

# ELECTRICAL AND ULTRASOUND BONE GROWTH STIMULATORS

**Policy Number:** DME 006.22 T2

**Effective Date:** October 1, 2018

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**Related Policies**

None

## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

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

## CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package <sup>1</sup> Durable Medical Equipment (DME) <sup>2</sup>
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes
Precertification with Medical Director Review Required	No
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Outpatient, Home
Special Considerations	<sup>1</sup> CPT codes 20975 and 20979. <sup>2</sup> HCPCS codes E0747, E0748, E0749 and E0760.

## BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

## Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

### 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, 22<sup>nd</sup> edition, 2018:**

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

### 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 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)

*CPT® is a registered trademark of the American Medical Association*

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)

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 May 3, 2018)

### POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	<ul style="list-style-type: none"><li>• Updated coverage rationale to clarify electrical and electromagnetic bone growth stimulators are proven and medically necessary in certain circumstances; see MCG™ Care Guidelines, 22<sup>nd</sup> edition, 2018 for <i>medical necessity</i> clinical coverage criteria</li><li>• Archived policy version DME 006.21 T2</li></ul>