IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201909 FEBRUARY 21, 2019

IHCP adds coverage for transcranial magnetic stimulation

Effective March 21, 2019, the Indiana Health Coverage Programs (IHCP) will cover transcranial magnetic stimulation (TMS) for the treatment of depression for adults 18 years of age and older. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages for dates of service (DOS) on or after March 21, 2019.

Provider requirements

TMS services must be performed and/or supervised by a qualified provider. The following requirements must be met:

- The qualified provider must be a psychiatrist or neurologist that has completed and demonstrated proficiency in TMS treatment at a university-based training course or a company-sponsored training course.
- The qualified provider must personally supervise the initial individual motor threshold determinations, treatment parameter definition, and course of TMS treatment planning.
- Subsequent delivery and management of TMS sessions may be performed by the qualified provider or an appropriately trained technician under the direct supervision of the qualified provider ensuring the patient has someone in attendance at all times during the TMS session.
- During subsequent delivery and management of TMS sessions the qualified provider must meet face to face with the patient when there is a change in the patient's mental status and/or other significant change in clinical status.

Prior authorization

Coverage for TMS treatment requires prior authorization (PA) of medical necessity. Left prefrontal TMS of the brain is considered medically necessary for use with adults who meet the following criteria:

- Have a confirmed diagnosis of severe major depressive disorder (MDD) (single or recurrent episode)
- Have one or more of the following:
  - The patient has demonstrated resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. (At least one of the treatment trials must have been administered as an adequate course of mono- or poly-drug therapy; antidepressants involving standard therapeutic doses of at least 4 weeks duration)
  - Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents with distinct side effects
  - History of response to TMS in a previous depressive episode (evidenced by a greater than 50%improvement in a standard rating scale for depression symptoms)
  - Is currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT), and TMS is considered a less invasive treatment option
- Have undergone a trial of an evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms

Reimbursement and billing

The Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®[1]) codes in Table 1 will be covered for the reimbursement of TMS services.

Table 1 – Procedure codes covered for TMS treatment, effective for DOS on or after March 21, 2019

Procedure code	Description
90867	Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression) [initial, including cortical mapping, motor threshold determination, delivery and management]
90868	Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression), per session [subsequent delivery and management per session]
90869	Transcranial magnetic stimulation treatment (stimulates nerve cells in brain to improve symptoms of depression) [subsequent motor threshold redetermination with delivery and management]

Reimbursement of procedure codes in Table 1 is allowed in the outpatient setting. The procedure codes will be linked to the following revenue codes:

- 920 – *Other Diagnostic Service-General Classification*
- 940 – *Other Therapeutic Services (Also See 095X, An Extension of 094X)-General Classification*

The codes in Table 1 will be priced as follows:

- Outpatient – Maximum fee
- Professional – Paid at 40% of billed charges

This coverage information will be reflected in the *Revenue Codes Linked to Specific Procedure Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers and in the next regular update to the *Professional Fee Schedule* and the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

PA criteria and reimbursement information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA criteria and reimbursement information within the managed care delivery system. Questions about managed care should be directed to the MCE with which the member is enrolled.

QUESTIONS?

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