

Department of Origin: Integrated Healthcare Services	Effective Date: 03/05/24
Approved by: Integrated Health Quality Management Subcommittee	Date approved: 03/05/24
Clinical Policy Document: Neuromodulation, Transcranial Magnetic Stimulation (TMS)	Replaces Effective Clinical Policy Dated: 03/07/23
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PURPOSE:

The intent of this clinical policy is to ensure care is medically necessary.

Please refer to the member’s benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member’s benefit plan or certificate of coverage, the terms of the member’s benefit plan document will govern.

POLICY:

Benefits must be available for health care services. Health care services must be ordered by a provider. Health care services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

GUIDELINES:

Medical Necessity Criteria – Must satisfy the following: I or II, and none of III

- I. Initial use – must satisfy all of the following: A – D, or E
 - A. Member is aged 18 or older.
 - B. Member’s current major depressive episode (MDE) meets *DSM* criteria for major depressive disorder (MDD).
 - C. Other causes of MDE have been excluded – none of: 1 - 5
 - 1. Bipolar 1 disorder; and
 - 2. Schizoaffective disorder; and
 - 3. Substance/medication-induced depressive disorder; and
 - 4. Depressive disorder due to another medical condition; and
 - 5. Personality disorders.
 - D. Member has demonstrated treatment resistance, during the current episode or a similar previous episode, as supported by both of the following: 1 and 2
 - 1. Member did not experience a *clinically significant response* to adequate *psychopharmacologic medication* trials, as evidenced by the following: a – b, or c
 - a. At least 2 trials involving antidepressants with different mechanisms of action; and
 - b. At least 2 trials involving augmentors; or
 - c. Member developed severe, treatment-limiting adverse (“side”) effects.
 - 2. Member did not experience a *clinically significant response* to an adequate trial of psychotherapy, where acceptable modalities include any of the following: a - c
 - a. Individual psychotherapy; or
 - b. Intensive outpatient program (IOP); or
 - c. Partial hospitalization program (PHP).
 - E. If the member is aged 18 or older and currently receiving electro-convulsive therapy, TMS may be considered reasonable and necessary as a less invasive treatment option.

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II. Continuation/maintenance – must satisfy any of the following: A - B

- A. The member has had a *clinically significant response* to TMS in a previous depressive episode; or
- B. The member is currently receiving or is a candidate for electroconvulsive therapy (ECT) and TMS is considered a less invasive treatment option.

III. Contraindications – none of the following: A - D

- A. Seizure disorder or any history of seizure.
[Note: Seizures induced by ECT, alcohol withdrawal seizures, or isolated febrile seizures in infancy without subsequent treatment or recurrence are acceptable.]
- B. Presence of acute or chronic psychotic symptoms or disorders (eg, schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode.
- C. Neurological conditions (eg, epilepsy, advanced cerebrovascular disease, advanced dementia, increased intracranial pressure, history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system [CNS]).
- D. Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items (eg, cochlear implant, implanted cardioverter defibrillator [ICD], pacemaker, vagus nerve stimulator [VNS], or metal aneurysm clips or coils, staples, or stents). [Note: Dental amalgam fillings are acceptable for use with TMS.]

EXCLUSIONS (not limited to):

Refer to member’s Certificate of Coverage or Summary Plan Description

DEFINITIONS:

Clinically significant response:

50% or greater reduction in objective depression rating scales (see Attachment A)

DSM:

The most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health Disorders.

Psychopharmacologic medications:

- Selective serotonin reuptake inhibitors (eg, citalopram, fluoxetine, paroxetine, sertraline, Trintellix [vortioxetine], Viibryd [vilazodone])
- Serotonin norepinephrine reuptake inhibitors (eg, desvenlafaxine, duloxetine, Fetzima [levomilnacipran], venlafaxine)
- Bupropion
- Tricyclic antidepressants (eg, amitriptyline, clomipramine, desipramine, nortriptyline)
- Mirtazapine
- Monoamine oxidase inhibitors (eg, selegiline, tranylcypromine)
- Serotonin modulators (eg, nefazodone, trazodone)
- Augmentation with such as, but not limited to, atypical neuroleptics, “thyroid” such as Cytomel (lithium), lithium, anticonvulsants, L-methylfolate

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Prior Authorization: Yes, per network provider agreement

CODING:

CPT

90867 Therapeutic repetitive transcranial magnetic stimulation treatment; initial, including cortical mapping, motor threshold determination, delivery and management

90868 Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management, per session

90869 Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent motor threshold re-determination with delivery and management

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Attachment A

Examples of Standardized Depression Rating Scales

- Beck Depression Inventory (BDI)
- Geriatric Depression Scale (GDS)
- Hamilton Depression Rating Scale (HAMD)
- Inventory of Depressive Symptomatology-Systems Review (IDS-SR)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- Personal Health Questionnaire Depression Scale (PHQ-9)
- Quick Inventory of Depressive Symptoms (QID)

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

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Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).