Electrical and Ultrasound Bone Growth Stimulators

Policy Number: 2020T0561N
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Instructions for Use

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Coverage Rationale

Electrical and electromagnetic bone growth stimulators are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 24th edition, 2020:

- Bone Growth Stimulators, Electrical and Electromagnetic ACG: A-0565 (AC)
- Bone Growth Stimulators, Ultrasonic ACG: A-0414 (AC)

Click here to view the MCG™ Care Guidelines.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

HCPCS Codes*	Required Clinical Information
Electrical and Electromagnetic Bone Growth Stimulators	

E0747
E0748
E0749
	Medical notes documenting all of the following:
	• Current physician prescription or order
	• Documentation explaining the reason the member will need a bone growth stimulator
	• Any risk factors that apply:
	  ○ Member with co-morbid conditions such as diabetes, obesity, osteoporosis, or current tobacco use that could compromise bone healing
	  ○ Spondylolisthesis (including grade)
	  ○ If the member has had or will be having a spinal fusion, include the following:
	  ▪ Date of surgery, either past or future and number of vertebral levels fused; or
	  ▪ Documentation of failed spinal fusion and date of reoperation of same site

Ultrasonic Bone Growth Stimulators	
E0760	Medical notes documenting all of the following: • Current physician prescription or order • Documentation to explaining the reason the member will need a bone growth stimulator

HCPCS Codes*	Required Clinical Information
Ultrasonic Bone Growth Stimulators	

	In addition to the requirements above, medical office notes documenting all of the following for:
	• Acute Fracture or Non-Union Fracture
	  ○ Date, site and type of fracture
	  ○ Diagnostic imaging reports
	  ○ Treatment of the fracture, including treatment already completed and treatment planned
	• Tibial Osteotomy
	  ○ Treatment plan (including treatment already completed and treatment planned)

**For code descriptions, see the Applicable Codes section.*

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
20975	Electrical stimulation to aid bone healing; invasive (operative)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

Coding Clarification: Utilize HCPCS code E0748 when reporting bone growth stimulation for all anatomical levels of the spine.

HCPCS Code	Description
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The FDA regards bone growth stimulators as significant-risk (Class III) devices. Because the list of products used for bone growth stimulation is extensive, see the following website for more information and search by product name in device name section: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 13, 2020)

Centers for Medicare and Medicaid Services (CMS)

Medicare covers electrical and electromagnetic bone growth stimulators when criteria are met. Refer to the National Coverage Determination (NCD) for Osteogenic Stimulators 150.2. Local coverage determinations (LCDs) exist; see the LCDs for Osteogenesis Stimulators. (Accessed January 14, 2020)

Policy History/Revision Information

Date	Summary of Changes
08/01/2020	**Template Update** • Reformatted policy; transferred content to new template
04/01/2020	**Coverage Rationale** • Replaced reference to "MCG™ Care Guidelines, *23rd* edition*, 2019*" with "MCG™ Care Guidelines, *24th* edition*, 2020*" **Supporting Information** • Archived previous policy version 2019T0561M

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. 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).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.