UnitedHealthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

ELECTRICAL AND ULTRASOUND BONE GROWTH STIMULATORS

Policy Number: CS037.~~K~~**L** **Effective Date**: ~~August 1, 2019~~**TBD**

Instructions for Use

Table of Contents **Page**

Commercial Policy

- Electrical and Ultrasound Bone Growth Stimulators

APPLICATION

This policy does not apply to the state**s** of **Nebraska and** Tennessee.~~,~~

- **For the state of Nebraska, refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Nebraska Only)**
- **For the state of Tennessee** refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Tennessee Only).

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, **[**2~~3~~**4th**~~rd~~ edition, 20**20**~~19~~**]**:

- Bone Growth Stimulators, Electrical and Electromagnetic ACG: A-0565 (AC)
- Bone Growth Stimulators, Ultrasonic ACG: A-0414 (AC)

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 federal, state or contractual requirements 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 Coverage Determination 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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Coding Clarification: Utilize HCPCS code E0748 when reporting bone growth stimulation for all anatomical levels of the spine.

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, non-invasive

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 **January 13, 2020**~~December 26, 2018~~)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare covers electrical and electromagnetic bone growth stimulators when criteria are met. Refer to the National Coverage Determination (NCD) for Osteogenic Stimulators 150.2. Local coverage determinations (LCDs) exist; see the LCDs for. Osteogenesis Stimulators. (Accessed January 14, 2020)
~~Medicare covers electrical and electromagnetic bone growth stimulators when criteria are met. Refer to the National Coverage Determination (NCD) for Osteogenic Stimulators (150.2). Local coverage determinations (LCDs) exist; see the LCDs for Osteogenesis Stimulators.~~
~~(Accessed December 27, 2018)~~

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
TBD	**Application** • **Added language to indicate this policy does not apply to the states of:** o **Nebraska; refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators (for Nebraska Only)** **Coverage Rationale** • **Replaced references to "MCG™ Care Guidelines, 23rd edition, 2019" with "MCG™ Care Guidelines, 24th edition, 2020" (refer to 24th edition for complete details on applicable updates to the MCG™ Care Guidelines)** **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** • **Updated FDA and CMS sections to reflect the most current information** • **Archived previous policy version CS037.K**

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy 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. The UnitedHealthcare Medical 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.