Health Alliance™

Medical Policy & Procedure

Policy Name:	Medical Policy: Transcranial Magnetic Stimulation	Policy #:	MP-320

Policy Information	
Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (06/23/2023), Lori Slaughter (06/22/2023)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

NOTE: Please refer to plan documents for prior authorization necessity/status.

Interpretations

1. **Health Alliance uses InterQual criteria to determine the medical necessity of Transcranial Magnetic Stimulation. The InterQual criteria are available in the Utilization Management software system and can be accessed by providers when submitting an authorization digitally.**
2. **Investigational Indications:**

2.1 TMS is considered investigational for all other psychiatric and neurologic disorders.

2.2 All other types of TMS are considered investigational, including but not limited to synchronized TMS, intermittent TMS, continuous TMS, low field magnetic stimulation, and theta burst stimulation.

Medicare Advantage Criteria details:

- No NCDs available.
- Enter Regional LCD/LCA ID in Medicare website/link below for criteria details.
- MCD Search (cms.gov)

Regional Medicare Admin Contractor (MAC) – Member's state	Regional LCD/LCA Identifier	Applicable Criteria
NGS (IL)	L33398/A57528	Applicable NGS LCD/LCA
Noridian (WA)	L37088/A55904	Applicable Noridian LCD/LCA
Palmetto (NC)	L34869/A57813	Applicable Palmetto LCD/LCA
WPS (IA, IN)	L34641/A57598	Applicable WPS LCD/LCA
CGS (OH)	L36469/A57047	Applicable CGS LCD/LCA

Codes

*Codes listed are for informational purposes only and do not necessarily indicate that prior authorization is or is not required or coverage is guaranteed.	
90867	Therapeutic repetitive transcranial 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

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Hayes, Inc. Hayes Medical Technology Directory. High-Frequency Left Repetitive Transcranial Magnetic Stimulation for Treatment-Resistant Major Depressive Disorder. Lansdale, PA; Hayes, Inc.: October 2017 (annual review).
2. Lam RW, Chan P, et al. (2008) "Repetitive transcranial magnetic stimulation for treatment-resistant depression: A systemic review and metaanalysis". *Can J Psychiatry;53(9):* pp. 621–631.
3. Gomes PVO, Brasil-Neto JP, et al. (2012). "A randomized, double-blind trial of repetitive transcranial magnetic stimulation in obsessive-compulsive disorder with three-month follow-up". *J Neuropsychiatry Clin Neurosci*; 24(4): pp. 437–443.
4. Shi C, Yu X, et al. (2014). "Revisiting the therapeutic effect of rTMS on negative symptoms in schizophrenia: A meta-analysis". *Psych Res*; 205: pp. 505–513.
5. Dunner DL, Aaronson ST, et al. (2014) "A multisite, naturalistic, observational study of transcranial magnetic stimulation for patients with pharmacoresistant major depressive disorder: Durability of benefit over a 1-year follow up period". *J Clin Psychiatry*; 75(12): pp. 1394–1401.
6. Holtzheimer PE. Unipolar depression in adults: Indications, efficacy, and safety of transcranial magnetic stimulation (TMS). In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on February 20, 2018.)

History

Created Date:	06/19/18
Effective Date:	06/19/18
Next Review Date:	06/23/2024
Revision Date:	06/18/19 – MDC-Annual review, no changes.
	06/24/20 – MDC-Annual review, Clear Coverage language updated to Guiding Care/InterQual.
	08/17/21 – MDC-Annual review, no changes.
	07/19/22 – MDC-Annual review, minor addition in 2 for readability.
	06/20/23 – MDC-Annual review, no changes.