ELECTRICAL AND ULTRASOUND BONE GROWTH STIMULATORS

Guideline Number: MMG036.L **Effective Date**: August 1, 2019

Instructions for Use

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Related Policies

None

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.

Required Clinical Information

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
- 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 guideline 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 and Guidelines 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)

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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

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.
(Accessed December 26, 2018)

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2019	**Applicable Codes** • Added instruction to utilize HCPCS code E0748 when reporting bone growth stimulation for all anatomical levels of the spine (no change to guidelines) **Supporting Information** • Archived previous policy version MMG036.K

INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare 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 benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline 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. UnitedHealthcare West Medical Management 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.