

## Medical Necessity Guidelines: Transcranial Magnetic Stimulation (rTMS)

Effective: October 16, 2019

<b>Prior Authorization Required</b>	<b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
<p><b>Applies to:</b>  <b>COMMERCIAL Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409</li> <li><input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</li> <li>• CareLink<sup>SM</sup> – Refer to <a href="#">CareLink Procedures, Services and Items Requiring Prior Authorization</a></li> </ul> <p><b>TUFTS HEALTH PUBLIC PLANS Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</li> <li><input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607</li> </ul> <p>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p><b>SENIOR Products</b></p> <ul style="list-style-type: none"> <li>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the <a href="#">Tufts Health Plan SCO Prior Authorization List</a></li> <li>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the <a href="#">Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</a></li> </ul>	

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

### OVERVIEW

Repetitive transcranial magnetic stimulation (rTMS) uses a specifically designed magnetic coil that is placed in contact with the scalp to generate rapidly alternating magnetic fields and produces electrical stimulation of superficial cortical neurons. The procedure is generally administered daily over a four to seven week period. The FDA approved rTMS in October 2008 for use in the treatment of treatment-refractory Major Depressive Disorder based on the results of a multisite randomized controlled clinical trial using high frequency pulses over the left prefrontal cortex (HFL-TMS). HFL-rTMS requires no anesthesia or sedation.

Please use the [Repetitive Transcranial Magnetic Stimulation Request Form \(Standard Form\)](#).

### CLINICAL COVERAGE CRITERIA

Tufts Health Plan has developed the following Guidelines for determining when rTMS is medically necessary. All five of the below must be met:

1. The Member must have a diagnosis of Major Depression (single or recurrent episode) as defined by the most recent International Classification of Diseases or Diagnostic and Statistical Manual
- AND**
2. The Member must demonstrate resistance to treatment as evidenced by one of the following:
    - A lack of clinically significant response, in the depressive treatment episode, to four trials, from at least two different agent classes, including at least one anti-depressant medication, administered at an adequate dose and duration of at least 4 weeks **and** adequate trials of at least two (2) evidence-based augmentation therapies (at least four weeks in duration at adequate therapeutic doses);
    - or**
    - Inability to tolerate psychopharmacologic agents as evidenced by failed trials of four such agents with distinct, documented side effects (or medical contraindications that prevent four such trials);

**or**

- A history of clinically significant response to rTMS in a previous depressive episode; **or**
- A history of clinically significant response to electroconvulsive therapy (ECT) in a previous or current MDD episode **or** The Member meets expert consensus guidelines for ECT but is unable to tolerate ECT, and rTMS is proposed as a less invasive alternative;

**AND, IN ADDITION, ALL OF THE FOLLOWING MUST BE MET**

3. An unsuccessful trial has been undertaken, during the current depressive episode, 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;
4. The rTMS treatment is delivered by a device that is FDA-approved or FDA-cleared for the treatment of MDD in a safe and effective manner. rTMS treatment should generally follow the protocol and parameters specified in the manufacturer’s user manual, with modifications only as supported by the published scientific evidence base;
5. The order for treatment (or retreatment) will be written by a physician (MD or DO) who will examine the patient and review the record. The physician must have experience in administering rTMS therapy and must certify that the treatment will be given under direct supervision of this physician, i.e., he or she will be in the area and will be immediately available for each treatment.

**AUTHORIZATION GUIDELINES**

Thirty (30) visits over 7 weeks followed by six (6) taper treatments.

Treatment planning service (90867) once per course of treatment.

**LIMITATIONS**

**Tufts Health Plan will not cover rTMS under the following circumstances:**

- For formats other than HFL-rTMS, as their use is considered experimental
- rTMS should not be used for Members who have conductive, ferromagnetic or other magnetic-sensitive metals implanted in their head and located less than 30 cm from the rTMS magnetic coil, including but not limited to cochlear implants, implanted electrodes or stimulators, aneurysm clips or coil, or bullet fragments.
- In a setting other than a medical office or facility.
- The use of rTMS as a maintenance therapy to prevent relapse is not supported by controlled clinical trials and is therefore not considered medically necessary.

**CODES**

For the purposes of this guideline Tufts Health Plan will require the use of the diagnosis codes in Table 1 and the CPT procedure codes in Table 2.

The Member must have one of the following ICD-10 diagnoses to be considered for coverage.

**Table 1: ICD-10 Diagnosis Codes**

ICD-10 Diagnosis Code	Description
F32.2	Major depressive disorder, single episode, severe without psychotic features
F33.2	Major depressive disorder, recurrent severe without psychotic features

**Table 2: CPT Procedure Codes**

CPT Procedure Code	Description
90867	Therapeutic repetitive Magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Subsequent delivery and management, per session
90869	Subsequent motor threshold re-determination with delivery and management

**REFERENCES**

None

## APPROVAL HISTORY

- September 20, 2012: Reviewed by the Mental Health Operations and Policy Committee
- March 1, 2013: Revised, added code descriptions from 2013 Current Procedural Terminology; revised: Thirty six (36) treatment visits (90868) over 13 weeks including taper visits at the end of treatment, if necessary.  
Revised: Subsequent motor threshold re-determination with delivery and management (90869), if needed, once per course of treatment; added: Not Covered for USFHP
- March 25, 2013: Added ICD-10 codes
- October 1, 2013: Reviewed by the Mental Health Operations and Policy Committee and renewed with the addition of "including at least one anti-depressant medication".
- October 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans, Tufts Health Plan – Network Health Medicaid Plans, and Tufts Health Plan – Network Health OneCare Plans.
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: remove fax number from Type of Review box.
- March 16, 2015: Added fax number back into "Applies to" Section.
- April 7, 2015: Reviewed by the Mental Health Operations and Policy Committee and updated to track with CMS Region 1 Local Coverage Determination;
- April 8, 2015 Approved by IMPAC and effective October 1, 2015.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- April 19, 2016: Fax number updated for Tufts Health Unify. Coding updated, ICD-9 CM codes removed.
- August 9, 2016: Reviewed and approved by the Behavioral Health Operations and Policy Committee with no changes.
- October 27, 2016: Reviewed by the Behavioral Health Practitioner Advisory Committee and accepted with no changes.
- November 9, 2016: Reviewed and Approved by the Integrated Medical Policy Advisory Committee, with no changes.
- December 28, 2016: Coding updated
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 11, 2017: Reviewed by BH Operations and Policy committee with the following edits: In Overview section deleted "takes approximately 40 minutes" and ". Has about a 5% discontinuation rate due to adverse effects(mostly headache or scalp pain) and no systemic side effects. There are no long-term studies of rTMS." Reformatted Coverage Guidelines section in order to make requirements clearer.
- November 3, 2017: Reviewed by Behavioral Health Practitioner Advisory Committee. Approved with the following change: allowed psychopharmacology step therapy requirement to be met if psychopharmacology is medically contraindicated.
- November 8, 2017: Reviewed by the Integrated Medical Policy Advisory Committee and approved with one change. Language newly added on 11/3/17 was edited for clarity.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes

## BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

[Provider Services](#)