Electrical Bone Growth Stimulation of the Appendicular Skeleton
Corporate Medical Policy

File name: Electrical Bone Growth Stimulation of the Appendicular Skeleton
File code: UM.SPSVC.11
Last Review: 08/2015
Next Review: 08/2016
Effective Date: 01/01/16

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I- Procedural Coding Table
Attachment II- ICD Coding Table

When a service may be considered medically necessary

- Noninvasive electrical bone growth stimulation may be considered medically necessary as treatment of fracture non-unions or congenital pseudoarthroses in the appendicular skeleton (the appendicular skeleton includes the bones of the shoulder girdle, upper extremities, pelvis, and lower extremities). The diagnosis of fracture nonunion must meet ALL of the following criteria:
  - at least 3 months have passed since the date of fracture;
  - serial radiographs have confirmed that no progressive signs of healing have occurred;
  - the fracture gap is 1 cm or less; and
  - the patient can be adequately immobilized; and
  - is of an age likely to comply with non-weight bearing for fractures of the pelvis and lower extremities.

When a service is considered investigational

Investigational applications of electrical bone growth stimulation include, but are not limited to, immediate postsurgical treatment after appendicular skeletal surgery, stress fractures, or for the treatment of fresh fractures, delayed union, arthrodesis or failed arthrodesis.
Implantable and semi-invasive electrical bone growth stimulators are considered investigational.

Definitions

Fresh Fracture
A fracture is most commonly defined as “fresh” for 7 days after the fracture occurs. Most fresh closed fractures heal without complications with the use of standard fracture care, i.e., closed reduction and cast immobilization.

Delayed Union
Delayed union is defined as a decelerating healing process as determined by serial x-rays, together with a lack of clinical and radiologic evidence of union, bony continuity, or bone reaction at the fracture site for no less than 3 months from the index injury or the most recent intervention. In contrast, nonunion serial x-rays (described next) show no evidence of healing. When lumped together, delayed union and nonunion are sometimes referred to as “un-united fractures.”

Nonunion
There is not a consensus for the definition of non-unions. One proposed definition is failure of progression of fracture healing for at least 3 consecutive months (and at least 6 months following the fracture) accompanied by clinical symptoms of delayed/nonunion (pain, difficulty weight bearing).

The original FDA labeling of fracture non-unions defined non-unions as fractures that had not shown progressive healing after at least 9 months from the original injury. The original FDA labeling defined nonunion as follows: “A nonunion is considered to be established when a minimum of 9 months has elapsed since injury and the fracture site shows no visibly progressive signs of healing for minimum of 3 months.” This timeframe is not based on physiologic principles but was included as part of the research design for FDA approval as a means of ensuring homogeneous populations of patients, many of whom were serving as their own controls. Others have contended that 9 months represents an arbitrary cutoff point that does not reflect the complicated variables that are present in fractures, i.e., degree of soft tissue damage, alignment of the bone fragments, vascularity, and quality of the underlying bone stock. Some fractures may show no signs of healing, based on serial radiographs as early as 3 months, while a fracture nonunion may not be diagnosed in others until well after 9 months. The current policy of requiring a 3-month timeframe for lack of progression of healing is consistent with the definition of nonunion as described in the clinical literature.

Rationale
In the appendicular skeleton, electrical stimulation (with either implantable electrodes or noninvasive surface stimulators) has been investigated for the treatment of delayed union, nonunion, and fresh fractures.
Noninvasive Bone Growth Stimulation

Nonunion
The policy regarding electrical bone stimulation as a treatment of nonunion of fractures of the appendicular skeleton is based on the labeled indications by the U.S. Food and Drug Administration (FDA). FDA approval was based on a number of case series in which patients with non-unions, primarily of the tibia, served as their own control. These studies suggest that electrical stimulation results in subsequent unions in a significant percentage of patients.

A 2008 systematic review of electromagnetic bone growth stimulation by Griffin et al included 49 studies, 3 of which were randomized controlled trials (RCTs). The 2 RCTs that included patients with nonunion, and the single RCT that included patients with delayed union, are described next.

A 1994 RCT by Scott and King compared capacitive coupled electric fields with sham treatment (dummy unit) in 23 patients with nonunion (fracture at least 9 months old and without clinical or radiographic sign of progression to union within the last 3 months) of a long bone. Patients with systemic bone disorders, synovial pseudoarthrosis, or fracture gap of greater than half the width of the bone were excluded. In this trial, electrodes were passed onto the skin surface through holes in the plaster cast. Twenty-one patients completed the protocol (10 treatment, 11 controls). Six months after beginning treatment, an orthopedic surgeon and a radiologist, neither of them involved in the patients’ management, examined radiographs and determined that 6 of 10 in the treatment group healed, while none of those in the control group healed (p=0.004).

