

# Clinical Policy: Transcranial Magnetic Stimulation for Treatment Resistant Major Depression

Reference Number: WA.CP.BH.200

Last Review Date: 09/2023

Effective Date: 10/01/2023

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## 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  $\geq 10$  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).<sup>1</sup>

## 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 over seven weeks with 6 taper treatments when the following conditions are met:
  - A. Age  $\geq 18$  years with a diagnosis of major depressive disorder without psychosis,
  - B. Oversight of treatment is provided by a licensed psychiatrist or P-ARNP,
  - C. Depression that is unresponsive to trial therapy at a maximum tolerated dose for 4-12 weeks of one antidepressant from two of the following five classes:
    - Selective Serotonin Reuptake Inhibitors (SSRI)
    - Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
    - Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)
    - Norepinephrine/Dopamine Reuptake Inhibitor (NDRI)
    - Serotonin Antagonist Reuptake Inhibitor (SARI)Failed trials require a level of compliance considered adequate by the provider and may include failures that did not meet the duration requirement due to adverse events or reactions.
  - D. Treatment is provided in an outpatient setting.

- E. Does not have any of the following contraindications:
- 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 (e.g., cochlear implants, implanted electrodes/stimulators, aneurysm clips or coils, stents, bullet fragments, metallic dyes in tattoos),
  - Diagnosis of schizophrenia, schizophreniform disorder, or schizoaffective disorder,
  - Other neurological conditions exist (e.g., epilepsy, Parkinson’s disease, multiple sclerosis, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the CNS, or any other degenerative neurologic condition),
  - A minimum of 3 month substantiated early remission from substance use disorder
- II. Maintenance treatment with TMS is not medically necessary, as there is not sufficient peer reviewed literature to support it.

### Background

This policy is based entirely on Washington State Health Care Authority (HCA) guidance.

### 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
Typos corrected: Added “BH” to policy number. Changed “six taper treatments” to “6 taper treatments”.	08/23	09/23

### 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-bg-20230401.pdf>  
Revision effective April 1, 2023.

**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.

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**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.

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