ELECTRICAL AND ULTRASOUND BONE GROWTH STIMULATORS

Policy Number: CS037.L

Effective Date: August 1, 2019

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APPLICATION

This policy does not apply to the states of Louisiana and Tennessee.

- For the state of Louisiana, refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Louisiana Only).
- For the state of Tennessee, refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Tennessee Only).

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, 23rd edition, 2019:

- 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.

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 federal, state or contractual requirements 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 Coverage Determination Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>20975</td>
<td>Electrical stimulation to aid bone healing; invasive (operative)</td>
</tr>
<tr>
<td>20979</td>
<td>Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)</td>
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* CPT® is a registered trademark of the American Medical Association

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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>E0747</td>
<td>Osteogenesis stimulator, electrical, noninvasive, other than spinal applications</td>
</tr>
<tr>
<td>E0748</td>
<td>Osteogenesis stimulator, electrical, noninvasive, spinal applications</td>
</tr>
</tbody>
</table>
Electrical and Ultrasound Bone Growth Stimulators

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

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/pmncfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm).

(Checked December 26, 2018)

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 December 27, 2018)

POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>12/04/2019</td>
<td><strong>Coverage Rationale</strong>&lt;br&gt;• Added reference link to MCG™ Care Guidelines</td>
</tr>
<tr>
<td>08/01/2019</td>
<td><strong>Application</strong>&lt;br&gt;• Added language to indicate this policy does not apply to the state of Tennessee; refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Tennessee Only)&lt;br&gt;<strong>Applicable Codes</strong>&lt;br&gt;• Added instruction to utilize HCPCS code E0748 when reporting bone growth stimulation for all anatomical levels of the spine (no change to guidelines)&lt;br&gt;<strong>Supporting Information</strong>&lt;br&gt;• Archived previous policy version CS037.K</td>
</tr>
</tbody>
</table>

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The 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.