MEDICAL POLICY – 7.01.85

Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures

Related Medical Policies:
1.01.05 Ultrasound Accelerated Fracture Healing Device
7.01.07 Electrical Bone Growth Stimulation of the Appendicular Skeleton
7.01.542 Lumbar Spinal Fusion

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Spinal fusion is a surgery that causes the bones of the spine (the vertebrae) to grow together and become like one bone. A graft is used and then the body’s own processes create the fusion over time. In some cases, the fusion processes can be helped along with electrical stimulation. Stimulators send electrical pulses or current through tissues, toward the bone. Electrical bone growth stimulators appear to make bone cells grow. Electrical bone growth stimulators are either noninvasive, invasive (implantable), or semi-invasive (semi-implantable).

- Noninvasive stimulators deliver current through small patches (electrodes) or coils placed on the skin.
- Invasive electrical stimulation use devices that are implanted in the body.
- Semi-invasive stimulators use needle-like electrodes placed through the skin.

This policy discusses when noninvasive and invasive electrical bone growth stimulators may be considered medically necessary for spinal fusions. Semi-invasive stimulators are considered investigational (unproven) for spinal fusions.
Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

### Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Stimulation</th>
<th>Medical Necessity</th>
</tr>
</thead>
</table>
| Invasive or noninvasive electrical bone growth stimulation | Invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to lumbar spinal fusion surgery in patients at high risk for fusion failure, defined as having ANY one of the following criteria:  
  - Alcoholism  
  - Current tobacco use  
  - Diabetes  
  - Fusion to be performed at more than one level  
  - Grade III or worse spondylolisthesis  
  - One or more previous failed spinal fusion(s)  
  - Renal disease  
  - Steroid use  
  - As a treatment of patients with failed lumbar spinal fusion                                                                                       |

<table>
<thead>
<tr>
<th>Stimulation</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-invasive electrical bone growth stimulation</td>
<td>Semi-invasive electrical bone growth stimulation is considered investigational as an adjunct to lumbar fusion surgery and for failed lumbar fusion.</td>
</tr>
</tbody>
</table>
| Invasive, semi-invasive, and noninvasive electrical bone growth stimulation | Invasive, semi-invasive, and noninvasive electrical bone growth stimulation is considered investigational:  
  - As an adjunct to cervical fusion surgery and for failed cervical spine fusion  
  - As an adjunct for healing of lumbar spondylolysis (pars interarticularis defect/fracture)                                                                 |
Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>20974</td>
<td>Electrical stimulation to aid bone healing; noninvasive (non-operative)</td>
</tr>
<tr>
<td>20975</td>
<td>Electrical stimulation to aid bone healing; invasive (operative)</td>
</tr>
<tr>
<td>HCPCS</td>
<td></td>
</tr>
<tr>
<td>E0748</td>
<td>Osteogenesis stimulator, electrical, non-invasive, spinal applications</td>
</tr>
<tr>
<td>E0749</td>
<td>Osteogenesis stimulator, electrical, surgically implanted</td>
</tr>
</tbody>
</table>

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

**Failed spinal fusion**: a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays done over 3 months in a row.

**Spinal fusion**: A surgical procedure that joins (fuses) two or more bones in the spine (vertebrae) using bone grafts or metal rods.

**Spondylolysis/isthmic spondylolysis**: A stress fracture or defect in the bone connecting one facet joint to another (pars interarticularis). This condition may be seen in adolescents involved in sports.

Benefit Application

Invasive electrical stimulation will be billed as a component of the hospital bill. Noninvasive devices may be adjudicated according to the member’s benefits for durable medical equipment.
Background

Both invasive and noninvasive electrical bone growth stimulators have been investigated for use after spinal fusion surgery, with or without associated instrumentation, to enhance the chances of obtaining a solid spinal fusion. Noninvasive devices have also been investigated to treat a failed fusion.

Electrical and electromagnetic fields can be generated and applied to bones through the following methods:

- Invasive devices require surgical implantation of a current generator in an intramuscular or subcutaneous space, while an electrode is implanted within the fragments of bone graft at the fusion site. The implantable device typically remains functional for 6 to 9 months after implantation and, although the current generator is removed in a second surgical procedure when stimulation is completed, the electrode may or may not be removed. Implantable electrodes provide constant stimulation at the nonunion or fracture site but carry increased risks associated with implantable leads.

