

The IHCP covers transcranial magnetic stimulation (TMS) for the treatment of depression for adults 18 years of age and older.^[19]

Clinical Policy: Transcranial Magnetic Stimulation for Treatment Resistant Major Depression

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[Coding Implications](#)

[Revision Log](#)

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Description

Transcranial Magnetic Stimulation (TMS) is a non-invasive treatment that uses pulsed magnetic fields to induce an electric current in a localized region of the cerebral cortex. An electromagnetic coil placed on the scalp induces focal, patterned current in the brain that temporarily modulates cerebral cortical functioning. Stimulation parameters may be adjusted to alter the excitability of the targeted structures in specific cortical regions. TMS parameters include cranial location, stimulation frequency, pattern, duration, intensity, and the state of the brain under the coil.¹

Policy/Criteria

I. The IHCP covers transcranial magnetic stimulation (TMS) for the treatment of depression for adults 18 years of age and older.^[19]

II. It is the policy of Managed Health Services that requests for initial treatment with repetitive transcranial magnetic stimulation (rTMS), deep TMS (dTMS), or Theta Burst Stimulation (iTBS) are considered medically necessary for **adults ≥ 18 years of age** when meeting all the following criteria:

- A. The member/enrollee has a confirmed diagnosis of major depressive disorder (MDD), severe (single episode or recurrent), per most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- B. The member/enrollee does not have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder;
- C. The member/enrollee has one or more of the following:
 1. 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 four weeks duration);
 2. Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents with distinct side effects;

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3. Currently receiving or is a candidate for and has declined electroconvulsive therapy (ECT), and TMS is considered a less invasive treatment option.
- D. The member/enrollee has participated in an adequate trial of evidence-based psychotherapy (such as weekly cognitive behavioral therapy and/or interpersonal therapy) during the current episode of illness, without significant improvement.
Note: This therapy should overlap with the antidepressant trials.
- E. The member enrollee is referred for TMS treatment by the provider treating the member/enrollee's MDD;
- F. A comprehensive psychiatric evaluation to determine the necessity for TMS has been completed by a qualified licensed provider, such as one of the following:
 1. Psychiatrist (MD, DO, or MBBS [Bachelor of Medicine, Bachelor of Surgery]);
 2. Psychiatric Mental Health Nurse Practitioner (PMHNP);
- G. Direct supervision of treatment is provided by a qualified provider. All of the following must be met:
 1. The qualified provider must be a psychiatrist or neurologist who has completed and demonstrated proficiency in TMS treatment at a university-based training course or a company-sponsored training course; *and*
 2. The qualified provider must personally supervise the initial individual motor threshold determinations, treatment parameter definition and course of TMS treatment planning; *and*
 3. 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 member/enrollee has someone in attendance at all times during the TMS session; *and*
 4. 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 or other significant change in clinical status.
- H. Request is for up to 36 sessions;
Note: Recommended schedule is five days a week for six weeks, with an optional six sessions for tapering.
- I. The treatment is administered using a Food and Drug Administration (FDA)-cleared device and utilized in accordance with the FDA labeled indications such as but not limited to the following:
 1. NeuroStar[®] Advanced TMS Therapy System;
 2. Apollo TMS Therapy System;
 3. BrainsWay Deep TMS;
 4. Horizon TMS Therapy System;
 5. MagVita TMS Therapy with MagPro R20;
 6. MagVita TMS Therapy System w/Theta Burst Stimulation;
 7. Neurosoft TMA (Cloud TMS);
 8. Nexstim Brain Therapy;
 9. Magstim Horizon 3.0 TMS Therapy System Range;
- J. The member/enrollee does not have any of the following contraindications:
 1. Presence of conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 30 cm of TMS coil placement other than dental fillings to include but not limited to the following:

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- a. Cochlear implant;
 - b. Implanted electrodes/stimulators;
 - c. Aneurysm clips or coils;
 - d. Stents;
 - e. Bullet fragments;
 - f. Metallic dyes in tattoos;
2. Vagus nerve stimulator leads in the carotid sheath;
 3. Less than three months of substantiated remission from substance use disorder;
- K. No changes to psychotropic treatment during the course of TMS treatment unless clinical documentation justifies the change (such as administration of concomitant ketamine, esketamine, or other infusion therapy);
- L. Documentation of rTMS, iTBS or dTMS protocol used;
- M. Planned use of an evidence based standardized depression rating scale (including severity), documenting the score prior to treatment, and monitored throughout the course of treatment.

