Repetitive Transcranial Magnetic Stimulation (rTMS) Authorization Request

INSTRUCTIONS: Please address all 5 pages of this form in its entirety and save it to your desktop prior to beginning. All fields in this form are required unless otherwise indicated (optional / applicable). If you have questions about this request, call Blue Cross Blue Shield of North Dakota (BCBSND) Utilization Management at 800-952-8462.

Please send the completed authorization request form with all supporting clinical documentation by:

- Fax: 701-277-2971
- Mail: BCBSND
  4510 13th Ave S
  Attn: Utilization Management Fargo ND 58121

☐ Initial Request ☐ Concurrent Request

Member Information	
Patient First Name	Patient Last Name
Patient Date of Birth (MM/DD/YYYY)	Member ID (including alpha-numeric prefix)
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Provider Information		
Requesting Provider First Name	Requesting Provider Last Name	
Fax Number	Specialty/Taxonomy Code (Optional)	
NPI	TIN (Optional)	
Address Line 1		
Address Line 2 (Optional)		
City	State	Zip

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Servicing Provider/Servicing Facility Information		
Service Provider First and Last Name or Facility Name		Phone Number
Fax Number	NPI	TIN (Optional)
Address Line 1		
Address Line 2 (Optional)		
City	State	Zip

Completed by Information	
Completed by Name	
Completed by Contact Phone Number	Today's Date (MM/DD/YYYY)

Contact for Additional Questions	
Additional Contact Name	Additional Contact Phone Number

The following list of diagnosis and procedure codes is for reference only and are subject to change without notice. The inclusion of a code does not guarantee claim payment. BCBSND uses CPT®, HCPCS®, and ICD-10® manuals as well as other nationally recognized standards for coding and billing purposes, unless BCBSND has published a specific policy stating otherwise. Documentation must support all requirements for each code submitted on a claim, for example time-based codes must include documentation that supports the number of minutes spent face-to-face with the provider unless otherwise specified in the manual. Documentation that does not support a submitted code will result in that claim line being denied.

Service Information	
Start of Care Date (MM/DD/YYYY)	To Date (If applicable)

Diagnosis Code(s)
Please check the codes that you are requesting services for:

- ☐ **F32.1** Major depressive disorder, single episode, moderate.
- ☐ **F32.2** Major depressive disorder, single episode, severe without psychotic features.
- ☐ **F33.1** Major depressive disorder, recurrent, moderate.
- ☐ **F33.2** Major depressive disorder, recurrent, severe without psychotic features.

Does the member have any other psychiatric conditions or history of?
☐ No ☐ Yes, please explain below.

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Service Information (Continued)

Does the member have any medical diagnoses or is there any medical concerns

☐ No ☐ Yes, please explain below.

Treatment Code(S)

Please check the codes that you are requesting services for:

☐ **90867** Therapeutic Repetitive Transcranial Magnetic Stimulation (rTMS) treatment; Initial, including cortical mapping, motor threshold determination.

Number of units requested per 6-month period: _____

☐ **90868** Therapeutic Repetitive Transcranial Magnetic Stimulation (rTMS) treatment; Subsequent delivery and management, per session.

Number of units requested per 6-month period: _____

☐ **90869** Therapeutic Repetitive Transcranial Magnetic Stimulation (rTMS) treatment; Subsequent motor threshold re-determination with delivery and management.

Number of units requested per 6-month period: _____

Clinical Information

Prior rTMS Treatment History

Does the member have a history of receiving Therapeutic Repetitive Transcranial Magnetic Stimulation (rTMS) treatment for major depressive episode?

☐ No ☐ Yes, please list the dates of the last course of treatment, percentage of effectiveness and improvement, and list any complications from prior course.

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Clinical Information (Continued)

Therapy Related Questions

1. Has the member ever had psychotherapy?
   ☐ No ☐ Yes, please explain current or past therapy effectiveness.

2. Will the first treatment include determination of correct magnetic pulse strength and placement of coil? ☐ Yes ☐ No, please explain why not below.

3. Please list below the type of measurement scale that will be used and how often it will be used to track effectiveness of treatment.

Past and Current trials of antidepressants with its classification (SSRI, MOAI, TCA, NRI, Other)

Medication & Dose	Class	Trial Dates to	Discontinue Reason
Medication & Dose	Class	Trial Dates to	Discontinue Reason
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Clinical Information (Continued)

Contradictions

1. Does the member have any implanted or embedded metals, magnetic materials, or stimulators with leads that are controlled by or use electrical or magnetic signals?
   ☐ No ☐ Yes, please explain below.

2. Does the member have any history of neuorlogical disorders? ☐ No ☐ Yes, please explain below.

3. Does the member have any current or past substance use issues?
   ☐ No ☐ Yes, please explain below with date of last use.

4. Does the member have any history of treatment non-adherence related to primary mental health diagnosis? ☐ No ☐ Yes, please explain below.