PerformCARE®	Policy and Procedure

Name of Policy:	Requests for Transcranial Magnetic Stimulation
Policy Number:	CM-055
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Department
Related Stakeholder(s):	Member Services
Applies to:	Associates
Original Effective Date:	10/03/24
Last Revision Date:	10/15/24
Last Review Date:	10/15/24
OMHSAS Approval Date:	10/03/24
Next Review Date:	10/01/25

Policy: Transcranial Magnetic Stimulation (TMS) services require prior authorization.

Purpose: To outline the procedure for seeking authorization for Transcranial Magnetic Stimulation (TMS) services.

Definitions: None

Acronyms: **TMS:** Transcranial Magnetic Stimulation
CCM: Clinical Care Manager
LOC: Level of Care
MNG: Medical Necessity Guidelines

Procedure:

1. A Provider will verify that criteria are met for service requests prior to submitting requests for TMS services per PerformCare MNG Attachment 2.
2. A Provider requests prior authorization for TMS services by submitting the PerformCare TMS Authorization Request form to PerformCare.
3. The Provider is required to complete all information on the form for the request to be valid. PerformCare will make telephonic outreach to the Provider to inform of an invalid request and provide an opportunity for resubmission.
4. All initial and maintenance requests for TMS are to be reviewed by a PerformCare Psychiatrist Advisor.
5. The standard approval/denial process is followed *per CM-013 Approval/Denial Process and Notification*.

6. PerformCare will generate an authorization for maximum of 36 sessions for 12 weeks based on request meeting MNG for TMS for initial request and 36 for 12 months for maintenance requests.
7. For treatment of acute episodes of depression, TMS is intended to be a time-limited, evidence-based service, to be delivered within 36 sessions, over 12 weeks. Additional sessions will be considered on a case-by-case basis.
8. A Provider will follow the same request and form submission process for additional sessions of acute treatment and for maintenance treatment as initial service requests. Additional session requests are to be submitted two (2) weeks prior to the expiration of the current authorization period to avoid a gap in services.
    8.1 A Provider will follow the same request and form submission process for a for maintenance sessions.
9. All TMS Providers are required to utilize FDA approved TMS equipment.

Related Policies: *CM-004 Psychiatrist Advisor/Psychologist Advisor Consultation*
CM-011 Clinical Care Management Decision Making
CM-013 Approval/Denial Process and Notification
QI-044 Grievance Policy

Related Reports: None

Source Documents and References: None

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1a Requests for Transcranial Magnetic Stimulation form*
Attachment 1b Requests for Transcranial Magnetic Stimulation form (Keystone FQHC)
Attachment 2 PerformCare Medical Necessity Guidelines for Transcranial Magnetic Stimulation

Approved by:

Primary Stakeholder

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CM-055 Requests for Initial and Continued Transcranial Magnetic Stimulation (TMS)
Attachment 2 PerformCare Medical Necessity Guidelines for TMS

PerformCare will utilize the following admission Guidelines for medical necessity review for TMS.

Initial TMS Admission Criteria:

Population: Adults ages 18 and above.

Must meet A, B, C and either D or E.

A. Major Depressive Disorder (without psychosis)

B. Have no contraindications to TMS treatment. Including that there have been no ferromagnetic objects in the head/neck area including no vagus nerve stimulator leads.

C. Currently in Moderate to Severe Major Depressive Episode, as defined by DSM 5 (or current version).

D. Have failed 2 or more antidepressant medications as defined below (Must meet D.1 and D.2 and either D.3 or D.4).

Meet D.1 and D.2

D.1 Adequate Dose: The member should have been treated with a dose that is consistent with the recommended/appropriate therapeutic range for that medication.

D.2 Adequate Duration: A sufficient trial period of at least 4 weeks at an appropriate therapeutic dose.

Meet D.3 or D.4

D.3 A Lack of Therapeutic Response: Despite optimal duration and dosage, the member does not achieve a significant improvement in symptoms. This should be measured by standardized clinical scales and/or the provider's clinical judgment.

D.4 Intolerable Side Effects: the member experiences side effects that are significant enough to preclude continued use of the medication (even if there is some degree of symptom improvement).

E. Antidepressant medications contraindicated for **one or more** of the following reasons:

E.1 Potential for serious medication adverse effects due to underlying medical condition or a history of such reaction.

E.2 Potential for serious worsening of underlying medical condition, or history of such as worsening with antidepressant treatment.

E.3 Potential serious drug-drug interaction or a history of such a reaction.

E.4 Pregnancy.

E.5 Postpartum and breast feeding.

E.6 Have positively responded to TMS treatment in the past.

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Maintenance TMS Admission Criteria:

Population: Adults ages 18 and above.

Must meet A, B, C and either D or E.

A. Major Depressive Disorder (without psychosis)

B. Have no contraindications to TMS treatment. Including that there have been no ferromagnetic objects in the head/neck area including no vagus nerve stimulator leads.

C. Currently in Moderate to Severe Major Depressive Episode, as defined by DSM 5 (or current version).

D. Have failed 2 or more antidepressant medications as defined below (Must meet D.1 and D.2 and either D.3 or D.4).

Meet D.1 and D.2

D.1 Adequate Dose: The member should have been treated with a dose that is consistent with the recommended/appropriate therapeutic range for that medication.

D.2 Adequate Duration: A sufficient trial period of at least 4 weeks at an appropriate therapeutic dose.

Meet D.3 or D.4

D.3 A Lack of Therapeutic Response: Despite optimal duration and dosage, the member does not achieve a significant improvement in symptoms. This should be measured by standardized clinical scales and/or the provider's clinical judgment.

D.4 Intolerable Side Effects: the member experiences side effects that are significant enough to preclude continued use of the medication (even if there is some degree of symptom improvement).

E. Antidepressant medications contraindicated for **one or more** of the following reasons:

E.1 Potential for serious medication adverse effects due to underlying medical condition or a history of such reaction.

E.2 Potential for serious worsening of underlying medical condition, or history of such as worsening with antidepressant treatment.

E.3 Potential serious drug-drug interaction or a history of such a reaction.

E.4 Pregnancy.

E.5 Postpartum and breast feeding.

E.6 Have positively responded to TMS treatment in the past.

AND F

F. Have relapsed within one year or less of cessation of TMS for acute treatment of depressive episode despite psychopharmacologic maintenance treatment OR have relapsed within one year or less of cessation of TMS for acute treatment of depressive episode and cannot tolerate psychopharmacologic maintenance treatment.