Transcranial Magnetic Stimulation

Lines of Business	*Document Type*
Commercial, Medicaid, Medicare	Policy
Who This Applies To	***States***
Health Services	Idaho, Montana, 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 by a qualified psychiatrist or Psychiatric Mental Health Nurse Practitioner (PMHNP) and administered under the supervision of 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 (single or recurrent episode) without psychotic features documented by standardized depression rating scales, examples of evidence-based depression scales include, but are not limited to the following:
    - Beck's Depression Inventory (BDI)
        - 0 to 13 – Minimal depression
        - 14 to 19 - Mild depression
        - 20 to 28 - Moderate depression
        - 29 to 63 – Severe depression
    - Hamilton Depression Rating Scale
        - 0 to 7: Not depressed
        - 8 to 13: Mild (subthreshold)

- 14 to 18: Moderate (mild)
- 19 to 22: Severe (moderate)
- >23: Very severe (severe)

- Montgomery-Asberg Depression Rating Scale (MADRS)
  - 0 to 6: Not depressed
  - 7 to 19: Mild depression
  - 20 to 30: Moderate depression
  - 31 to 39: Severe depression
  - 40 to 60: Extremely severe depression
- Patient Health Questionnaire-9 (PHQ-9)
  - 0 to 4: Not depressed
  - 5 to 9: Mild depression
  - 10 to 14: Moderate depression
  - 15 to 19: Moderately severe depression
  - 20 to 27: Severe depression

4. Member has treatment resistant depression, or has experienced inadequate response with **BOTH** of the following during the current depressive episode occurring within the past 5 years (i.e., for purposes of this policy, the current depressive episode begins with the most recent onset of acute symptoms):
   a. Two antidepressant medications from at least two different classes, having different mechanisms of action (see Definition Section) at the maximally tolerated labeled dose, each used for at least 8 weeks (to qualify as an adequate antidepressant drug trial, the member's dose during the failed trials should have been at or above the minimal effective therapeutic dose for that antidepressant)
   b. Augmentation therapy along with the primary antidepressant used for at least 8 weeks (see Definition Section); if the augmenting agent is an antidepressant, the augmenting agent must be from a different class than the primary antidepressant. The augmenting agent should have been at or above the minimal effective therapeutic dose (which is typically the minimal labeled dose)
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

a. Additional courses of remapping are considered medically necessary if the member is not responding to ensure the most accurate treatment location, or if there is concern that motor threshold may have changed.

Note: Re-mapping does not increase the medically necessary number of TMS sessions, as treatment is provided during remapping.

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 (2) months **AND** three (3) months have elapsed since the completion of the last course of treatment

Medicaid

Prior authorization is required.

A. Initial Transcranial Magnetic Stimulation (TMS) Therapy

PacificSource Community Solutions (PCS) follows Guideline Note 102 of the OHP Prioritized List of Health Services to determine medical necessity or medical appropriateness for initial TMS therapy.

- 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
  - Maximum of 30 sessions (once a day, up to 5 times per week for six weeks) for initial treatment, followed by up to 6 taper treatments units of 90868 treatment delivery
  - Up to 2 units of 90869 motor threshold redetermination.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Note 102, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

B. Repeat Transcranial Magnetic Stimulation (TMS) Therapy

PacificSource Community Solutions (PCS) follows Guideline Note 102 of the OHP Prioritized List of Health Services to determine medical necessity or medical appropriateness for repeat TMS therapy:

- Repeat treatment may be covered if the patient responded to the initial treatment (defined as at least 50 percent reduction in depression score on standardized rating scale); and
- At least 3 months have elapsed since the initial treatment.

Medicare

PacificSource Medicare follows Article A57692 and Local Coverage Determination (LCD) L37086 for transcranial magnetic stimulation (TMS).

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.

PacificSource considers accelerated, high-dose intermittent theta burst stimulation (aiTBS) (e.g., Stanford Accelerated Intelligent Neuromodulation Therapy (SAINT)) to be experimental, investigational, or unproven.

PacificSource considers Magnetic e-Resonance Therapy (MeRT), including EEG-guided or biomarker-guided personalized TMS protocols to be experimental, investigational, or unproven.

PacificSource considers TMS administered in conjunction with ketamine therapy to be experimental, investigational, or unproven. **Note:** PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

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

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Definitions

Antidepressant Medication Classes:

- aminoketones (Wellbutrin/SR/XL [bupropion]);
- monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine);
- noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone);
- selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft);
- serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER);
- tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine**); and**
- serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone).

Augmentation therapy - Includes any of the following therapies:

- Two FDA-approved antidepressants with different mechanisms of action used concomitantly,
- An FDA-approved antidepressant and a second-generation antipsychotic used concomitantly that is FDA approved for augmenting depression treatment,
- An FDA-approved antidepressant and lithium used concomitantly,
- An FDA-approved antidepressant and thyroid hormone T3 used concomitantly.

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 - Scheduled TMS sessions provided after completion of an initial or repeat treatment course to sustain clinical response or remission, prevent relapse, or prolong symptom improvement..

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

Repeat TMS - A subsequent course of TMS therapy provided after completion of a prior TMS course when depressive symptoms recur or worsen following a documented clinical response.

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

Related Policies

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

New and Emerging Technologies - Coverage Status

Tobacco Cessation

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Appendix A. Document Control – *to update appendix fields, go to Properties Wizard*

Version 2 **of Doc #** 676

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Applicable regulation(s):

- 42 CFR § 422.101(b-c)
- CCO Contract, Exhibit B, Part 2 § 3(b)(6)
- OAR 410-120-1200 Excluded Services and Limitations
- OAR 410-141-3820 Covered Services
- OAR 410-141-3825 Excluded Services and Limitations
- OAR 410-151-0001 Definitions
- OAR 410-151-0002 Coverage Requirements
- OAR 410-151-0003 Utilization Management Requirements
- ORS 414.766 Behavioral health treatment
- ORS 743A.168 Behavioral health treatment

Policy Function: Posted to PacificSource.com - Clinical Policy

External entities affected: N/A

LOBO Committee Review completed: Committee Approval Date: 09/17/2026