# Transcranial Magnetic Stimulation

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

## Enterprise Policy

*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 determination 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 at frequencies between 1 to 50 Hz via an electromagnetic coil with the goal of stimulating the areas of the brain which manage mood regulation. TMS must be ordered by and supervised by a psychiatrist. A nurse practitioner with independent practice authority and specialization in psychiatry (e.g. a psychiatric mental health nurse practitioner [PMHNP]) may also order and provide TMS without supervision by a psychiatrist, in accordance with each state's scope of practice laws and regulation.

TMS should be administered using a Food and Drug Administration (FDA) cleared device and in accordance with the FDA labeled indications. In addition, 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 a seizure and certified in basic life support training – the TMS operator must monitor the patient, especially for adverse events, during treatment administration; and
- Administers TMS under the direct supervision of the TMS prescriber.

## Criteria

### Commercial

**Prior authorization required**

PacificSource considers transcranial magnetic stimulation (TMS) medically necessary when **ALL** of the following criteria are met:

- Documentation meets MCG B-801-T BHG criteria for Transcranial Magnetic Stimulation;
- At least one medication trial used an augmentation strategy; and
- Demonstrated failure to respond to evidence based psychotherapy, as documented by an objective metric (e.g., PHQ-9 rating scale or similar rating scale for depressive symptoms).

Medical Director review is **required** for TMS treatment for the following clinical indications:

  - Provider is requesting additional sessions after recently completing the initial course of treatment.
  - Provider is requesting treatment for a member who has previously completed TMS treatment.
  - Proposed treatment plan is requesting sessions beyond a standard course of treatment. A standard course of TMS treatment is 1 unit of 90867 treatment planning, up to 35 units of 90868 treatment delivery, and up to 2 units of 90869 motor threshold re-determination.

### Medicaid:

PacificSource Medicaid follows Guideline Note 102 of the OHP Prioritized List of Health Services and Local Coverage Determination (LCD) L37088 for coverage of transcranial magnetic stimulation for up to 36 units. Requests for 37 or more units require prior authorization and medical director review.

### Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L34522 for transcranial magnetic stimulation.

## Experimental/Investigational/Unproven

TMS is considered experimental, investigational or unproven for treatment of all other psychiatric and neurologic disorders not noted above.

## Coding Information

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

## References

Hayes Medical Technology Directory. Comparative Effectiveness Review of High Frequency Left Repetitive Transcranial magnetic Stimulation Versus Other Neurostimulation Approaches to Treatment-Resistant Depression. (2016, December 1, annual review 2020, February). Hayes, a Division of TractManager.

Hayes Medical Technology Directory. High-Frequency Left Repetitive Transcranial Magnetic Stimulation for Treatment-Resistant Major Depressive Disorder. (2016, November 3, annual review 2020, January 31). Hayes, a Division of TractManager.

MCG™ Ambulatory Care 24th Edition. Transcranial Magnetic Stimulation ORG: B-801-T (BHG).

McClintock SM, Reti IM, Carpenter LL, et al. Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression. *J Clin Psychiatry*. 2018;79(1):16cs10905. doi:10.4088/JCP.16cs10905

UpToDate. Unipolar Depression in Adults: Indications, Efficacy, and Safety of Transcranial Magnetic Stimulation. May 9, 2019.

## Appendix

**Policy Number:**

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**Author(s):**

**Depts:** Health Services

**Commercial Ops:** 6/2021

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