

Electrical and Ultrasound Bone Growth Stimulators (for North Carolina Only)

Policy Number: CSNCT0561.03
Effective Date: March 1, 2023

[➔ Instructions for Use](#)

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Related Policies
None

Application

This Medical Policy only applies to the state of North Carolina.

Coverage Rationale

Electrical Bone Growth Stimulators

The use of invasive or noninvasive electrical bone growth stimulators are considered proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy for Physician, 1A-6 Invasive Electrical Bone Growth Stimulation](#) and the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy for Medical Equipment, 5A-1, Physical Rehabilitation Equipment and Supplies](#).

Ultrasound Bone Growth Stimulators

The use of ultrasonic bone growth stimulators is proven and medically necessary for the treatment of nonunion of long bone fractures in certain circumstances. For medical necessity clinical coverage criteria, refer to the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy for Medical Equipment, 5A-1, Physical Rehabilitation Equipment and Supplies](#).

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)

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Coding Clarification: Use 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, refer to the following website for more information and search by product name in the Device Name field on either the 510(k) page or on the Premarket Approvals page using Product Codes LOE (for stimulator, invasive bone growth), LOF (for stimulator, bone growth, non-invasive), or LPQ (for ultrasound bone growth stimulators): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed July 21, 2022)

References

North Carolina Medicaid, Division of Health Benefits, Clinical Coverage Policies, Invasive Electrical Bone Growth Stimulation, No: 1A-6. [NC Medicaid: Invasive Electrical Bone Growth Stimulation, 1A-6](#). Accessed February 28, 2023.

North Carolina Medicaid, Division of Health Benefits, Clinical Coverage Policies, Physical Rehabilitation Equipment and Supplies, No: 5A-1. <https://medicaid.ncdhhs.gov/media/12396/download?attachment>. Accessed February 28, 2023.

Policy History/Revision Information

Date	Summary of Changes
03/01/2023	Supporting Information <ul style="list-style-type: none"> Added <i>FDA</i> section Updated <i>References</i> section to reflect the most current information Archived previous policy version CSNCT0561.02

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.