| MEDICAL POLICY | Bone Growth Stimulators (Medicare Only) |
|---|---|
| **Effective Date: 10/1/2022**<br>  <br>10/1/2022<br>Medical Officer Date | Medical Policy Number: 226<br>Medical Policy Committee Approved Date: 12/17; 12/18; 7/19; 8/2020; 9/2021; 9/2022 |

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

## SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

## APPLIES TO:

Medicare Only

## MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

| Service | Medicare Guidelines |
|---|---|
| *Osteogenic Stimulators* | • National Coverage Determination (NCD) for Osteogenic Stimulators (150.2)<br>• Local Coverage Determination (LCD): Osteogenesis Stimulators (L33796)<br><br>**NOTE:** For definitions of "multiple level fusion" or "multilevel spinal fusion" and "long bone", please see the "Appendices" found in LCD L33796. |

## BILLING GUIDELINES

General

See associated local coverage articles (LCAs) for related billing and coding guidance:

- Local Coverage Article (LCA): Osteogenesis Stimulators- Policy Article (A52513)

## HCPCS CODES

| Medicare Only | |
| --- | --- |
| Prior Authorization Required | |
| **Spinal Electrical Bone Growth Stimulator** | |
| 20974 | Electrical stimulation to aid bone healing; noninvasive (nonoperative) |
| 20975 | Electrical stimulation to aid bone healing; invasive (operative) |
| E0748 | Osteogenesis stimulator, electrical, non-invasive, spinal applications |
| E0749 | Osteogenesis stimulator, electrical, surgically implanted |
| **Non-Spinal Electrical Bone Growth Stimulator** | |
| 20974 | Electrical stimulation to aid bone healing; noninvasive (nonoperative) |
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications |
| **Ultrasound Bone Growth Stimulator** | |
| 20979 | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative) |
| E0760 | Osteogenesis stimulator, low intensity ultrasound, non-invasive |
| No Prior Authorization Required | |
| A4559 | Coupling gel or paste, for use with ultrasound device, per oz |

## INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously

considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.