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Transcranial Magnetic Stimulation (TMS) Questionnaire

Email: ClientServices@prms.com
Fax: 703-276-9530

1. What date do you want coverage to begin for TMS? _____

2. Will you be using the NeuroStar device by Neuronetics?
   - ☐ Yes – go to question 3
   - ☐ No – please answer the following:
     a. What device will you be using?
     _____
     b. Is the device cleared by the FDA?
     ☐ Yes
     For what exact indicated use has the device been cleared?
     _____
     ☐ No

3. Please provide evidence of your completion of training for the use of TMS Therapy. If the training program is one that was not sponsored by Neuronetics, please include a brochure detailing the program.

4. Please verify whether you have a General Liability policy to provide coverage for the equipment.

5. Please provide information as to the number of employees in your practice who will be trained in conducting TMS and their professional titles.

6. Please provide an example of the informed consent form and any other materials that will be used as part of the informed consent process with patients for TMS therapy.

7. Please describe your patient selection process.
   _____
   _____

8. Will you be administering TMS Therapy outside of the manufacturer's standardized treatment parameters (e.g., for NeuroStar: left prefrontal cortex, 120% of patient's observed motor threshold, 10 pulses per second, 26 second intertrain and 4 second train duration)?
   - ☐ Yes – If yes, proceed to a and b below.
   - ☐ No – If no, you have completed the questionnaire.
     a. What percentage of your TMS Therapy will be administered outside of the manufacturer's standardized treatment parameter? _____%
     b. Is there evidence-based support for all of your treatments administered outside of the manufacturer's standardized treatment parameters?
     ☐ Yes
     ☐ No