Osteogenic Bone Growth Stimulators

DRAFT

Humana

Medicaid Medical Coverage Policy

Original Effective Date: 08/22/2022
Effective Date: xx/xx/xxxx
Review Date: 10/07/2025
Policy Number: LA.CLI.053.001
Line of Business: Medicaid
State: LA

Table of Contents

Description
Coverage Limitations
References
Coverage Determination
Change Summary

Disclaimer

The Clinical Coverage Policies are reviewed by the Humana Medicaid Coverage Policy Adoption (MCPA) Forum. Policies in this document may be modified by a member's coverage document. Clinical policy is not intended to preempt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. References to CPT® codes or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee of claims payment. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from Humana.

~~Summary of Changes:~~

~~10/16/2024: Annual Review, minor grammatical changes and updated references to most recent edition reviewed. Updated to include FDA verbiage not approved as a rental device. 1/20/2025: Updated language approved by LDH.~~

~~Scope:~~

~~This policy applies to all Humana Healthy Horizons™ in Louisiana (Plan) associates who administer, review, or communicate covered physical and behavioral health benefits and services to eligible enrolled members.~~

~~Policy:~~

Description

Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Coverage is limited to reimbursement for electrical and ultrasonic noninvasive types of bone growth stimulators. ~~The Plan will not provide reimbursement for invasive types of bone growth stimulators.~~

This item has not been approved by the U.S. Food and Drug Administration (FDA) for rental. Therefore, the Plan will not approve payment for an osteogenic bone growth stimulator as a rental device.

Coverage Determination

Non-Spinal Non-Invasive Electrical Stimulators

Humana Healthy Horizons in Louisiana members may be eligible under the Plan for nonspinal noninvasive bone growth stimulators for the following indications:

~~Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:~~

- ~~The f~~**F**ailure of long bone fractures to heal. Failure is considered to have occurred after a period of six (6) months from the initial date of treatment has elapsed; **OR**

- ~~The f~~**F**ailure of long bone fusions. Failure is considered to have occurred after a period of nine (9) months from the initial date of treatment has elapsed; **OR**

- ~~The t~~**T**reatment of congenital pseudo-arthroses. There is no minimal time requirement after the diagnosis.

Non-Spinal Non-invasive Ultrasonic Stimulators

Humana Healthy Horizons in Louisiana members may be eligible under the Plan for nonspinal noninvasive ultrasonic bone growth stimulators when the following criteria are met:

~~Non-Spinal non-invasive ultrasonic bone growth stimulators may be considered medically necessary under the following circumstances:~~

- ~~The~~ Failure of a non-union fracture to heal. Failure is considered to have occurred after a period of ninety (90) days following treatment ~~has occurred~~; **AND**

- Documentation consists of two (2) sets of radiographs, one before treatment and the second occurring 90 days after treatment; ~~and~~ **AND**

- ~~The~~ Radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs

Spinal Noninvasive Electrical Stimulators

Humana Healthy Horizons in Louisiana members may be eligible under the Plan for spinal noninvasive electrical bone growth stimulators for the following indications:

~~Spinal non-invasive electrical bone growth stimulators may be considered medically necessary:~~

- When a minimum of nine (9) months has elapsed since the beneficiary had fusion surgery which resulted in a failed spinal fusion; **OR**

- When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine (9) months has elapsed since fusion surgery was performed at the same level which is being fused again). As long as nine (9) months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; **OR**

- Following a multi-level spinal fusion (**eg,** ~~i.e.,~~ involving three (3) or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum time requirement for application after surgery.

~~Definitions: - N/A~~

Coverage Limitations

Humana Healthy Horizons in Louisiana members may NOT be eligible under the Plan for an invasive type of bone growth stimulator. This is considered not medically necessary.

A review of the current medical literature shows that there is no evidence to determine that this service is standard medical treatment. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature examining benefit and long-term clinical outcomes establishing the value of this service in clinical management.

References

1. **Louisiana Department of Health. Medicaid Services Manual. Chapter 18: Durable Medical Equipment, Section 18.2.25 Electrical Stimulators.** https://ldh.la.gov/medicaid. **Published September 1, 2010. Updated June 25, 2025.**

~~State of Louisiana Bureau of Health Services Financing. Durable Medical Equipment Provider Manual, Chapter Eighteen of the Medicaid Services Manual, DME (2/28/2023). Accessed (10/16/2024).~~

~~Version Control:~~

Change Summary

08/22/2022: Policy creation-Approved by LDH for Readiness
05/15/2023: Approved by LA UM Committee
09/06/2023: Changed to new template for Annual Review Due by 5.15.24.
01/12/2024: Minor changes made.
10/07/2025: Annual Review, No Coverage Change. New Clinical Coverage Policy Template Edits align with state-specific content

~~Non-Compliance:~~

~~Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services, or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules, and regulations.~~

~~Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet on Hi! (Workday & Apps/Associate Support Center).~~