

# Electrical and Ultrasonic Bone Growth Stimulators (for Louisiana Only) **Retired April 1, 2026**

**Policy Number:** CS037LA1.F

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[Instructions for Use](#)

Content mandated by Louisiana Department of Health

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## Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with state requirements.

## Coverage Rationale

### Osteogenic Bone Growth Stimulators

Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion. Medicaid coverage is limited to reimbursement for electrical and ultrasonic non-invasive types of bone growth stimulators. Medicaid will not provide reimbursement for invasive types of bone growth stimulators.

This item has not been approved by FDA for rental. Therefore, Medicaid will not approve payment for an osteogenic bone growth stimulator as a rental device.

### Non-Spinal Non-Invasive Electrical Stimulators

Non-spinal non-invasive electrical bone growth stimulators may be considered under the following circumstances:

- The failure of long bone fractures to heal (a period of six months from the initial date of treatment must elapse before failure is considered to have occurred); or
- The failure of long bone fusions (a period of nine months from the initial date of treatment must elapse before failure is considered to have occurred); or
- The treatment of congenital pseudoarthroses (there is no minimal time requirement after the diagnosis)

### Non-Spinal Non-Invasive Ultrasonic Stimulators

Non-spinal non-invasive ultrasonic bone growth stimulators may be considered under the following circumstances:

- The failure of a non-union fracture to heal (a period of 90 days following treatment has occurred); and
- Documentation consists of two sets of radiographs, one before treatment and the second occurring 90 days after treatment; and
- Radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs

## Spinal Non-Invasive Electrical Stimulators

Spinal non-invasive electrical bone growth stimulators may be considered:

- When a minimum of nine months has elapsed since the beneficiary had fusion surgery which resulted in a failed spinal fusion; or
- When there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery (meaning more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again); as long as nine months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; or
- Following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1); there is no minimum requirement for application after surgery

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
<b>Electrical Bone Growth Stimulator: Non-Spinal (Invasive, Noninvasive)</b>	
*20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
*20975	Electrical stimulation to aid bone healing; invasive (operative)
<b>Ultrasound Bone Growth Stimulator</b>	
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

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**Coding Clarification:** Utilize HCPCS code E0748 when reporting bone growth stimulation for all anatomical levels of the spine.

HCPCS Code	Description
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
*E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive

Codes labeled with an asterisk (\*) are not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program.

## References

Louisiana Department of Health: Durable Medical Equipment Provider Manual, Section 18.2 – Osteogenic Bone Growth Stimulators of the Medicaid Services Manual:

<https://www.lamedicaid.com/provweb1/providermanuals/manuals/DME/DME.pdf>. Accessed September 30, 2025.

## Policy History/Revision Information

Date	Summary of Changes
04/01/2026	<ul style="list-style-type: none"><li>Retired policy; Louisiana plan membership disenrolled on Apr. 1, 2026</li></ul>
02/01/2026	<p><b>Title Change</b></p> <ul style="list-style-type: none"><li>Previously titled <i>Electrical and Ultrasound Bone Growth Stimulators (for Louisiana Only)</i></li></ul> <p><b>Medical Records Documentation Used for Reviews</b></p> <ul style="list-style-type: none"><li>Added language to indicate:<ul style="list-style-type: none"><li>Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service</li><li>Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested</li><li>The patient's medical record must contain documentation that fully supports the medical necessity for the requested services</li><li>This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures</li><li>Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request</li></ul></li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Archived previous policy version CS037LA1.E</li></ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.