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MEDICAL POLICY – 2.01.109

Navigated Transcranial Magnetic Stimulation for Preoperative Neurosurgical Mapping

BCBSA Ref. Policy:	2.01.109	
Effective Date:	**Feb. 5, 2027**	RELATED MEDICAL POLICIES:
Last Revised:	Oct. 13, 2026	2.01.526 Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders
Replaces:	N/A	

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Introduction

Navigated transcranial magnetic stimulation (nTMS) is a technology that uses magnetic pulses to help identify areas of the brain that control movement or language. It is sometimes used before brain surgery to help doctors plan procedures involving tumors or other brain lesions located near important brain functions. Brain tumors and other intracranial lesions can affect how a person moves, speaks, or understands language when they occur near these critical areas of the brain. Before surgery, doctors may use different mapping methods to better understand the location of these functions and reduce the risk of complications. Navigated transcranial magnetic stimulation combines magnetic stimulation with brain imaging to create a map of functional areas of the brain. Navigated transcranial magnetic stimulation (nTMS) for preoperative motor or language mapping are considered investigational (unproven). There's not enough evidence to show they are effective.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Procedure	Investigational
Navigated transcranial magnetic stimulation (nTMS)	**Navigated transcranial magnetic stimulation (nTMS) of the brain using an FDA-cleared device and modality is considered investigational for preoperative motor or language mapping in individuals undergoing surgery for brain tumors or other intracranial lesions near eloquent cortex (e.g., Nexstim Navigated Brain Stimulation Systems).**

Coding

Code	Description
CPT	
64999	Unlisted procedure, nervous system

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Related Information

N/A

Evidence Review

Description

Navigated transcranial magnetic stimulation (nTMS) is a noninvasive method of mapping functional cortical areas before neurosurgery. The Nexstim navigated brain stimulation system integrates transcranial magnetic stimulation with magnetic resonance imaging (MRI)-based

neuronavigation to localize motor or language-related cortical sites. Mapping data may be exported for surgical planning, neuronavigation, and diffusion tensor imaging tractography. In individuals with brain tumors involving or near eloquent cortex, the clinical purpose is to improve preoperative risk assessment, guide the surgical approach, and support maximal safe resection while reducing permanent neurologic deficits.

Background

Brain Tumor Surgery Near Eloquent Cortex

Maximal safe resection is a central goal in brain tumor surgery. Greater extent of resection may improve tumor control and survival in selected gliomas and metastases, but neurologic injury can reduce quality of life, delay adjuvant therapy, and worsen outcomes. Lesions involving motor or language areas require individualized planning to balance resection goals against the risk of permanent deficit, which depends on accurate preoperative identification of functional cortex to guide the surgical approach, tailor craniotomy size, and counseling the individual. Mapping of brain function may be used to help determine the surgical approach, estimate the risk of resection, guide the size and location of the craniotomy, and counsel patients about potential postoperative deficits. Intraoperative direct cortical stimulation or direct electrical stimulation is generally considered the reference standard for identifying eloquent cortex, but it is performed during surgery. Preoperative mapping techniques may provide information before surgery, but intraoperative stimulation is still commonly used to confirm functional boundaries when clinically indicated.

Noninvasive Preoperative Mapping Techniques

Functional magnetic resonance imaging is commonly used for noninvasive localization of brain function. Functional magnetic resonance imaging identifies areas of altered blood oxygenation during performance of a task, such as movement or language testing. These signals indicate cortical regions involved in the task, but they do not necessarily establish that a region is essential for that function. Results may also be affected by patient cooperation, paresis, tumor-related vascular changes, edema, and task performance. Magnetoencephalography is another noninvasive mapping technique which records magnetic fields generated by neuronal activity and may be used to localize functional regions, including sensory or motor areas. Diffusion tensor imaging tractography may be used to estimate the course of white matter pathways, such as the corticospinal tract or language-related tracts. Tractography is an anatomic imaging

technique and does not itself determine whether a cortical or subcortical site is functionally essential.

