AmeriHealth Caritas Louisiana

Transcranial Magnetic Stimulation

Reimbursement Policy ID: RPC.0035.2100

Recent review date: 10/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement for transcranial magnetic stimulation (TMS) for the treatment of severe major depressive disorder. TMS is a noninvasive technique using a device approved by the U.S. Food and Drug Administration (FDA) to apply brief magnetic pulses to the brain for the treatment of severe major depressive disorder. Repetitive TMS (rTMS) is typically applied daily in patients with resistant major depression disorder who have failed previous trials of antidepressants in the current depressive episode.

Exceptions

N/A

Reimbursement Guidelines

TMS is eligible for reimbursement when delivered in an outpatient setting to adults 18 and older. Prior authorization may be required. In addition, according to our policy and the American Medical Association Current Procedural Terminology (AMA-CPT) Manual, subsequent TMS (90868 or 90869) should not be reported unless an initial (90867) or subsequent TMS (90868 or 90869) has been reported within the previous seven days. CPT code 90867 should be reported only once (within a 6-week time period) per patient for the episode (initial planning) and NOT in conjunction with CPT codes 90868 or 90869. Do not report CPT code 90869 in conjunction with 90867 or 90868.

Appropriate CPT codes are below.

CPT Code	Description
90867	Therapeutic repetitive transcranial stimulation (rTMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Subsequent delivery and management, per session
90869	Subsequent major threshold redetermination with delivery and management

Claims for TMS services must include the appropriate diagnosis code for major depressive disorder without psychotic features to be eligible for reimbursement. Medical record documentation must support the diagnosis code(s) submitted.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. https://www.amerihealthcaritasla.com/pdf/provider/newsletters/2024/082924-provider-alert-ib-24-27-transcranial-magnetic-stimulation-revised-082924
VII. Applicable Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

10/2026	Reimbursement Policy Committee Approval
10/2026	• Policy updated to include supporting diagnosis for TMS services • Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval

07/2026	No major changes • No major changes
08/2025	Reimbursement Policy Committee Approval
08/2025	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
11/2024	Reimbursement Policy Committee Approval
	Precedes Act 319