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Bone Growth (Osteogenesis) Stimulators (BGS) MP9076

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information: Concurrent use of electrical and ultrasound stimulation devices is not eligible for coverage

Prevea360 Health Plan Medical Policy:

Electrical or Electromagnetic Bone Growth Stimulators

1.0 An electrical bone growth stimulator **requires** prior authorization through the Health Services Division and is considered medically necessary for **ANY** of the following clinical situations:

1.1 Treatment of long bone fracture nonunion (excluding those related to malignancy), of the appendicular skeleton (including the bones of the shoulder girdle, upper extremities, pelvis, and lower extremities) when **ALL** of the following are present:

1.1.1 The fracture was acquired secondary to trauma or surgery; **AND**

1.1.2 There is evidence of adequate fracture care (e.g. casting, immobilization, internal fixation); **AND**

1.1.3 At least 90 days have elapsed since the fracture and institution of conventional fracture treatment; **AND**

1.1.4 There is documentation of non-union of the fracture and that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator, as demonstrated by two (2) sets of radiographs separated by a minimum of 90 days (measured from the date of the most recent medical or surgical intervention) **AND**

1.1.5 The fracture gap is one (1) centimeter or less.

1.2 Treatment of failed or high risk spinal fusion (all regions of the spine) when **ANY** of the following criteria are met:

1.2.1 Failed fusion when a minimum of six (6) months has elapsed since the last surgery

1.2.2 Bone growth stimulator is being used as adjunctive treatment with fusion surgery on higher risk member with a mature skeleton and **ALL** of the following criteria are met:

1.2.2.1 Member has risk factors for fusion failure as indicated by **ANY** of the following: diabetes, obesity (BMI equal to or greater than 30), osteoporosis, current tobacco use, continuous oral corticosteroid use for greater than six (6) months, renal disease; **AND**

1.2.2.2 Fusion is at high risk of failure, as indicated by **ANY** of the following:

1.2.2.2.1. History of previous failed fusion

1.2.2.2.2. Surgery will fuse multiple levels with three (3) or more vertebrae involving (2) or more vertebral spaces (e.g. C2-C4, L3-L5, L4-S1, etc)

1.2.2.2.3. Grade II or worse spondylolisthesis is noted.

2.0 The use of electrical bone growth stimulation is considered experimental and investigational and therefore not medically necessary for **ANY** of the following, including but not limited to:

2.1.1 Long bones with fresh fractures

2.1.2 Nonunion of appendicular bones other than long bones

2.1.3 Delayed union of long bone fractures when criteria of 1.1 are not met

2.1.4 Biologically inert nonunion better suited to bone grafting

2.1.5 Scaphoid fractures (all types: e.g. nonunion, acute/fresh, delayed union)

Ultrasonic Bone Growth Simulators

3.0 Ultrasonic bone growth stimulation **requires** prior authorization through the Health Services Division and is considered medically necessary for **ANY** of the following clinical situations:

3.1 Acute fracture when **ALL** of the following criteria are met:

3.1.1 Fresh fracture of the tibia in a skeletally mature member; **AND**

3.1.2 Orthopedic closed management with or without reduction; **AND**

3.1.3 Fracture less than seven (7) days old; **AND**

3.1.4 Fracture gap is less than or equal to 1 cm; **AND**

3.1.5 None of the following contraindications are present:

3.1.5.1 Fracture that is pathological or associated with malignancy

3.1.5.2 Fracture is unstable, or requires surgical intervention or internal or external fixation

3.1.5.3 Postreduction displacement greater than 50 percent or postreduction angulation or malalignment

3.1.5.4 Presence of pacemaker or implantable defibrillator

3.2 Non-union fracture (including scaphoid) when **ALL** of the following criteria are met:

3.2.1 Fracture does not involve the skull or vertebrae, and is not tumor related; **AND**

3.2.2 The facture was acquired secondary to trauma or surgery (including tibial osteotomy); **AND**

3.2.3 There is evidence of adequate fracture care (e.g. casting, immobilization, internal fixation; **AND**

3.2.4 The fracture gap is less than or equal to 1 centimeter

3.2.5 There is documentation of non-union of the fracture and that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator, as demonstrated by two (2) sets of radiographs separated by a minimum of 90 days (measured from the date of the most recent medical or surgical intervention)

