


<b>MEDICAL POLICY</b>	<b>Transcranial Magnetic Stimulation (Medicare Only)</b>
<b>Effective Date: 12/1/2022</b>	Medical Policy Number: 268
 12/1/2022	Medical Policy Committee Approved Date: 11/2020; 11/2021; 11/2022
Medical Officer	Date

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

## SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

## APPLIES TO:

Medicare Only

### MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Transcranial Magnetic Stimulation (rTMS)</i>	Local Coverage Determination (LCD): Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder ( <a href="#">L37088</a> )

## BILLING GUIDELINES

See the associated local coverage article (LCA) for additional billing and coding guidance:

- LCA: Billing and Coding: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder ([A57693](#))

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**CPT/HCPCS CODES**

<b>Medicare Only</b>	
Prior Authorization Required	
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

**INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

**REGULATORY STATUS**

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.