Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Osteogenesis Stimulators

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The

completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

Osteogenesis Stimulator devices are a noninvasive alternative therapy to promote bone healing in fractures that have failed to heal on their own. The devices are designed to generate an electrical current to a fracture or bone fusion site to stimulate bone growth or osteogenesis. Osteogenesis stimulators are most effective in nonunion or delayed union fractures. Nonunion fractures are broken bones that fail to heal while delayed union fractures are broken bones that take more time than expected to heal. Bone growth stimulators are intended to be used as an adjunct to conventional interventions to fractures (e.g., cast immobilization, rest, or bracing).

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tufts Health One Care** plan members the following criteria is used: NCD - Osteogenic Stimulators (150.2) (cms.gov), LCD - Osteogenesis Stimulators (L33796) (cms.gov) and Article - Osteogenesis Stimulators - Policy Article (A52513) (cms.gov)

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for electrical bone growth stimulators:

1. Osteogenesis Stimulator, Electrical Noninvasive, Not Spinal Applications
2. Osteogenesis Stimulator, Electrical Noninvasive, Spinal Applications
3. Osteogenesis Stimulator, Low Intensity Ultrasound, Noninvasive

Limitations

The Plan considers electrical bone growth stimulators as not medically necessary for all other indications.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes – Osteogenesis Stimulator, Electrical Noninvasive, Not Spinal Application

Code	Description
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)

Table 1: CPT/HCPCS Codes – Osteogenesis Stimulator, Electrical Noninvasive, Spinal Application

Code	Description
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)

Table 1: CPT/HCPCS Codes – Osteogenesis Stimulator, Low Intensity Ultrasound, Noninvasive

Code	Description
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

Approval And Revision History

June 17, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- June 24, 2020: Fax number for Unify Updated
- April 2021: New Policy launched for Harvard Pilgrim Health Care
- July 21, 2021: Reviewed by MPAC, coding updated for Harvard Pilgrim Health Care, renewed without changes
- November 16, 2022: Reviewed by Medical Policy Approval Committee, renewed without changes
- November 16, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and Approved by the UM committee effective January 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee effective January 1, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual upgrade, effective July 1, 2025
- June 18, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.