# Clinical Policy: Bone Growth Stimulator

Reference Number: WA.CP.MP.508
Last Review Date: 05/21
Effective Date: 06/01/21

Coding Implications
Revision Log

**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 pseudarthrosis

**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, separated by a minimum of 90 days, 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**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT® Codes | Description |
|---|---|
| 20974 | Electrical stimulation to aid bone healing; noninvasive (nonoperative) |
| 20975 | Electrical stimulation to aid bone healing; invasive (operative) |
| 20979 | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative) |

| HCPCS Codes | 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 |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Policy developed. | 09/19 | 09/19 |
| Annual review. References updated | 06/20 | 07/20 |
| Annual review. Typographical corrections. Replaced "member" with "member/enrollee' in all instances. Updated references | 05/21 | 06/21 |

**References**


1. Hayes, W. (Center for Evidence-based Policy, Oregon Health & Science University). Bone Growth Stimulators. Washington Health Technology Assessment. July 31, 2009.
2. Washington State Health Care Authority. Physician-related Services/Health Care Billing Guide https://www.hca.wa.gov/assets/billers-and-providers/physician-related-servs-bg-20210401.pdf Effective April 1, 2021.
3. Center for Medicare and Medicaid Services. National Coverage Determination for Osteogenic Stimulators (150.2), version 2. Effective 4/27/2005. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=65&ver=2


**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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

**Note: For Medicaid members/enrollees**, 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.