III. It is the policy of health plans affiliated with Centene Corporation that requests for **retreatment** with rTMS, dTMS or iTBS **for adults ≥ 18 years of age** will be reviewed on a case-by-case basis by a medical director, informed by all the following:

- A. The member/enrollee has a confirmed diagnosis of major depressive disorder (MDD), severe (single episode or recurrent), per most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- B. The member/enrollee does not have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder;
- C. Current depressive symptoms have worsened to a PHQ-9 severity score ≥ 15 (or equivalent in other standardized depression severity scale);
- D. Prior treatment response demonstrated at least a 50% improvement in baseline standardized depression rating scores, (with a documented 6-month duration of response);
- E. The member/enrollee is referred for TMS treatment by the provider treating the member/enrollee's MDD;
- F. A comprehensive psychiatric evaluation to determine the necessity for TMS retreatment has been completed by a qualified licensed provider, such as one of the following:
 1. Psychiatrist (MD, DO, or MBBS [Bachelor of Medicine, Bachelor of Surgery]);
 2. Psychiatric Mental Health Nurse Practitioner (PMHNP);
- G. The member/enrollee has participated in an adequate trial of evidence-based psychotherapy (such as weekly cognitive behavioral therapy and/or interpersonal therapy) during the current episode of illness, without significant improvement;
- ~~H.~~ H. Direct supervision of treatment is provided by a qualified provider. All of the following must be met:
 1. The qualified provider must be a psychiatrist or neurologist who has completed and demonstrated proficiency in TMS treatment at a university-based training course or a company-sponsored training course; *and*

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2. The qualified provider must personally supervise the initial individual motor threshold determinations, treatment parameter definition and course of TMS treatment planning;
and
 3. 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 member/enrollee has someone in attendance at all times during the TMS session; *and*
 4. 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 or other significant change in clinical status.
- I. Request is for up to 36 sessions;
Note: Recommended schedule is five days a week for six weeks, with an optional six sessions for tapering;
- J. The treatment is administered using a Food and Drug Administration (FDA)-cleared device and utilized in accordance with the FDA labeled indications such as but not limited to the following:
1. NeuroStar[®] Advanced TMS Therapy System;
 2. Apollo TMS Therapy System;
 3. BrainsWay Deep TMS;
 4. Horizon TMS Therapy System;
 5. MagVita TMS Therapy with MagPro R20;
 6. MagVita TMS Therapy System w/Theta Burst Stimulation;
 7. Neurosoft TMA (Cloud TMS);
 8. Nexstim Brain Therapy;
 9. Magstim Horizon 3.0 TMS Therapy System Range;
- K. The member/enrollee does not have any of the following contraindications:
1. Presence of conductive or ferromagnetic or other magnetic-sensitive metals implanted or embedded in head or neck within 30 cm of TMS coil placement other than dental fillings to include but not limited to the following:
 - a. Cochlear implant;
 - b. Implanted electrodes/stimulators;
 - c. Aneurysm clips or coils;
 - d. Stents;
 - e. Bullet fragments;
 - f. Metallic dyes in tattoos;
 2. Vagus nerve stimulator leads in the carotid sheath;
 3. Less than three months of substantiated remission from substance use disorder;
- L. No changes to psychotropic treatment during the course of TMS treatment, unless clinical documentation justifies the change (such as administration of concomitant ketamine, esketamine, or other infusion therapy);
- M. Documentation of rTMS, iTBS or dTMS protocol used;
- N. Planned use of an evidence-based standardized depression rating scale (including severity), documenting the score prior to treatment, and monitored throughout the course of treatment;

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- O. If the member/enrollee is not achieving remission, consideration of treatment augmentation or potential alternative treatment such as Electroconvulsive Therapy (ECT).

IV. It is the policy of Managed Health Services that **maintenance treatment** with repetitive transcranial magnetic stimulation (rTMS), Theta Burst Stimulation (iTBS) or deep transcranial magnetic stimulation (dTMS) is considered not medically necessary, as there is insufficient evidence in the published, peer-reviewed literature to support it.

V. It is the policy of Managed Health Services that there is insufficient evidence in the published peer-reviewed literature to support the safety and efficacy of *MRI guided theta burst stimulation*, including but not limited to, *Stanford Accelerated Intelligent Neuromodulation Therapy (SAINT)*, beyond established TMS/TBS techniques.

Background

Psychotherapy and pharmacologic treatment are considered first-line interventions for individuals diagnosed with major depressive disorder (MDD). For patients who do not achieve adequate response to these standard treatments, alternative somatic therapies may be considered, including electroconvulsive therapy (ECT) and repetitive transcranial magnetic stimulation (TMS). Unlike ECT, TMS is a non-invasive neuromodulation technique that does not require general anesthesia and does not induce seizure activity. The clinical effects of TMS vary based on stimulation parameters, including waveform, frequency, intensity, and treatment duration. When administered under appropriate clinical supervision and in accordance with manufacturer-specific treatment protocols, FDA-cleared TMS devices have demonstrated an acceptable safety profile.²

On June 3, 2025, Hayes published its annual review of maintenance rTMS for prevention of recurrent depression in adults. The review concluded that there was a very low-quality body of evidence to draw conclusions regarding the effectiveness and safety of rTMS as a maintenance treatment. There are currently no clinical practice guidelines or position statements that propose definitive patient selection criteria for maintenance rTMS for treatment of MDD.³

*Literature Review***Repetitive Transcranial Magnetic Stimulation (rTMS)²**

rTMS is currently the most widespread form of TMS for clinical applications. In rTMS, magnetic pulses are delivered in a rapid series or “train.” When rTMS is used, multiple single-pulse stimuli are presented at a specific frequency, intensity, and time duration. In the context of MDD treatment, rTMS is often delivered at a frequency ≥ 10 Hertz (Hz) and targets the dorsolateral prefrontal cortex, a region important for high order executive function.

