biofeedback: A behavioral training program that is used to educate a person on the control of physiologic responses such as heart rate, blood pressure, skin temperature, and/or muscle tension Biofeedback provides auditory, sensory, or visual information from physiological responses, enabling an individual to gain voluntary control over that response. Biofeedback is not a treatment, per se, but a tool to help patients learn how to perform pelvic muscle exercise (PME) training effectively. The goal of biofeedback is to reduce or eliminate the signs and symptoms of incontinence or constipation through learned control of physiological responses of the body and directing the individual to the specific muscle groups needed to be strengthened to help control elimination.

Biofeedback is used as a behavioral treatment for pelvic floor muscle re-education. The pelvic floor refers to the structure of connective tissues and muscles that close off the pelvic outlet and act as a "floor" to the abdominal pelvic cavity. The external sphincter of the urethra and the anal sphincter are in continuity with these muscles. Patients with incontinence are taught bladder-sphincter biofeedback methods along with pelvic floor exercises. Biofeedback-assisted pelvic muscle exercises (PME) incorporates the use of an electronic device (electrodes) and/or mechanical device (small sensor placed near the patient's anus or inserted into the patient's vagina or rectum) to relay visual and/or auditory evidence of pelvic floor muscle tone, in order to improve awareness of pelvic floor musculature and to assist patients in the performance of PME. These techniques record bladder, rectal sphincter, and abdominal pressures along with electrical activity. By watching the information as it is recorded on a computer screen or through audio tones the patient learns to relax the bladder and abdominal muscles and correctly contract the pelvic floor muscles. Biofeedback enables the patient to improve pelvic muscle function through muscle awareness, which, when combined with a home exercise program, leads to increased muscle strength and improved coordination. Biofeedback sessions used to treat incontinence or constipation generally last about half an hour and are used to establish an effective pelvic floor exercise routine. The number of medically necessary biofeedback sessions used for the treatment of urinary incontinence, fecal incontinence, or dyssynergia-type constipation is **up to four (4) sessions** when Plan criteria are met, as specified below in the Medical Policy Statement section.

Medical Policy Statement

Biofeedback is considered medically necessary for the treatment of urinary incontinence (stress, urgency, mixed, or overflow urinary incontinence), fecal incontinence, and/or dyssynergia-type constipation for a Plan member (regardless of gender) when provided in the outpatient setting when ALL of the following criteria are met and documented in the member's medical record (including documentation of urodynamic test results, if performed and applicable), as specified below in items 1 through 5:

1. The member has failed a documented trial of pelvic muscle exercise (PME) training, as defined below with ALL of the following criteria met in items a through c:

    a. The trial was completed for a duration of at least four (4) weeks; AND

    b. The trial included an ordered plan of care for pelvic muscle exercises to increase muscle strength; AND

    c. There is no clinically significant improvement in the member's symptom(s) after the trial; AND

2. The member is cognitively intact; AND

3. ONE (1) of the following criteria is met for the Plan member, as specified below in items a through c:

    a. The member is six (6) years of age or older on the date of service with stress, urgency, mixed, or overflow urinary incontinence; OR

    b. The member is six (6) years of age or older on the date of service with fecal incontinence when the member has some degree of rectal sensation and the ability to contract the sphincter voluntarily; OR

    c. The member is 18 years of age or older on the date of service with chronic dyssynergic-type constipation and BOTH of the following applicable criteria are met, as specified below in item (1) and item (2):

        (1) Failed three (3) months of conventional treatment that includes the use of laxatives, dietary changes (e.g., high-fiber diet), and attempting defecation after meals; AND

        (2) The treating provider has documented that the member's condition meets the Rome criteria for functional constipation in effect on the date of service (with Rome IV effective May 2016) with the member experiencing **at least two (2) of the following symptoms over the preceding three (3) months**, as specified below in items (a) through (f):

(a) Fewer than three spontaneous bowel movements per week; AND/OR

(b) Straining for more than 25% of defecation attempts; AND/OR

(c) Lumpy or hard stools for at least 25% of defecation attempts; AND/OR

(d) Sensation of anorectal obstruction or blockage for at least 25% of defecation attempts; AND/OR

(e) Sensation of incomplete defecation for at least 25% of defecation attempts; AND/OR

(f) Manual maneuvering required to defecate for at least 25% of defecation attempts; AND

4. The member's treatment plan includes biofeedback with medical record documentation of the member's diagnosis, frequency of biofeedback training, and individual instructions related to biofeedback (e.g., practice and follow through); AND

5. Biofeedback training will be used to manage the member's symptom(s) for **up to four (4) sessions**.

Limitations

1. The Plan considers the use of biofeedback to be experimental or investigational when medical necessity criteria in the Medical Policy Statement section of this policy are NOT met (including age-related guidelines). The Plan considers biofeedback for all other indications to be experimental and investigational, including but not limited to the treatment of idiopathic constipation.

