Magellan HEALTHCARE®

Transcranial Magnetic Stimulation (TMS) Fax Cover Sheet

Complete this cover sheet, along with the TMS Treatment Checklist, and fax to Magellan.

For a **non-California** commercial/Medicare member, fax to **1-888-656-4967**.
For a **Blue Shield of California** member, fax to **1-888-656-3510**.
For a **Sharp Health Plan** or **Scripps Health Plan** member, fax to **1-888-656-4967**.

For *initial* requests, complete this fax cover sheet and the TMS checklist, sections I-VI.

For *concurrent* requests, complete this fax cover sheet and the TMS checklist, sections III, IV, and V, and include updated scores in comments, section VI.

For *converting already authorized services under CPT codes 90868 to 90869*, complete this fax cover sheet and the TMS checklist, section VI. Include clinical rationale for request in comments, section VI.

For *date extensions*, complete questions 1-4 below. Provider must sign section VI of the TMS checklist, but the rest of the checklist does not need to be completed.

1. Date of last TMS session: _____
2. Number of TMS sessions completed by above date: _____
3. Date to which existing authorization should be extended: _____
4. Reason authorization requires extension (provide detailed clinical information): _____

Complete the following:

Patient information

Patient name:	Patient date of birth:
Health plan:	Insurance ID number:
Subscriber name:	Subscriber's employer:
Street address:	City/state/ZIP code:
Phone number:	

Provider information

TMS psychiatrist name:

Service address (where TMS will take place):

Phone number: Fax number:

Taxpayer ID Number: NPI:

Magellan MIS number: Email:

Date TMS psychiatrist was certified to perform TMS via completion of a university-based course in TMS or a course approved by the device manufacturer:

Start date of TMS service: Appointment time:

Includes 90869: ☐ Yes ☐ No

Behavioral health and substance use diagnosis codes:

Physical health diagnosis codes:

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Transcranial Magnetic Stimulation Treatment Checklist

To help ensure the safe and proper treatment of patients diagnosed with major depression using transcranial magnetic stimulation (TMS), Magellan providers must review the questions below and mark the applicable responses.

Fax the *completed form* and *documentation that supports your request:*

- For a **non-California** commercial/Medicare member, fax to **1-888-656-4967**.
- For a **Blue Shield of California** member, fax to **1-888-656-3510**.
- For a **Sharp Health Plan** or **Scripps Health Plan** member, fax to **1-888-656-4967**.

Unsigned or incomplete forms will not be processed.

Section I

Provider/Request Information

1. Has the attending psychiatrist completed training and are they certified to provide TMS services?	☐ Yes ☐ No
2. Is this request for **initial course of TMS** treatment of a patient?	☐ Yes ☐ No
3. Is this a request for **additional** sessions for current course of TMS after an initial set of sessions was already authorized? *If yes, complete only Section IV for additional sessions beyond the first authorization.*	☐ Yes ☐ No
4. Is this request for TMS for **repeat** treatment of a patient? *If yes, complete Section V below.*	☐ Yes ☐ No
5. Is this request for TMS for **maintenance** therapy, **continuous** therapy, **rescue** therapy, or extended active therapy of a patient?	☐ Yes ☐ No

Section II

Patient Information - Initial TMS Treatment

1. Patient's age at the start of TMS treatment.	_____
2. Is the patient pregnant?	☐ Yes ☐ No
3. What is the diagnosis for which this TMS treatment is to address?	_____
4. List patient's co-occurring behavioral health diagnoses, neurologic disorder(s), or substance use disorder. *List the other diagnoses:* _____ _____	

5. Was evidence-based psychotherapy (cognitive behavioral therapy, interpersonal therapy or behavioral activation, with 8-16 sessions during 6-8 weeks) to treat depression (major depressive disorder) attempted of an adequate frequency and duration without significant improvement in depressive symptoms as document by standardized rating scales that reliably measure depressive symptoms? *If yes, list therapy type, number of sessions, number of weeks and timeframe for treatment:* _____ _____ _____ _____	☐ Yes ☐ No
6. Has the patient lacked a clinically significant response to medications during this depressive episode? Approximately when did this depressive episode start? _____ How many failed antidepressant medications have been tried during the depressive episode? *List all medications, dosage and length of treatment (see section III if additional space needed)*: _____ _____ _____	☐ Yes ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
7. Has the patient demonstrated an inability to tolerate medication treatment as evidenced by two trials of antidepressant agents from two different agent classes, with distinct side effects? *List side effects per medication (see section III if additional space needed):* _____ _____ _____	☐ Yes ☐ No
8. Does the patient have a history of response to electroconvulsive therapy (ECT) in a previous or current episode or an inability to tolerate ECT?	☐ Yes ☐ No
9. Is the patient medically stable?	☐ Yes ☐ No
10. Do you attest that the patient does not have a contraindication for TMS?	☐ Yes ☐ No
11. Is there a clinical contraindication for ECT?	☐ Yes ☐ No
12. Did you discuss with the patient that ECT may be a possible treatment option (for major depressive disorder) and the patient refused ECT?	☐ Yes ☐ No
13. Does the patient have access to a suitable environment and professional and/or social supports after recovery from the procedure?	☐ Yes ☐ No
14. Does the patient have any presence of psychotic symptoms in this or prior depressive episodes?	☐ Yes ☐ No

