Transcranial Magnetic Stimulation

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon* ☐ *Washington*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Transcranial magnetic stimulation (TMS) is a noninvasive technique where brief pulses of magnetic energy are applied to the scalp via an electromagnetic coil with the goal of stimulating the areas of the brain which manage mood regulation.

The following coverage information applies to both repetitive Transcranial Magnetic Stimulation (rTMS) and deep Transcranial Magnetic Stimulation (dTMS).

TMS should be administered using a Food and Drug Administration (FDA) cleared device and in accordance with the FDA labeled indications.

The TMS device operator should be a clinical professional, such as a certified medical assistant, medical technician with relevant experience, physician assistant, or nurse, who meets the following qualifications:

- Is trained and certified to deliver TMS, including TMS device operation;
- Is trained as a first responder to respond to a seizure and is certified in basic life support training. The TMS operator must monitor the patient, especially for adverse events, during treatment administration.

The TMS device operator must administer treatment under the direct supervision of the TMS prescriber:

- The attending prescriber must be in the area and immediately available. The prescriber will assess the patient at each treatment and be present in the area, but not necessarily provide the treatment.
- The attending prescriber must monitor and document the member's clinical progress during treatment.

Criteria

Commercial

Prior authorization is required.

A. Initial Transcranial Magnetic Stimulation (TMS) Therapy

PacificSource considers initial TMS to be medically necessary when **ALL** of the following criteria are met:

1. TMS is ordered and supervised by a qualified psychiatrist, nurse practitioner, physician, or physician assistant who possesses evidence in knowledge, training, and expertise to perform all aspects of the TMS procedure based on the scope of practice standards and regulations established by each state:
    a. Physician assistant must have a signed supervisory or collaborative agreement with a physician in accordance with governing state and federal regulations. The supervising physician must also meet the qualification described above and practice within the same TMS provider organization
2. Member meets **ONE** of the following age requirements:
    a. 18 years of age or older
    b. 15 - 17 years old (requires MD Review for approval)
3. Member has a confirmed diagnosis of severe major depressive disorder documented by standardized depression rating scales (e.g., Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HAM-D), etc.)
4. Member has treatment resistant depression as documented by failure of at least two different antidepressant medications from two different classes despite adequate duration, dosage, and medication adherence
5. The member has no contraindications to TMS such as:
    a. Acute or chronic psychotic symptoms or disorders
    b. Implanted devices in or around the head
    c. Seizure disorder or increased risk of seizures
6. Proposed treatment plan is within a standard course of treatment, which includes: 1 unit of 90867 treatment planning, up to 36 units of 90868 treatment delivery, and up to 2 units of 90869 motor threshold redetermination

B. Repeat Transcranial Magnetic Stimulation (TMS) Therapy

PacificSource considers repeat Transcranial Magnetic Stimulation (TMS) to be medically necessary when **ALL** of the following criteria are met:

1. All of the above criteria are met
2. Member had a previous positive response to treatment as documented by at least 50% reduction in symptoms as documented by standardized depression rating scales (e.g., PHQ-9, Beck Depression Inventory)
3. Improvement in symptoms was maintained for at least two months after completion of the most recent course of treatment

Medicaid

Prior authorization is required.

PacificSource Community Solutions (PCS) follows Guideline Note 102 of the OHP Prioritized List of Health Services.

If medical necessity criteria is met, as outlined in Guideline Note 102, PCS may authorize a treatment plan within a standard course of treatment, which includes 1 unit of 90867 treatment planning, up to 36 units of 90868 treatment delivery, and up to 2 units of 90869 motor threshold redetermination.

Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L37088 for transcranial magnetic stimulation.

Experimental/Investigational/Unproven

PacificSource considers TMS to be experimental, investigational, or unproven for any indication not listed above, including all other psychiatric (e.g., obsessive compulsive disorder), neurologic, and substance use (e.g., tobacco cessation for nicotine addiction) disorders.

PacificSource considers maintenance TMS to be experimental, investigational, or unproven.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

90867 Therapeutic repetitive transcranial magnetic stimulation treatment; planning

90868 Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session

90869 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

Definitions

Initial TMS – a treatment for severe major depressive disorder using a non-invasive neurostimulation technique to modulate cortical excitability when other treatment modalities have not improved symptoms.

Maintenance therapy – Prolonged TMS weekly, biweekly, or monthly treatment sessions to maintain improvement and/or results, when no remission has occurred.

Relapse - Re-emergence of a depressive episode of full or significant depressive symptoms after remission.

Repeat TMS – Another course of TMS therapy provided after receiving the initial course of TMS when a relapse occurs.

Remission – A period of two or more months with no or mild depressive symptoms.

Related Policies

Tobacco Cessation

References

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Appendix

Policy Number:

Effective: 10/1/2020 **Next review:** 11/1/2025

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): Local Coverage Determination (LCD) L37088, Guideline Note 102 of the OHP Prioritized List of Health Services, ORS 414.766, 743A.168 and 743B.505.

Commercial Ops: 2/2025

Government Ops: 2/2025