

TRANSCRANIAL MAGNETIC STIMULATION FOR DEPRESSION

Effective Date: April 6, 2018

Review Dates: 2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16,
2/17, 2/18

Date Of Origin: February 10, 2010

Status: Current

Summary of Changes

Clarifications:

- Pg. 1, I, A, language added to reflect authorization for Transcranial Magnetic Stimulation (TMS) is determined by the clinical finding and TMS indications recommended by Behavioral Health InterQual®.

Deletions:

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Additions:

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I. POLICY/CRITERIA

A. Coverage criteria

Authorization for Transcranial Magnetic Stimulation (TMS) is determined by the clinical findings and TMS indications recommended by Behavioral Health InterQual®.

B. Limitations and exclusions

1. Treatment for patients non-compliant with prior therapies is not covered
2. Failure to monitor and document patient response will result in denial of further coverage.
3. If the coverage criteria are met, a typical treatment course consists of an initial six weeks of therapy, up to 30 visits and 6 taper treatments.
4. Maintenance therapy with TMS is not considered medically necessary because no clinical trials have been done to demonstrate the clinical benefit nor have clinical trials been done to document the optimal frequency or duration of maintenance therapy.
5. Repeat acute treatment for relapse of depressive symptoms is considered medically necessary if the patient responded to prior treatment, specifically >50% improvement in score by use of a validated, evidence-based depression monitoring tool, such as HAM-D, MADRS or QIDS. If the patient meets these criteria Priority Health will authorize an additional 30 visits for acute phase treatment followed by additional six visits for tapering therapy.

C. Provider requirements

The treating psychiatrist and facility must meet the following criteria:

1. The psychiatrist will be onsite and available for direct supervision during the procedure.

2. The psychiatrist and any other person performing the procedure will have successfully completed NeuroStar’s TMS Therapy System training or an equivalent training, and submit documentation of such training.
3. Psychiatrist, any other person performing the procedure and facility will comply with all operating instructions and guidelines contained in the NeuroStar TMS Therapy System User Manual and the FDA TMS Device Regulation and Guidance Documents.
4. Provider uses one of the following validated, evidence-based depression monitoring tools: HAM-D, MADRS, IDS-SR or QIDS for monitoring treatment response and remission.
5. Provider submits an updated copy of the administered HAM – D, MADRS, IDS-SR or QIDS demonstrating moderate to severe depression during the current depressive episode with the initial authorization request.
6. Provider submits an updated copy of the administered HAM-D, MADRS, IDS-SR or QIDS upon completion of the treatment episode and 6 months post treatment episode (pending member is still under the care of the provider).

This policy is based on review and recommendations of Priority Health’s Technology Assessment Committee in December 2008 and Behavioral Health Committee in December 2009.

Note: Not covered by Medicaid, Healthy Michigan Plan, requests for services must be coordinated with CMH.

II. MEDICAL NECESSITY REVIEW

Required Not Required Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*

- ❖ **MEDICARE:** Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IV. DESCRIPTION

Repetitive transcranial magnetic stimulation (rTMS) is a noninvasive technique that is being investigated as a treatment for major depression. Brief pulses of magnetic energy are applied to the scalp via a large electromagnetic coil to generate low levels of electrical current in underlying brain tissue. The goal of TMS is to stimulate areas of the brain involved in mood regulation in order to lessen the duration or severity of depressive episodes.

More than 75 studies and 8 metaanalyses have been published evaluating the efficacy of TMS. General findings include: TMS therapeutically effective, but the magnitude of clinical effect in question; active TMS significantly superior to sham in short-term acute treatment of treatment resistant depression (TRD) with clinically significant results; treatment is well-tolerated, few dropouts due to adverse effects; response and remission rates are low, unknown if effect is sustained. Limitations include: short treatment durations (1-2 weeks) in published studies; and response and remission rates low compared to most medication studies of TRD. (Daskalakis, et.al. and Lam et. al.). The Lam, et. al. metaanalyses calculated the number needed to treat (NNT) as 6 for the defined response rate, 7 for the defined remission rate.

V. CODING INFORMATION

The procedure is covered by the Plan when the above criteria is met and is billed by the licensed psychiatrist with the following codes:

ICD-10 Codes that may apply:

- F32.2 Major depressive disorder, single episode, severe without psychotic features
- F32.3 Major depressive disorder, single episode, severe with psychotic features
- F33.2 Major depressive disorder, recurrent severe without psychotic features
- F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms

CPT/HCPCS Codes:

Not covered for Priority Health Medicaid

- 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

Revenue Codes:

0940 Other Therapeutic Services - General

VI. REFERENCES

Repetitive transcranial magnetic stimulation for treatment-resistant depression: a systematic review and metaanalysis. Lam RW, Chan P, Wilkins-Ho M, Yatham LN. Can J Psychiatry. 2008 Sep; 53(9):621-31.

Repetitive transcranial magnetic stimulation for major depressive disorder: a review. Daskalakis, Z.J., Levinson, A. J., Fitzgerald, P.B. Can J Psychiatry. 2008 Sep; 53 (9): 555-566.

Hayes, Inc. Transcranial Magnetic Stimulation for Major Depression, June 2010. Update June 2011, June 2012, March 2014, March 2015 & November 2017. Lansdale, PA.

FDA

@<https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM265272.pdf> (July 26, 2011)

Local Coverage Determination (LCD) for TRANSCRANIAL MAGNETIC Stimulation (L32038) @ <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=32038&ContrId=64&ver=8&ContrVer=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&Keyword=transcranial+magnetic&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAABAAAA&> (Retrieved January 18, 2012, December 11, 2015 & January 5, 2018).

Aetna Clinical Policy Bulletin: Transcranial Magnetic Stimulation and Cranial Electrical Stimulation @ http://www.aetna.com/cpb/medical/data/400_499/0469.html (Retrieved January 18, 2012, January 7, 2013, December 11, 2015 & January 5, 2018).

Cigna Medical Coverage Policy: Transcranial Magnetic Stimulation @ http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/index.html#medT (Retrieved January 18, 2012, January 7, 2013, December 11, 2015 & January 5, 2018).

Regence Medical Policy: Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders @ <http://blue.regence.com/trgmedpol/medicine/med148.pdf> (Retrieved January 18, 2012 & January 5, 2018)
NeuroStar TMS Therapy System User Manual. <https://neurostar.com/pdf/52-40030-000-NeuroStar-TMS-Therapy-System-User-Manual-Supplement.pdf>
Updated May 2014

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