MEDICAL POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Transcranial Magnetic Stimulation for Treatment of Depression-WI MP-MM-1634	09/01/2025
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Transcranial Magnetic Stimulation for Treatment of Depression

B. Background

Transcranial magnetic stimulation (TMS) was originally introduced in 1985 as a noninvasive treatment modality for treatment-resistant Major Depressive Disorder (MDD). Brief, repetitive pulses of magnetic energy are sent to the scalp via a large electromagnetic coil, generating a low level of electrical stimulation. These magnetic fields pass through the skull and induce electrical currents that depolarize neurons in a focal area of the surface cortex. The magnetic field generated by this type of stimulation is very small and cannot be felt by the patient but is strong enough to flow into the brain without inducing seizures or creating a need for anesthesia.

TMS is generally an outpatient procedure with conscious patients and sessions that vary between 30 to 40 minutes. Treatment can be delivered as a single pulse or as a series of pulses. Despite variability in the number of pulses delivered per session and the number of sessions per patient, research indicates that typical TMS consist of treatment up to 5 days a week for up to 6 weeks. A tapering schedule is used to end treatment.

C. Definitions

- **Acute (Index) Course of Treatment** – The initial series of treatment given to relieve acute symptoms of the MDD.
- **Adequate Trial** – Taking a drug at least 4 weeks at or near the maximum dose for the specific medication as approved by the Food and Drug Administration (FDA) or documentation exists that higher doses were not tolerated when the dose is less than the FDA-approved maximum.
- **Continuation TMS** – Treatment beginning after the acute/index course lasting up to 6 months and designed to prevent the worsening of symptoms and continued treatment for a depressive episode that has not yet remitted.
- **Depression Rating Scale** – Scales standardized for national use that reliably assess the range of symptoms, both type and magnitude, most commonly observed in adults with MDD. Listed below are examples of commonly used scales:
  - Beck Depression Inventory (BDI)
  - Geriatric Depression Scale (GDS)
  - Hamilton Depression Rating Scale (HAM-D)
  - Patient Health Questionnaire-9 (PHQ-9)
  - Quick Inventory of Depressive Symptomatology (QIDS)
- **Maintenance TMS** – Regularly scheduled TMS sessions on a weekly, biweekly, or monthly basis to prevent relapse of depressive symptoms.
- **Medication Side Effects** – Unexpected effects that cause significant distress, inhibit daily function, have the potential to worsen health, or are life threatening.
- **Remission** – The absence of significant signs or symptoms of a major depressive episode during the previous 2 months.

D. Policy

I. A review of medical necessity is required for initial and continuation courses of TMS.

II. TMS is considered medically necessary when **all** the following criteria are met:

A. *Member is 18 years of age or older.*

B. *There is a confirmed diagnosis of MDD*, single or recurrent, with a current severe episode as evidenced by a recent score on a standardized depression rating scale and at least **one** of the following:

1. *resistance to treatment evidenced by a lack of a clinically significant response during a current or previous depressive episode **and** adequate trials of 2 antidepressant agents*, including at least 2 different agent classes *at or near the maximum effective dose and duration* for each class approved by the FDA
2. i*nability to tolerate a therapeutic dose of medications evidenced by documentation in the medical record* of 2 trials of antidepressant agents *with distinct side effects*
3. *history of response to TMS in a previous depressive episode,* as evidenced by a greater than 50% improvement on a standardized depression rating scale
4. currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT) with TMS considered a less invasive treatment option

C. Completion of a trial of evidence-based psychotherapy for MDD with appropriate frequency and duration without significant improvement for 12 weeks, alone or combined with psychopharmacologic agents.

D. None of the following conditions or contraindications are present:

1. epilepsy or history of seizure or presence of other neurologic diseases that may lower seizure threshold (eg, cerebrovascular accident, severe head trauma, increased intracranial pressure)
2. *acute or chronic psychotic symptoms or disorders (eg, schizophrenia, schizophreniform, schizoaffective disorder)*
3. *cochlear implants or deep brain stimulators*
4. current use of substances that may significantly lower seizure threshold (eg, alcohol or stimulants)
5. *metallic hardware or implanted magnetic-sensitive medical devices (eg, implanted cardioverter-defibrillators, pacemakers, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging coil (eg, less than or equal to 30 cm to the discharging coil)*
6. unstable medical disorders

III. *Additional treatment courses of TMS are considered medically necessary when **all** the following have been met:*

A. 30 days since last session of TMS

B. *a history of response to TMS in a previous depressive episode* evidenced by a greater than 50% improvement on a standardized depression rating scale

C. *medical necessity is met per Section II above*

IV. TMS maintenance treatment is not considered medically necessary. There is not sufficient evidence in peer reviewed literature to assess net benefit versus harm for patients.

V. Additional criteria:
   A. *TMS must be administered by an FDA-cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters.*
   B. *A treatment course should not exceed 5 days a week for 6 weeks (total of 30 sessions), followed by a 3-week taper of 3 treatments in 1 week, 2 treatments the next week, and 1 treatment in the last week.*
   C. TMS can be ordered by and performed under direction of a neurologist, licensed psychiatrist, or psychiatric nurse practitioner who has examined the member, reviewed the record when it is within scope of practice, and has experience in administering TMS therapy within scope of practice.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	08/14/2024	New market. Approved at Committee.
Date Revised	06/04/2025	Annual review. Changed medication trial from 4 to 2 prior to TMS. Updated reference list. Approved at Committee.
Date Effective	09/01/2025	
Date Archived		

H. References

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