15. Does the patient have any neurologic conditions that include epilepsy, seizures, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system? *If yes, state which condition(s):* _____ _____ _____	☐ Yes ☐ No
16. Does the patient have any conductive, ferromagnetic, or other magnetic-sensitive materials implanted in their head which are non-removable and within 30cm of the TMS magnetic coil? Examples include cochlear implants, implanted electrodes/stimulators, aneurysm clips, coils or stents, and bullet fragments. *If yes, state which material(s):* _____ _____ _____	☐ Yes ☐ No
17. Does the patient have any presence of vagus nerve stimulator leads in the carotid sheath?	☐ Yes ☐ No
18. Is the patient currently also receiving esketamine intranasal, ketamine infusion or other infusion therapies for major depression disorder?	☐ Yes ☐ No
19. Does the patient and/or legal guardian understand the purpose, risks and benefits of TMS, and provide consent?	☐ Yes ☐ No
20. Is there documentation of a clinical evaluation performed by a psychiatrist or other qualified behavioral health professional who is appropriately trained to provide TMS, to include: • A psychiatric and substance use history, including past response to antidepressant medication(s) and/or TMS and/or ECT, mental status and current functioning; *and* • A medical history and examination when clinically indicated.	☐ Yes ☐ No

Section III

Patient Information – Medication Details

If there are more medications, add to comments in section VI.

Medication Name	Class	Highest Dosage	Length of Trial	Reason for Discontinuation

Section IV

Patient Information – **ADDITIONAL Sessions**

What was the baseline score just prior to start of current course of TMS and the depression-monitoring instrument used? *See the Appendix for more information on depression monitoring scales.*	Score: _____ Instrument: _____ Date: _____

Section V

Patient Information - **REPEAT Treatment**

1. Is this request for treatment beyond 30-36 sessions? *If yes, answer question #2 below.*	☐ Yes ☐ No
2. What was the baseline score just prior to the current request for TMS and the depression-monitoring instrument used?	Score: _____ Instrument: _____ Date: _____
3. As a result of 30-36 TMS treatments received previously, did the patient achieve at least a 50% improvement with a standardized rating scale during the initial TMS episode? *If yes, complete questions a, b and c below.* a. Which standardized rating scale was used? _____ b. What was the baseline score of the scale used prior to start of TMS? _____ c. What was the score at the completion of TMS? _____	☐ Yes ☐ No
4. How long has it been since the completion of the last TMS session?	Date of completion of last TMS: _____

Section VI

Comments: *Additional behavioral health/substance use history, medications, therapy, rationales, current symptoms, questions*

I understand and agree that as part of participation in the TMS treatment program, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, and clinical competence, and any other criteria used by Magellan for determining initial and ongoing eligibility for participation.

I certify that all information provided by me in this checklist is true, correct, and complete to the best of my knowledge and belief.

Provider Signature: **Date:**

Provider Printed Name:

Appendix

Depression Monitoring Scales

Standardized Rating Scale Name	Note	Acronym	Scale Range	None OR Normal	Mild	Moderate	Moderate Severe	Severe	Very Severe
Geriatric Depression Scale	Long Version - 30 Questions	**GDS**	0 -30	0-9	10-19	NA	NA	20-30	NA
The Personal Health Questionnaire Depression Scale	NA	**PHQ-9**	0-27	0-4	5-9	10-14	15-19	20-27	NA
The Beck Depression Inventory	Original Version	**BDI**	0-63	0-9 (minimal)	10-18	19-29	NA	30-63	NA
The Hamilton Rating Scale for Depression	17 Questions	**HAM-D**	0-52	0-7	8-16	17-23	NA	≥24	NA
The Hamilton Rating Scale for Depression	24 Questions	**HAM-D**	0-15	0-4	5-8	8-11	NA	12-15	≥23
The Inventory for Depressive Symptomatology	Self Reported Version - 30 questions	**IDS-SR**	0-84	0-13	4-25	26-38	NA	39-48	49-84
The Montgomery-Asberg Depression Rating Scale	NA	**MADRS**	0-60	0-6	7-19	20-34	NA	NA	34-60
The Quick Inventory of Depressive Symptomatology	Clinician Administered Version - 16 questions	**QIDS-16**	0-27	0-5	6-10	11-15	NA	16-20	21-27