Clinical Policy: Transcranial Magnetic Stimulation for Treatment Resistant Major Depression

Reference Number: WA.CP.BH.200
Last Review Date: 04/24
Effective Date: 11/01/24

Coding Implications
Revision Log

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

Description

Transcranial magnetic stimulation (TMS) is a noninvasive brain stimulation technique used for the treatment of psychiatric and neurological disorders, including Major Depressive Disorder (MDD). TMS works by passing electrical energy through a coil to generate an electromagnetic field. When placed over the scalp, the stimulation coil focuses a pulse of electrical current that penetrates the cortical surface two centimeters (cm) to four cm and directly alters local superficial neuronal activity. The objective is to stimulate areas of the brain involved in mood regulation to lessen the duration or severity of depressive episodes. TMS is typically delivered in a train of pulses, also known as repetitive TMS (rTMS), at a frequency ≥ 10 Hertz (Hz) and generally targets the dorsolateral prefrontal cortex, a region important for high order executive function. An alternative to conventional rTMS, is Theta Burst Stimulation (TBS), which is a form of rTMS wherein short bursts of three to five pulses per second are administered at a higher frequency (50 Hz) but with a specific interburst interval that generates an overall lower stimulation frequency (5 Hz).[1]

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment and Billing Guideline, that TMS for patients with treatment resistant major depressive disorder may be **medically necessary** for up to 30 treatment sessions including tapering when the following conditions are met:

A. Age ≥ 18 years with a diagnosis of major depressive disorder,
B. Failure of at least two different antidepressant medications from at least two separate classes at maximum tolerated dose for 4-12 weeks in separate trials,
C. Administered according to FDA-cleared protocol.
D. Does not have any of the following contraindications:
    1. History of seizures,
    2. Presence of conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 30 cm of TMS coil placement other than dental fillings to include but not limited to the following:
        a. Cochlear implant,
        b. Implanted electrodes/stimulators,
        c. Aneurysm clips or coils,
        d. Stents,
        e. Bullet fragments,
        f. Metallic dyes in tattoos.
    3. Vagus nerve stimulator leads in the carotid sheath,

4. Other implanted stimulators controlled by or that use electrical or magnetic signals such as but not limited to the following:
   a. Deep brain stimulation,
   b. Cardiac pacemaker,
   c. Cardioverter defibrillator,
   d. Intracardiac lines,
   e. Medication pumps.
5. Less than three months of substantiated remission from substance use disorder,
6. Severe dementia,
7. Severe cardiovascular disease,
8. Known non-adherence with previous treatment for depression,
9. Acute psychotic disorders in the current depressive episode,
10. Active suicidal ideation with intent.

II. Repeat TMS for patients with treatment resistant major depressive disorder may be **medically necessary** for up to 30 treatment sessions when all the following conditions are met:
   A. Member/enrollee meets the criteria in Section I,
   B. Improvement in symptoms is maintained for at least six weeks following initial treatment session, and
   C. Member/enrollee has shown evidence of 30% or more improvement on the Hamilton Depression Rating Scale, or a minimally clinically important difference on a validated scale for depression, with most recent TMS treatment.

III. TMS is not covered for obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), smoking cessation, nor substance use disorder (SUD).

Background
This policy is based entirely on Washington State Health Care Authority (HCA) guidance and Health Technology Clinical Committee Assessment.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted.	07/23	08/23
Revised to reflect updated Billing Guideline and revised HTA	04/24	04/24
Added contraindications	08/24	09/24

References

1. Reddy, S., Kahwati, L., Kugley, S., Ovelman, C., Ng, V., Rains, C., RTI International (University of North Carolina). *Transcranial Magnetic Stimulation for Treatment of Selected Behavioral Disorders*. Washington Health Technology Assessment. February 21, 2023.
2. Washington State Health Care Authority, Health Technology Committee. Final Findings and Decision. *Transcranial Magnetic Stimulation (TMS).* Adopted June 23, 2023.
3. Washington State Health Care Authority. Mental Health Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svcs-20240401.pdf Revision effective April 1, 2024.

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; 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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.