



Transcranial Magnetic Stimulation (TMS) Fax Cover Sheet

Complete this cover sheet, along with the TMS Treatment Checklist, and fax to Magellan
or complete and submit your request online.

Commercial/Medicare/non-California member fax: **1-888-656-4967**

Western Health Advantage member fax: **1-888-656-4789**

Blue Shield of California member fax: **1-888-656-3510**

Or complete and submit online: www.MagellanProvider.com (sign in and select *Request Member Care*)

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:



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*
or complete and submit your request online:

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Unsigned or incomplete forms will not be processed.

Section I

Provider/Request Information

1. Has the attending psychiatrist completed training and is he/she certified to provide TMS services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this request for TMS for initial treatment of a patient? <i>If yes, skip forward and complete Section II and Section III below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is this a request for further sessions up to a total of 30-36 sessions for current course of TMS after an initial set of sessions was already authorized? <i>If yes, complete only Section IV for additional sessions beyond the first authorization.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is this request for TMS for repeat treatment of a patient? <i>If yes, complete Section V below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is this request for TMS for maintenance therapy, continuous therapy, rescue therapy, or extended active therapy of a patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section II

Patient Information - Initial TMS Treatment

1. Is the patient at least 18 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the patient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the patient have a confirmed DSM-5 diagnosis of a major depressive disorder, severe?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>4. Does the patient have a diagnosis of another psychiatric or neurologic disorder, such as substance use disorder, bipolar disorder, migraine headaches, obsessive-compulsive disorder, or schizophrenia? <i>If yes, list the other diagnoses:</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Was evidence-based psychotherapy for depression attempted of an adequate frequency and duration without significant improvement in depressive symptoms as document by standardized rating scales that reliably measure depressive symptoms? <i>If yes, list therapy type, number of sessions, number of weeks and timeframe for treatment:</i></p> <hr/> <hr/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Has the patient lacked a clinically significant response to medications during the current depressive episode?</p> <p>How many failed agent classes of medications have been tried during the current depressive episode? <i>List all medications, dosage and length of treatment (see section III if additional space needed):</i></p> <hr/> <hr/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<p>7. Has the patient demonstrated an inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from at least two different agent classes, with distinct side effects? <i>List side effects per medication (see section III if additional space needed):</i></p> <hr/> <hr/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>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?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9. Is the patient medically stable?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>10. Is there a contraindication for TMS due to patient's medical status and/or comorbid medical condition?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>11. Is there a clinical contraindication for ECT?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>12. Did the patient refuse ECT?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>13. Does the patient have access to a suitable environment and professional and/or social supports after recovery from the procedure?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

14. Does the patient have any presence of psychotic symptoms in the current depressive episode?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Does the patient have acute or chronic psychotic disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Does the patient have a seizure disorder or any history of seizures? <i>If yes, provide additional information:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Does the patient have any neurologic conditions that include epilepsy, 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? <i>If yes, state which condition(s):</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. 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. <i>If yes, state which material(s):</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Does the patient have any presence of vagus nerve stimulator leads in the carotid sheath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Is the patient currently also receiving esketamine intranasal, ketamine infusion or other infusion therapies for major depression disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Does the patient and/or legal guardian understand the purpose, risks and benefits of TMS, and provide consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Is there documentation of a clinical evaluation performed by a psychiatrist who is appropriately trained to provide TMS, to include: <ul style="list-style-type: none"> • A psychiatric and substance use history, including past response to antidepressant medication(s) and/or TMS and/or ECT, mental status and current functioning; <i>and</i> • A medical history and examination when clinically indicated. 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section III

Patient Information – Clinical Detail

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 – Further Sessions

What is the baseline score just prior to TMS and the depression-monitoring instrument used? <i>See the Appendix for more information on depression monitoring scales.</i>	Score: Instrument:
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Section V – Repeat Treatment

Patient Information - Repeat Treatment

1. TMS is reasonable and necessary for up to 30 visits over a seven-week period, followed by six taper visits. Is this request for treatment beyond 30-36 sessions? <i>If yes, answer question #2 below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What is the baseline score just prior to TMS and the depression-monitoring instrument used?	Score: Instrument:
3. Which of the following apply to this patient/request? Despite reasonable and therapeutic efforts, clinical findings indicate: a. The presenting problems continue that meet the TMS severity of need criteria. b. Additional problems have emerged that meet the TMS severity of need criteria. c. Based on the patient's history and/or clinical findings, discharge from TMS would result in an exacerbation of the patient's condition or status.	<input type="checkbox"/> a <input type="checkbox"/> b <input type="checkbox"/> c

<p>4. As a result of an initial series of 30-36 TMS treatments, did the patient achieve at least a 50% improvement with a standardized rating scale during the initial TMS episode? <i>If yes, complete questions a, b and c below.</i></p> <p>a. Which standardized rating scale was used? _____</p> <p>b. What was the baseline score of the scale used? _____</p> <p>c. What was the score of most improved? _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Has it been at least three months since the last TMS session?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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