MEDICAL COVERAGE POLICY	
SERVICE:	**Medicaid Bone Growth Stimulators**
Policy Number:	**270**
Effective Date:	**10/01/2020**
Last Review:	**08/27/2020**
Next Review Date:	**08/27/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Medicaid Bone Growth Stimulators

PRIOR AUTHORIZATION: Required.

POLICY: For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Noninvasive Electrical Bone Growth Stimulators may be medically necessary for Medicaid members when **ALL** of the following are met:

- Serial radiographs have confirmed that no progressive signs of healing have occurred
- The fractured gap is 1 cm or less
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions
- The member has a diagnosis requiring a bone growth stimulator as indicated by **1 or more** of the following:
  - ✓ Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care
  - ✓ Delayed unions of fractures of failed arthrodesis at high risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Ultrasonic bone growth stimulators may be medically necessary for Medicaid members when **ALL** of the following criteria are met:

- Bone growth stimulator is being used for delayed fracture union or osteotomy healing, as indicated by 1 or more of the following:
- Two sets of radiographs that meet **ALL of** the following:
  - ✓ Images are obtained prior to starting treatment with bone growth stimulator
  - ✓ Images are separated by at least 90 days
  - ✓ Written interpretation by physician who states that there has been no clinically significant evidence of fracture healing between the two sets of radiographs

- No malignancy at fracture site
- Patient skeletally mature

Coverage for a second or more device(s) may be medically necessary when the above medical necessity criteria are met. This limitation is in place whether or not the previous request was approved under the current benefit plan.

OVERVIEW:

Internal and external bone growth (osteogenic) stimulators are a benefit of Texas Medicaid. Bone growth stimulators are a benefit for skeletally-mature individuals only.

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device that transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity, pulsed ultrasound waves.

A noninvasive electrical bone growth stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound bone growth stimulator (procedure code E0760) are benefits of Texas Medicaid for DME providers when provided in the home setting. An invasive electrical bone growth stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic bone growth stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid members when the member experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudarthrosis.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudoarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the member begins treatment with the bone growth stimulator.

MANDATES: The Alberto N Agreement (Section 8.1) states that all DME policies, guidelines, or provider manuals will prominently display the following statement when describing the scope of DME available to beneficiaries:

> Medicaid beneficiaries under the age of 21 years are entitled to all medically necessary DME. DME is medical necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or condition. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under the age of 21 years if medically necessary. Likewise, time period for replacement of DME will not apply to Medicaid beneficiaries under the age of 21 years if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medical necessary.

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CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	E0747 E0760
CPT Not Covered:	
ICD10 codes:	
ICD10 Not covered:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	08/27/2020	New policy

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to the health plan so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Texas Medicaid Provider Procedures Manual: http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx
2. The Alberto N Agreement (Section 8.1): http://www.tmhp.com/Homepage%20File%20Library/Archive/Second%20Partial%20Settlement%20Agreement.pdf