ELECTRICAL AND ULTRASOUND BONE GROWTH STIMULATORS

Policy Number: DME 006.24 T2

Conditions of Coverage

This policy applies to Oxford Commercial plan membership.

Benefit Type
- General benefits package
- Durable Medical Equipment (DME)

Referral Required
- No

Authorization Required
- Yes

Precertification with Medical Director Review Required
- No

Applicable Site(s) of Service
- Inpatient, Outpatient, Home

Special Considerations
- \(^1\)CPT codes 20975 and 20979
- \(^2\)HCPCS codes E0747, E0748, E0749 and E0760

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).

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.

Electrical and Electromagnetic Bone Growth Stimulators

Medical notes documenting all of the following:
- Current physician prescription or order
- Documentation explaining the reason the member will need a bone growth stimulator
Required Clinical Information

Electrical and Electromagnetic Bone Growth Stimulators (continued)

- 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

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

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)

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.

<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>
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<tr>
<td>20979</td>
<td>Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)</td>
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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<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>
<tr>
<td>E0749</td>
<td>Osteogenesis stimulator, electrical, surgically implanted</td>
</tr>
<tr>
<td>E0760</td>
<td>Osteogenesis stimulator, low intensity ultrasound, noninvasive</td>
</tr>
</tbody>
</table>

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

**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](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm).

(Accessed December 26, 2018)
INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 Oxford reserves the right 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. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

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