Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Transcranial Magnetic Stimulation (rTMS)

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	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax please refer to this reference chart for the appropriate fax number (varies by product).

For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

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 a 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

Transcranial magnetic stimulation (TMS) uses a specifically designed magnetic coil that is placed in contact with the scalp to generate rapidly alternating magnetic fields and produces electrical stimulation of superficial cortical neurons. The procedure is generally administered daily over a four-to-seven-week period. The FDA approved rTMS in October 2008 for use in the treatment of treatment- refractory Major Depressive Disorder based on the results of a multisite randomized controlled clinical trial using high frequency pulses over the left prefrontal cortex (HFL-TMS).HFL-rTMS requires no anesthesia or sedation

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual Subsets or SmartSheets to obtain prior authorization for transcranial magnetic stimulation (TMS):

1. Repetitive Transcranial Magnetic Stimulation Including Taper Sessions
2. Deep Transcranial Magnetic Stimulation Including Taper Sessions
3. Theta Burst Stimulation Including Taper Sessions

Limitations

The Plan considers transcranial magnetic stimulation (TMS) as not medically necessary for **ANY** of the following:

1. In a setting other than a medical office or facility.
2. The use of TMS as a maintenance therapy to prevent relapse is not supported by controlled clinical trials and is therefore not considered medically necessary

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
90867	Therapeutic repetitive Magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

Approval And Revision History

March 15, 2023: Reviewed by the Medical Policy Approval Committee (MPAC), effective July 1, 2023

Subsequent endorsement date(s) and changes made:

- August 16, 2023: Reviewed by MPAC, renewed without changes, template updated effective November 1, 2023
- December 2023: Rebranded Unify to One Care, effective January 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, codes 90867, 90868, and 90869 added to PA for Direct, MA Together, RITogether effective, October 1, 2024
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025. Harvard Pilgrim Health Care Stride Medicare Advantage, removed as an applicable product from 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
- 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.