

**Medical Policy
Bone Growth Stimulators**

Document Number: 009

	Commercial and Qualified Health Plans	MassHealth
Authorization required	X	X
No notification or authorization		
Not covered		

Overview

The purpose of this document is to describe the guidelines AllWays Health Partners utilizes to determine medical appropriateness for bone growth stimulation for the treatment of acute fractures and non-union fractures, and in conjunction with spinal fusion. Coverage for the use of bone growth stimulation requires prior authorization. AllWays Health Partners does not cover invasive electrical bone growth stimulators.

Coverage Guidelines

As of February 20, 2017, medical necessity for bone growth stimulators is determined through McKesson’s InterQual® criteria. To access the InterQual® Criteria Lookup Tool, log in to AllWays Health Partners’ Provider website at allwaysprovider.org. AllWays Health Partners covers certain types of bone growth stimulation for the treatment of specific acute fractures, and non-union fractures, or in conjunction with spinal fusion when recommended by the member’s primary care provider or referring specialist and when the request meets medical necessity criteria.

Exclusions

AllWays Health Partners does not provide coverage for:

1. Acute fracture that requires surgical intervention or internal or external hardware fixation.
2. Fracture of any age of the axial skeleton, pectoral girdle, pelvis, phalanx, or sesmoid.
3. Treatment of sesmoiditis.
4. Avulsion fracture of any age.
5. Stress fracture of any age other than tarsal navicular fracture or Jones fracture when criteria above are met.
6. Adjunct to avascular necrosis of a femoral head repair.
7. A member with any contraindications listed in the device’s package insert.
8. Replacement or repair when:
 - a) It is still under manufacture warranty;
 - b) It is lost, stolen or damaged due to improper care, or misuse, or neglect (AllWays Health Partners may require proof of the stolen or damaged item. Proof consist of a police report, pictures, or corroborating statement); and
 - c) The member has a functioning model and a newer or upgraded model is not medically necessary.

Definitions

Gustilo Grading for open fractures:

Grade I: Clean wound smaller than 1 cm in diameter, appears clean, simple fracture pattern, no skin crushing.

Grade II: A laceration larger than 1 cm but without significant soft-tissue crushing, including no flaps, degloving, or contusion. Fracture pattern may be more complex.

Grade III: An open segmental fracture or a single fracture with extensive soft-tissue injury. Also included are injuries older than 8 hours. Type III injuries are subdivided into three types:

Grade III A: Adequate soft-tissue coverage of the fracture despite high-energy trauma or extensive laceration or skin flaps.

Grade III B: Inadequate soft-tissue coverage with periosteal stripping. Soft-tissue reconstruction is necessary.

Grade III C: Any open fracture that is associated with vascular injury that requires repair.

Long bone fracture non-unions: Having no visible evidence of healing for at least 3 months as confirmed by a minimum of 2 sets of radiographs taken a minimum of 90 days apart. Each radiograph must show multiple views of the fracture site.

Failed spinal fusion: Spinal fusion that has not healed as evidenced by serial imaging with greater than 9 months past initial surgery and 3 months of lack of progressive healing.

Spondylolisthesis Grading

Grade I: 0-25% vertebral slippage

Grade II: 25-50% vertebral slippage

Grade III: 50-75% vertebral slippage

Grade IV: 75-100% vertebral slippage

Grade V: Greater than 100% vertebral slippage.

CPT/HCPC Codes

Authorized CPT/HCPCS Codes	Code Description
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
E0747	Osteogenesis stimulator, electrical, noninvasive , other than spinal applications
E0748	Osteogenesis stimulator, electrical, noninvasive , spinal applications
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive

Effective

June 2018: Annual Update.

April 2018: Added codes.

February 2017: McKesson’s InterQual® criteria replaced the criteria as indicated in the policy.

October 2016: Annual update.

October 2015: Annual review, no substantial change in the literature.

October 2014: Annual review without substantial changes in medically necessary indicators.

August 2013: Annual update, added invasive bone growth stimulators to exclusions after literature and independent practitioner review.

August 2012: Annual update, no changes.

August 2011: Effective date

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