Medicare Medical Policy

Transcranial Magnetic Stimulation

MEDICARE MEDICAL POLICY NUMBER: 268

Effective Date: 11/1/2026

Last Review Date: 8/2026

Next Annual Review: 11/2026

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
Repetitive Transcranial Magnetic Stimulation (rTMS) (90867-90869)	Local Coverage Determination (LCD): Transcranial Magnetic Stimulation (TMS) (L37086)
Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*) • **Medicare Coverage Manuals:** Medicare does not have criteria for TMS in a coverage manual. • **National Coverage Determination (NCD):** Medicare does not have an NCD for TMS. • **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** While there are LCDs for repetitive transcranial magnetic stimulation (rTMS) which state that "all other uses of TMS therapy are considered investigational or experimental" and are non-covered, as of the most recent policy review, no LCDs explicitly address other TMS services, such as accelerated TMS or precuneus magnetic stimulation. • Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered "not fully established" as defined under CFR § 422.101(6)(i)(C) as there are no Medicare coverage criteria available for the TMS services listed below. • ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*	
Accelerated transcranial magnetic stimulation (CPTs 0889T-0892T) *Precuneus magnetic stimulation (CPTs 0997T, 0998T)*	Company medical policy for Transcranial Magnetic Stimulation I. These services are considered **not medically necessary** for Medicare Plan members based on the Company medical policy. See *Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

MEDICARE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Plan's Medicare policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

While there are LCDs available for transcranial magnetic stimulation (TMS) services, they are specific to repetitive TMS (rTMS) procedures. Other TMS techniques or procedures are not addressed by these Medicare coverage policies, and therefore, Medicare coverage criteria are not fully established for these TMS-related procedures.

Since there are not fully established Medicare coverage criteria for the use of an implantable magnetic esophageal ring in the treatment of GERD (e.g., LINX Reflux Management System) available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria for LINX Reflux Management System will be applied. The Company medical policy non-coverage position is consistent with the above noted Medicare references.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

Several transcranial magnetic stimulation devices have received FDA clearance, for a variety of indications. Examples of such systems include, but may not be limited to, the following:[1]

Major Depressive Disorder

- Brainsway H-Coil Deep TMS System
- Neurostar TMS Therapy
- Horizon 3.0 TMS Therapy
- MagVita TMS Therapy System w/Theta Burst Stimulation
- Nextstim Navigated Brain Therapy (NBT) System 2
- Rapid2 Therapy System
- Neurosoft TMS

Obsessive Compulsive Disorder

- Brainsway Deep Transcranial Magnetic Stimulation System

Migraine with Aura

- Cerena Transcranial Magnetic Stimulator (TMS) Device
- SpringTMS®

Accelerated TMS System for Refractory Depression

- Stanford Neuromodulation Therapy (SNT; formerly Stanford Accelerated Intelligent Neuromodulation Therapy, or SAINT Neuromodulation System). May also be seen as the Magnus Neuromodulation System used with SAINT Technology.

QuantalX's Delphi-MD technology has received the Breakthrough FDA Designation status for two separate indications:

- Identifying patients at risk of dementia and stroke, enabling early identification of functional and structural brain abnormalities indicative of early-stage neurodegeneration.

- Diagnosing Normal Pressure Hydrocephalus (NPH) patients and predicting their response to the effective treatment of ventriculoperitoneal shunting (VPS) surgery.

For any TMS system not otherwise listed in this policy, please refer to the FDA's 510(k) Premarket Notification website using product code "OBP."

BILLING GUIDELINES AND CODING

GENERAL

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

- LCA: Billing and Coding: Transcranial Magnetic Stimulation (TMS) (A57693)

CODES*		
CPT	0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report
	0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold–starting location, neuronavigation files and target report, review and interpretation
	0890T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day
	0891T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day
	0892T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day
	0997T	Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location, dose, and intensity for magnetic stimulation therapy, derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram, including automated data processing, transmission, analysis, generation of treatment parameters with review, interpretation, and report
	0998T	Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus, utilizing magnetic resonance imaging-based neuronavigation, with management, per day
	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
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. U.S. Food and Drug Administration (FDA). 510(k) Premarket Notification - Product Code OBP. Page Last Updated: 9/22/2025. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. Last Accessed: 9/24/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
12/2022	Annual review (converted to new format 2/2023)
1/2024	Annual review, no change to criteria; Q1 2024 Code updates
7/2024	Q3 2024 Code updates
12/2024	Annual review, no change to criteria (8/15/2025: Replaced L37088 with L37086 due to Noridian JF consolidation with JE LCD policies)
12/2025	Annual review, no change to criteria
1/2026	Q1 2026 code updates
11/2026	Interim update, revise criteria for non-rTMS procedures