



## Clinical Medical Policy Bone Growth Stimulators

### Benefit Coverage:

Conditional benefit; approval is based on review of medical necessity documentation.

### Description:

An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound in an attempt to accelerate the healing time of a fracture.

A multilevel spinal fusion is one which involves 3 or more vertebrae (e.g. L3-L5, L4-S1, etc).

A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal.

### Coverage Determination:

Bone Growth Stimulators are a clinical option when determined medically necessary by the Medical Management Department. **Prior authorization is required.**

Criteria	HCPCS Codes	Diagnosis
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<p>A nonspinal electrical osteogenesis stimulator is covered only if any of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator. NOTE: Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.</li> <li>2. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery.</li> <li>3. Congenital pseudoarthrosis.</li> </ol>	E0747	733.82 755.8
Criteria	HCPCS Codes	Diagnosis
<p>A spinal electrical osteogenesis stimulator is covered <b>only</b> if any of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Failed spinal fusion where a minimum of nine months has elapsed since the last surgery.</li> <li>2. Following a multilevel spinal fusion surgery (see definitions above).</li> <li>3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.</li> <li>4. Other high risk of spinal fusion failure secondary to: <ul style="list-style-type: none"> <li>• BMI of 35 or greater, or</li> <li>• Current ETOH or tobacco use, or</li> <li>• Diabetes or Renal Disease</li> <li>• Degenerative osteoarthritis, or</li> <li>• Grade II or worse spondylolisthesis</li> </ul> </li> </ol>	E0748	<p>250.00 250.01 250.02 250.03 250.10 250.11 250.12 250.13 250.2 250.20 250.21 250.22 250.23 250.30 250.31 250.32 250.33 250.40 250.41 250.42 250.43 250.50 250.51 250.52 250.60 250.61 250.63 250.63 250.70 250.71 250.72 250.73 250.80 250.81 250.82 250.83 250.90 250.91 250.92 250.93</p> <p>403.00 403.01 403.10 403.11 403.90 403.91</p> <p>724.9</p>
<p>An ultrasonic osteogenesis stimulator is covered only if all of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Nonunion of any of the following fractures:</li> </ol>		



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Closed Fracture of Rib(s) unspecified – open fracture of sternum	E0760	807.00 807.01 807.02 807.03 807.04 807.05 807.06 807.07 807.08 807.09 807.10 807.11 807.12 807.13 807.14 807.15 807.16 807.17 807.18 807.19 807.2 807.3
Closed Fracture of Acetabulum – Unspecified Open Fracture of Pelvis	E0760	808.0 808.1 808.2 808.3 808.41 808.42 808.43 808.49 808.51 808.52 808.53 808.59 808.8 808.9
<b>Criteria</b>	<b>HCPCS Codes</b>	<b>Diagnosis</b>



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<p>Closed Fracture of Clavicle Unspecified Part – Open Fracture of Multiple Sites of Phalanx or Phalanges of Hand</p>	<p>E0760</p>	<p>810.00 810.01 810.02 810.03 810.10 810.11 810.12 810.13</p> <p>811.00 811.01 811.05 811.03 811.09 811.10 811.11 811.12 811.13 811.19</p> <p>812.00 812.01 812.02 812.03 812.09 812.10 812.11 812.12 812.13 812.19 812.20 812.21 812.30 812.31 812.40 812.41 812.42 812.43 812.44 812.49 812.50 812.51 812.52 812.53 812.54 812.59</p> <p>813.00 813.01 813.02 813.03 813.04 813.05 813.06 813.07 813.08 813.10 813.11 813.12 813.13 813.14 813.15 813.16 813.17 813.18 813.20 813.21 813.22 813.23 813.30 813.31 813.32 813.33 813.40 813.41 813.42 813.43 813.44 813.45 813.50 813.51 813.52 813.53 813.54 813.80 813.81 813.82 813.83 813.90 813.91 813.92 813.93</p> <p>814.00 814.01 814.02 814.03 814.04 814.05 814.06 814.07 814.08 814.09 814.10 814.11 814.12 814.13 816.13 814.14 814.15 814.16 814.17 814.18 814.19</p> <p>815.00 815.01 815.02 815.03 815.04 815.09 815.10 815.11 815.12 815.13 815.14 815.19</p> <p>816.00 816.01 816.02 816.03 816.10 816.11 816.12 816.13</p>
<p><b>Criteria</b></p>	<p><b>HCPCS Codes</b></p>	<p><b>Diagnosis</b></p>



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<p>Fracture of Unspecified Intracapsular Section of Neck of Femur or Femur Closed – Open Fracture of One or More Phalanges of Foot</p>	<p>E0760</p>	<p>820.00 820.01 820.02 820.03 820.09  820.10 820.11 820.12 820.12 820.19  820.21 820.22 820.30 820.31 820.32  820.8 820.9</p> <p>821.00 821.01 821.10 821.11  821.20 821.21 821.22 821.23  821.29 821.30 821.31 821.32  821.33 821.39</p> <p>822.0 822.1 823.00 823.01 823.02  823.10 823.11 823.12 823.20 823.21  823.22 823.30 823.31 823.32 823.40  823.41 823.42 823.80 823.81 823.82  823.90 823.91 823.92</p> <p>824.0 824.1 824.2 824.3 824.4  824.5 824.6 824.7 824.8 824.9</p> <p>825.0 825.1 825.20 825.21 825.22  825.23 825.24 825.25 825.29 825.30  825.31 825.32 825.33 825.34 825.35  825.39</p> <p>826.0 826.1</p>
<p>Nonunion of any of the following fractures:  2. A minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days. Each radiograph set must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and  3. The fracture is not of the skull or vertebrae; and  4. The fracture is not tumor related.</p>	<p>E0760</p>	

**Exclusions:**

Use of an ultrasonic osteogenic stimulator for the treatment of a fresh fracture or delayed union will be denied as not medically necessary.



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*CMP Number:* CMP-001.01

*CMP Cross Reference:*

*References:*

1.) Centers for Medicare and Medicaid Services (CMS). Decision memo for ultrasound stimulation for nonunion fracture healing (CAG-00022R). Medicare Coverage Database. Baltimore, MD: CMS; April 27, 2005. Available at:  
<http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=135>.

2.) NHIC, Corp. Medicare Part B Contractor. DME MAC Jurisdiction A, Medical Policies (Local Coverage Determinations):  
[http://www.medicarenhic.com/dme/medical\\_review/mr\\_lcds/mr\\_lcd\\_current/lcd%20for%20osteogenesis%20stimulators%201206%2Eshtml](http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/lcd%20for%20osteogenesis%20stimulators%201206%2Eshtml)

*Created:*

*Annual Review Month:* July

*Review Dates:* 9/13/06, 9/2/08, 3/9/10

*Revision Dates:* 9/13/06, 9/2/08

*Approval Dates:* 09/01/02, 4/12/07, 9/9/08, 3/9/10