Electrical and Ultrasound Bone Growth Stimulators (for Louisiana Only)

Policy Number: CS037LA1.A
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Instructions for Use

Content mandated by Louisiana Department of Health

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Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.

Coverage Rationale

Osteogenic Bone Growth Stimulators

Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Medicaid coverage is limited to reimbursement for electrical and ultrasonic non-invasive types of bone growth stimulators. Medicaid will not provide reimbursement for invasive types of bone growth stimulators.

This item has not been approved by FDA for rental. Therefore, Medicaid will not approve payment for an osteogenic bone growth stimulator as a rental device.

Non-Spinal Non-Invasive Electrical Stimulators

Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:

- The failure of long bone fractures to heal. A period of six months from the initial date of treatment must elapse before failure is considered to have occurred
- The failure of long bone fusions (a period of nine months from the initial date of treatment must elapse before failure is considered to have occurred); or
- The treatment of congenital pseudoarthroses. There is no minimal time requirement after the diagnosis.

Non-Spinal Non-Invasive Ultrasonic Stimulators

Non-spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:

- The failure of a non-union fracture to heal. A period of 90 days following treatment has occurred.
- Documentation consists of two sets of radiographs, one before treatment and the second occurring 90 days after treatment; and
- The radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs

Spinal Non-Invasive Electrical Stimulators

Spinal non-invasive electrical bone growth stimulators may be considered:

- When a minimum of nine months has elapsed since the beneficiary had fusion surgery which resulted in a failed spinal fusion
- When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again). As long as nine months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; or
- Following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum requirement for application after surgery.

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 Guidelines may apply.

CPT Code	Description
Electrical Bone Growth Stimulator: Non-Spinal (Invasive, Non-Invasive)	
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975	Electrical stimulation to aid bone healing; invasive (operative)
Ultrasound Bone Growth Stimulator	
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, non-invasive

References

Louisiana Department of Health: Durable Medical Equipment Provider Manual, Section 18.2 – Osteogenic Bone Growth Stimulators of the Medicaid Services Manual: https://www.lamedicaid.com/provweb1/providermanuals/manuals/DME/DME.pdf. Accessed March 2, 2021.

Policy History/Revision Information

Date	Summary of Changes
04/01/2021	• Created state-specific policy version for content addressed in the *Louisiana Department of Health: Durable Medical Equipment Provider Manual*

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 InterQual® criteria, 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.