Clinical Policy: Transcranial Magnetic Stimulation for Treatment Resistant Major Depression

Reference Number: IA.BH.200
Effective Date: 6.28.22
Last Review Date: 6.22
Line of Business: Medicaid

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 technique approved as a modality for treatment resistant major depression (TRD). Brief repetitive pulses of magnetic energy are applied to the scalp via a large electromagnetic coil to generate low levels of electrical current in the underlying brain tissue. The intent is to stimulate areas of the brain involved in mood regulation to lessen the duration or severity of depressive episodes. (From Policy: CP.BH.200)

Policy/Criteria

I. It is the policy of Iowa Total Care® that TMS is medically necessary when ALL the following criteria are met:
- A. Adult 18 years of age or older.
- B. Diagnosis of major depressive disorder or persistent 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. Considered treatment refractory based on lack of a clinically significant response to four different psychopharmacologic agents from two different classes administered at therapeutic doses for the current depressive episode. The trialed agents should be administered for at least 6 weeks
- E. No contraindications to TMS are present (see section on contraindications).
- F. Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has been offered and declined by the patient.

II. It is the policy of Iowa Total Care® that TMS requests will be reviewed by a medical director for a treatment course of 36 sessions.

III. It is the policy of Iowa Total Care® that TMS maintenance therapy is considered **not medically necessary** as there is insufficient evidence to support this treatment at the present time.

IV. It is the policy of Iowa Total Care® that retreatment may be considered medically necessary when ALL 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.
C. No contraindications to TMS are present (see section on contraindications).

V. It is the policy of Iowa Total Care® that the following are TMS contraindications:
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.
E. Diagnosis of severe cardiovascular disease.

VI. t is the policy of Iowa Total Care® that TMS is investigational for the following:
A. TMS is considered investigational in the treatment of all or other psychiatric or neurological disorders, including but not limited to bipolar disorder, OCD, dementia, substance abuse, chronic pain syndrome, eating disorders, PTSD, and schizophrenia.
B. Literature does not support use of TMS in the pediatric population younger than 18 years of age.
    1. Additional concerns of using stimulation in the developing brain need to be addressed that show safety and long-term efficacy of therapy.
    2. Therefore, TMS would be considered investigational for this group.

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

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

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

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	6.23.22	
Updated the amount of sessions to be approved from 30, then 6 to 36 per committee meeting on 6/29/22.	6.30.22	

References

Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression. May 2017. The Journal of Clinical Psychiatry 79(1). DOI: 10.4088/JCP.16cs10905.

Evidence-based guidelines on the therapeutic use of repetitive transcranial magnetic stimulation (rTMS).

June 2014. Clinical neurophysiology: official journal of the International Federation of Clinical Neurophysiology 125(11).

DOI: 10.1016/j.clinph.2014.05.021.