

Transcranial Magnetic Stimulation

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Related Policies
None

Policy Summary

[↪ See Purpose](#)

Overview

Transcranial magnetic stimulation (TMS) is a non-invasive, non-systemic treatment that uses Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields to induce an electric current in a localized region of the cerebral cortex. An electromagnetic coil is placed on the scalp that induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures.

When used as an antidepressant therapy, TMS produces a clinical benefit without the systemic side effects typical with oral medications, has no adverse effects on cognition, and unlike electroconvulsant therapy does not induce amnesia or seizures. TMS (also known as rTMS) offers a well-tolerated, non-pharmacologic alternative that does not require attendant anesthesia services and can be administered in an outpatient setting for patients with DSM-IV defined Major Depressive Disorder who have failed to benefit from initial treatment of their depression. When effective, TMS may prevent the need to utilize more complex pharmaceutical augmentation strategies (e.g., atypical antipsychotic medication), electroconvulsive therapy (ECT), and inpatient hospitalization at later stages of the illness.

Covered Indications

Left prefrontal TMS is considered reasonable and necessary for patients diagnosed with severe Major Depression (single or recurrent episode) as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), who also have at least one of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. At least one of the treatment trials must have been administered at an adequate course of mono or poly-drug therapy; or
- Inability to tolerate psychopharmacologic agents as evidenced by trials of four such agents with distinct side effects; or
- History of good response to TMS in a previous episode; or
- If patient is currently receiving electro-convulsive therapy, TMS may be considered reasonable and necessary as a less invasive treatment option.

Coverage Limitations

The benefits of TMS use must be carefully considered against the risk of potential side effects in patients with any of the following:

- Seizure disorder or any history of seizure (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence).
- Presence of psychotic symptoms in current depressive episode.
- Chronic or acute psychotic disorder such as Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder.
- Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system
- Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including, but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, Vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples or stents.

Documentation Requirements

- All documentation must be maintained in the patient's medical record
- The medical record documentation must support the medical necessity of the services as directed in this policy.

The attending physician must monitor and document the patient's clinical progress during treatment. The attending physician must use evidence-based validated depression monitoring scales such as the Geriatric Depression Scale (GDS), the Personal Health Questionnaire Depression Scale (PHQ-9), the Beck Depression Scale (BDI) Hamilton Rating Scale for Depression (HAM-D), the Montgomery Asberg Depression Rating Scale (MADRS), the Quick Inventory of Depressive Symptomatology (QIDS) or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) to monitor treatment response and the achievement of remission of symptoms.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	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

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

Definitions

rTMS: Repetitive Transcranial Magnetic Stimulation

TMS: Transcranial Magnetic Stimulation

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L33398 Transcranial Magnetic Stimulation	A57528 Billing and Coding: Transcranial Magnetic Stimulation	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L34522 Transcranial Magnetic Stimulation for Major Depressive Disorder	A57647 Billing and Coding: Transcranial Magnetic Stimulation for Major Depressive Disorder	First Coast	FL, PR, VI	FL, PR, VI
L34641 Transcranial Magnetic Stimulation (TMS)	A57598 Billing and Coding: Transcranial Magnetic Stimulation (TMS)	WPS	AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY	KS, IA, IN, MI, MO, NE
L34869 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	A57813 Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	Palmetto		AL, GA, NC, SC, TN, VA, WV
L34998 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	A57072 Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L36469 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	A57047 Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	CGS	KY, OH	KY, OH
L37086 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	A57692 Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L37088 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	A57693 Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

CMS Benefit Policy Manual

[Chapter 2 Inpatient Psychiatric Hospital Services](#)

UnitedHealthcare Commercial Policy

[Transcranial Magnetic Stimulation](#)

Other(s)

[Clinical Trial for Neural Predictors and Longitudinal Neural Correlates of Deep Transcranial Magnetic Stimulation for Treating Major Depression; Trial Identifier NCT01409317; Study Started April 2013, Estimated Study Completion April 2017](#)
[Clinical Trial for Repetitive Transcranial Magnetic Stimulation\(rTMS\) in the Treatment of Depression; Trial Identifier NCT01198561; Study Started February 2006; Estimate Study Completion August 2013](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
03/10/2021	<ul style="list-style-type: none">Routine review; no change to guidelinesArchived previous policy version MPG313.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website.

Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).