2. Home use of biofeedback therapy is considered experimental or investigational.

3. Plan Medical Director review is required after the member has received a fourth session of biofeedback training and additional sessions are requested to manage the member's symptoms.

Definitions

Dyssynergic Defecation/Dyssynergic-Type Constipation: Difficulty with defecation related to pelvic floor dysfunction. The condition affects up to one half of patients with chronic constipation. This acquired behavioral problem is due to the inability to coordinate the abdominal and pelvic floor muscles to evacuate stools.

Functional Urinary Incontinence: All forms of involuntary urination without any structural anatomical or neurological deficit.

Organic Urinary Incontinence: Rare form of urinary incontinence caused by anatomical malformations such as abnormally located terminal portion of the ureter or malformed urethra.

Overactive Bladder: Problem with bladder storage function that causes a sudden urge to urinate. The urge may be difficult to suppress, and overactive bladder can lead to the involuntary loss of urine (incontinence).

Pathological Urinary Incontinence: Organic and functional (or psychosomatic) causes of urinary incontinence.

Pelvic Floor Muscle Training (PFMT): Training used as a first-line conservative therapy to treat women with urgency urinary incontinence, stress urinary incontinence, and/or mixed urinary incontinence. PFMT utilizes pelvic floor muscles to increase urethral pressure and is believed to inhibit detrusor muscle contractions. PFMT (e.g., Kegel exercises) may be a self-directed regimen or a clinician-guided program and may or may not include biofeedback.

Physiological Urinary Incontinence: Urinary incontinence is regarded as normal in the first few years of life and is classified as pathological only after the fifth (5th) year of life has been completed (i.e., up to the child's sixth birthday). The range of normal continence development is very wide and can extend beyond the age of five (5) for "late developers."

Rome Criteria: Evidence-based, multicultural-oriented criteria used to diagnose and classify functional gastrointestinal disorders with recommended clinical applications. Rome criteria were initially introduced in 1988 and have become the research-standard definition of functional constipation. Rome IV was released in May 2016 and is the fourth version of these criteria.

Urgency/Frequency Syndrome: A syndrome in adults characterized by frequent urination of at least seven (7) times per day that is associated with a strong desire to void (urgency).

Urinary Incontinence: The unintentional loss of urine and/or the inability to retain urine due to the loss of bladder control. The major types of urinary incontinence are listed below in items 1 through 5:

1. **Mixed Incontinence:** Urine loss that is caused by a combination of stress and urge incontinence and is most common in women.

2. **Overflow Incontinence:** Urine loss that occurs when the amount of urine produced exceeds the bladder's holding capacity; it can occur as a result of bladder obstruction or injury and in men as a result of an enlarged prostate.

3. **Stress Incontinence:** Urine loss caused by increased intra-abdominal pressure that occurs during exercise, coughing, laughing, sneezing, and in men who have had prostate surgery.

4. **Total Incontinence:** Uncontrolled or continuous urinary leakage caused by neurological dysfunction, surgery, or anatomical defects.

5. **Urge Incontinence:** Urine loss caused by involuntary bladder contractions that occurs more often in adults.

Urinary Retention: A condition where the bladder overfills without causing the sensation of the need to urinate. Obstructive urinary retention is a condition due to an obstruction of the ureter, which may possibly be caused by kidney stones, fibroid tumors, or bladder neck obstruction from prostate hypertrophy. Non-obstructive urinary retention is caused by a lack of coordination between the bladder and detrusor sphincter mechanisms or a weak or non-existent bladder contraction.

