Transcranial Magnetic Stimulation (TMS) Fax Cover Sheet

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

Commercial/Medicare/non-California member fax: **1-888-656-4967**
Blue Shield of California member fax: **1-888-656-3510**

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:

Magellan HEALTHCARE®

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:*

Commercial/Medicare/Non-California member fax: **1-888-656-4967**
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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?	☐ Yes ☐ No
2. Is this request for TMS for initial treatment of a patient? *If yes, skip forward and complete Section II and Section III below.*	☐ Yes ☐ 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? *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. Is the patient at least 18 years old?	☐ Yes ☐ No
2. Is the patient pregnant?	☐ Yes ☐ No
3. Does the patient have a confirmed DSM-5 diagnosis of a major depressive disorder, severe?	☐ Yes ☐ No
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? *If yes, list the other diagnoses:*	☐ Yes ☐ No

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? *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 the current depressive episode? How many failed agent classes of medications have been tried during the current 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 psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from at least 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. Is there a contraindication for TMS due to patient's medical status and/or comorbid medical condition?	☐ Yes ☐ No
11. Is there a clinical contraindication for ECT?	☐ Yes ☐ No
12. Did the patient refuse 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 the current depressive episode?	☐ Yes ☐ No
15. Does the patient have acute or chronic psychotic disorder?	☐ Yes ☐ No
16. Does the patient have a seizure disorder or any history of seizures? *If yes, provide additional information:*	☐ Yes ☐ 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? *If yes, state which condition(s):* _____ _____ _____	☐ Yes ☐ 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. *If yes, state which material(s):* _____ _____ _____	☐ Yes ☐ No
19. Does the patient have any presence of vagus nerve stimulator leads in the carotid sheath?	☐ Yes ☐ No
20. Is the patient currently also receiving esketamine intranasal, ketamine infusion or other infusion therapies for major depression disorder?	☐ Yes ☐ No
21. Does the patient and/or legal guardian understand the purpose, risks and benefits of TMS, and provide consent?	☐ Yes ☐ No
22. Is there documentation of a clinical evaluation performed by a psychiatrist 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 – 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? *See the Appendix for more information on depression monitoring scales.*	Score: Instrument:

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? *If yes, answer question #2 below.*	☐ Yes ☐ 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.	☐ a ☐ b ☐ c

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? *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? _____ c. What was the score of most improved? _____	☐ Yes ☐ No
5. Has it been at least three months since the last TMS session?	☐ Yes ☐ 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