MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2022
Policy Number: *475*	**Subject:** Transcranial Magnetic Stimulation (TMS)

Definition

Transcranial Magnetic Stimulation (TMS) is a noninvasive procedure for treatment-resistant depression that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression. The use of this treatment will be an alternative when medication trials are not working and/or the side effects of medication is intolerable for the member.

Medical Necessity Criteria

(1) Must have been diagnosed by a licensed physician/psychiatrist with one of the following within the past 30 days:

(a) F32.2 – Major Depressive Disorder, single episode, severe without psychotic features

(b) F32.3 -- Major Depressive Disorder, single episode, severe with psychotic features

(c) F33.2 -- Major Depressive Disorder, recurrent episode, severe without psychotic features

(d) F33.3 -- Major Depressive Disorder, recurrent episode, severe with psychotic features

(2) Must meet at least one of the following:

(a) Member has failed to respond to at least four medication trials from at least two antidepressant medication classes.

(b) Inability to tolerate four agents from two different agent classes with distinct side effects.

(c) The member has declined Electroconvulsive Therapy (ECT) in favor of TMS as a less invasive option.

(3) There must be documentation of the use of an evidence-based psychotherapy known to be effective in the treatment of Major Depressive Disorder that was provided and lacked significant improvement in depressive symptoms as determined by an evidenced-based depressive symptom inventory.

(4) The referral for TMS treatment and repeat treatment must be written by a physician or psychiatrist licensed to practice medicine who has examined the patient and reviewed the record and has experience administering TMS therapy. The treatment must be given under the supervision of this physician or psychiatrist.

(5) TMS must be delivered by a device that is FDA approved for the treatment of Major Depressive Disorder in a safe and effective manner. TMS should follow the protocol and parameters specified in the manufacturer's user manual, with modifications only as supported by the published scientific evidence base.

Exclusions

TMS is not covered in the following circumstances and is considered not reasonable and necessary:

(1) There is a presence of psychotic symptoms in the current episode.

(2) There is a presence of conductive, ferromagnetic or other magnetic-sensitive metals implanted in the member's head that are non-removable and within 30cm of the TMS magnetic coil.

(3) The member has been diagnosed with Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder.

(4) There are neurological conditions that include the following:

(a) epilepsy;

(b) parkinson's disease;

(c) multiple sclerosis;

(d) cerebrovascular disease;

(e) dementia;

(f) increased intracranial pressure;

(g) history of repetitive or severe head trauma;

(h) primary or secondary tumors in the central nervous system; or

(i) any other degenerative neurologic condition.

(5) There is active substance use.

Provider Requirements

(1) Transcranial Magnetic Stimulation may be provided by a Montana Licensed Physician or Psychiatrist with the required training and equipment to provide TMS.

(2) Providers must track and submit the outcome measures located in Policy 475a to Montana Medicaid on a semi-annual basis.

Service Requirements

(1) Member must meet the medical necessity requirements listed above; and

(2) The member has chosen TMS as their choice of treatment as indicated in the most current ITP.

(3) For initial treatment: maximum 30 visits (up to 5 times per week) over a 6 to 7-week period with a 2-week taper (6 taper sessions).

(4) For those in relapse: maximum 30 visits (up to 5 times per week) over a 6 to 7-week period with a 2-week taper (6 taper sessions).

(5) The attending physician/psychiatrist must monitor and document the member's clinical progress during treatment with the use of standardized, evidence-based rating scales as noted in Medical Necessity Criteria.

Utilization Management

(1) Prior authorization is required.

(2) Continued stay review is required for repeat acute treatment for relapse of depressive symptoms if the member responded to prior treatments as evidenced by a > 50 percent improvement in a standard rating scale (as noted in Medical Necessity Criteria (3) above) for depressive symptoms for up to 30 visits for the acute phase treatment followed by an additional 6 visits for tapering.

(3) The provider must document in the file of the member that the member meets the medical necessity criteria.