In 2003, Simonis et al compared pulsed electromagnetic field stimulation and placebo treatment for tibial shaft fractures un-united at least 1 year after fracture, no metal implant bridging the fracture gap, and no radiologic progression of healing in the 3 months before treatment. All 34 patients received operative treatment with osteotomy and unilateral external fixator before randomization. Treatment was delivered by external coils. Patients were assessed monthly for 6 months, and clinical and radiographic assessments were conducted at 6 months. Treatment was considered a failure if union was not achieved at 6 months. In the treatment group, 89% of fractures healed compared with 50% in the control group (p=0.02). While a larger percentage of smokers in the treatment group healed than compared with those in the control group, the number of smokers in each group was not comparable, and the difference in healing rates between groups was not statistically significant. The authors conclude that the available evidence supports the use of pulsed electromagnetic field (PEMF) therapy in the treatment of nonunion of the tibia and suggest that future trials should consider which modality of electromagnetic stimulation and in which anatomic sites the treatment is most effective.

Delayed Union
Shi et al reported a randomized sham-controlled trial that included 58 patients with delayed union of surgically reduced long-bone fractures (femur, tibia, humerus, radius ulna). Delayed union was defined as a failure to heal after at least 16 weeks and not more than 9 months following surgical reduction and fixation of the fracture. Patients with fracture nonunion, defined as failure to heal after more than 9 months, were
excluded from the study. Treatment with 8 hours of PEMF per day was stopped when no radiographic progression was observed over 3 months or when union was achieved, with union defined as no pain during joint stressing or during motion at the fracture site and callus bridging for 3 of 4 cortices on blinded assessment. Three months of treatment resulted in a slight, but not statistically significant, improvement in the rate of union between PEMF-treated patients and controls (38.7% vs 22.2%). The success rate was significantly greater with PEMF (77.4% vs 48.1%) after an average of 4.8 months of treatment. The time to union was not significantly different between PEMF (4.8 months; range, 2–12) and sham controls (4.4 months; range, 2–7).

In a double-blind RCT by Sharrard from 1990, PEMF stimulation was compared with a sham procedure using a dummy device in 45 patients with delayed union of the tibia. Stimulators were positioned on the surface of the plaster cast. Treatment began 16 to 32 weeks after injury. Patients with fracture gaps greater than 0.5 cm after reduction, systemic disease, or taking steroids were excluded, as well as patients with marked bony atrophy or hypertrophy. Fifty-one patients were recruited, and 45 completed the protocol (20 treatment, 25 control). In the treatment group, 3 patients achieved union, 2 achieved probable union, 5 showed progression to union, and 10 showed no progress after 12 weeks. In the control group, none had united, 1 had probably united, 3 progressed toward union, and 17 showed no progress.

The policy regarding electrical stimulation of delayed unions is based on a 1992 TEC Assessment of the RCT by Sharrard, 12 which offered the following conclusions:

Sharrard reported radiographic evidence of healing at the end of the 12-week treatment period. Radiographs were rated separately by a radiologist and an orthopedic surgeon. Their inconsistent rating methods and uncertain comparability in their findings make the radiographic evidence difficult to interpret. In addition, it is uncertain whether radiographic evidence of healing after 12 weeks of treatment, an intermediate outcome, predicts health outcomes such as healing and need for subsequent surgery. In this study, there were no statistically significant differences between the active and sham groups on clinical outcomes such as movement at the fracture site, pain, and tenderness. Thus, Sharrard’s health outcome data do not show that noninvasive electrical bone growth stimulation delivers an advantage over placebo.