In 2025, Tang and colleagues completed a systematic review and meta-analysis of 27 randomized controlled trial (RCTs) to examine neuromodulation treatment for adolescents diagnosed with depression. Across the studies, sample sizes ranged from 32 to 152 participants, totaling 2,075 individuals aged 8–21 years diagnosed with depression. All studies used TMS based treatments, with a duration range of 1 to 8 weeks and sessions range from 10–40. Most studies (24) combined rTMS with medication. The functioning scales used for outcome measures

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include the Hamilton Depression Scale (HAMD), Self-Rating Depression Scale (SDS), T-score for depression in Symptom Checklist-90 (SCL-90), and the Montgomery-Asberg Depression Rating Scale (MADRS). The results showed large, clinically significant reductions in symptoms (HAMD-17: SMD = 3.503; HAMD-24: SMD = 3.375; both $p < 0.001$), though heterogeneity was high ($I^2 > 95\%$).⁵

Deep Transcranial Magnetic Stimulation (dTMS)⁴

Deep TMS is administered by commercially available rTMS devices that theoretically stimulate brain structures beneath the superficial prefrontal cortex using magnetic coils (H coils); these H coils can induce a magnetic field with a deeper and wider distribution than the standard (figure eight) coils used for surface cortical TMS. The depth of stimulation beneath with H coils is approximately 4 cm; H coils also stimulate surface cortical structures.

In 2019, Filipčić, et.al, conducted a randomized trial to the clinical outcome between TMS protocols delivered by H1-coil and the figure 8 coil. Based upon network meta-analyses of randomized trials, the efficacy and acceptability of deep TMS appears to be comparable to that of surface cortical TMS and theta burst TMS. A four-week randomized trial compared add-on deep TMS (20 sessions) with surface cortical TMS in patients with treatment-resistant depression ($n = 147$) who continued to receive stable, ongoing pharmacotherapy. Although remission in the two groups was comparable, response occurred in more patients who were treated with adjunctive deep TMS than surface cortical TMS (67 versus 44 percent). In addition, all-cause discontinuation occurred more than twice as often with deep TMS than surface cortical TMS (10 and 4 percent of patients).⁶

Theta burst Stimulation (iTBS)⁴

iTBS is a form of rTMS wherein short bursts of three to five pulses per second are administered at a higher frequency (50 Hz) but with a specific interburst interval that generates an overall lower stimulation frequency (5 Hz).

In 2021, a systematic review conducted by Voigt et al, focused on theta burst stimulation of TRD. The reviewers included 8 RCTs comparing theta burst stimulation to sham treatment and 1 comparing theta burst stimulation to conventional rTMS. As measured by the HAM-D, Theta burst stimulation was superior to sham on response (RR 2.4; 95% CI: 1.27 to 4.55; $p = .007$; $I^2 = 40\%$). There was no statistically significant difference between theta burst stimulation and conventional rTMS (RR 1.02; 95% CI: 0.85 to 1.23; $p = .80$; $I^2 = 0\%$). There is no difference between theta burst stimulation and rTMS in the incidence of adverse events.⁷

American Psychiatric Association (APA)⁸

In July 2024, APA published a position statement on TMS administration, “TMS is a safe and effective evidence based medical treatment when administered by TMS-trained psychiatrists for appropriately selected patients. Training in evidence-based TMS therapy for residents and insurance coverage for TMS are needed to provide access to TMS.”

American Academy of Child & Adolescent Psychiatry (AACAP)⁹

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In April 2024, AACAP published a review on emerging mental health treatment in adolescents. AACAP reports that although TMS is FDA approved for ages 15 years and older, further research is needed to establish safety and efficacy in this age group.

*Food and Drug Administration (FDA)*¹⁰

In October 2008, conventional repetitive TMS (TMS) was FDA cleared for the treatment of adults with major depressive disorder (MDD) who had one failed medication trial. In 2013, deep and conventional repetitive TMS (dTMS) was cleared for treatment resistant MDD. In August 2018, Intermittent Theta Burst Stimulation (iTBS) was first approved by the FDA. In 2024, the FDA approved NeuroStar Advanced Therapy as an adjunct to an existing therapy for the treatment of MDD in adolescents aged 15-21 years. In March 2025, the FDA approved the Magstim Horizon Inspire and Horizon 3.0 Transcranial Magnetic Stimulation (TMS) systems for treating adolescents aged 15–21 years with major depressive disorder (MDD).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT [®] Codes	Description
90867	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management
90868	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent motor threshold re-determination with delivery and management
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	08/26	08/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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