



Medicare Part C Medical Coverage Policy

Transcranial Magnetic Stimulation Treatment

Origination: January 01, 2020

Review Date: July 19, 2023

Next Review: July 2025

DESCRIPTION OF PROCEDURE

Transcranial Magnetic Stimulation (TMS) is a non-invasive treatment that uses pulsed magnetic fields to induce an electric current in a localized region of the cerebral cortex. An electromagnetic coil placed on the scalp induces focal current in the brain that temporarily modulates cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Stimulation parameters may be adjusted to alter the excitability of the targeted structures in specific cortical regions. Repetitive TMS (rTMS) has been investigated as treatment for pharmacoresistant depression.

POLICY STATEMENT

Coverage will be provided for Transcranial Magnetic Stimulation Treatment when it is determined to be medically necessary when the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

- A. **Preauthorization by the Plan is required;**
- B. **Treatment provided should be performed using only an FDA approved device for resistant MDD and/or OCD.**

Major Depressive Disorder (MDD):

Initial Treatment- Left prefrontal rTMS of the brain is considered medically necessary for use in an adult who meets 1 and 2 of the following criteria:

1. Member has a confirmed diagnosis of severe Major Depressive Disorder (MDD) single or recurrent episode; **AND**
2. Member has 1 (one) or more of the following:
 - Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to 4 (four) trials of psychopharmacologic agents in the current depressive episode from at least 2 (two) different agent classes.
 - Inability to tolerate psychopharmacologic agents as evidenced by 4 (four) trials of psychopharmacologic agents from at least 2 (two) different agent classes, with distinct side effects; or
 - History of response to rTMS in a previous depressive episode; or
 - If member is currently receiving electro-convulsive therapy (ECT), rTMS may be considered reasonable and necessary as a less invasive treatment option **AND**
3. A trial of an evidence-based psychotherapy known to be effective in the treatment of Major Depressive Disorder (MDD) of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms. **AND**
4. The order for treatment (or retreatment) is written by a psychiatrist (MD or DO) who has examined the member and reviewed the record. The physician will have experience in administering TMS therapy. The treatment shall be given under direct supervision of this physician (physician present in the area but does not necessarily personally provide the treatment).

*****Note:** TMS for treatment resistant MDD is reasonable and necessary for up to twenty (20) visits over a four (4) week period followed by five (5) visits for tapering for members in remission; for members who show at least a twenty-five percent (25%) improvement

by means of the standard tests for depression (examples of the standard tests for depression are listed below under Retreatment), the therapy may be continued for an additional two (2) weeks (an additional ten (10) visits) with an additional six (6) visits for tapering.

Retreatment (Major Depressive Disorder)

Retreatment may be considered for members who met the guidelines for the initial treatment and subsequently developed relapse of depressive symptoms if the member has responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms (e.g., Geriatric Depression Scale (GDS), Patient Health Questionnaire Depression Scale (PHQ-9), Beck Depression Inventory (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery-Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS) or Inventory of Depressive Symptomatology-Systems Review (IDS-SR).

Obsessive Compulsive Disorder (OCD):

Initial Treatment- rTMS of the brain is considered medically necessary for use in a member who meets 1 and 2 of the following criteria:

1. Has a confirmed diagnosis of **OCD** as per DSM-5 criteria; **AND**
2. Member has 1 (one) or more of the following:
 - Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to a trial of 2 distinct psychopharmacologic agents, administered for a minimum of 8 weeks, **OR**
 - Inability to tolerate psychopharmacologic agents as evidenced by trials of psychopharmacologic agents from 2 distinct psychopharmacologic agents, **OR**
 - History of response to TMS for OCD in the past that was clinically meaningful, **OR**
 - If member is currently receiving antipsychotics, opioids, benzodiazepines, glutamatergic agents, or other agents which could be considered investigational or risky treatments, TMS may be considered reasonable and necessary as a safer treatment option.

AND

3. A trial of an evidence-based psychotherapy known to be effective in the treatment of OCD for a minimum of 8 weeks duration without significant improvement in OCD symptoms as documented by standardized rating scales that reliably measure OCD symptoms. **AND**

4. The order for treatment (or retreatment) is written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The physician will have experience in administering TMS therapy and will prescribe an evidence-based OCD TMS protocol. The treatment shall be given under direct supervision of this physician (physician present in the area but does not necessarily personally provide the treatment).

TMS is reasonable and necessary for OCD for a minimum of 29 visits over a 6-week period. Extensions in 2-to-4-week increments will be cleared based on clinical need with evidence of response from the first 29 sessions. If members cannot go in 5 days a week, treatments may be administered 3 days a week over a longer period of time.

Retreatment (Obsessive Compulsive Disorder)

Retreatment for OCD may be considered for members who met the guidelines for initial treatment and experienced at least a 30% reduction in the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score, as long as the improvement persisted for at least 1 month after the prior treatments ended.

WHEN COVERAGE WILL NOT BE APPROVED

- When all the criteria above are not met.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: 90867, 90868, 90869

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES

The benefits of TMS use must be carefully considered against the risk of potential side effects in members with any of the following:

1. Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)
2. Presence of acute or chronic psychotic symptoms or disorders (such as schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode; **or**

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3. Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system, **or**
4. Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including, but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, Vagus Nerve Stimulator (VNS), or metal aneurysm clips or coils, staples or stents. Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS.

*****Note:** When these conditions are present, Medical Director Review is required.

References:

1. Medicare Local Coverage Determination for Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults– LCD L34869; Effective Date. Accessed via www.cms.gov. Viewed LCD on 06/13/2023.

Policy Implementation/Update Information:

Revision Date:

December 18, 2019: Policy Development

November 8, 2021: Annual Review; No CMS Updates. Minor Revisions Only.

February 16, 2022: CMS Update; Added Coverage under Indications for Coverage for Initial Treatment and Retreatment for the Diagnosis of OCD to go into effect 3/13/22.

July 19, 2023: Verbiage added to reflect LCD per staff request. No CMS Updates. Minor Revisions only.

Approval Dates:

Medical Coverage Policy Committee: July 19, 2023

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