In 2011, Griffin et al published a Cochrane review of electromagnetic field stimulation for treating delayed union or nonunion of long bone fractures in adults. In addition to the 3 RCTs previously reviewed, the systematic review included a 1984 study by Barker et al that randomized 17 participants with tibial nonunion to electromagnetic field stimulation or sham treatment. Thus, 4 studies with a total of 125 participants were included for analysis. The primary outcome measure was the proportion of participants whose fractures had united at a fixed time point. For this outcome, the overall pooled effect size was small and not statistically significant (risk ratio, 1.96; 95% confidence interval, 0.86 to 4.48). Interpretation is limited due to the substantial clinical and statistical heterogeneity in the pooled analysis. In addition, there was no reduction in pain found in 2 trials, and none of the studies reported functional outcomes. The authors concluded that electromagnetic stimulation may offer some benefit in the treatment of delayed union and nonunion, but the evidence is inconclusive and insufficient to inform current practice.
Section Summary
Two randomized sham-controlled trials have been identified on the treatment of delayed union with PEMF. In the Sharrard study, radiographic healing was improved at 12 weeks, but there were no statistically significant differences between groups for clinical outcomes. In the study by Shi et al, only the rate of healing at an average of 4.8 months was statistically significant, and it is not clear if this is a prespecified end point. The time to healing was not reduced by PEMF. Additional study is needed to permit greater certainty regarding the effect of this technology on delayed union.

Appendicular Skeletal Surgery
A comprehensive search found 2 small RCTs on noninvasive electrical bone growth stimulation after orthopedic surgery. In 1988, Borsalino et al reported a randomized double-blind sham-controlled trial of pulsed electromagnetic field stimulation (8 h/d) in 32 patients who underwent femoral intertrochanteric osteotomy for osteoarthritis of the hip. Radiographic measurements at 90 days revealed significant increases in the periosteal bone callus and in trabecular bone bridging at the lateral, but not the medial cortex. The study is limited by the small sample size and the lack of clinical outcomes.

A 2004 trial randomized 64 patients (144 joints with triple arthrodesis or subtalar arthrodesis) to pulsed electromagnetic field stimulation for 12 hours a day or to an untreated control condition. Patients at high risk of nonfusion (rheumatoid arthritis, diabetes mellitus, or on oral corticosteroids) were excluded from the study. Blinded radiographic evaluation found a significant decrease in the time to union (12.2 weeks for talonavicular arthrodesis vs 17.6 weeks in the control group; 13.1 weeks for calcaneocuboid fusion vs 17.7 weeks for the control group). Clinical outcomes were not assessed.

Fresh Fractures
A multicenter, double-blind, randomized sham-controlled trial evaluated 12 weeks of pulsed electromagnetic field stimulation for acute tibial shaft fractures. The end points examined were secondary surgical interventions, radiographic union, and patient-reported functional outcomes. Approximately 45% of patients were compliant with treatment (>6 hours daily use), and 218 patients (84% of 259) completed the 12-month follow-up. The primary outcome, the proportion of participants requiring a secondary surgical intervention because of delayed union or nonunion within 12 months after the injury, was similar for the 2 groups (15% active, 13% sham). Per protocol analysis comparing patients who actually received the prescribed dose of pulsed electromagnetic field stimulation versus sham treatment also showed no significant difference between groups. Secondary outcomes, which included surgical intervention for any reason (29% active, 27% sham), radiographic union at 6 months (66% active, 71% sham), and the 36-Item Short-Form Health Survey Physical Component Summary score (44.9 active, 48.0 sham) and Lower Extremity Functional Scales at 12 months (48.9 active, 54.3 sham), also did not differ significantly between the groups.

Hanneman et al reported a multicenter double-blind, randomized, sham-controlled trial (N=102) that found little advantage of 6 weeks of PEMF for the treatment of fresh (≤5 days from injury) scaphoid fractures.18 Outcomes included the time to clinical and
radiologic union and functional outcome at 6, 9, 12, 24, and 52 weeks. Radiologic union measured by computed tomography was not significantly different between the 2 groups. The median time to clinical union was 6 weeks in both groups. The return to normal range of movement at the wrist was 12 weeks in both groups. Grip strength of the dominant hand returned to normal earlier with PEMF, but there was no significant difference in return of grip strength of the non-dominant hand.

These sham-controlled RCTs do not support a benefit for electromagnetic stimulation as an adjunctive treatment for fresh fractures.

**Stress Fractures**
In 2008, Beck et al reported a well-conducted RCT (N=44) of capacitively coupled electric fields (OrthoPak) for healing acute tibial stress fractures. Patients were instructed to use the device for 15 hours each day, and usage was monitored electronically. Healing was confirmed when hopping 10 cm high for 30 seconds was accomplished without pain. Although an increase in the hours of use per day was associated with a reduction in the time to healing, there was no difference in the rate of healing between treatment and placebo. Power analysis indicated that this number of patients was sufficient to detect a difference in healing time of 3 weeks, which was considered to be a clinically significant effect. Other analyses, which suggested that electrical stimulation might be effective for the radiologic healing of more severe stress fractures, were preliminary and a beneficial effect was not observed for clinical healing.

