

	Transcranial Magnetic Stimulation	
	Policy Number: POL-PP-259	Original Creation Date: 10/1/2025
	Version Number: Version	Version Effective Date: 11/1/2025
	Policy Status: Active	Next Review Date: 11/1/2026

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input checked="" type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Transcranial magnetic stimulation (TMS) is a non-invasive procedure that is performed without any anesthesia. An alternating current is used to perform stimulation of the cortex of the brain to help the release of certain neurotransmitters like dopamine, serotonin, and norepinephrine. The treatment procedure has been considered for use in a host of

behavioral and neurological conditions, including depression, Alzheimer's disease, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), schizophrenia, panic disorder, epilepsy, Parkinson's disease, migraine headache, etc.

Policy

The following healthcare professional are authorized to perform TMS.

- Psychiatrists
- Neurologists
- Clinical Psychologists

A separate diagnostic evaluation service, such as 90792 Psychiatric diagnostic evaluation with medical services, is not separately reimbursable on the same day as TMS treatment. Per code description, on the day TMS is initiated, a thorough evaluation of the patient's mental health history is conducted and is included in CPT 90867.

90867

CPT 90867 is only reported once for a patient during the initial session and should not be reported again throughout the course of the treatment. During the initial session, mapping of the cerebral cortex will be performed to determine the location where the electric stimulation will be applied.

In the same session, the motor threshold will be determined or, in other words, the minimum strength of electric current that is needed to evoke a motor response and the repeated application of this electric current to bring about the therapeutic effects. Since the descriptor to 90867 includes the terms, "cortical mapping, motor threshold determination, delivery and management," report one unit of the code for the entire session and not multiple units of the code for each part of the treatment.

(Do not report 90867 in conjunction with 90868, 90869, 95860, 95870, 95928, 95929, 95939, 0889T, 0890T, 0891T, 0892T, includes E/M services, psychotherapy, and psychiatric diagnostic evaluation related to TMS therapy)

90868

TMS therapy is characterized by a series of treatments, which can vary in frequency and duration but commonly include sessions done five days a week for four to six weeks. During succeeding visits, the previously determined motor threshold is used to repeat the delivery of the electrical stimulation to the same area of the cortex to bring about the desired therapeutic effects. For these subsequent visits, you will have to report 90868. Again, like 90867, you will report only one unit of the code for the entire session.

(Do not report 90868 in conjunction with 90867, 90869, 0889T, 0890T, 0891T, 0892T, includes E/M services, psychotherapy, and Psychiatric diagnostic evaluation related to TMS therapy)

90869

If the applied stimulation is not having the desired effects, it may be necessary to redetermine the motor threshold. In such a case, this subsequent visit should not be reported with 90868. Instead, you should use 90869 to report this visit. Again, 90869 is also reported only once for the entire session.

(Do not report 90869 in conjunction with 90867, 90868, 95860-95870, 95928, 95929, 95939, 0889T, 0890T, 0891T, 0892T, TMS codes includes E/M services, psychotherapy, and psychiatric diagnostic evaluation related to TMS therapy).

For other possible National Correct Coding Initiative Conflicts please see

[NCCI Procedure to Procedure edits](#)

CPT 90868 (TMS subsequent delivery and management) will be denied without CPT 90867 (initial treatment TMS) billed first on a previous date of service.

CPT 90689 (subsequent motor threshold redetermination) will be denied without CPT 90868 billed first on a previous date of service.

Coding	
CPT/HCPCS	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 and Resources

This policy has been developed through consideration of the following:

National correct Coding Initiative
American Medical Association CPT Manual
Blue KC Provider Reference Guide

Related Documents

N/A

Revision History

Version	Date	Summary of Revisions
001	11/01/2025	Initial version