Priority Health	BILLING POLICY No. 127
TRANSCRANIAL MAGNETIC STIMULATION (TMS)	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Transcranial magnetic stimulation (TMS) is a procedure in which magnetic pulses are repeatedly delivered through the scalp to targeted areas of the brain to stimulate groups of neurons and, thereby, relieve certain symptoms or disorders. Two types of repetitive TMS, standard repetitive TMS and deep TMS, have been demonstrated to be effective for major depressive episodes in patients 18 years or older with major depressive disorder who fail to improve on antidepressant medications. Deep TMS is a type of repetitive TMS with deeper penetration of the magnetic pulses.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

The attending physician is responsible for monitoring and documenting the patient's clinical progress throughout the course of treatment. To assess treatment response and determine symptom remission, the physician must utilize evidence-based, validated depression assessment tools. Acceptable instruments include the Geriatric Depression Scale (GDS), Patient Health Questionnaire-9 (PHQ-9), Beck Depression Inventory (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery-Åsberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory of Depressive Symptomatology – Self-Report (IDS-SR).

Billing details

TMS is considered reasonable and medically necessary for an initial course of up to 20 sessions over a 4-week period, followed by 5 tapering sessions for patients who achieve remission. For patients demonstrating at least a 25% improvement on validated depression rating scales (e.g., GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, IDS-SR), treatment may be extended for an additional 2 weeks (10 sessions), with 6 additional tapering sessions.

Retreatment may be appropriate for patients who previously met the criteria for initial treatment and subsequently experienced a relapse of depressive symptoms, provided they had a documented response to prior TMS (i.e., greater than 50% improvement on standard depression scales) or a relapse following remission. Retreatment should follow the same protocol as the initial course.

Maintenance TMS therapy is considered experimental/investigational and is not deemed medically necessary.

The term "medical necessity" is used to mean care that is determined to be effective, appropriate, and necessary to treat a given patient's disorder. To determine medical necessity for TMS, the Priority Health Behavioral Health department relies on InterQual® Behavioral Health criteria.
Authorization is required. Requests must include:

- Current Diagnosis
- Onset of current depressive episode
- Dates of current or recent outpatient therapy
- A copy of the depression screening tool completed by the member
- Notation of all medication trials that have been completed
- Information regarding any medical contraindications

In-network providers

In-network providers can request authorization for TMS using GuidingCare.
Request an authorization

Out-of-network providers

If you're a provider located within the state of Michigan and would like to join our provider network, visit our credentialing application page.

Out-of-network providers request mental health and substance use disorder services using our Transcranial Magnetic Stimulation (TMS) authorization form.

The treatment must be provided by use of a device approved by the FDA for the purpose of supplying TMS.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

- Article - Billing and Coding: Transcranial Magnetic Stimulation (TMS) (A57598)
- LCD - Transcranial Magnetic Stimulation (TMS) (L34641)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made