**Invasive Bone Growth Stimulation**
A comprehensive search for implantable bone stimulators identified a small number of case series, all of which focused on foot and ankle arthrodesis in patients at high risk for nonunion (summarized in reference in Petrisor and Lau20). Risk factors for nonunion included smoking, diabetes mellitus, Charcot (diabetic) neuroarthropathy, steroid use, and previous nonunion. The largest case series described outcomes of foot or ankle arthrodesis in 38 high-risk patients. Union was observed in 65% of cases by follow-up evaluation (n=18) or chart review (n=20). Complications were reported in 16 (40%) cases, including 6 cases of deep infection and 5 cases of painful or prominent bone stimulators necessitating stimulator removal. A multicenter retrospective review described outcomes from 28 high-risk patients with arthrodesis of the foot and ankle. Union was reported for 24 (86%) cases at an average of 10 weeks; complications included breakage of the stimulator cables in 2 patients and hardware failure in 1 patient. Five patients required additional surgery. Prospective controlled trials are needed to evaluate this procedure.

The 1992 TEC Assessment indicated that semi-invasive bone growth stimulators are no longer in wide use.

**Clinical Input Received From Physician Specialty Societies and Academic Medical Centers** While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.
2012 Input
In response to requests, input was received from 5 academic medical centers while this policy was under review in 2012. The input supported use of noninvasive electrical bone growth stimulation for the treatment of fracture non-unions or congenital pseudoarthroses of the appendicular skeleton. Input agreed that noninvasive electrical bone growth stimulation is investigational for immediate postsurgical treatment after appendicular skeletal surgery and treatment of fresh fractures. Most reviewers considered the use of noninvasive electrical bone growth stimulation to be investigational for the treatment of delayed union, for arthrodesis, or for the treatment of failed arthrodesis.

Summary of Evidence
There is evidence from randomized controlled trials (RCTs) and systematic reviews of clinical trials that noninvasive electrical stimulators improve fracture healing for patients with fracture nonunion. This evidence is not from high-quality RCTs, however, and systematic reviews provide qualified support for this conclusion. Based on the available evidence and the lack of other options for patients with nonunion, electrical stimulation may be considered medically necessary for the U.S. Food and Drug Administration (FDA)—approved indications of fracture non-unions or congenital pseudoarthroses in the appendicular skeleton when specific criteria are met. There is insufficient evidence to permit conclusions regarding the efficacy of noninvasive electrical bone growth stimulation for treatment of stress fractures or delayed union, or following surgery of the appendicular skeleton. In addition, 2 recent randomized trials found no benefit of electrical bone growth stimulation for fresh fractures. Use of noninvasive electrical bone growth stimulation for these conditions is considered investigational.

The literature for implantable bone stimulators of the appendicular skeleton consists of a small number of case series. In addition, no semi-invasive devices have FDA clearance or approval. The use of invasive or semi-invasive electrical bone growth stimulators is considered investigational.

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

- Surgical implantation of a cathode at the fracture site with the production of direct current electrical stimulation. 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 using 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 over the skin and are worn for 6 to 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 obviating the need for a surgical procedure to remove the generator when treatment is finished.

In the appendicular skeleton, electrical stimulation has been primarily used to treat tibial fractures, and thus this technique has often been thought of as a treatment of the long bones. According to orthopedic anatomy, the skeleton consists of long bones, short bones, flat bones, and irregular bones. Long bones act as levels to facilitate motion, while short bones function to dissipate concussive forces. Short bones include those composing the carpus and tarsus. Flat bones, such as the scapula or pelvis, provide a broad surface area for attachment of muscles. Despite their anatomic classification, all bones are composed of a combination of cortical and trabecular (also called cancellous) bone. Each bone, depending on its physiologic function, has a different proportion of cancellous to trabecular bone. At a cellular level, however, both bone types are composed of lamellar bone and cannot be distinguished microscopically.

**Regulatory Status**

The noninvasive OrthoPak® Bone Growth Stimulator (BioElectron) received FDA premarket approval in 1984 for treatment of fracture nonunion. Pulsed electromagnetic field systems with FDA premarket approval (all noninvasive devices) include Physio-Stim® from Orthofix Inc., first approved in 1986, and OrthoLogic® 1000, approved in 1997, both indicated for treatment of established nonunion secondary to trauma, excluding vertebrae and all flat bones, in which the width of the nonunion defect is less than one-half the width of the bone to be treated; and the EBI Bone Healing System® from Electrobiology Inc., which was first approved in 1979 and indicated for non-unions, failed fusions, and congenital pseudoarthroses. No distinction was made between long and short bones. FDA has approved labeling changes for electrical bone growth stimulators that remove any timeframe for the diagnosis.

