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Medicare Advantage Policy Manual **Policy ID:** M-MED148

Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member.

The Medicare Advantage Medical Policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and the Centers of Medicare and Medicaid Services (CMS) policies, when available. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and in some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services.

DESCRIPTION

"Transcranial Magnetic Stimulation (TMS) is a non-invasive treatment that uses pulsed magnetic fields to induce an electric current in a localized region of the cerebral cortex. An electromagnetic coil placed on the scalp induces focal current in the brain that temporarily modulates cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Stimulation parameters may be adjusted to alter the excitability of the targeted structures in specific cortical regions. Repetitive TMS (rTMS) has been investigated as treatment for pharmacoresistant depression." *(Noridian LCD L37088)*

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals*	None

National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder (L37088) **Scroll to the "Public Version(s)" section at the bottom of the LCD for links to prior versions if necessary.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- All chart notes and medical records pertinent to the request, such as History and Physical;
- Documentation of prior treatments (e.g., psychopharmacologic agents, prior rTMS treatments, electroconvulsive therapy [ECT], etc.), and the response to those treatments
- Number of requested treatment sessions, and indicate if the request is for an initial treatment or a retreatment.
- Name of device to be used for rTMS treatment *(according to LCD L37088, treatment must be provided by a device which has been FDA-approved for the purpose of supplying TMS)*.

REGULATORY STATUS

The Food and Drug Administration (FDA) granted 510(k) approval for the following devices:

- Brainsway™ H-Coil Deep TMS System (Brainsway, Ltd.) received FDA clearance for the treatment of depressive episodes in patients suffering from major depressive disorder who have failed to respond to antidepressant medications in their current episode of depression.
- Cerena™ TMS device (Eneura Therapeutics) received de novo marketing clearance for the acute treatment of pain associated with migraine headache with aura. Warnings, precautions, and contraindications include the following:
    - Safety and effectiveness have not been established in pregnant women, children under the age of 18, and adults over the age of 65.
- Magvita TMS Therapy System® is indicated for the treatment of Major Depressive Disorder in adult patients who failed to receive satisfactory improvement from prior antidepressant medication in the current episode.

- NeuroStar® (formerly known as NeoPulse®) TMS Therapy system (Neuronetics, Inc.) received de novo clearance for the treatment of major depressive disorder in adults who have failed a six-week course of one antidepressant medication.
- Rapid2 Therapy System from Magstim Company Limited is indicated for the treatment of Major Depressive Disorder in adult patients who have failed to achieve satisfactory improvement from prior antidepressant medication in the current episode.
- SpringTMS® received FDA clearance for the treatment of migraines, with aura.

Of note, the fact a service or procedure has been “FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary." Medicare contractors evaluate services, procedures, drugs or technology to determine if they may be considered Medicare covered services. *(Noridian LCD L35008)* The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety and effectiveness, CMS or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

CROSS REFERENCES

Electrical Stimulation and Electromagnetic Therapy Devices, Durable Medical Equipment, Policy No. M-83

REFERENCES

None

CODING

Codes	Number	Description
CPT	90867	Therapeutic repetitive transcranial 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
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*