Urodynamic Testing: A test or procedure that evaluates the effectiveness of the bladder, sphincters, and/or urethra at storing and releasing urine. Detrusor (bladder wall muscle) over-activity may predict decreased response to biofeedback. Currently, there are no other known clinically or urodynamically important predictors or mediators of biofeedback-assisted pelvic muscle training response.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member's benefit plan. Please refer to the member's benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

CPT Codes	Description: Codes Covered When Medically Necessary
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)
HCPCS Code	**Description: Code Covered When Medically Necessary**
E0746	Electromyography (EMG), biofeedback device

Clinical Background Information

Urinary incontinence, or the unintentional loss of urine, is a major problem in the United States that can negatively impact the quality of life, predominately in women and the elderly population. Incontinence has several causes; women are most likely to develop urinary incontinence either during pregnancy and childbirth, or after the hormonal changes of menopause due to weakened muscles of the pelvis. Older men can become incontinent as the result of prostate surgery. Other possible risk factors for the development of urinary incontinence include pelvic trauma, hysterectomy, recurrent urinary tract infections, spinal cord damage, advanced age, caffeine, and medications such as diuretics, sedatives, beta-blockers, over-the-counter cold remedies, and diet tablets.

Urinary incontinence is categorized as stress, urge, mixed, overflow, or total. A subtype of urge incontinence, called urge-frequency syndrome, is characterized by the need to void more than seven (7) times a day with uncontrollable urgency and without the loss of urine. Treatment options for urinary incontinence include behavioral strategies, Kegel exercises, physical therapy, collagen injections, pharmacological interventions, biofeedback, temporary electric stimulation, and reconstructive surgery. First-line treatment consists of the non-invasive therapies, followed by electrical stimulation before surgical intervention is considered. According to the American College of Obstetricians and Gynecologists (ACOG) Practice Guidelines, behavioral therapy, including bladder training and prompted voiding, improves symptoms of urge and mixed incontinence and can be recommended as a noninvasive treatment in many women.

Evidence-based recommendations developed by the American Neurogastroenterology and Motility Society (ANMS) and the European Society of Neurogastroenterology and Motility (ESNM) include the use of biofeedback for the short-term and long-term treatment of constipation with dyssynergic defecation. The 2013 American Gastroenterological Association's (AGA) position statement on constipation for adults state that biofeedback improves symptoms in more than 70% of patients with defecatory disorders, with success based on the motivation of the patient and frequency and intensity of the treatment.

At the time of the Plan's most recent policy review, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 30.1.1 includes medically necessary indications for biofeedback therapy rendered by a practitioner in an office or other facility setting for the treatment of urinary incontinence. CMS covers biofeedback for the treatment of stress urinary incontinence and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training (with a failed documented trial defined as no documented clinically significant improvement in urinary incontinence after completing four [4] weeks of PME training). Home use of biofeedback therapy is not covered by CMS. No NCD or local coverage determination (LCD) was found related to the treatment of a defecatory dysfunction (e.g., idiopathic constipation, fecal incontinence, dyssynergic defecation). Verify CMS criteria in the applicable NCD or LCD and coverage guidelines in in effect on the date of the prior authorization request for a Senior Care Options member.

Proposed treatment for stress urinary incontinence and/or urge urinary incontinence may include (but are not limited to) additional services specified in the following NCDs: NCD 230.10 for incontinence control devices, including mechanical/hydraulic incontinence control devices and collagen implants; NCD 230.18 for sacral nerve stimulation for urinary incontinence; and/or NCD 230.8 for a non-implantable pelvic floor electrical stimulator. According to NCD 230.16, the use of bladder stimulators, spinal cord electrical stimulators, rectal electrical stimulators, and/or bladder wall stimulators are not considered reasonable and necessary for Medicare beneficiaries, and CMS does not reimburse for these devices or for their implantation. At the time of the Plan's most recent policy review, no NCD was found from CMS for posterior tibial nerve stimulation for the treatment of incontinence and/or for any other indication; LCDs L34436 and L33396 were identified for posterior tibial nerve stimulation applicable to Massachusetts, and the service may be considered medically necessary when criteria in the applicable LCD are met. Determine if applicable CMS criteria are in effect for the requested service in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member by evaluating the requested treatment and clinical indication(s) for the service or device.