**Reference Resources**


24. Adopted BCBSA policy MPRM 7.01.07

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member’s contract language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required for services outlined in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this
policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s plan documents or contact the customer service department.

Policy Implementation/Update Information

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<thead>
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<th>Date</th>
<th>Information</th>
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<tr>
<td>Aug 2015</td>
<td>Adopted BCBSA policy MPRM 7.01.07</td>
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</tbody>
</table>

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal http://www.bcbsvt.com/provider-home latest news and communications.

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD
Senior Medical Director
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer
# Attachment I
## Procedural Coding Table

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
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<tbody>
<tr>
<td><strong>CPT</strong></td>
<td>20974</td>
<td>Electrical stimulation to aid bone healing; noninvasive</td>
<td>Prior Approval is required</td>
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<td></td>
<td></td>
<td>(nonoperative)</td>
<td></td>
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<tr>
<td><strong>HCPCS</strong></td>
<td>E0747</td>
<td>Osteogenesis stimulator, electrical, noninvasive, other than spinal</td>
<td>Prior Approval is required</td>
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<tr>
<td></td>
<td></td>
<td>applications</td>
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The following codes will be **denied as Not Medically Necessary, Non-Covered, Contract Exclusions or Investigational**

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
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<tbody>
<tr>
<td><strong>CPT</strong></td>
<td>20975</td>
<td>Electrical stimulation to aid bone healing; invasive</td>
<td>Investigational</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(operative)</td>
<td></td>
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<tr>
<td><strong>HCPCS</strong></td>
<td>E0749</td>
<td>Osteogenesis stimulator, electrical, surgically implanted</td>
<td>Investigational</td>
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**Type of Service** Medicine, Durable Medical Equipment  
**Place of Service** Inpatient, Outpatient
### Attachment II

**ICD-10 Code Table**

The following codes are considered medically necessary when applicable criteria is met.

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S32.2xxK-</td>
<td>Fracture of coccyx</td>
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<tr>
<td>S32.9xxK</td>
<td></td>
</tr>
<tr>
<td>S42.00xK-</td>
<td>Fracture of shoulder and upper arm</td>
</tr>
<tr>
<td>S42.92xK</td>
<td></td>
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<tr>
<td>S49.00xK-</td>
<td>Other and unspecified injuries of shoulder and upper</td>
</tr>
<tr>
<td>S49.199K</td>
<td>arm</td>
</tr>
<tr>
<td>S52.00xK-</td>
<td>Fracture of forearm</td>
</tr>
<tr>
<td>S52.92xN</td>
<td></td>
</tr>
<tr>
<td>S59.00xK-</td>
<td>Other and unspecified injuries of elbow and forearm</td>
</tr>
<tr>
<td>S59.299K</td>
<td></td>
</tr>
<tr>
<td>S62.00xK-</td>
<td>Fracture at wrist and hand level</td>
</tr>
<tr>
<td>S62.92xK-</td>
<td></td>
</tr>
<tr>
<td>S72.00xK-</td>
<td>Fracture of femur</td>
</tr>
<tr>
<td>S72.92xN</td>
<td></td>
</tr>
<tr>
<td>S79.00xK-</td>
<td>Other and unspecified injuries of hip and thigh</td>
</tr>
<tr>
<td>S79.199K</td>
<td></td>
</tr>
<tr>
<td>S82.00xK-</td>
<td>Fracture of lower leg, including ankle</td>
</tr>
<tr>
<td>S82.92xN</td>
<td></td>
</tr>
<tr>
<td>S89.00xK-</td>
<td>Other and unspecified injuries of lower leg</td>
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<tr>
<td>S89.399K</td>
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</tr>
<tr>
<td>S92.00xK-</td>
<td>Fracture of foot and toe, except ankle</td>
</tr>
<tr>
<td>S92.919K</td>
<td></td>
</tr>
</tbody>
</table>

Fracture nonunion codes for the appendicular skeleton - 7th digit “K” is subsequent encounter for nonunion (in forearm, femur, lower leg & ankle fractures 7th digits “M” and “N” are also nonunion for certain types of open fractures - in fractures of the shoulder, humerus, wrist, hand and foot there isn’t separation of open vs. closed nonunions).