Clinical Policy: Transcranial Magnetic Stimulation (TMS)

Reference Number: LA.CP.MP.526c
Date of Last Revision: 09/24

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description
TMS is a noninvasive method of delivering electrical stimulation to the brain. A magnetic field is delivered through the skull, where it induces electric currents that affect neuronal function. TMS can be performed in an office setting as it does not require anesthesia and does not induce a convulsion.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that Elective that TMS is considered **medically necessary** when **all** the following criteria are met:

A. Member is 18 years of age or older;
B. Diagnosis of major depressive disorder (DSM 5 diagnostic terminology);
C. Failure of a full course of evidence-based psychotherapy, such as cognitive behavioral therapy for the current depressive episode;
D. Failure or intolerance to psychopharmacologic agents, choose **one** of the following:
    1. Failure of psychopharmacologic agents, **both** of the following:
        a. Lack of clinically significant response in the current depressive episode to four trials of agents from at least two different agent classes; and
        b. At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with antidepressants, involving standard therapeutic doses of at least six weeks duration.
    2. The member is unable to take anti-depressants due to **one** of the following:
        a. Drug interactions with medically necessary medications; or
        b. Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode; and
E. No contraindications to TMS are present (see section on contraindications); and
F. Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has been offered and declined by the member.

NOTE: Maintenance therapy is not deemed medically necessary due to a lack of sufficient evidence to support this treatment at the present time.

Retreatment

II. It is the policy of Louisiana Healthcare Connections that Retreatment is deemed medically necessary when **all** of the following criteria have been met:

A. Current major depressive symptoms have worsened by 50 percent from the prior best response of the PHQ-9 score;
B. Prior treatment response demonstrated a 50 percent or greater reduction from baseline depression scores; and
C. No contraindications to TMS are present (see section on contraindications below).

Contraindications

III. It is the policy of Louisiana Healthcare Connections that Treatment of major depression and persistent depressive disorder is contraindicated for individuals with the following noted history and diagnoses:

A. History of seizure disorder. Individuals with dehydration may be more prone to seizures so hydration prior to treatments is recommended;
B. Metal implants or devices present in the head or neck;
C. Substance abuse at the time of treatment;
D. Diagnosis of severe dementia; and
E. Diagnosis of severe cardiovascular disease.

Coding Implications

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CPT® Codes	Description
90867[1]	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

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
New Policy	9/24	10/23/24	11/22/24

References

1. LDH Professional Services Provider Manual. 5.1:Covered Services. Transcranial Magnetic Stimulation.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status;

[1] Reported once per course of treatment.

evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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