

Medical Necessity Guidelines: Osteogenesis Stimulators, Noninvasive

Effective: June 17, 2020

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
<p>Applies to:</p> <p>COMMERCIAL Products</p> <p><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409</p> <p><input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</p> <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>TUFTS HEALTH PUBLIC PLANS Products</p> <p><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</p> <p><input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</p> <p><input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</p> <p><input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304</p> <p>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products</p> <ul style="list-style-type: none"> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List 	
<p>To obtain InterQual[®] SmartSheets[™]:</p> <ul style="list-style-type: none"> Tufts Health Plan Commercial Plan products and Tufts Health Freedom 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. 	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires prior authorization for noninvasive osteogenesis stimulators when used in the home.

To obtain prior authorization, an InterQual SmartSheet for **Osteogenesis Stimulator, Noninvasive** must be completed and faxed to the appropriate fax number listed above according to Plan.

The following individual InterQual SmartSheets are to be used when requesting prior authorization:

- Osteogenesis Stimulator, Electrical, Noninvasive, Not Spinal Applications**
- Osteogenesis Stimulator, Electrical, Noninvasive, Spinal Applications**
- Osteogenesis Stimulator, Low Intensity Ultrasound, Noninvasive**

CODES

Durable Medical Equipment REQUIRING PRIOR AUTHORIZATION:

Tufts Health Plan uses InterQual SmartSheet(s) for the following durable medical equipment and the associated HCPCS code(s).

OSTEOGENESIS STIMULATOR, ELECTRICAL, NONINVASIVE, NOT SPINAL APPLICATIONS

The following HCPCS code(s) require prior authorization:

Code	Description
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications

Code	Description
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)

OSTEOGENESIS STIMULATOR, ELECTRICAL, NONINVASIVE, SPINAL APPLICATIONS

The following HCPCS code(s) require prior authorization:

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

OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NONINVASIVE

The following HCPCS code(s) require prior authorization:

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

APPROVAL HISTORY

November 19, 2014: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC). Effective April 1, 2015 Bone Growth Stimulators will require an InterQual® SmartSheet(s)TM for each code listed. Former Medical Necessity Guidelines for Electric and Ultrasound Bone Growth Simulators are combined into this one guideline. CPT code E0749 removed.

Subsequent Endorsement Date(s) and Changes Made:

- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document.
- September 9, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- August 10, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 13, 2017: Reviewed by IMPAC, renewed without changes
- July 25, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 Interqual upgrade for Tufts Health Commercial products including Tufts Health Freedom Plan. Effective December 17, 2018, Interqual upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, Interqual upgrade effective for Tufts Health RITogether. MNG title changed from Bone Growth Stimulators to Osteogenesis Stimulators, Noninvasive
- June 19, 2019: Reviewed by IMPAC, renewed without changes
- June 17, 2020: Reviewed by IMPAC, renewed without changes
- June 24, 2020: Fax number for Unify updated

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.

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.

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