Priority Health	BILLING POLICY No. 104
OSTEOGENESIS	
Date of origin: June 19, 2025	**Review dates: July 2026, Aug 2026**

POLICY OVERVIEW

An electrical osteogenesis stimulator is a device that delivers electrical stimulation to enhance bone healing. A noninvasive electrical stimulator is defined by an external power source linked to a coil or electrodes that are positioned on the skin or over site of a fracture or bone fusion (site may have cast or brace).

An ultrasonic osteogenesis stimulator may also be utilized to promote healing at a fracture site. This device generates low-intensity, pulsed ultrasound waves over the skins surface at the fracture site.

MEDICAL POLICY

- Durable Medical Equipment (#91110)
- Stimulation Therapy and Devices (#91468)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

Osteogenesis devices billed with HCPCS codes E0747, E0748, and E0760 are classified as Class II devices. These codes will require KF modifier appended to all claims submitted with these codes.

- **E0747**: Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
- **E0748**: Osteogenesis stimulator, electrical, noninvasive, spinal applications
- **E0760**: Osteogenesis stimulator, low intensity ultrasound, noninvasive

Osteogenesis devices billed with HCPCS code E0749 are classified as Class III devices. This code will require KF modifier appended to all claims submitted with this code.

- **E0749**: Osteogenesis stimulator, electrical, surgically implanted

Pay close attention to anatomical site outlined in HCPCS code. Selecting a code that does not align to anatomical location and site supported in medical record will result in a denial.

HCPCS code A4559 should be used for ultrasound conductive coupling gel when ultrasonic osteogenesis stimulator is used.

For DME item or equipment that is disposable (or the majority component required for functionality is disposable), use HCPCS A9270. Disposable items do not meet the definition of a DME item or equipment and are not payable.

Devices reported without a payable diagnosis as detailed in the medical policy will result in a denial. Modifier KX should be appended to codes to indicate medical policy criteria is met.

Modifiers

- **KF**: Required for Class II & III devices per CMS bulletin transmittal 13846
- **KX**: Requirements specified in the medical policy have been met

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list above may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference Article - Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) for documentation requirements.

- Documentation must include a written order prior to delivery
- Face to face encounter with a physician must occur prior to written order
- Documentation must support medical necessity as outlined in medical policy above.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

RELATED POLICIES

- Durable medical equipment (DME) refill requirements
- Durable medical equipment (DME) place of service (POS)

REFERENCE

- https://www.cms.gov/files/document/r13846cp.pdf

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
07/2026	Updated Class II devices under coding section and modifier section for KF
08/2026	Corrected the verbiage for the KF modifier per CMS bulletin 07/01/2026