Clinical Policy: Bone Growth Stimulator

Reference Number: WA.CP.MP.508
Last Review Date: 09/19

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity guidelines for bone growth stimulators.

Policy/Criteria
I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that electrical non-invasive bone growth stimulators are considered medically necessary for the following conditions:
   A. Nonunion of long bone fractures where fracture healing ceased 3 or more months prior as demonstrated by serial radiographs. Serial radiographs must include:
      1. A minimum of 2 sets of radiographs, each including multiple views of the fracture site
      2. Radiographs must be a minimum of 90 days apart
   B. Failed fusion with a minimum of 9 months elapsed since the last surgery
   C. Adjunct to a covered spinal fusion surgery for patients with either
      1. A high risk of pseudarthrosis due to previously failed spinal fusion at the same site or
      2. A multiple level fusion involving 3 or more vertebrae (e.g., L3-L5, L4-S1)
   D. Congenital pseudarthroses

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that electrical invasive bone growth stimulators are considered medically necessary for the following conditions:
   A. Nonunion of long bone fractures where fracture healing ceased 3 or more months prior as demonstrated by serial radiographs. Serial radiographs must include:
      1. A minimum of 2 sets of radiographs, each including multiple views of the fracture site
      2. Radiographs must be a minimum of 90 days apart
   B. Adjunct to a covered spinal fusion surgery for patients with either
      1. A high risk of pseudarthrosis due to previously failed spinal fusion at the same site or
      2. A multiple level fusion involving 3 or more vertebrae (e.g., L3-L5, L4-S1)

III. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that ultrasonic bone growth stimulators are considered medically necessary for the following conditions:
   A. Nonunion of long bone fractures meeting both of the following criteria:
      1. A minimum of 2 sets of radiographs, each including multiple views of the fracture site and
      2. Physician statement of no clinical evidence of fracture healing between the two sets of radiographs
   B. Fresh fractures at high risk for non-union.
IV. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that bone growth stimulators are considered not medically necessary for the following conditions:
   A. Nonunion of skull or vertebrae
   B. Tumor-related nonunion of bone

V. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that ultrasonic bone growth stimulators are considered not medically necessary for the following conditions:
   A. Delayed fracture healing
   B. Concurrent use with other non-invasive stimulators.

Background
This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications
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<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>20974</td>
<td>Electrical stimulation to aid bone healing; noninvasive (nonoperative)</td>
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<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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<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>E0747</td>
<td>Osteogenesis stimulator, electrical, noninvasive, other than spinal applications</td>
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<tr>
<td>E0748</td>
<td>Osteogenesis stimulator, electrical, noninvasive, spinal applications</td>
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<tr>
<td>E0749</td>
<td>Osteogenesis stimulator, electrical, surgically implanted</td>
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<tr>
<td>E0760</td>
<td>Osteogenesis stimulator, low intensity ultrasound, noninvasive</td>
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Reviews, Revisions, and Approvals

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<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>Approval Date</th>
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<td>Policy developed.</td>
<td>09/19</td>
<td>09/19</td>
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References

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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