Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Transcranial Magnetic Stimulation and Electroconvulsive Therapy
PAGE: 1 of 7	**REPLACES:** NA
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PRODUCT TYPE: Medicare, Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) licensed Utilization Management (UM) staff use written criteria based on sound clinical evidence to make Transcranial Magnetic Stimulation (TMS), repetitive Transcranial Magnetic Stimulation (rTMS), and Electroconvulsive Therapy (ECT) pre-service decisions.

B. Policy

1. Repetitive Transcranial Magnetic Stimulation (rTMS) pre-service clinical criteria for initial treatment include:

1.1. A confirmed diagnosis of Severe Major Depressive Disorder (MDD), single or recurrent episode, and one or more of the following:

1.1.1. Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to four trials of psychopharmacologic agents in the current depressive episode from at least two different agent classes. At least one of the treatment trials must have been administered at an adequate course of mono- or poly-drug therapy; or

1.1.2. Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes, with distinct side effects; or

1.1.3. History of response to rTMS in a previous depressive episode; or

1.1.4. If member is currently receiving electro-convulsive therapy, rTMS may be considered reasonable and necessary as a less invasive treatment option, and

1.2. A trial of an evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in

depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms, and

1.3. The order for treatment (or retreatment) is written by a psychiatrist (MD or DO) who has examined the patient, and reviewed the record. The physician will have experience in administering TMS therapy.

1.3.1. The treatment shall be given under direct supervision of this physician (physician present in the area, but does not necessarily personally provide the treatment).

2. TMS is reasonable and necessary for up to twenty (20) visits over a four (4) week period followed by five (5) visits for tapering for those in remission;

2.1. For those who show at least a twenty-five (25)% improvement by means of the standard tests for depression, the therapy may be continued for an additional two (2) weeks (an additional ten (10) visits) with an additional six (6) visits for tapering.

3. Retreatment of Transcranial Magnetic Stimulation (TMS) may be considered for patients who met the guidelines for initial treatment and subsequently developed relapse of depressive symptoms if the patient responded to prior treatments as evidenced by a greater than fifty (50)% improvement in standard rating scale measurements for depressive symptoms, which may include:

3.1. Geriatric Depression Scale (GDS),

3.2. Personal Health Questionnaire Depression Scale (PHQ-9),

3.3. Beck Depression Scale (BDI),

3.4. Hamilton Rating Scale for Depression (HAM-D),

3.5. Montgomery Asberg Depression Rating Scale (MADRS),

3.6. Quick Inventory of Depressive Symptomatology (QIDS), or

3.7. Inventory for Depressive Symptomatology Systems Review (IDS-SR).

4. Experimental or investigational use of TMS, including maintenance therapy, is not covered.

5. Electroconvulsive Therapy (ECT) pre-service clinical criteria include:

5.1. Major Depressive, bipolar, schizophrenic, or schizoaffective disorder in members when one or more of the following conditions are present:

5.1.1. Acute suicidality with high risk of acting out suicidal thoughts,

5.1.2. Psychotic features,

5.1.3. Rapidly deteriorating physical status due to complications from the depression, such as poor oral intake,

5.1.4. Catatonia,

5.1.5. History of poor response to multiple adequate trials of medications and/or,

5.1.6. Combination treatments, or

5.1.7. Member is unable or unwilling to comply with or tolerate side effects of available medications, or

5.1.8. Member has a co-morbid medical condition that prevents the use of available medications.

5.1.9. History of good response to ECT during an earlier episode of the illness,

5.1.10. The member is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

5.1.10.1. The frequency and number of treatments need to be determined by the severity of illness and by the relative benefits and risks of ECT treatment.

6. Appropriate available treatment environment characterized by:
- **6.1.** The most normative,
- **6.2.** Least restrictive,
- **6.3.** Culturally and linguistically appropriate,
- **6.4.** Evidence based and/or evidence informed, and
- **6.5.** Extent of family and community supports.

C. Procedure

1. Referrals:
   - **1.1.** Referred member must be enrolled in Trillium Community Health Plan.
   - **1.2.** If member is at immediate risk of acute medical care without intervention member is directed to medical services.
2. Participating or non-participating providers always require a prior authorization (PA) based on Authorization Required Qualifier (ARQ), prior to the first date of service.
3. For initial requests for TMS authorizations, provider must submit:
   - **3.1.** PA request.
   - **3.2.** Updated behavioral health assessment or addendum information completed by a psychiatrist (MD or DO) who has experience in administering TMS therapy, examined the member and, reviewed the record, within the previous sixty (60) days, including:
     - **3.2.1.** Sufficient biopsychosocial information to support the presence of a covered Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) diagnosis, and
     - **3.2.2.** An order for treatment (or retreatment) of TMS.
4. For initial requests for ECT authorizations, provider must submit:
   - **4.1.** PA request.
   - **4.2.** Updated behavioral health assessment or addendum information completed within the previous sixty (60) days, including:
     - **4.2.1.** Sufficient biopsychosocial information to support the presence of a covered Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) diagnosis, and
     - **4.2.2.** A recommendation for ECT.
5. TBH Licensed Utilization Management (UM) staff:
   - **5.1.** Determine clinical appropriateness and medical necessity of requested services, indicated by:
     - **5.1.1.** Level I Review of clinical information submitted, including behavioral health assessment and pertinent medical documentation, and
     - **5.1.2.** Level II Review completed by Licensed Behavioral Health Practitioner (LBHP).
     - **5.1.3.** Refer to TBH Complex Care Management (CCM) staff when necessary to ensure the provision of care coordination (CC), treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

