Billing and Coding Guidelines

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Transcranial Magnetic Stimulation (TMS)

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CMS National Coverage
Pub. 100-01.1816 & 1842 Contractor responsibility for determination of medically reasonable and necessary services, items [Fed Reg 60, No. 181, p.48422]
1862 (a)(1)(A) Medically Reasonable & Necessary.
1862 (a)(1)(D)&(E) Investigational or Experimental.

Coding Guidelines:
Specific coding guidelines for this policy:
This is a non-coverage policy for repetitive transcranial magnetic stimulation performed for the FDA-approved indication of treatment of major depression and any off-label uses.

CPT codes 90867 and 90868 are non-covered.

General guidelines for all claims.

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.

General guidelines for carrier or Part B MAC claims

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

General guidelines for fiscal intermediary or Part A MAC claims:

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.

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03/01/2012

Revision History, Explanation/Number
06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

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.