- Noninvasive electrical bone growth stimulators generate a weak electrical current within the target site by using either pulsed electromagnetic fields, capacitive coupling, or combined magnetic fields. In capacitive coupling, small skin pads/electrodes are placed on either side of the fusion site and worn for 24 hours per day until healing occurs, or up to 9 months. In contrast, pulsed electromagnetic fields are delivered via treatment coils that are placed into a back brace or directly onto the skin and are worn for 6–8 hours per day for 3 to 6 months. Combined magnetic fields deliver a time-varying magnetic field by superimposing the time-varying magnetic field onto an additional static magnetic field. This device involves a 30-minute treatment per day for 9 months. Patient compliance may be an issue with externally worn devices.

- Semi-invasive (semi-implantable) stimulators use percutaneous electrodes and an external power supply, thus eliminating the need for a surgical procedure to remove the generator when treatment is finished.
Summary of Evidence

The evidence for invasive or noninvasive methods of electrical bone growth stimulation as an adjunct to lumbar spine fusion surgery in individuals who have a high risk for lumbar spinal fusion failure includes a systematic review, a TEC Assessment, and randomized controlled trials (RCTs). Relevant outcomes are symptoms, change in disease status, and functional outcomes. Results from these trials indicate that in patients with risk factors for failed fusion, either invasive or noninvasive electrical bone stimulation increases the fusion rate. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for noninvasive methods of electrical bone growth stimulation in individuals who have failed a previous lumbar spinal fusion includes a TEC Assessment and studies where patients served as their own controls. Relevant outcomes are symptoms, change in disease status, and functional outcomes. Data indicate that noninvasive electrical stimulation improves the fusion rate in this population. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for invasive or noninvasive electrical bone growth stimulation in individuals who are undergoing cervical spinal fusion surgery or who have previously failed a cervical spine fusion includes an RCT. Relevant outcomes are symptoms, change in disease status, and functional outcomes. The only controlled trial published to date had methodologic limitations and the efficacy of electrical stimulation in the cervical spine has not been established. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2017 did not identify any ongoing or unpublished trials that would likely influence this review.

Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may provide appropriate reviewers who collaborate with and make recommendations during this process, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.
In response to requests, input was received from 2 physician specialty societies and 3 academic medical centers while this policy was under review for January 2011. Clinical input agreed with the criteria for high risk of fusion failure of the lumbar spine. The input on electrical stimulation for the cervical spine was mixed. Specifically, some of those providing input agreed that data do not demonstrate improved outcomes with use of electrical stimulation in cervical spine fusion surgery. Most reviewers agreed that the large number of dropouts, non-significant difference in fusion rates by ITT analysis, and lack of data on functional outcomes (eg, pain, return to usual activity) limited interpretation of the published study results.

Practice Guidelines and Position Statements

North American Spine Society

In 2016, the North American Spine Society (NASS) issued a coverage recommendation for electrical bone growth stimulators.18

1. “For augmentation of spinal fusion in any and all regions of the spine including occipital-cervical, cervical, cervicothoracic, thoracic, thoracolumbar, lumbar and lumbosacral spinal regions in patients at high-risk for the development of pseudarthrosis (ie, nonunion) who exhibit one or more of the following:

   a. Are undergoing spinal fusion of two or more motion segments (3 vertebrae)

   b. Are undergoing a revision spinal fusion (eg, repeat surgery for a previously unhealed fusion attempt)

   c. Are smokers who cannot stop smoking in preparation for fusion due to the nature of the underlying condition (eg, acute traumatic fracture)

   d. Exhibit one or more of the following comorbidities when undergoing primary lumbar fusion:

      i. Diabetes

      ii. Inflammatory arthritis (eg, rheumatoid arthritis) that has required long-term corticosteroid therapy

      iii. Immunocompromised (eg, undergoing chemotherapy and radiation therapy to the spine, hypogammaglobulinemia, granulocytopenia, acquired immune deficiency syndrome, chronic granulomatous disease)
iv. Systemic vascular disease

v. Osteopenia or osteoporosis

2. In the lumbar spine, the following forms of electrical stimulation are indicated in high-risk patients with the specific techniques outlined. In all other regions of the spine, coverage for the same indications is recommended although there is less supporting evidence.

   a. DCS [direct current stimulation: electrodes implanted within or very close to the location of the desired fusion] and CCS [capacitance coupling stimulation; 2 electrodes placed on the skin over the fusion site] for posterolateral fusion using autograft and extender

   b. PEMFS [pulsed electromagnetic field stimulation: coils that produce a time-varying magnetic field around the area of the desired fusion] for lumbar interbody fusion.”

