

## Medical Policy:

### Biomagnetic Therapy

POLICY NUMBER	LAST REVIEW
MG.MM.ME.59C8	August 9, 2024

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines 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. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

## Definitions

Biomagnetic therapy (aka magnetic therapy, magnetherapy, magnotherapy, static magnetic field therapy or therapeutic magnets) consists of placing a magnet on or near the skin using a variety of devices (e.g., bracelets, necklaces, insoles, sleeves, head bands, mattress pads, etc.) to create an electromagnetic field to areas of musculoskeletal damage or perceived discomfort. Proposed uses include degenerative joint conditions such as osteoarthritis, joint and tendon injury.

## Guideline

Biomagnetic therapy is considered investigational and not medically necessary.

## Limitations and Exclusions

Biomagnetic therapy, in any capacity, is not considered medically necessary for pain management (or any disease/condition) due to insufficient evidence of therapeutic value.

## Procedure Codes

97799	Unlisted physical medicine/rehabilitation service or procedure
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## References

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4. Colbert AP, Markov MS, Carlson N, et al. Static magnetic field therapy for carpal tunnel syndrome: a feasibility study. *Arch Phys Med Rehabil*. 2010; 91(7):1098-1104.
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8. Richmond SJ, Brown SR, Campion PD, et al. Therapeutic effects of magnetic and copper bracelets in osteoarthritis: a randomised placebo-controlled crossover trial. *Complement Ther Med*. 2009; 17(5-6):249-256.
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## Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Dec. 2019	ConnectiCare adopts the clinical criteria of its parent corporation EmblemHealth