BlueCross BlueShield of North Carolina

Medicare Part C Medical Coverage Policy

Transcranial Magnetic Stimulation Treatment

Origination: January 01, 2020
Review Date: December 18, 2019
Next Review: December, 2021

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 (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. 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- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and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.

INDICATIONS FOR COVERAGE

A. **Preauthorization by the Plan is required;**

B. Treatment provided should be performed using only an FDA approved device for TMS.

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**

***Note:** Access to commonly prescribed psychopharmacologic agents and adequate dosages can be accessed on the Care Management SharePoint site in the Behavioral Health Resource Folder.

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 patient 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 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

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).

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**
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 with Treatment Resistant Major Depressive Disorder– LCD L34869; Effective Date. Accessed via www.cms.gov. Viewed LCD on 12/18/19.

Policy Implementation/Update Information:

Revision Date:

December 18, 2019: Policy Development

Approval Dates:

Medical Coverage Policy Committee: December 18, 2019

Policy Owner: Carolyn Wisecarver, RN, BSN
Medical Policy Coordinator