**American Association of Neurological Surgeons and the Congress of Neurological Surgeons (AANS/CNS)**

Updated 2014 guidelines from the AANS/CNS state that there is no evidence published after their 2005 guidelines that conflicts with the previous recommendations regarding bone growth stimulation.\(^{19}\)

Based on a single level II study from 2009, the routine use of direct current stimulation (DCS) in patients older than age 60 years was not recommended. Use of DCS was recommended as an option for patients younger than 60 years of age, based on Level III and IV studies showing a positive impact on fusion rate. However, comments regarding the level III study were that it was a poorly designed and poorly conducted cohort study consisting of an exceedingly small heterogeneous population of patients, and the overall recommendation was level C. There was insufficient evidence to recommend for or against the use of pulsed electromagnetic field stimulation (PEMFS) as a treatment alternative to revision surgery in patients presenting with pseudoarthrosis following posterolateral lumbar fusion (PLF, single level IV study). No additional studies investigating the efficacy of capacitive coupled electrical stimulation were identified.

The 2005 AANS/CNS guidelines stated that there is class II and III evidence (nonrandomized comparative trials and case series) “to support the use of direct current stimulation or capacitatively coupled stimulation for enhancing fusion rates in high-risk patients undergoing lumbar PLF. A beneficial effect on fusion rates in patients not at “high risk” has not been convincingly demonstrated, nor has an effect been shown for these modalities in patients treated with interbody fusion. There is limited evidence both for and against the use of PEMFS
for enhancing fusion rates following PLF. Class II and III medical evidence supports the use of PEMFS for promoting arthrodesis following interbody fusion. Although some studies have purported to demonstrate functional improvement in some patient subgroups, other studies have not detected differences. All of the reviewed studies are significantly flawed by the use of a four-point patient satisfaction scale as the primary outcome measure. This outcome measure is not validated. Because of the use of this flawed outcome measure and because of the conflicting results reported in the better-designed studies that assess functional outcome, there is no consistent medical evidence to support or refute use of these devices for improving patient outcomes.²⁰

U.S. Preventive Services Task Force Recommendations

Electrical stimulation of the spine is not a preventive service.

Medicare National Coverage

Medicare covers noninvasive electrical stimulators for the following²¹:

- Failed fusion, where a minimum of 9 months has elapsed since the last surgery AND
- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Medicare covers invasive electrical stimulators:

- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Regulatory Status

**Implantable Devices**

The following implantable device received FDA premarket approval (PMA):
• The OsteoStim® (Electro-Biology, Inc.), which may also be marketed under the trade name SPF (Biomet), has received FDA PMA in 1986.

**Noninvasive Devices**

Noninvasive bone growth stimulators that have received FDA PMA include:

• The SpinalPak® bone growth stimulator system from Biolectron (a subsidiary of Electro-Biology Inc., Parsippany, NJ) is a capacitive coupling system, received PMA in 1999 for use as an adjunct to primary lumbar spinal fusion at one or two levels.

• The EBI Bone Healing System® from Biolectron (a subsidiary of Electro-Biology Inc., Parsippany, NJ) is a pulsed electromagnetic field system which was first approved in 1979 with FDA PMA and indicated for nonunions, failed fusions, and congenital pseudoarthroses. The device is secured with a belt around the waist.

• SpinaLogic Bone Growth Stimulator® (Regentek, a division of dj Orthopedics - formerly OrthoLogic, Tempe, AZ) received PMA in 1994 as a combined magnetic field portable device. This device is secured with a belt around the waist.

• Spinal-Stim Lite® (Orthofix Inc., Richardson, TX) received PMA in 1996 as a spinal adjunct to the Physio-Stim®. This device was approved to increase the probability of fusion success and as a non-operative treatment for the salvage of failed spinal fusion, where a minimum of 9 months has elapsed since the last surgery.

• The Stim® (Orthofix Inc., Richardson, TX) is a pulsed electromagnetic field system that was approved in 2004 as an adjunct to cervical fusion surgery in patients at high risk for non-fusion. An illustration of how this particular device is worn is available at online site: [http://web.orthofix.com/Products/Pages/Cervical-Stim.aspx](http://web.orthofix.com/Products/Pages/Cervical-Stim.aspx) Accessed June 2017.