Navigated Transcranial Magnetic Stimulation

Navigated transcranial magnetic stimulation is an adjunctive noninvasive technique that combines transcranial magnetic stimulation with magnetic resonance imaging-based neuronavigation as a complement to intraoperative direct cortical or direct electrical stimulation. A magnetic coil delivers stimulation to targeted cortical regions while a navigation system estimates the location, direction, and strength of the electric field relative to the patient's brain imaging. For motor mapping, single-pulse navigated transcranial magnetic stimulation is applied to cortical regions while motor evoked potentials are recorded from target muscles using electromyography. Sites where stimulation produces a reproducible motor response are considered motor-positive and may be exported to neuronavigation systems for surgical planning or used as seed regions for corticospinal tract tractography. For language mapping, repetitive navigated transcranial magnetic stimulation is delivered during a language task, commonly object naming. Stimulation-associated naming or speech errors are classified to identify cortical regions where stimulation disrupts language-task performance. Language-mapping protocols vary across studies, including stimulation frequency, number of pulses, intensity, picture-to-trigger interval, language task, and error-threshold rules.

Summary of Evidence

For individuals undergoing brain surgery for tumors or lesions in or near eloquent motor cortex who receive navigated transcranial magnetic stimulation (nTMS) for presurgical motor mapping, the evidence includes systematic reviews, same-patient mapping-validation studies, comparative studies versus other mapping modalities, and nonrandomized clinical outcome studies. Relevant outcomes include motor-map localization accuracy, change in surgical planning, extent of resection, residual tumor, unexpected residual tumor, postoperative motor deficit or paresis, functional status, craniotomy size, surgery duration, survival, and adverse events. Mapping-validation studies generally support spatial concordance between nTMS and intraoperative direct cortical stimulation/direct electrical stimulation (DCS/DES), with reported nTMS-to-DCS/DES distances ranging from approximately 2.1 mm to 11.4 mm, and several studies suggest closer agreement with DCS/DES for nTMS than for functional magnetic resonance imaging (fMRI) or magnetoencephalography (MEG). Comparative clinical studies more consistently favored nTMS-informed planning for resection-related outcomes than for motor-function

outcomes: studies reporting gross total resection (GTR) generally showed higher GTR rates with nTMS-informed planning, residual tumor and unexpected residual tumor were generally less frequent with nTMS, and craniotomy size was smaller in several comparative cohorts. However, postoperative motor outcomes were less consistent, with permanent or long-term motor deficit/worsening rates ranging approximately from 2.9% to 17.1% in nTMS groups and from 0% to 29.3% in comparator groups; some studies showed lower permanent paresis with nTMS, while others showed similar or worse motor outcomes despite improved resection. Systematic-review findings were also mixed: one motor-focused meta-analysis reported lower odds of new permanent motor deficit and higher odds of GTR with nTMS-guided surgery, while another review using a different nTMS-versus-DCS/control evidence set found no statistically significant difference in postoperative paresis. Safety reporting was inconsistently reported, although serious nTMS-specific adverse events were rarely reported. The evidence remains limited by nonrandomized designs, historical or matched controls, single-center expertise, heterogeneous tumor populations, variable follow-up, inconsistent definitions of permanent motor deficit, presence of different nTMS devices including non-Food and Drug Administration (FDA)-approved devices, and frequent use of multimodal surgical bundles. These limitations make it difficult to isolate the independent effect of nTMS on durable motor outcomes, survival, quality of life, or adverse events. The evidence is insufficient to determine that adjunct use of nTMS for presurgical motor mapping improves net health outcomes compared with standard presurgical planning; therefore, nTMS for presurgical motor mapping is considered investigational.

For individuals undergoing brain surgery for tumors or lesions in or near language-eloquent cortex who receive repetitive nTMS for presurgical language mapping, the evidence includes same-patient diagnostic-validation studies versus intraoperative direct cortical stimulation (DCS), comparative clinical/workflow cohorts, and tractography/outcome-prediction studies. Relevant outcomes include diagnostic sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) versus DCS; identification of language-negative cortex; localization of intraoperative speech arrest; surgical-planning workflow; extent of resection; postoperative transient and permanent aphasia; language performance; craniotomy size; and adverse events. Diagnostic-validation studies generally support nTMS as a preoperative adjunct with high sensitivity and NPV but low and variable specificity and PPV. Across validation studies, reported performance ranged approximately from sensitivity 87% to 100%, specificity 13% to 67%, PPV 16% to 57%, and NPV 84% to 100%, suggesting stronger utility for identifying language-negative regions than for definitively identifying essential language-positive cortex. nTMS map availability was associated with fewer early medium-to-severe language deficits in one cohort, and smaller craniotomies in another; a matched cohort showed greater early improvement in preoperative language deficit and better 6-week language performance, but no significant difference at 3 months; and a larger nTMS-based asleep-resection cohort reported

