Draft

Billing and Coding Guidelines

LCD Database ID Number
DL32220

LCD Version Number

LCD Title
Transcranial Magnetic Stimulation (TMS)

Contractor's Determination Number
NEURO-010

Revision Effective Date

AMA CPT/ ADA CDT Copyright Statement

CMS National Coverage
CMS IOM Publication 100-1
SSA §1816 & 1842 Contractor responsibility for determination of medically reasonable and necessary services, items
1862 (a)(1)(A) Medically Reasonable & Necessary.
1862 (a)(1)(D)&(E) Investigational or Experimental.

Coding Guidelines:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier ("Waiver of Liability Statement Issued as Required by Payer Policy") should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Fiscal Intermediary (FI) and Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Part A MAC, occurrence code 32 and the date of the ABN is required.

GX modifier (Notice of Liability Issued, Voluntary Under Payer Policy) should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions *other* than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, FI and Part A MAC systems will automatically deny the services.

The –GZ modifier (DEFINITION) should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

Specific coding guidelines for this policy:

This is a **non-coverage** policy for the FDA-approved indication of repetitive transcranial magnetic stimulation for the treatment of major depression and any off-label uses.

Claims for CPT codes 90867 and 90868 are non-covered.

For claims submitted to the carrier or Part B MAC:

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

For claims submitted to the fiscal intermediary or Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*

- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*

- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-08, *Medicare Program Integrity Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*

- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Claims for repetitive transcranial magnetic stimulation (rTMS) are **non-reimbursable.**

Date Published

Revision History, Explanation/Number

Notes:
Italicized lettering (font) indicates CMS wording

* An asterisk indicates most recent publishing or revision

NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.