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/09/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 09/30/08: Utilization Management Committee (UMC) 10/22/08: Quality Improvement Committee (QIC)	01/01/09 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Heath Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for the Senior Care Options Product(s): 01/01/16

Policy title was *Biofeedback for Urinary Incontinence, Outpatient* from 01/01/09 to 01/31/17.
Policy title changed to *Biofeedback for Incontinence, Outpatient* from 02/01/17 to 10/31/17.
Policy title was *Biofeedback in an Outpatient Setting to Treat Bladder and/or Bowel Dysfunction (Including Incontinence)* from 11/01/17 to 11/30/19.
As of 12/01/19, the policy title is *Biofeedback in an Outpatient Setting to Treat Incontinence or Constipation*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
09/22/09	Updated coding (removed CPT 90875 and 90876 from this policy), no changes to clinical criteria.	Version 2	09/22/09: MPCTAC 10/28/09: QIC
10/01/10	No changes to criteria, updated references, codes and template.	Version 3	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	No criteria changes, updated references, and added commercial language.	Version 4	10/19/11: MPCTAC 11/29/11: QIC
07/01/12	Off cycle review for Well Sense Health Plan, revised Summary statement, reformatted Clinical Guideline Statement, deleted diagnosis codes from code list, deleted Massachusetts contract references.	Version 5	08/03/12: MPCTAC 09/05/12: QIC
12/01/12	Updated Summary and Description of Item or Service sections, referenced Plan's *Experimental and Investigational Treatment* and *Medically Necessary* policies, updated applicable code list and deleted diagnosis codes, revised language in Applicable Coding section, updated references. Added limitations related to home use. Revised title to specify an outpatient setting for the service. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."	Version 6	12/10/12: MPCTAC 01/31/13: QIC
12/01/13	Review for effective date 02/01/14. Updated Description of Service and References. Revised first paragraph in Medical Policy Statement section without changing criteria. Added definition for urodynamic testing.	02/01/14 Version 7	12/18/13: MPCTAC 01/21/14: QIC
12/01/14	Review for effective date 02/01/15.	02/01/15	12/17/14: MPCTAC

Policy Revisions History			
	Updated references.	Version 8	01/14/15: QIC
10/01/15	Review for effective date 12/01/15. Updated list of applicable products and corresponding notes. Updated References and Definitions sections.	12/01/15 Version 9	10/21/15: MPCTAC 11/11/15: QIC
11/25/15	Review for effective date 01/01/16. Revised language in the Applicable Coding section.	01/01/16 Version 10	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
10/01/16	Review for effective date 02/01/17. Revised policy title. Updated Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations section (by including an age criterion).	02/01/17 Version 11	10/19/16: MPCTAC 11/09/16: QIC
10/01/17	Review for effective date 11/01/17. Updated the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised policy title. Administrative changes made to the Medical Policy Statement and Limitations sections.	11/01/17 Version 12	10/18/17: MPCTAC
10/01/18	Review for effective date 01/01/19. Administrative changes made to the Definitions, References and Other Applicable Policies sections. Criteria updated in the Medical Policy Statement and Limitations sections.	01/01/19 Version 13	10/17/18: MPCTAC
09/01/19	Review for effective date 12/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections. Policy title revised.	12/01/19 Version 14	09/18/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide updates to codes included in the Applicable Coding section.	01/01/20 Version 15	Not applicable because industry-wide code changes.
09/01/20	Review for effective date 10/01/20.	10/01/20	09/16/20: MPCTAC

Policy Revisions History			
	Administrative changes made to the References and Other Applicable Policies sections.	Version 16	

Last Review Date

09/01/20

Next Review Date

09/01/21

Authorizing Entity

MPCTAC

Other Applicable Policies

Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Medically Necessary*, policy number OCA 3.14
Medical Policy - *Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder*, policy number OCA 3.561
Medical Policy - *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)*, policy number OCA 3.562
Medical Policy - *Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions*, policy number OCA 3.563
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.31
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy SCO 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18
Reimbursement Policy - *Non-Participating Provider*, policy number SCO 4.5
Reimbursement Policy - *Non-Participating Provider*, policy number WS 4.5
Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38
Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number SCO 4.608
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number WS 4.28

Reference to Applicable Laws and Regulations

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114.3 CMR 17.00. Code of Massachusetts Regulations. Division of Health Care Finance and Policy. Medicine.

130 CMR. Code of Massachusetts Regulations. Division of Medical Assistance.

211 CMR 52.00. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers.

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He-W 500. New Hampshire Code of Administrative Rules. Medical Assistance.

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He-W 543. New Hampshire Code of Administrative Rules. Medical Assistance. Hospital Services.

New Hampshire Department of Health and Human Services (DHHS). Certified Administrative Rules. Accessed at: https://www.dhhs.nh.gov/oos/bhfa/rules.htm

RSA 420-E. New Hampshire Revised Statutes Annotated. Insurance. Licensure of Medical Utilization Review Entitles.

Disclaimer Information:

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as

the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.