Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Update – Chapter 17: Mental Health Services

Transcranial Magnetic Stimulation

Effective October 15, 2023

This update applies to *Chapter 17: Mental Health Services.* All requirements and details in Chapter 17 still apply. The following text is updated in the chapter following an HTCC update to Transcranial Magnetic Stimulation:

Payment policy: Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression

General information

The insurer covers transcranial magnetic stimulation (TMS) on a limited basis. Authorization for this treatment is dependent upon the conditions of coverage noted in the coverage decision for TMS therapy.

Prior authorization

Prior authorization is required before initiating TMS treatment. Each course of treatment requires separate prior authorization.

Who must perform these services to qualify for payment

Authorized services must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical PhD or PsyD psychologist

Requirements for billing

Billing of TMS codes must be in accordance with CPT® code definitions.

Evaluation and Management (E/M) service activities related to cortical mapping, motor threshold determination, and/or delivery and management of TMS aren't separately payable.

Services that can be billed

Transcranial magnetic stimulation (TMS) is covered for workers with treatment resistant major depressive disorder when the conditions of coverage are met as outlined in L&I's coverage decision.

Bill TMS using CPT® codes **90867**, **90868**, and/or **90869**.

If a significant separately-identifiable E/M service (which may include medication management or a psychotherapy service) is performed, then an E/M or psychotherapy code may be billed in addition to CPT® codes **90867**-**90869**. Use modifier **-25** for a separately identifiable E/M service. Use modifier **-59** for a separately identifiable psychotherapy service.

Documentation requirements

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan.

Chart notes must contain documentation that justifies the level, type, and extent of services billed.

When billing a significant separately-identifiable service using either modifier **-25** or **-59**, the services must be documented separately.

Payment limits

The total number of combined sessions allowed for CPT® codes **90867**, **90868** and **90869** is 30 per course of treatment. Each course of treatment requires separate prior authorization. Additional treatment courses must meet the guidelines described in L&I's coverage decision.

90869 may be billed up to a max of 2 units per treatment course.

Treatment related to multiple claims for the same worker is subject to split billing. See Chapter 2: Information for All Providers for more information.

Services that aren't covered

TMS protocol that isn't FDA-approved isn't covered.

Bills for services performed without prior authorization will be denied.