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## **1.0 Description of Procedure**

Electrical osteogenic stimulation is used to augment the repair of long bones. Nonunion of long bone fractures, for the purpose of this policy, exists when serial radiographs (anterior–posterior and lateral images) show no progressive healing in a fracture for three or more months prior to starting treatment with the electrical osteogenic stimulator. Electrical osteogenic stimulation can be performed invasively, semi-invasively, or non-invasively.

### **1.1 Invasive and Semi-Invasive Stimulation**

Invasive devices provide electrical stimulation directly at the fracture site through implantation of a coiled cathode wire into the fracture site. The power pack for the device is implanted in an intramuscular or subcutaneous space near the fracture site and connected to the cathode, creating a self-contained system with no external components. The semi-invasive procedure, called percutaneous, uses an external power supply and electrodes are inserted through the skin into the bone.

### **1.2 Non-Invasive Stimulation**

Non-invasive devices consist of pads that are attached to an external power supply and placed over the cast or directly on the skin. An electromagnetic field is created between the pads at the fracture site.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

*EPSDT provider page:* <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### 3.0 When the Procedure Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### 3.1 Invasive Stimulation

Invasive electrical osteogenic stimulation is covered in cases unresponsive to conventional treatment modalities for the following.

- a. Adjunct treatment to spinal fusion in recipients with a prior history of failed spinal fusion at the same site or recipients undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae.
- b. Non-union of long bones.

### 3.2 Non-invasive Stimulation

Non-invasive electrical osteogenic stimulation is covered in cases unresponsive to conventional treatment modalities for the following.

- a. Adjunct treatment to spinal fusion in recipients with a history of failed spinal fusion at the same site or recipients undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae.
- b. Congenital pseudoarthroses.
- c. Failed fusion where a minimum of nine months has elapsed since the last surgery.
- d. Non-union of long bones.

## 4.0 When the Procedure Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 4.1 General Criteria

Electrical osteogenic stimulation is not covered when the coverage criteria in **Section 3.0** are not met.

### 4.2 Specific Criteria

Electrical osteogenic stimulation is not covered for the following contraindicators:

- a. Any indication of malignant change or pathologic fractures.
- b. Bone "gaps" wider than one centimeter.
- c. Childhood (epiphyseal growth changes).
- d. Decelerated fracture healing process as identified by x-ray.
- e. Gross motion at the non-union site in all planes when the limb is immobilized.
- f. Interposition of soft tissue or sequestrum between fragments.
- g. New fractures.
- h. Non-union in the presence of a synovial pseudoarthrosis.
- i. The presence of draining osteomyelitis (active osteomyelitis).
- j. The presence of magnetic fixation devices in the areas to be stimulated.

## 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

- a. Prior approval is required. The following medical documentation must be submitted with the prior approval request:
  1. The date of the injury and/or re-injury.
  2. The non-union of a long bone fracture must be documented by a minimum of two sets of radiographs, separated by a minimum of 90 days, each including multiple views of the fracture site with a written interpretation by a physician stating that there has been no evidence of fracture healing between the two sets of radiographs.
  3. Medical documentation of a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery.
  4. Medical evidence of congenital pseudarthrosis.
- b. Failure of a previous bone graft is not a contraindication to the use of a bone stimulator, provided coverage criteria are met.
- c. Stimulators require monthly inspection by the orthopedic surgeon.
- d. The physician E/M visit for the monthly inspection is included in the 24 legislated visit limit.
- e. There must be medical evidence that the recipient does not have any of the contraindications listed in **Section 4.0**.

## 6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this service may bill for this service.

## 7.0 Additional Requirements

There are no additional requirements.

## 8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### 8.1 Claim Type

Providers bill professional physician services on the CMS-1500 claim form.

## 8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill ICD-9-CM diagnosis code 733.82, “Non-union of fracture,” to support medical necessity.

## 8.3 Procedure Codes

CPT codes that are covered by the N.C. Medicaid program are 20974 and 20975.

## 8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

## 9.0 Policy Implementation/Revision Information

**Original Effective Date:** April 1, 1982

### Revision Information:

Date	Section Updated	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA’s EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age