Notice of Independent Review Decision

Case Number: Date of Notice: 12/18/2014

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Psychiatry

Description of the service or services in dispute:

Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Upheld (Agree)
- ☑ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Information Provided to the IRO for Review:

Patient Clinical History (Summary)

The patient is a year old male who has been diagnosed with major depressive disorder, recurrent, severe superimposed on dysthymia. Treatment to date includes medication management and various therapies including transcranial magnetic stimulation. Progress note dated indicates that the patient describes feeling somewhat tired with the transition from sertraline to Pristiq, but states his mood may be slightly better. The patient was treated with transcranial magnetic stimulation from 03/26/14 through 06/26/14. Progress note dated 04/21/14 indicates that the patient endorses extreme depression and feeling caught between wishing he would “win the lottery” or “jump off a cliff”. He states that his depression stared about years into his marriage and identified job loss and chronic marital conflict as related to his depression. Patient is hopeful about TMS even though he feels very hopeless. He has not found therapy to be overly helpful in relieving his symptoms. Note dated 04/29/14 indicates that the patient presents as having very slight improvement in depression, although he remains depressed. Progress note dated 06/12/14 indicates that the patient reports problems with falling asleep and staying asleep. Patient reports being more functional in his depression. He reports a small improvement in his anger/expression of anger. Note dated

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06/17/14 indicates that the patient still remains moderately depressed, and at this point would seem to show evidence of a partial response to medication and TMS, but certainly far from remission. Medications include Pristiq, trazodone and alprazolam. Diagnoses are major depressive disorder, recurrent, severe without psychotic features, chronic; anxiety disorder nos; and attention-deficit/hyperactivity disorder, combined type.

Determination letter dated 04/03/14 indicates that per BCBSIL medical policy Psy301.015, transcranial magnetic stimulation is considered experimental, investigational and unproven as a treatment of depression and other psychiatric or neurologic disorders including, but not limited, to schizophrenia or migraine headaches. Letter dated 05/02/14 indicates that the appeal has been denied. Per BCBSIL medical policy Psy301.015, transcranial magnetic stimulation is considered experimental, investigational and unproven as a treatment of depression and other psychiatric or neurologic disorders including, but not limited, to schizophrenia or migraine headaches. Letter dated 10/13/14 from Dr. indicates that TMS treatment was medically necessary for the patient. The patient showed evidence of "treatment resistant depression" with regard to psychotropic medication. This is evidenced by having little response to at least three medications in the past and over four since he has been seeing the patient in this current depressive episode from at least two antidepressant classes, as well as other medications clinically used to try and augment the effectiveness of the antidepressants.

Analysis and Explanation of the Decision include Clincial Basis, Findings and Conclusions used to support the decision.

The submitted plan and policy language indicates that repetitive transcranial magnetic stimulation may be considered medically necessary in the acute phase of treatment of major depression if certain conditions are met. The submitted records do appear to satisfy all criteria. There is a diagnosis of major depression. The patient has failed antidepressant medications with at least four medications from at least two different classes of antidepressants. The patient has been in formal cognitive behavioral therapy. PHQ scales have been administered throughout treatment. The patient does not present with contraindications to rTMS. Guidelines note that if these conditions are met, 36 acute phase sessions of rTMS can be authorized. As such, it is the opinion of the reviewer that the request for therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session 03/26/2014-06/26/2014 is recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines

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- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☑ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)
  BCBSIL MEDICAL POLICIES REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) NUMBER PSY301.015; EFFECTIVE DATE 07-01-2014

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