6. Expected outcome and discharge planning to lower level of care considers the following factors:
- **6.1.** Stabilization/improvement of symptoms,
- **6.2.** Stabilization/improvement of daily functioning,
- **6.3.** Prevention of higher LOC services, or
- **6.4.** Less restrictive LOC services are determined to be clinically appropriate.

7. When request is approved for TMS:
- **7.1.** Initial PAs (Certification) approved for a maximum of twenty (20) visits to occur within a four (4) week period followed by up to five (5) visits for tapering for those in remission.
- **7.2.** Concurrent (Recertification) authorization for additional codes or units, up to:
  - **7.2.1.** Ten (10) visits within a two (2) week period, if clinical justification demonstrates at least a 25% improvement by means of standard tests for depression, followed by up to six (6) additional visits for tapering.
  - **7.2.2.** A request for an extended or new date range will be treated as an initial PA request.

8. When request is approved for ECT:
- **8.1.** Initial PAs (Certification) will not exceed six (6) months.
- **8.2.** Concurrent (Recertification) authorization for additional codes or units within the current approved authorization range is based on additional clinical justification submitted.
  - **8.2.1.** A request for an extended or new date range will be treated as an initial PA request.

9. When TMS or ECT request is denied:
- **9.1.** If the initial (Certification) or concurrent (Recertification) review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.
- **9.2.** When the decision is to deny request, practitioner may request an expedited appeal if he/she disagrees with the determination.

10. When request is returned to sender:
- **10.1.** Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:
  - **10.1.1.** Member identifying information,
  - **10.1.2.** Requesting Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:
    - **10.1.2.1.** Medicaid Provider/DMAP number for non-par OP services requests,
  - **10.1.3.** Start date and end date for services,
  - **10.1.4.** ICD diagnostic code(s),
  - **10.1.5.** Billing code(s),
  - **10.1.6.** Number of units/visits/days for each billing code.
- **10.2.** Upon review, no authorization is required per the ARQ for participating providers.
- **10.3.** Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

10.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

10.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster.

10.4.2. Mechanical or administrative delays or errors by the Contractor or State Office.

10.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

10.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number.

10.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered.

10.4.3.3. The provider submitted the request for authorization within sixty (60) days of the date the eligibility was discovered (excluding retro-eligibility).

10.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

10.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests.

D. Definitions

Word / Term	Definition
ARQ	Authorization Required Qualifier.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Complex Care Management (CCM)	High-level of care management services for members with complex needs, including children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those non-adherent in less intensive programs; frail elderly, disabled, or end of life; experienced a critical event or have a complex diagnosis requiring oversight and coordination. Services include CM and CC for issues listed above, along with more frequent outreach to member to assess service plan compliance and progress toward goals. Key indicators of disease progress, e.g. HbaA1c levels and medication adherence will be monitored.
Complex Care Management (CCM) Staff	Licensed UM staff.
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an

	element in evaluation of medical necessity and appropriateness of medical and behavioral health care and services.
Electroconvulsive Therapy (ECT)	A procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure.
Licensed Utilization Management (UM) Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Behavioral Health Medical Director	Doctoral-level clinical psychologist or psychiatrist who acts in the role of Licensed Behavioral Health Practitioner (LBHP) for the purpose of UM decision making.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Oregon Health Plan (OHP)	In Oregon, the Medicaid Program is called OHP.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Transcranial Magnetic Stimulation (TMS)	A noninvasive method of brain stimulation.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity

	E.23.
Centers for Medicare and Medicaid Services	LCD L34641
Code of Federal Regulations	422.101(b)(1)-(5)
	422.566
Current NCQA Health Plan Standards and Guidelines	UM 2:C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
Health Evidence Review Commission	Guideline Note 69
	Guideline Note 102
Medicare Managed Care Manual	Chapter 13 (40.1)
Oregon Administrative Rules	420-120-1200

F. Related Material

Name	Location
Outpatient Mental Health Service Policy and Procedure	TBH Database

G. Revision Log

Type	Date
Merged policy and procedure into one document.	11-30-17
Added Transcranial Stimulation language	11-30-17
Updated Definition List	3-5-18
Added CCO and OHA Contract Citations	3-5-18
Added Return to Sender Language	3-5-18
Added Contingent and Concurrent Information	2-27-19
Update OARS	2-27-19
Updated Return to Sender Language	2-27-19
Updated Definitions	2-27-19