Medical Policy:
Biomagnetic Therapy

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.ME.59	8/8/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. 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. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare 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). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. 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. Each benefit plan 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 ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

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/Exclusions

Biomagnetic therapy is considered investigational and not medically necessary.

Procedure Codes

97799	Unlisted physical medicine/rehabilitation service or procedure

References

1. Carpenter JS, Wells N, Lambert B, et al. A pilot study of magnet therapy for hot flashes after breast cancer. Cancer Nursing. 2002; 25(2):104-109.
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3. Cheong YC, Smotra G, Williams AC. Non-surgical interventions for the management of chronic pelvic pain. Cochrane Database Syst Rev. 2014; (3):CD008797.
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.
5. Crawford F, Thomson C. Interventions for treating plantar heel pain. Cochrane Database of Syst Rev. 2003; (3):CD000416.
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7. Pittler MH, Brown, EM, Ernst E. Static magnets for reducing pain: systematic review and meta-analysis of randomized trials. CMAJ. 2007; 177(7):736-742.
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.
9. Richmond SJ, Gunadasa S, Bland M, Macpherson H. Copper bracelets and magnetic wrist straps for rheumatoid arthritis-analgesic and anti-inflammatory effects: a randomised double-blind placebo-controlled crossover trial. PLoS One. 2013; 8(9):e71529.
10. Specialty matched clinical peer review.
11. Stones W, Cheong YC, Howard FM. Interventions for treating chronic pelvic pain in women. Cochrane Database of Syst Rev. 2005; (2):CD000387.
12. Winemiller MH, Billow RG, Laskowski ER, et al. Effect of magnetic vs. sham-magnetic insoles on plantar heel pain. JAMA. 2003; 290(11):1474-1478.
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14. Therapies. 2004; 10(2):36-43.

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Aug. 8, 2025	Transferred policy content to individual company branded template
ConnectiCare	Dec. 2019	ConnectiCare adopts the clinical criteria of its parent corporation EmblemHealth