Minuteman Health

Clinical Review Criteria related to Transcranial Magnetic Stimulation (TMS)

I. Criteria for Approval

A. Members being referred for TMS must present with Treatment Resistant Depression as evidenced by:

1. Resistance to or inability to tolerate psychopharmacological agents as evidenced by

   - lack of clinically significant response to four adequate trials of at least 6 weeks duration of psychopharmacologic agents in the current depressive episode from at least two different agent classes,

   OR

   - inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes (at least one of which is in the antidepressant class), with distinct side effects,

   AND

2. Completion of a trial of psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms,

B. The UM Reviewers will review the prior authorization request for TMS according to the following specific criteria:

1. Member must have a current DSM-5 diagnosis of severe Major Depressive Disorder (MDD), single or recurrent episode, without psychotic features (F32.2 or F33.3), including documentation of baseline depression severity on HAM-D, MADRS, PHQ-9, BDI, or other appropriate tool to assess the severity of depression;

   AND

2. Member must have a recent treatment history that meets all three of the A criteria above

AND

3. Member must have

    a. been offered and declined trial of Electroconvulsive Therapy (ECT) during the current episode,

    OR

    b. have a history of non-response or adverse effects from ECT in the past

AND

4. The treating in-plan psychiatrist or psychiatric nurse specialist (i.e., the psychiatrist responsible for ongoing treatment of the member) must complete the *TMS Prior Authorization (PA) Form.*

AND

5. The psychiatrist to perform TMS treatment must have demonstrated to Minuteman Health, Inc. (MHI) that they have appropriate training in this procedure.

C. MHI covers repeated use of TMS for an acute relapse of a depressive episode as medically necessary when both of the following criteria are met:

1. All of the criteria for initial therapy are met,

AND

2. Member had more than a 50% improvement in prior TMS treatment episode(s) as evidenced by a validated rating scale for depressive symptoms.

D. MHI considers TMS maintenance therapy for depression to be experimental and investigational because the effectiveness and safety has not been established, and therefore this is not a covered service.

E. The following potential contraindications to TMS treatment have been considered by the provider, and if present, the provider has submitted to MHI an adequate clinical rationale of the safety and appropriateness of proceeding with TMS treatment, despite the contraindication(s):

1. Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

2. Presence of acute or chronic psychotic symptoms in the current depressive episode

3. Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors of the CNS

4. Presence of an implanted magnetic-sensitive medical device located less than or equal to 30cm from the TMS magnetic coil, or other implanted metal items, including but not limited to cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagus nerve stimulator, or metal aneurysm clips or coils, staples, or stents. Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS.

5. Patient is currently pregnant or nursing

6. Patient has a current suicide plan or recent suicide attempt

7. Patient has a current or past history of any of the following:

    a. Eating disorder
    b. Psychotic Disorder, including Schizophrenia and Schizoaffective Disorder
    c. Bipolar Disorder
    d. Substance Use Disorder
    e. Obsessive-Compulsive Disorder
    f. Post-traumatic Stress Disorder

F. The TMS treatment is delivered by a device that is FDA approved or FDA cleared for the treatment of MDD in a safe and effective manner.

G. Approval for TMS treatment will be for 1 unit of 90867, 34 units of 90868, and 1 unit of 90869; approval of any additional units requires clinical review.

II. References

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A

Comparative Effectiveness Review of High-Frequency Left Repetitive Transcranial Magnetic Stimulation Versus Other Neurostimulation Approaches to Treatment-Resistant Depression, December 1, 2016, last accessed 2/20/17

High-Frequency Left Repetitive Transcranial Magnetic Stimulation for Treatment-Resistant Major Depressive Disorder, November 3, 2016, last accessed 2/20/17.

Transcranial Magnetic Stimulation to Enhance Pharmacotherapy for Depression, March 19, 2014, last accessed 2/20/17

All above reports available at: https://www.hayesinc.com/

III. Summary of Changes

06/29/2017

- Changed rTMS policy to TMS policy
- Added disclaimer, updated references and last accessed dates

IV. Review Dates

HNE Review Dates: 4/2//2014, 4/2/2015, 2/3/2016, 04/04/2017, 06/01/2017
MHI Review Dates: 10/23/2014, 4/21/2016, 04/13/2017, 06/29/2017

Medical Guideline Disclaimer

The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member's benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.