**Semi-invasive Devices**

No semi-invasive electrical bone growth stimulator devices were identified with FDA approval or clearance.

FDA product codes: LOE (invasive bone growth stimulator), LOF (noninvasive bone growth stimulator)
References


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/15/03</td>
<td>Add to Surgery Section - New medical policy. Originally addressed electrical stimulation for spinal fusion in policy CP.MP.BC.7.01.07 along with electrical stimulation of the appendicular skeleton. This new policy now only addresses this indication. Policy statement essentially unchanged. Expanded discussion, new references added.</td>
</tr>
<tr>
<td>06/08/04</td>
<td>Replace policy - Policy reviewed; references added; no change in policy statement; Title updated.</td>
</tr>
<tr>
<td>06/14/05</td>
<td>Replace policy - Policy updated with literature search; no change in policy statement. Status changed from BC to AR.</td>
</tr>
<tr>
<td>06/09/06</td>
<td>Disclaimer and Scope update - No other changes.</td>
</tr>
<tr>
<td>10/14/08</td>
<td>Replace policy - Policy updated with literature search. Rationale updated with addition of 2005 American Association of Neurological Surgeons/Congress of Neurological Surgeons Treatment Guidelines. Reference added.</td>
</tr>
<tr>
<td>08/11/09</td>
<td>Replace policy - Policy updated with literature search; no change to the policy statement.</td>
</tr>
<tr>
<td>11/10/09</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>06/08/10</td>
<td>Replace policy - Replaces PR.7.01.534. On hold for 90 days, release to publish in November 2010.</td>
</tr>
<tr>
<td>11/01/10</td>
<td>Policy Published - Subsequent to release from 90-day hold; effective date 11/1/2010.</td>
</tr>
<tr>
<td>03/08/11</td>
<td>Replace policy - Policy updated with literature search through July 2010; references added and reordered; clinical input reviewed, no change in policy statement</td>
</tr>
<tr>
<td>01/11/12</td>
<td>Codes 0282T-0285T added.</td>
</tr>
<tr>
<td>12/19/12</td>
<td>Replace policy. Added 7.01.542 Lumbar fusion policy to related policies section. Rationale updated based on a literature search through August 2012. References 15-</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12/09/13</td>
<td>16 added, others renumbered or removed. Policy statement unchanged.</td>
</tr>
<tr>
<td>03/17/14</td>
<td>Replace policy. A literature search through August 26, 2013 did not prompt the addition of new references. Policy statement unchanged.</td>
</tr>
<tr>
<td>08/12/14</td>
<td>Update Related Policies. Remove 7.01.100 as it was archived.</td>
</tr>
<tr>
<td>04/17/15</td>
<td>Update Related Policies. Remove 7.01.529 as it was deleted and replaced with new policy 7.01.07.</td>
</tr>
<tr>
<td>05/27/15</td>
<td>Coding update: CPT codes 0282t, 0283T, 0284T and 0285T removed; these apply specifically to policy another policy (7.01.139).</td>
</tr>
<tr>
<td>12/08/15</td>
<td>Annual Review. Literature search done with no resultant change to the policy statement.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Interim review, approved December 13, 2016. Investigational statement amended with added diagnosis of lumbar spondylolysis (pars interarticularis defect/fracture). Reference added for this indication during annual review. Added Definition of Terms.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese):

本通知有关重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保單的重要訊息。本通知可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):


Lakkoofsa biblii’a 800-722-1471 (TTY: 800-842-5357) ti biblii’a.

Français (French):


Appelez le 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):


Hmoob (Hmong):


Ilokano (Ilocano):

Daytoy a Pakdaa ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaa mabaliny nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonu yenno coverage babaen iti Premera Blue Cross. Daytoy ket mabaliny dagiti importante a pelta iti daytoy a pakdaar. Mabaliny nga adda rumbeng nga aramiendiy nga addang sakbay dagiti partikular a naituding nga adda ldawp tapno mapatgalinayo ti coverage ti salun-atyo yenno tungong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tungong ti bukdoyo a pagasasao nga awan ti bayadanoy. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente.

Chiamà 800-722-1471 (TTY: 800-842-5357).

037338 (07-2016)

Russian (Russian): Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagpakawalang i sa pamamagitan ng Premera Blue Cross. Es posible que haya fechas claves en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).