VERMONT

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The Department of Vermont Health Access Medical Policy

Subject: Transcranial Magnetic Stimulation
Last Review: 12-22-2015
Revision 3:
Revision 2:
Revision 1: 11/13/14
Original Effective: 12/18/12

Description of Service or Procedure

"Transcranial magnetic stimulation (TMS) is a non-invasive method of brain stimulation. The technique involves placement of a small coil over the scalp and passing a rapidly alternating current through the coil wire which produces a magnetic field that passes unimpeded through the brain…The procedure is usually carried out in an outpatient setting and does not require anesthesia or analgesia." CMS

Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

Medicaid Rule

7103 Medical Necessity

7102.2 Prior Authorization Determination

Medicaid Rules can be found at http://humanservices.vermont.gov/on-line-rules

Coverage Position

Transcranial magnetic stimulation may be covered for beneficiaries:

- When prescribed by a licensed medical provider enrolled in the VT Medicaid program who is knowledgeable in the use of transcranial magnetic stimulation and who provides medical care to the beneficiary AND
- Who meet the clinical guidelines below.

Coverage Guidelines

Transcranial magnetic stimulation (TMS) of the brain is a Vermont Medicaid covered benefit for all eligible beneficiaries who meet the following criteria:

1. Has a confirmed diagnosis of severe major depressive disorder (MDD) (single or recurrent episode);
   AND
2. **One or more** of the following:
   - Resistance to treatment as evidenced by a lack of a clinically significant response to 4 trials of psychopharmacologic agents in the current depressive episode from at least 2 different agent classes, at or above the minimum effective dose and duration, and trials of at least 2 evidence-based augmentation therapies; **or**
   - Inability to tolerate psychopharmacologic agents as evidenced by 4 trials of psychopharmacologic agents with distinct side effects; **or**
   - History of good response to TMS in a previous depressive episode (evidenced by a greater than 50% improvement in a standard rating scale for depression symptoms); **or**
   - Is currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT) and TMS is considered a less invasive treatment option;
     AND
3. A trial of an evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms (*Note:* See Definition section for Depression Rating Scales);
   AND
4. TMS is administered by a U.S. Food and Drug Administration (FDA) cleared device for the treatment of MDD according to specified stimulation parameters, 30 sessions over a 7 week period followed by a 3 week taper of 3 TMS treatments in 1 week, 2 TMS treatments the next week, and 1 TMS treatment in the last week;
   AND
5. **None** of the following conditions or contraindications to TMS are present:
   - Seizure disorder or any history of seizure (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence); **or**
   - Presence of acute or chronic psychotic symptoms or disorders (such as schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode; **or**
   - Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items, including but not limited to a cochlear implant, implanted cardioverter defibrillator (ICD), pacemaker, vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples, or stents. (Note: Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS).

Investigational and Not Medically Necessary:

Transcranial magnetic stimulation of the brain is considered **investigational and not medically necessary** for MDD when the above criteria are not met, and for all other behavioral health indications and neuropsychiatric disorders (e.g., anxiety disorders, mood disorders, schizophrenia).

Clinical guidelines for repeat service or procedure

Additional transcranial magnetic stimulation treatment may be approved with medical justification from provider if above criteria is met.

Type of service or procedure covered

Transcranial magnetic stimulation (TMS)

CPT

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

References

Anthem Medical Policy BEH.00002. Transcranial Magnetic Stimulation for Depression and Other Neuropsychiatric Disorders. Last Review Date: 08/09/2012

American Psychiatric Association (APA). Practice Guidelines for the Treatment of Major Depressive Disorder. Published 2010. Accessed 11/30/12.

HealthNet National Medical Policy NMP 508. Transcranial Magnetic Stimulation. Effective Date March 2012.

Institute for Clinical and Economic Review. Nonpharmacologic Interventions for Treatment-Resistant Depression: Supplementary Data and Analyses to the Comparative Effectivelness Review of the Agency for Healthcare Research and Quality. Final Meeting Report. December 22, 2011.

NHIC, Corp. MAC-Part B, Region I. Local Coverage Determination (LCD) for Repetitive Transcranial Magnetic Stimulation (rTMS) (L32228). Effective March 17, 2012.

This document has been classified as public information.