4.0 The use of ultrasonic osteogenesis stimulator is considered experimental and investigational and therefore not medically necessary for **ANY** of the following, including but not limited to:

4.1 Delayed union fractures

4.2 Non-union fractures of the skull, vertebrae, and those that are tumor-related

4.3 Fresh non-tibial fractures

4.4 Scaphoid fractures when criteria of 3.2 are not met

4.5 Treatment of fresh fracture of the radius is considered not medically necessary

	Committee/Source	**Date(s)**
Document Created:	Utilization Management Committee/ Concurrent Review/Medicare Communiqué, July 1997	October 8, 1997
Revised:	Utilization Management Committee	November 12, 1997
	Utilization Management Committee/ HAYES/ Orthopedists	January 19, 2000
	Utilization Management Committee/ Medical Affairs Department	March 14, 2001
	Utilization Management Committee/ Medical Affairs	March 13, 2002
	Utilization Management Committee/ Medical Affairs	May 12, 2004
	Utilization Management Committee/Medical Affairs/Medicare Part B, 10/2005	February 8, 2006
	Utilization Management Committee/ Medical Affairs	April 8, 2009

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	Committee/Source	Date(s)
Revised:	Medical Director Committee/Medical Affairs	August 18, 2010
	Medical Director Committee/Medical Affairs	March 24, 2011
	Medical Director Committee/Medical Affairs	August 25, 2011
	Medical Director Committee/Medical Affairs	October 16, 2013
	Medical Director Committee/Medical Affairs	July 16, 2014
	Medical Policy Committee/Quality and Care Management Division	May 18, 2016
	Medical Policy Committee/Quality and Care Management Division	April 19, 2017
	Medical Policy Committee/Quality and Care Management Division	February 21, 2018
	Medical Policy Committee/Health Services Division	February 20, 2019
	Medical Policy Committee/Health Services Division	August 19, 2020
	Medical Policy Committee/Health Services Division	August 18, 2021
	Medical Policy Committee/Health Services Division	May 18, 2022
	Medical Policy Committee/Health Services Division	May 17, 2023
Reviewed:	Health Services	February 12, 1999
	Managed Care Division/ Medical Affairs Department	March 20, 2000
	Managed Care Division / Medical Affairs Department	April 11, 2001
	Utilization Management Committee/ HAYES, July 2000	October 10, 2001
	UMC/CMO/Director UM	March 13, 2002
	UM Committee (UMC)/Director UM/UMC Chair	March 12, 2003
	UM Committee (UMC)/Director UM/UMC Chair	March 10, 2004
	UM Committee (UMC)/Director UM/UMC Chair	March 9, 2005
	Reformatted	February 2006
	UM Committee (UMC)/Director UM/UMC Chair	March 8, 2006
	UM Committee (UMC)/Director UM/ UMC Chair	March 14, 2007
	UM Committee (UMC)/Director UM/ UMC Chair	March 12, 2008
	UM Committee (UMC)/Director UM/UMC Chair	April 8, 2009
	Medical Director Committee/Medical Affairs	August 18, 2010
	Medical Director Committee/Medical Affairs	August 25, 2011
	Medical Director Committee/Medical Affairs	August 15, 2012
	Medical Director Committee/Medical Affairs	April 17, 2013
	Medical Director Committee/Medical Affairs	October 16, 2013
	Medical Director Committee/Medical Affairs	April 16, 2014
	Medical Director Committee/Medical Affairs	July 16, 2014
	Medical Director Committee/Medical Affairs	April 15, 2015
	Medical Policy Committee/Quality and Care Management Division	April 20, 2016
	Medical Policy Committee/Quality and Care Management Division	May 18, 2016

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	Medical Policy Committee/Quality and Care Management Division	February 21, 2018
	Medical Policy Committee/Health Services Division	February 20, 2019
	Medical Policy Committee/Health Services Division	August 19, 2020
	Medical Policy Committee/Health Services Division	August 18, 2021
	Medical Policy Committee/Health Services Division	May 18, 2022
	Medical Policy Committee/Health Services Division	May 17, 2023

Published: 06/01/2023

Effective: 06/01/2023