Medical Coverage Policy
Policy Number – MP22-024E
Original review date – 05/31/22
Effective date – 10/20/2025

Transcranial Magnetic Stimulation (TMS)

Background

TMS is a non-invasive method to induce electric currents in certain areas of the brain. Metal coils are placed against the scalp to generate rapidly pulsing magnetic fields. This generates electric currents which are meant to stimulate certain areas of the brain involved in mood control and depression. Treatment for depression involves delivering repeated magnetic pulses, and is referred to as repetitive or rTMS. The stimulation parameters are specific to individual patients and are determined prior to beginning therapy. Treatment regimen is usually for five days a week for four to six weeks.

The standard form of rTMS stimulates the cortical surface of the brain and is called superficial TMS. Deep transcranial magnetic stimulation allows for direct stimulation of deeper subcortical structures. TMS does not require anesthesia. Unlike electro-convulsive therapy, TMS has not been associated with adverse memory effects.

Policy statement

Disclaimer: This policy is applicable to TRICARE Prime and Select beneficiaries and may not apply to Active Duty Service Members (ADSM) under Supplemental Health Care Program (SHCP) or TRICARE Prime Remote (TPR) in accordance with TRICARE Operations Manual (TOM) Chapter 17, Section 3. Please review TOM Chapter 17, Section 3, Paragraph 2.0 onwards, regarding SHCP coverage and any TRICARE-specific exclusions included in this coverage policy to accurately determine the benefit for ADSMs.

rTMS may be covered if the following criteria are met:

I. Age 18 years or older
II. Confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales such as Beck Depression Inventory, Hamilton Depression Rating Scale, Montgomery-Asberg Depression Rating Scale, Patient Health Questionnaire-9
III. Failure of pharmacotherapy in current depressive episode, as indicated by one or more of the following:
    a. Inadequate response to at least two classes of anti-depressant medications, taken for adequate duration and dosage, with documented adherence; OR
    b. Inability to tolerate at least two trials of agents as evidenced by documented side effects
IV. Absence of any of the following contraindications:
    a. Acute or chronic psychosis (e.g., schizophrenia, schizoaffective or schizophreniform disorder)
    b. Acute suicidal risk

c. Catatonia or life threatening inanition
d. Cochlear implant, deep brain stimulator, or vagus nerve stimulator
e. Epilepsy or history of seizure disorder
f. Metallic hardware or implanted magnetic-sensitive medical device (e.g., implanted pacemaker, metal aneurysm clips) within the electromagnetic field of the discharging coil
g. History of severe head trauma, increased intracranial pressure, or cerebrovascular accident

Repeat rTMS may be covered if the following criteria are met:

I. Relapse of severe major depressive disorder
II. Positive response to previous rTMS treatment as evidenced by a 50% or greater improvement in standardized rating scales

Limitations of coverage

I. rTMS is not considered medically necessary for any indications, other than those listed above, due to insufficient evidence of clinical efficacy
II. rTMS treatment more than once a day is unproven
III. Microcurrent therapy, or cranial electrostimulation is not covered for the treatment of anxiety, depression, insomnia, post-traumatic stress disorder, pain, or migraines due to unproven benefit per TRICARE policy manual

TRICARE Policy Manual (TPM)

Chapter 7, Section 3.7
5.2.13 Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMA (rTMS)) for the treatment of major depressive disorder (CPT procedure codes 90867, 90868, and 90869), is proven.
6.2 Preauthorizations
TMS requires preauthorization to ensure the beneficiary has failed to respond to a less intensive form of treatment or that a less intensive intervention is not more appropriate

TPM Chapter 7, Section 15.1
5.0 EXCLUSIONS
5.2 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression, insomnia, Post-Traumatic Stress Disorder (PTSD), pain, or migraines and electrical stimulation devices used to apply this therapy, are unproven.

Coding information

CPT Code	Description
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

References

1. TRICARE Policy Manual. Chapter 7, Section 3.7 TRICARE Manuals - Display Chap 7 Sect 3.7 (Change 42, Sep 12, 2025)
2. MCG Health. Behavioral Health Care 29th edition. Transcranial Magnetic Stimulation. ORG:B-801-T (BHG). Last updated: 06/13/2025
3. VA/DOD Clinical Practice Guideline for the Management of Major Depressive Disorder Version 4.0. 2022
4. Uptodate Inc. Unipolar Depression in Adults: Indications, Efficacy, and Safety of Transcranial Magnetic Stimulation (TMA). Last updated July 21, 2025

Revision History

October 2025: Updated references

September 2024: Updated criteria and references

December 2023: Updated references

Approved by

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Date of approval: 10/20/2025