higher gross total resection (GTR) than awake direct electrical stimulation (DES). Studies suggest that cortical nTMS points alone may be insufficient for predicting durable language outcomes. Safety reporting was inconsistent, but serious nTMS-specific adverse events were rarely reported; reported adverse events were more often intraoperative or postoperative events, including DCS-induced seizures, postoperative hemorrhage, ischemia or stroke, infection, and postoperative decreased vigilance preventing language assessment. The evidence remains limited by nonrandomized designs, same-patient diagnostic studies without direct clinical-utility endpoints, historical controls, single-center expertise, heterogeneous tumor populations and language tasks, variable follow-up, inconsistent outcome definitions, and multimodal surgical workflows that make it difficult to isolate the independent effect of nTMS. The evidence is insufficient to determine that routine use of nTMS for presurgical language mapping improves net health outcomes compared with standard presurgical planning and intraoperative DCS/DES mapping; therefore, repetitive nTMS for presurgical language mapping remains investigational.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in **Table 1**.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT07415668	Motor Eloquent Navigated Transcranial Magnetic Stimulation for Radiosurgery Planning	30	Apr 2029 (recruiting)
NCT04062305	Feasibility of Navigated Transcranial Magnetic Stimulation (nTMS) of Patients Treated With Stereotactic Radiosurgery for Brain Metastases in the Motor Cortex: A Comprehensive Cross-Sectional Assessment	22	May 2027 (active, not recruiting)
Unpublished			
NCT02879682	Randomized Controlled Multicenter Trial on the Impact of Presurgical Navigated	330	Apr 2023 (completed)

NCT No.	Trial Name	Planned Enrollment	Completion Date
	Transcranial Magnetic Stimulation for Motor Mapping of Rolandic Lesions		

NCT: national clinical trial. [a] Denotes industry-sponsored or cosponsored trial.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

International Federation of Clinical Neurophysiology

The International Federation of Clinical Neurophysiology published an updated committee report on the clinical diagnostic utility of nTMS in neurologic disorders in 2023.[34] The report describes nTMS as a diagnostic and monitoring technique in neurologic disease and states that TMS can be used to perform functional mapping of eloquent brain regions during preoperative assessment before surgical resection of brain tumors. This guidance supports the clinical role of TMS as a preoperative functional mapping modality but does not provide Nexstim-specific coverage criteria or evidence-graded recommendations for motor versus language mapping.

National Comprehensive Cancer Network

The NCCN Guidelines for Central Nervous System Cancers discuss preoperative functional MRI and/or diffusion tensor imaging fiber tracking, awake craniotomy, and motor and/or speech mapping as surgical adjuncts that may facilitate safe brain tumor surgery.[35] The guidelines describe fMRI as a noninvasive pre-treatment tool for evaluating eloquent brain regions in relation to tumors, while noting limitations related to patient task performance and availability

of specialized expertise. The guidelines do not specifically address navigated transcranial magnetic stimulation for presurgical mapping.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Devices for nTMS have been cleared for marketing by the US Food and Drug Administration (FDA) for diagnostic preprocedural mapping uses under the evoked response electrical stimulator classification. In December 2009, the Nexstim eXimia Navigated Brain Stimulation System received 510(k) clearance (K091457) for noninvasive mapping of the primary motor cortex of the brain to its cortical gyrus. The device provides information that may be used in the assessment of the primary motor cortex for preprocedural planning and is not intended for use during a surgical procedure.

In May 2012, the Nexstim Navigated Brain Stimulation System 4 and Nexstim NBS System 4 with NEXSPEECH received 510(k) clearance (K112881). The NBS System 4 was cleared for noninvasive mapping of the primary motor cortex for preprocedural planning. NEXSPEECH, when used with the NBS System 4, was cleared for noninvasive localization of cortical areas that do not contain essential speech function and provides information that may be used in presurgical planning for patients undergoing brain surgery. The FDA summary states that intraoperatively, localization information provided by NEXSPEECH is intended to be verified by direct cortical stimulation and that the device is not intended for use during a surgical procedure. Although Nexstim currently markets the NBS 6 System for diagnostic presurgical mapping, no additional FDA 510(k) clearances for NBS 6 diagnostic brain-mapping indications were identified beyond the predicate clearances.

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History

Date	Comments
11/01/26	New policy, approved October 13, 2026, effective for dates of service on or after February 5, 2027, following 90-day provider notification. Add to Medicine section.

Date	Comments
	Policy created with literature review through May 29, 2026. Navigated repetitive transcranial magnetic stimulation (nTMS) of the brain using an FDA-cleared device and modality is considered investigational for preoperative motor or language mapping in individuals undergoing surgery for brain tumors or other intracranial lesions near eloquent cortex.

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